



2016

## United States Foreign Policy Toward HIV/AIDS in Africa: The Role of Pharmaceutical Companies in the Formulation and Implementation of the President's Emergency Plan for AIDS Relief (PEPFAR) 2003-2008

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LOYOLA UNIVERSITY CHICAGO

UNITED STATES FOREIGN POLICY TOWARD HIV/AIDS IN AFRICA:  
THE ROLE OF PHARMACEUTICAL COMPANIES IN THE FORMULATION AND  
IMPLEMENTATION OF THE PRESIDENT'S EMERGENCY PLAN FOR AIDS  
RELIEF (PEPFAR) 2003-2008

A DISSERTATION SUBMITTED TO  
THE FACULTY OF THE GRADUATE SCHOOL  
IN CANDIDACY FOR THE DEGREE OF  
DOCTOR OF PHILOSOPHY  
PROGRAM IN POLITICAL SCIENCE

BY

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CHICAGO, IL

MAY 2016

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## ACKNOWLEDGEMENTS

I am grateful primarily to God and to my Ancestors because throughout my entire life they have supported, encouraged, and challenged me to always strive to understand that which should matter most about our human condition. HIV/AIDS, as a matter of life and death, is such an issue. It requires undivided attention, focused knowledge, and our deepest understanding in order to produce the best policies that will help promote the dignity and welfare of all those who are vulnerable to the pandemic.

I was blessed to work with terrific scholars whose insights and rigor challenged me and benefited my work tremendously. Throughout the entire process of my research and writing, all three professors who made up my dissertation committee – Prof. Vincent Mahler, Prof. Peter Sanchez, and Prof. Peter Schraeder – contributed constructively and significantly to the final product of my research project. Prof. Vincent Mahler was very thorough in reading my drafts and proposing how to refine my ideas. While he provided me with similar cases to compare and contrast my own research, Prof. Peter Sanchez was keen to discuss the substance of my arguments and broaden my perspectives. And Prof. Schraeder, my dissertation supervisor has been the very model of mentorship. He simply embodies what it means to be an educator; that is, a guide and leader who seeks to produce the best out of you. Selfless, insightful, challenging, such guidance, undivided attention, encouragements, and support led me through the writing process. To all three professors who saw me through moments of self-doubt in the process of completing the writing, I owe an inestimable debt of gratitude.

Of course, I would not have come to this program in the first place without the financial support that my Order secured for me. To the Society of Jesus and to all my fellow Jesuit brothers both in my Central Africa Province (ACE) and in the Chicago-Detroit Province (CDT), to the US Jesuit Conference, and to my Loyola University Chicago Jesuit community, I say a deep thank you. In a special way, I would like to acknowledge here that my religious superiors took the time and the trouble to travel long distances every year – from the Democratic Republic of the Congo to Chicago – to bring me the needed “cura personalis.” Although naming names incurs the danger of forgetting some very important people, I will mention a few of the other Jesuits who were instrumental in the completion of my work. These include Brian Paulson and Jim Hayes, Kevin Flaherty; Si Smith, Tom Worcester, Bob Birely and all the Jesuit Scholastics with whom I shared the community life at Gonzaga.

I am particularly grateful for the blessing that my family has always been to me. My father Heliodore Kafarhire and my mother Alice Bazalake and all my siblings have simply given me what any human being expects from his own: love, trust, and support. My late Aunt Dr. Pelagie Selemani is not here to celebrate the joy of my crossing the finish line but my gratitude will find its way to wherever she is. My faith has expanded during my studies in Chicago to see beyond what I believed during my childhood. And while this wonderful yet adventitious family was too far away, unable to soothe my Chicago winters’ anguishes, God gave me another family: Stacy Fifer and John Conour and their daughters. I am equally grateful to my brother Tom and his wife Cher; and to

my other American family Terry Johnson and Lunell Anderson whose families I consider my own.

I cannot fail to mention the friendship of my many other friends. I count you all among my Chicago blessings. They helped dampen the scourges of the doctoral studies nightmares and the “dépaysement” of living in a different culture. I won’t be able to name them all. Yet, they all contributed to my growth process while my doctoral studies lasted. I think particularly of Emmanuel Bueya, Charlotte Stroumza, and Bemnet Yigzaw to whom I owe them a huge debt of memory. Last but not least, my special gratitude goes to Fr. Jerry Overbeck (Pono), a man I will live to always love and respect. He taught me the wisdom of patience, authenticity, and the mantra from Helen Steiner Rice’s verses that “This Too Shall Pass!”

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## LIST OF ABBREVIATIONS

ABC	Abstinence, Be faithful, and use Condoms
ACT-UP	AIDS Coalition to Unleash Power
AGOA	African Growth and Opportunity Act
AIDS	Acquired Immune Deficiency Syndrome
AmFAR	American Foundation for AIDS Research
ANDA	Abbreviated New Drug Application
ARV	Antiretroviral
AZT	Azidothymidine, also Zidovudine
CBC	Congressional Black Caucus
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CESA	Chicago Committee to End Sterilization Abuse
CFR	Council on Foreign Relations
CIA	Central Intelligence Agency
CID	Center for Infectious Diseases
DATA	Debt, AIDS, Trade, Africa
DoD	Department of Defense
DSB	Dispute Settlement Body of the World Trade Organization
FDA	Food and Drug Administration
FTC	Federal Trade Commission

GAO	US Government Accountability Office
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GM	General Motors
GMHC	Gay Men Health Crisis
GRID	Gay-Related Immunodeficiency Disease
HAART	Highly Active Antiretroviral Therapy
HHS	Health and Human Services
HIV/AIDS	Human Immunodeficiency Virus (HIV) TRIPS
IAC	International AIDS Conference
IDUs	Injecting Drug Users
IFIs	International Financial Institutions
IPI	International Intellectual Property Institute
IOM	Institute of Medicine
IOs	International Organizations
LIFE	Leadership and Investment in Fighting an Epidemic
MAP	World Bank Multi-Country HIV/AIDS Program
MMWR	Morbidity and Mortality Weekly Report
MNCs	Multinational Corporations
MRSCA	South African Medicines and Related Substances Control Act of 1997
MSF	Médecins Sans Frontières
NARA	National Archives and Records Administration
NCDDG	National Cooperative Drug Development Grant
NCI	National Cancer Institute

NIH	National Institutes of Health
NIC	National Intelligence Council
NSC	National Security Council
NGOs	Nongovernmental Organizations
ODA	Overseas Development Assistance
OFBCI	The White House Office of Faith-Based and Community Initiative
OGAC	Office of Global AIDS Coordinator
ONAP	Office of National HIV/AIDS Policy at the White House
OVCs	Orphans and Vulnerable Children
PACHA	Presidential Advisory Council on HIV/AIDS
PDD	Presidential Decision Directives
PDM	Prescription Drug Marketing Act of 1987
PEPFAR	The President's Emergency Plan for HIV/AIDS Relief
PHS	Public Health Service
PhRMA	Pharmaceutical Research and Manufacturers of America
PLWAs	People Living With AIDS
PSAs	Public Service Announcements
R&D	Research and Development
SAPs	Structural Adjustment Programs
SSA	Sub-Saharan Africa
UCSF	University of California at San Francisco
UN	United Nations
UNAIDS	UN Joint Programme on HIV/AIDS

UNICEF	UN Children’s Fund
UNDP	UN Development Program
UNESCO	UN Scientific, Education, and Cultural Organization
UNFPA	UN Population Fund
UNGA	UN General Assembly
UNSC	UN Security Council
USAID	US Agency of International Development
USPTO	US Patent and Trademark Office
USTR	The US Trade Representative
TAC	Treatment Action Campaign
TASO	The AIDS Service Organization
WHO	World Health Organization
WTO	World Trade Organization

## ABSTRACT

During his 2003 State of the Union Address, President Bush announced his Emergency Plan for AIDS Relief (PEPFAR) and asked Congress, over the next five years, to authorize the appropriation of \$15 billion to provide treatment, prevention and care to people infected and affected by HIV/AIDS, mostly in Sub-Saharan Africa. Given the existing pattern of neglect and indifference in U.S.-Africa relations and the Bush campaign's statement in 2000 dismissing Africa from his foreign policy priorities, what then justifies his administration's undertaking of this massive foreign policy change? My dissertation offers insight into the role played by private US pharmaceutical companies in continuity and change in US HIV/AIDS foreign policy toward Africa. As global nonstate actors, these institutions were instrumental in shaping the perception about neoliberal international norms in the practice of the global public health welfare provision. PEPFAR represents a stark contrast to the Clinton Executive Order 13155 that attempted to reinstate the now defunct welfare state model and offers the conservative alternative that establishes the market monopoly over social issues. As a result, the provision of extraordinary resources to fight HIV/AIDS in resource-constrained countries, mostly in Africa, blocked the possibility of implementing two provisos in the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement, namely, the compulsory licensing and the parallel importation. By the same token, it allowed the

Bush administration to counter the claim of African governments to sovereignly regulate the antiretroviral patented HIV/AIDS drugs in the global market. In fact, the compulsory licensing and the parallel importation provisos received support at the national level from the Clinton administration through President Clinton's Executive Order 13155 in May 2000 marking a radical US HIV/AIDS policy change and, at the international level, through the 2001 Doha Declaration on the TRIPS Agreement and Public Health.

This qualitative case study uses process-tracing methods to uncover the implementation of a privatization agenda in US foreign policy toward Africa. Data for analysis are essentially collected from a thorough examination of primary documents, including presidential speeches, memos, directives, executive orders, and Congressional hearings. Secondly, the literature and secondary documents are reviewed and analyzed, most being reports from governmental agencies and non-governmental organizations. To supplement this process, in-depth interviews were conducted with key policy officials, corporate lobbyists, and human rights activists. The findings are compared with and contrasted to the case of US foreign policy toward HIV/AIDS in Uganda, one key US partner in Africa among other PEPFAR focus countries.

Key words: US foreign policy, HIV/AIDS, public health crisis, welfare provision, compassionate conservatism, privatization

## CHAPTER ONE: HIV/AIDS IN AFRICA AND US FOREIGN POLICY

### **Introduction**

President George W. Bush surprised his audience and the rest of the world during his State of the Union Address on January 28, 2003 when he announced the creation of the President's Emergency Plan for AIDS Relief (PEPFAR) to help African HIV/AIDS patients access the drug market. He requested that the US Congress authorize an unprecedented \$15 billion that would be spent in the next five years to help African countries tackle the HIV/AIDS public health pandemic (Lyman and Morrison 2006). As he put it, "I ask the Congress to commit \$15 billion over the next five years, including nearly \$10 billion in new money, to turn the tide against AIDS in the most afflicted nations of Africa and the Caribbean." Of that money, the administration hoped to spend \$4 billion on bilateral programs in HIV/AIDS research and tuberculosis (TB) projects in 100 non-focus countries; \$1 billion would contribute to the multilateral Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), and the remaining \$10 billion were allocated to 15 focus countries of which 12 are found in Africa.<sup>1</sup> This initiative, which was fully funded that year by the US Congress, has emerged as one of the most popular

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<sup>1</sup> White House Fact Sheet, "The President's Emergency Plan for AIDS Relief," at <http://www.whitehouse.gov/news/releases/2003/01/20030129-1.html> (accessed January 15, 2013).



and widely acclaimed foreign policy legacies of the controversial Bush presidency (Stein 2008; Moss 2009; Hindman and Schroedel 2011; Thomas 2001; Sachs 2005).

Scholars and policy analysts were nonetheless surprised by the Bush administration's launching of PEPFAR. At the onset of Bush's presidency, they had predicted the further marginalization of Africa in US foreign policy given the realist tendencies of the Bush White House inner circle. As one scholar surmised, "It is highly unlikely that a Bush White House will undertake high-level public relations initiatives, such as the 1994 White House Conference on Africa or a presidential visit to the continent," in spite of Clinton's historic trips to Africa in 1998 and 2000 that heralded rising US interests in that continent (Schraeder 2001:390). In fact, the Bush campaign team during the 2000 presidential election had ridiculed the Clinton administration's humanitarian foreign policy toward Africa (Dumbuya 2009:1).

Indeed, during a presidential debate with Democratic candidate Al Gore at Wake Forest University in North Carolina on October 11, 2000, then Texas Governor George W. Bush established a hierarchy of regional foreign policy priorities should he be elected the next American presidency. In his words,

Africa's important (...) but there's got to be priorities. And the Middle East is a priority for a lot of reasons as is Europe and the Far East, and our own hemisphere. Those are my four top priorities should I be the president. It's not to say we won't be engaged [in Africa], and working hard to get other nations to come together to prevent atrocity [like in Rwanda] (...). But we can't be all things to all people in the world. I am worried about over-committing our military around the world. I want to be judicious in its use. I don't think nation-building missions are worthwhile. For him, Africa did not "fit into the national strategic interests, as far as I (Bush) can see them" and therefore would not figure among his foreign policy priorities (quoted in Schraeder 2011:308). Moreover, throughout the 1990s, after the Cold War was over, most Republicans in Congress advocated for a reduction in US foreign aid to Africa, if not its total suppression,

given the absence of Cold War geopolitical “strategic interests.” This administration’s decision to increase foreign assistance to Africa is rather perplexing, especially in the aftermath of the 9/11 terrorist attacks, the 2002 economic recession, and most importantly, the ongoing war on terror in Afghanistan and the impending invasion of Iraq.

The purpose of this dissertation is to explain President Bush’s surprising foreign policy move and to make sense of his administration’s HIV/AIDS foreign policy toward Africa. To answer this foreign policy puzzle, this dissertation argues that the Bush administration chose to pursue an aggressive neoliberal agenda that gave priority to private businesses and nongovernmental organizations in implementing the president’s social welfare policies. Existing theories explaining the creation of PEPFAR followed a contingent or contextual expediency perspective such as the personal beliefs of the president, the bureaucratic constraints of policy-making, or the competition of interests in domestic politics. Such explanations are ancillary to the grand scheme of advancing public welfare through a market model of production and distribution of social goods. As a result, this dissertation propounds that neoliberalism, a powerful driving force in US foreign policy since the 1970s, can better explain the origins of President Bush’s policy preferences and the creation of PEPFAR. This theory also illuminates the important, powerful role that private US pharmaceutical companies have played in continuity and change in US HIV/AIDS foreign policy toward Africa. They contributed to the development of the official US response to the HIV/AIDS global public health crisis, shaping the timing and content of PEPFAR policy.

The remainder of this chapter proceeds in five parts. The first part provides a brief overview of the HIV/AIDS pandemic in context, with part two providing a general overview of the PEPFAR initiative as a US response to this global health crisis. The third part describes the context surrounding the Bush administration’s decision to create this

global public health policy. Part four outlines the research questions and underscores the study's rationale. A final section provides a brief overview of the remaining chapters.

### **Understanding the Context of the HIV/AIDS Pandemic**

Human Immunodeficiency Virus, or HIV, is the pathogen agent that causes Acquired Immune Deficiency Syndrome (AIDS). It attacks and weakens the immune system to the point of annihilating its capacity to resist other infections. AIDS, on the other hand, represents the last stage of HIV infection, depleting the immune system to the extent that the body can no longer defend itself against opportunistic diseases (Congressional Research Service, February 22, 2011).

In the mere 20 years since it was first discovered in the United States in 1981, HIV/AIDS had achieved a pandemic status. That is, it no longer affected a specific country or region, but the entire world. By the end of 2002, an estimated 42 million individuals were infected by and lived with HIV/AIDS around the world of whom more than 75 percent lived in Africa and the Caribbean (H.R. 1298, Sec. 2, §3 (A)). The United Nations Security Council (UNSC) listed it in 2000 as the number one killer in Africa, killing 10 times more people than all the armed conflicts in the continent since its initial eruption. As the United Nations (UN) Secretary General noted, “[b]etween 1999 and 2000 more people died of AIDS in Africa than in all the wars on the continent. [And] the spread of AIDS in Africa most likely outpaced the spread in any other region in the world. Although the average HIV prevalence rate among adult population (15-49 years) in almost all African countries exceeds 2 percent, it is more than 5 percent in 21 countries” (quoted in Stillwaggon 2006:4).

As far as public health is concerned, HIV/AIDS constitutes the most difficult health problem confronting sub-Saharan Africa, with the exception of malaria. Africa, with an HIV/AIDS infection rate at 8.8 percent (see Table 1), came to be seen as the epicenter of the pandemic.<sup>2</sup> Fisher and Rigamonti (2005:2) remark that as of December 2003,

[M]ore than twenty million people worldwide had died from AIDS [...]. There was an almost exponential growth of the epidemic in the early 1990s, particularly in Africa, which accounts for two-thirds of the people living with HIV/AIDS, while comprising only about eleven percent of the world's population.

On July 20, 2000, a UNAIDS Press Release stated that the pandemic had reversed the social, economic, and political development of the past three decades. HIV/AIDS was aggressively eating up the development achievements and jeopardized the continent's future. As Former UN Secretary General Special Envoy for HIV/AIDS in Africa Lewis (2006:45) warned, “[E]very goal [among the Millennium Development Goals] is put in jeopardy by AIDS.” And Dixon, McDonald, and Roberts (2001:383) note, “despite the very large number of premature deaths from AIDS in recent years, it is only recently that estimates of life expectancy have begun to decline. For some countries in the AIDS-belt estimates are suggesting that life expectancy is now less than 40 years” (US Bureau of Census, 1998). As a matter of fact, HIV/AIDS has reduced life expectancy in many African countries to an average of 46.7 years, and in some countries, to lower than 40 years. “Without AIDS, life expectancy in the year 2010 in Zimbabwe would be 70 years,

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<sup>2</sup> Prevalence measures the number or rate of the sexually active adult population aged between 15 and 49 years that are living with HIV infection in a specified time period. While Africa represented eight times higher that of the rest of the world at 1.1 percent, the prevalence rates distribution represented 2.3 percent in the Caribbean, 0.2 percent in North Africa and the Middle East, South and Southeast Asia represented 0.56 percent, and 0.6 percent were in North America (UNAIDS 2003).

in Botswana 66 years, and in Zambia 60 years” (Worldwatch Issue Alert of October 31, 2000 quoted by IPI 2000:5).<sup>3</sup>

Table 1. Regional HIV/AIDS Statistics and Features (End of 2000)

	Adults & children living with HIV/AIDS	Adults & children newly infected with HIV	Adult prevalence rate*	% of HIV-positive adults who are women	Main mode(s) of transmission for those living with HIV/AIDS**
Sub-Saharan Africa	25.3 million	3.8 million	8.8%	55%	Hetero
North Africa & Middle East	400,000	80,000	0.2%	40%	Hetero, IDU
South and South-East Asia	5.8 million	780,000	0.56%	35%	Hetero, IDU
East Asia & Pacific	640,000	130,000	0.07%	13%	IDU, Hetero, MSM
Latin America	1.4 million	150,000	0.5 %	25%	MSM, IDU, Hetero
Caribbean	390,000	60,000	2.3%	35%	Hetero, MSM
Eastern Europe & Central Asia	700,000	250,000	0.35%	25%	IDU
Western Europe	540,000	30,000	0.24%	25%	MSM, IDU
North America	920,000	45,000	0.6%	20%	MSM, IDU, Hetero
Australia & New Zealand	15,000	500	0.13%	10%	MSM
TOTAL	36.1 million	5.3 million	1.1%	47%	

(\*) The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 2000, using 2000 population numbers; (\*\*) Hetero (heterosexual transmission), IDU (transmission through injecting drug use), MSM (sexual transmission among men who have sex with men)

(Source: Adapted from UNAIDS report, 2000).

<sup>3</sup> UNAIDS Press Release on July 20, 2000. “UNAIDS Calls on G8 for Massive Increase in Resources to Fight AIDS,” available at <http://www.thebody.com/content/art661.html>. Last consultation January 4, 2015.

HIV/AIDS affects people in their prime. Those who would normally be working to support their families or serve their nations are diminished in their capacity to work to the extent that they become dependent on their families and incur expenses that they cannot sustain. In fact, the impacts of HIV/AIDS and related diseases on human security, socioeconomic development, and state capabilities cannot be overstated. It endangers national economic security. As one scholar remarks, the consequences of the epidemic, predicted since the early 1990s, are “now being seen in falling life expectancies, increasing numbers of orphans, and terrible tolls on households, learning, teaching, health systems, agriculture and business sectors across the board” (Dietrich 2005:271). The HIV/AIDS pandemic has come to represent one of the greatest moral, social, political, economic, and scientific challenges of our time. As such, the HIV/AIDS pandemic is seen as one of the most serious threats to global collective security and economic development, as well as to human rights in Africa (De Cock et al. 2002; De Waal 2003a).

Perceiving the urgency of the HIV/AIDS global situation to demand immediate action, the United Nations Secretary General Kofi Annan challenged the international community in the face of the threat posed by the HIV/AIDS pandemic to end the conspiracy of silence, stigma and shame and work to terminate this epidemic's onslaught. In July 2001, he proposed the creation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFTAM), a multilateral initiative launched in January 2002 to circumvent UN bureaucratic sluggishness. In addition, the international community included among the Millennium Development Goals (MDGs) the halting and reversing of the spread of HIV/AIDS among the eight MDGs.

## **Overview of the PEPFAR Initiative**

Against the above international backdrop, President Bush announced the PEPFAR initiative in his January 2003 State of the Union Address. Four months later on May 27, 2003, he signed into law Public Law 108-25, “The United States Leadership against HIV/AIDS, Tuberculosis, and Malaria Act of 2003.” PEPFAR initially was a five-year bilateral initiative of the US government, committed to scaling up programs for treatment, prevention, and care of HIV/AIDS patients, mostly in Africa (Bush 2003a). From the moment of its authorization, PEPFAR has come to be regarded as a bold foreign policy move on the part of the US government. Its goals are to increase access to antiretroviral treatment for 2 million people, to prevent 7 million new HIV infections, and to provide care to 10 million people among those infected or affected by HIV/AIDS (also summarized as the “2-7-10” goals). When authorizing the appropriation of \$15 billion for fiscal years 2004-2008, Congress required the executive to (a) establish the Office of the Global AIDS Coordinator (OGAC) in the State Department, (b) develop a comprehensive integrated 5-year strategy for a coordinated US government response to the global HIV/AIDS crisis, (c) emend the Foreign Assistance Act of 1961 to define eligibility for US HIV/AIDS assistance, and (d) develop mandated goals, benchmarks, and metrics for program evaluation.

The OGAC was effectively established in the State Department as an ambassador-level position. President Bush appointed Randy Tobias, former CEO of the US private pharmaceutical company Eli Lilly & Co., to be the first PEPFAR Ambassador (2004-2006). Ambassador Mark Dybul succeeded Tobias (2006-2009). While the PEPFAR Global Coordinator reports directly to the Secretary of State, his office is comprised of a

small permanent staff that receives technical expertise and support from implementing agencies of the federal US government. The OGAC provides evaluation of progress made by PEPFAR programs and monitors results in the fight against HIV/AIDS. The OGAC's roles are threefold: (a) the coordination of and collaboration among different US federal agencies involved in the implementation of HIV/AIDS activities for achieving the "2-7-20" goals in focus countries; (b) the oversight of the funding supply chain from the US government to the implementing agencies of partner nations; and (c) bilateral partnership with host countries in order to harmonize national policies with US strategy to combat the HIV/AIDS pandemic.

PEPFAR was conceptualized as a comprehensive, integrated five-year strategy to harmonize US global policy to combat HIV/AIDS. Ambassador Tobias developed and introduced his 5-year strategy to Congress on February 23, 2004, or "9 months after the act had been signed into law. [This comprehensive plan] stressed that the strategy should be viewed as a work in progress, something that could change in response to changes in the HIV/AIDS pandemic and the knowledge and tools available" (IOM 2007:67-68). It focused on four principles including a rapid expansion of services, identification of new partners and building capacity for sustainable and effective responses to HIV/AIDS, bold leadership and sound policy environment for combating HIV/AIDS and mitigating its consequences, and implementing a strong information system that would foster best practices. Also, his message underscored the collaboration and cooperation among a wide range of partners. This approach assigned priorities for allocating resources to relevant agencies of the executive branch, which included the Departments of State, Defense,



Commerce, Labor, Health and Human Services, and especially the Centers for Disease Control and Prevention, National Institutes of Health, US Food and Drug Administration, USAID, and Peace Corps.

PEPFAR also amends parts of the Foreign Assistance Act of 1961 to define eligibility and formulas for US HIV/AIDS assistance. Accordingly, the President should provide an appropriate level of assistance through nongovernmental and faith-based organizations in countries in Sub-Saharan Africa, the Caribbean, and other developing countries in areas affected by the HIV/AIDS pandemic. Although the US had supported multilateral efforts through the Global Fund to Fight AIDS, Tuberculosis, and Malaria, PEPFAR favored a strategic bilateral approach that emphasized a rapid scale-up and rollout of interventions in a limited number of countries. Yet, the “2-7-10” treatment, prevention, and care goals of PEPFAR reflected the contemporary World Health Organization (WHO)’s “3 by 5” program that aimed to distribute antiretroviral (ARV) treatment to 3 million people in 50 developing countries by the end of 2005.

Deeming that focus should be put on delivering measurable results, the choice and strategy of the Bush administration sought to concentrate efforts on 15 specific focus countries, which collectively were estimated to concentrate and account for more than half of all global HIV infections (Ingram 2010:610). Twelve of these countries are located in Africa and included Botswana, Cote d’Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda and Zambia; two others are found in the Caribbean: Haiti and Guyana; and one added a year later – Vietnam – is located in Asia (IOM 2007:4). It was also PEPFAR’s ambition to achieve the following: to provide ARV treatment to 2 million people in the next five years, a significant increase

from the 50,000 who could afford the expensive treatment in the early 2000s; to prevent 7 million new infections, given the rate of up to 2.5 million yearly occurrence of new infections; and to provide care for 10 million patients from AIDS and those directly affected by the pandemic, including orphans and vulnerable children.<sup>4</sup>

As for developing mandated goals, benchmarks, and measurable results, in September 2008, OGAC announced that PEPFAR's "2-7-10" goals had been met. Observers contend, however, that monitoring and evaluation of PEPFAR results can be contentious due to the overlap of PEPFAR with other programs such as the Global Fund, WHO, the World Bank MAP, and other donors and host country initiatives, given that they all seek credit for successes with their stakeholders (Fischer et al. 2009). The actual disbursement on global HIV/AIDS programs for the next five fiscal years (2004-2008) exceeded the requested \$15 billion to reach a total of \$18.1 billion (Salaam-Blyther 2012) (see Table 2). Most of the money was provided through governmental agencies such as USAID, CDC, or the Department of Defense. First, to scale up the treatment of 2 million people, 55% of the total budget was apportioned for the therapeutic medical care of individuals infected with HIV. Of this amount, three-quarters was allocated for the purchase and distribution of antiretroviral (ARV) pharmaceuticals while the rest of the amount was spent on related care. Second, Congress earmarked another 20% of PEPFAR's total budget for prevention programs.

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<sup>4</sup> US Leadership Against AIDS, Tuberculosis and Malaria Act of 2003 (Public Law 108-25). [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108\\_cong\\_public\\_laws&docid=f:pub1025.108.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_public_laws&docid=f:pub1025.108.pdf); See also Jennifer Kates, José-Antonio Izazola, and Eric Lief, *Financing the response to AIDS in low- and middle-income countries: International assistance from the G8, European Commission and other donor Governments, 2007*. Washington DC: Kaiser Family Foundation, 2008. [http://www.kff.org/hivaids/upload/7347\\_04-2.pdf](http://www.kff.org/hivaids/upload/7347_04-2.pdf).

Table 2. Global HIV/AIDS Requests and Funding FY2004-2008 (Current US\$ Millions)

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual
Bilateral request	1,835.0	2,095.0	2,729.0	3,642.0	4,958.5
Actual funding	1,643.0	2,263.4	2,653.7	3,699.2	4,958.5
Global Fund request	200.0	200.0	300.0	300.0	300.0
Global Fund actual fund	546.6	347.2	544.5	724.0	840.3
Total Request	2,035.0	2,295.0	3,029.0	3,942.0	5,258.5
Total Fund	2,189.6	2,610.6	3,198.2	4,423.2	5,868.1

Besides funding programs aimed at preventing 7 million new infections, at least one-third of the budget was reserved for education programs on abstinence-until-marriage. Third, of the remaining 25%, Congress required that 15% be spent on palliative care of 10 million individuals with HIV/AIDS, while the remaining 10% went to assist orphans and vulnerable children (OVCs) affected by HIV/AIDS. Yet, half the money designated for OVCs was to be distributed through non-profit, nongovernmental organizations, including faith-based organizations implementing programs at the community level (IOM 2007:67).

To this day, the PEPFAR initiative represents the US global health response and commitment in addressing the HIV/AIDS pandemic. It is regarded as the largest global health initiative in history initiated by one nation to address a single disease; the “largest commitment by any nation to combat a single disease in human history” (White House 2007); or simply “the greatest global health commitment in history” (Frist, 2008) (OGAC

2005:11; Ingram 2010:613). Indeed, “[t]he US commitment to PEPFAR underpinned a dramatic increase in international assistance for the response to HIV/AIDS in low and middle-income countries from 2002-2007” (Fischer et al. 2009:16). The policy provoked different reactions, both hopeful and suspicious, among observers of US foreign policy toward Africa. By expanding the US HIV/AIDS global policy efforts and by dedicating unprecedented levels of resources to treatment and care of HIV-infected people, the PEPFAR initiative sought to overcome the established prevention strategy that dominated the US HIV/AIDS global policy prior to the Bush administration. While the policy dramatically expanded resources to meet the various aspects –economic, social, and ethical – of the challenges posed by the HIV/AIDS pandemic, “activist groups [hoped this US response would] be a stepping stone to a larger and more equi global health agenda (MSF, 2009; Ooms et al., 2008),” as Ingram (2010:607) puts it.

### **Context of the Bush Administration’s Decision to Launch PEPFAR**

It is a well-established assumption among Africanist scholars that Africa is a backwater in official US foreign policy-making circles, since it represents little strategic significance to US foreign policy. US foreign policy toward Africa is characterized by neglect and indifference and this region has remained one of least concern within the global foreign policy hierarchy despite old ties reaching as far back as 1789. As US presidents and the Congress traditionally have devoted less attention to Africa, most of US foreign policy initiatives are delegated to bureaucrats and political appointees, an attitude reinforced by the perception that Africa falls primarily under the responsibility of Europe due to its colonial ties and other historical reasons (Clough 1992; Schraeder 1994).

Until the onset of the Cold War, the US government pursued a “hands off” foreign policy approach toward Africa. Only the redefinition of vital interests in terms of containing communism’s spread wherever it appeared after the Second World War and concerns about newly independent African states’ vulnerability to communism in the early 1960s led the US to monitor situations and intervene on the continent, using both South Africa and Zaire as proxy outposts (Schraeder 1994; Skinner 1998; Rothchild and Keller 2006; Keller 2006). The end of the Cold War in the early 1990s resulted in “a certain degree of US retrenchment from the African continent from 1989 to 2001,” subsequently bringing the continent back into the traditional realm of policy neglect and bureaucratic routine (Schraeder 2011:302-303). Behrman (2004:71) summarizes this in the following statement,

As the iron curtain lifted, ushering in the new post-Cold War era, Africa seemed to lose [even] its geostrategic relevance. It was deemed a poor continent in which the United States had no major economic partners. It represented a small export market. There were major military flashpoints that threatened to spill over into other regions. There were no nuclear weapons on the continent. No Southern African country presented a particular military threat – to U.S. interests, at any rate. There was no major domestic constituency driving U.S. engagement in the continent.

Throughout the 1980s and 1990s, the US HIV/AIDS official policy attitude toward Africa remained lukewarm as focus was mostly put on the disease’s domestic aspect. However, HIV/AIDS gained a new salience in policy-making circles in 2000, a year which achieved symbolic status both in US domestic politics, owing to the presidential election to be held in November of the same year, and in international politics, because of a global movement focusing on Africa and demanding a reassessment of development policies. The disease was strongly associated with the condition of poverty and solutions revolving around debt cancellation, increases in foreign aid, and the promotion of free

trade, which also began to be linked to the issue of public health and HIV/AIDS. As a matter of fact, HIV/AIDS did not just become a foreign policy priority issue overnight. The conditions were ripe for the pandemic to acquire a greater international significance given the human, social, economic, and political consequences it entailed. Fukuyama (2012:53) argues that whilst “social forces and conditions do not simply ‘determine’ ideologies, as Karl Marx once maintained... ideas do not become powerful unless they speak to the concerns of large numbers of ordinary people.” For many policy analysts, HIV/AIDS was identified as the culprit sabotaging international development efforts (Lewis 2006:17; Sachs 2005:188).

Most developing countries and human rights organizations accused the US government of choosing to protect the commercial interests of US pharmaceutical companies rather than urging the poor’s human right to life in developing countries. In fact, at the heart of the HIV/AIDS global crisis was the issue of prohibitive costs of antiretroviral (ARV) drugs that had created a discrepancy in access to treatment between patients living in wealthy developed countries and those living in resource-constrained countries. Aware of the salience that the HIV/AIDS crisis had acquired in domestic and global politics and experiencing increasing pressure on his administration, President Clinton reversed his policy supporting US pharmaceutical companies. In a presidential election year, he issued Executive Order 13155 on May 10, 2000, a policy change that was monumental, although never implemented because of the change in administration. This new policy urged African governments to enact responsible public health policies for their citizens – even if that meant overriding the Trade Related Aspects of Intellectual Property Rights (TRIPS) Agreement.

In the international community, the year 2000 was also meaningful in that it prompted assessments of Western development policies toward Africa, in an attempt to explain the HIV/AIDS global crisis. Many international organizations, including the United Nations (UN) Security Council (UNSC) and the UN General Assembly (UNGA), the World Bank, UNAIDS, and WHO and its 2000 Commission on Macroeconomic and Health, produced an impressive body of literature relating HIV/AIDS to human security, the human rights, and global security.<sup>5</sup> They identified HIV/AIDS among the culprits that sabotaged international development efforts (Lewis 2006:17; Sachs 2005:188). Shortly after the July 2000 13th International AIDS Conference in Durban, South Africa, the UNSC passed Resolution 1308 expressing deep concerns about the HIV/AIDS pandemic and calling for action to curb the threat posed to the world's security by the illness (Dietrich 2007:281).

### **Research Questions and Rationale of the Study**

Given the history of US HIV/AIDS foreign policy during the 1980s and 1990s, the traditional neglect of Africa in US foreign policy, and the Republicans' decade-long battle in Congress to shrink – or abolish altogether – the foreign assistance programs, (now that the Cold War's strategic interest in such projects was waning during the 1990s), and finally, the context of the 2002 economic recession following the 9/11 terrorist attacks, the creation of PEPFAR and the magnitude of its foreign aid increase

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<sup>5</sup> National Intelligence Council, "The Global Infectious Disease Threat and Its Implications for the United States" (2000), available at <http://www.wilsoncenter.org/sites/default/files/Report6-3.pdf> (last visited Oct. 22, 2014); PACHA, *No Time To Spare*, September 2000; Médecins Sans Frontières, "Statement by MSF on TRIPS and Affordable Medicines," at <http://www.msfacecess.org/about-us/media-room/press-releases/statement-m%C3%A9decins-sans-fronti%C3%A8res-msf-trips-and-affordable-0>; (last view Oct. 22, 2014); International Crisis Group, *HIV/AIDS as a Security Threat* (2001), available at <http://www.crisisgroup.org/~media/Files/africa/HIVAIDS%20as%20a%20Security%20Issue.pdf>

encountered disbelief. Existing patterns of neglect and indifference in US foreign policy toward Africa, the traumas of the terrorist attacks in September 2001, the ongoing war in Afghanistan and the impending war in Iraq, and the global economic outlook in the beginning of the new Millennium, were all factors that led observers of US Africa foreign policy to expect less from the Bush realist administration.

The creation of PEPFAR remains puzzling for the above reasons alone, not to mention the nature of American domestic politics wherein policy-makers reveal profound differences in regards to the very goals, values, and frameworks from which they interpret and make political decisions. Since, after all, one of the main features of US policy-making is competition for power between the executive and the legislative branches of the government, and the conflict of interests existing between Democrats and Republicans in Congress, the bipartisan support that PEPFAR received is rather unconventional (Hill 2003; Russell 2004; Dietrich 2005). All of the above only buttresses the extreme surprise and bewilderment caused by the Bush administration's creation of a foreign policy that focuses attention and resources on a region of little strategic interest.

Hence, this exponential increase of foreign assistance to meet the challenges of the HIV/AIDS public health in Africa requires further explanation. Especially, given the complexity of the HIV/AIDS phenomenon in Africa and the challenges it poses to the global public health apparatus – the political, epistemological, and ethical dimensions pertaining to the HIV/AIDS debate in the international system – the Bush administration's foreign policy innovation with regard to HIV/AIDS requires further understanding. This dissertation seeks to provide that explanation.



This dissertation analyzes the power and influence of the private sector, namely, the US private pharmaceutical companies, in the development, continuity and change of the US HIV/AIDS foreign policy toward Africa. To do so, it aims at answering the following questions:

- (1) What might best explain the creation of PEPFAR in 2003 in contradiction to the US's traditional neglect of Africa, a continent ranking low in terms of US foreign policy priorities?
- (2) Given the emergencies of the moment in the context of post-9/11 terrorist attacks, the 2002 economic recession, and especially the build up to the war in Iraq, which required parsimonious use of public resources, what justifies this astronomical increase of US foreign aid to deal with HIV/AIDS global public health crisis, especially as the US's foreign policy priority in Africa?
- (3) And finally, why did Congress lend bipartisan support to this policy initiative favoring Africa?

President Bush gives the rationale for requesting these funds. As he explained during his speech, AIDS can be prevented thanks to antiretroviral (ARV) drugs availability. Even the lives of HIV/AIDS patients in resource-constrained countries can be extended for many years if they have access to ARV treatment. HIV/AIDS patients in poor countries in Africa with limited access to treatment should also benefit from these life-saving drugs because generic versions have allowed the cost to be lowered. As the president put it in his speech,

[...] the cost of those drugs has dropped from \$12,000 a year to under \$300 a year, which places a tremendous possibility within our grasp.” Yet, “on the continent of Africa, nearly 30 million people have the AIDS virus, including 3 million children under the age of 15. There are whole countries in Africa where more than one-third of the adult population carries the infection. More than 4 million require immediate drug treatment. Yet across that continent, only 50,000 AIDS victims – only 50,000 – are receiving the medicine they need (...). [T]o 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*. This comprehensive plan will prevent 7 million new AIDS infections, treat at least 2 million people with life-extending drugs and provide

humane care for millions of people suffering from AIDS and for children orphaned by AIDS. (Bush 2003, emphasis added).

It is important to note, however, that the change in US HIV/AIDS foreign policy toward Africa in 2003 was an ad hoc policy, contingent both on US domestic politics and international pressures. Many in the US policy-making establishment continued to claim, for instance, that the HIV/AIDS pandemic was only one expression of many African problems. For African governments supported by international nongovernmental organizations (NGOs), the HIV/AIDS global health crisis stemmed from the impacts of Western distorted trade policies, that is, from the monopolistic pricing of US patented antiretroviral (ARV) drugs on the global market. While the former sought protection of the patent regime, which they claimed constituted the lifeblood for R&D-based pharmaceutical industry's investment, innovation and economic profitability, the latter pressured for change in US HIV/AIDS and trade policies to allow the developing countries greater access to medical treatment.

This dissertation has both theoretical and practical policy relevance. It will add to existing literature on continuity and change in post-Cold War US Africa foreign policy by refuting the assumption that US foreign policy neglect and indifference towards Africa result from a lack of strategic stakes, and that the presence or absence of a rival contender or a threat to "perceived US interest" determines US policy behavior toward Africa. This work will also make a methodological contribution in assuming that processes in foreign policy decision-making do not evolve in the formal logic of predictability since the interpretation of the situation is bounded and in dependence on the nature of the interest involved. That is, policy issues are best solved by a sequence of structured individual existential initiatives in response to different situations like the process illustrated in the

common dialogical strategy of a player solving a crossword puzzle or playing a game of chess against a rival, not by logical moves (Heelan 2004). Hence, it becomes crucial to identify the causal mechanisms that explain specific policies developments, but also to make bounded theoretical generalizations.

Finally, the practical policy relevance of this work is tied to prominent debates around Africa's poverty, the social welfare infrastructure, political leadership, and moral and cultural values. It proposes a reevaluation of the role that both state and non-state actors should play in providing for the public good, especially when confronted by humanitarian challenges like HIV/AIDS and poverty in Africa. In fact, at the beginning of the new millennium, the HIV/AIDS global crisis posed a collective action dilemma. Given the waning capabilities of national governments in the post-Cold War environment, let alone the failed state in Africa and the private sector vying for more power and autonomy (Rothkopf 2012; Rosenberg 2005; Collier and Collier 1991; Ikenberry 1994; Pierson 2000), this dissertation will provide new intellectual grounds for devising a cosmopolitan welfare ethics.

### **Chapter Summaries and Organization**

The remainder of this dissertation is divided into five chapters. Chapter II assesses competing theories and analyzes the neglected role of private US pharmaceutical companies in the continuity and change of US HIV/AIDS foreign policy toward Africa. While existing theories (compassionate conservatism, Bush's reelection in 2004, the Christian evangelical right, and bureaucratic politics) are necessary in explaining both the context and the institutional constraints in the making of PEPFAR, they do not sufficiently account for PEPFAR's size, structure, and especially timing. This chapter

thus propounds the privatization theory, which regards the neoliberalism agenda in repealing state interventionism and advocates market solutions and private initiatives in advancing human welfare. As a result, this chapter considers PEPFAR as being illustrative of the pursuit and implementation of the Bush administration's neoliberal ideas giving priority to business corporations and nonprofit organizations, either religious or nonreligious, instead of pursuing the traditional interventionism of the welfare state.

Chapter III surveys continuity and change in US HIV/AIDS foreign policy toward Africa prior to the creation of PEPFAR. Both Presidents Reagan (1981-1988) and Bush Senior (1989-1992) dominated the first HIV/AIDS decades and their administrations paid very little attention to the international dimension of HIV/AIDS. This neglect reflected the low domestic policy attention they paid to the disease given their moral and economic conservative beliefs. While the Clinton administration was forced to change its foreign policy indifference toward Africa, in the aftermath of the Rwanda genocide, the global HIV/AIDS crisis had matured at the turning of the New Millennium. The pandemic came to be seen as a chronic disease in most developed countries thanks to the development of the Highly Active Antiretroviral Therapy (HAART) but remained the number one killer in developing countries. Protests, mobilizations, and pressure against the TRIPS led the Clinton administration to change its staunch support of US pharmaceutical companies by enacting Executive Order 13155, which was never implemented given the change in administration through George W. Bush's election.

Chapter IV identifies determinants of and analyzes the decision-making process leading to PEPFAR's creation. Using the neoliberalism theory of privatization, it uncovers the motivations of policy makers and the different sources of preference and

influence existing at both domestic and international levels. It also explains, comprehensively, the rationale, timing, and substance of this Bush administration's US HIV/AIDS foreign policy toward Africa. Although President Bush's political motivations compelled him to listen to other constituencies, the powerful influence of the private sector and US pharmaceutical companies, instrumentally, structurally, and normatively, outweighed all other interest groups. As a result, PEPFAR appears to be a repeal, in subtle ways, of the Clinton administration's legacy – Executive Order 13155 – and a neoliberal business model for the provision of social welfare.

Chapter V examines the implementation of PEPFAR in Uganda. Taking into account the evolution of US foreign policy toward Africa's Great Lakes region, it raises important questions about the Ugandan success story in the fight against HIV/AIDS, widely promoted in the literature of the US HIV/AIDS global policy.

Finally, Chapter VI summarizes the learning process about this research and suggests new directions for further research on US HIV/AIDS foreign policy toward Africa.

## CHAPTER TWO: COMPETING THEORIES AND THE ROLE OF US PHARMACEUTICAL COMPANIES IN THE MAKING OF PEPFAR

### **Introduction**

Some degree of scholarly attention has been paid to the question of why the Bush conservative administration picked a liberal foreign policy issue and decided to heavily invest in combating HIV/AIDS in Africa. Moens (2004), Dumbuya (2009) and Laurent (2004), for instance, concur with the idea that analytical attention should focus on the compassionate conservatism beliefs of President Bush that informed his humanitarian concerns for victims of HIV/AIDS in poor countries. Others like Russell (2004) and Dietrich (2007) consider the Bush administration's adoption of the HIV/AIDS global health crisis to be motivated by presidential politics as a measure both to aid re-election in 2004 and deflect attention from the war in Iraq. Yet, a third line of argument propounds the prominence achieved by the Christian evangelical right, a natural constituency of the Bush administration, which also had the ear of the president from the very beginning of the term. Arguably, the religious right brought the issue of HIV/AIDS to the foreign policy attention of the president (Burkhalter 2004; Lancaster 2007). Finally, there is also the opinion that maintains that President Bush's agenda to reform the government bureaucracy, especially with regard to the delivery of foreign aid, contributed to the shaping of PEPFAR. As a result, he created the Millennium Challenge Corporation of which PEPFAR was the logical offshoot (Olasky 2000; Bush 2010).

The goal of this chapter is to reevaluate these positions; to highlight the strength and limitations of each; and also to fill the theoretical gap by integrating the overlooked role of the neoliberal privatization agenda in US foreign policy and the influence of private US pharmaceutical companies. The neoliberal privatization agenda in US post-Cold War foreign policy has the potential to better explain the development of US foreign policy toward HIV/AIDS in Africa. Neglect in considering the influence of private pharmaceutical corporations in explaining US foreign policy continuity and change toward HIV/AIDS in Africa may have a direct bearing on policy relevance.

From the emergence of HIV/AIDS in the US in the early 1980s, during the development of the palliative antiretroviral treatment in the mid-1990s, and all the way to the Bush administration's decision to create PEPFAR in 2003, US pharmaceutical companies have been intimately and instrumentally associated with shaping perception of the disease, the domestic and international policy-making environment, and the acceptable policy solutions adopted by the US government. Yet, in spite of these powerful actors' roles and influence, existing literature tends to overlook, obscure, and even obfuscate them when considering the evolution of US foreign policy toward HIV/AIDS in Africa.

The remainder of this chapter is divided into four parts. The first reviews and analyzes the classic explanations of PEPFAR. The second propounds a neoliberal privatization theory of US post-Cold War foreign policy. The third discusses why PEPFAR is a good case study that demonstrates the role of privatization in US foreign

policy toward HIV/AIDS in Africa. Finally, the fourth discusses some methodological issues with regard to gathering qualitative data in the process of writing this dissertation.

### **Classical Explanations of PEPFAR**

**President Bush's adherence to compassionate conservatism.** PEPFAR has been regarded as the outcome of President Bush's altruism imbued with his compassionate conservatism beliefs. Arguably, his Christian values and humanitarian concerns compelled him to act on behalf of the victims of HIV/AIDS in countries with limited economic resources. Proponents of this view consider that the compassionate conservative doctrine encompasses the core religious beliefs and philosophical perspective that shaped President Bush's worldview and forestructure, i.e., the set of common descriptive categories, praxes that mediate applications of these categories, and particular hypotheses about the subject matter at hand – which permits a particular understanding of any given situation.<sup>1</sup> That is, compassionate conservatism constitutes the lens through which he interpreted the issues of the world and accordingly formed his domestic and international welfare policy preferences (DiLulio 2002; Laurent 2004; Dumbuya 2009).

Although he became a strong critic of the Bush administration after resigning from his position as the first appointed director of the newly created Office of Faith-Based and Community Initiative (OFBCI) at the White House, DiLulio believes that altruistic and humanitarian concerns inspired and motivated President Bush's Africa

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<sup>1</sup> I borrow this concept from hermeneutics the branch of philosophy that deals with interpretation. Forestructure, in this context, refers to “antecedently developed, already entrenched, cognitive systems, or merely heuristic structures awaiting testing and deployment” through which an image, representation or worldview is created and a relationship established. See Patrick Heelan (1984:79).



HIV/AIDS initiative. He gives a personal testimony about President Bush's personality and dubs the Bush administration the "Mayberry Machiavellis" for its groupthink mentality decision-making style; that is, a disheartening substitution of political calculations in place of policy substance and discussion. However, he still maintains that President Bush is "a godly man, a moral leader, and a highly admirable person of enormous personal decency who truly feels deeply for others and loves this country with a passion" (quoted by Moens 2004:2).

Both McAdams (2011) and Moens (2004) also corroborate this view as they claim that beyond fiscal conservatism, the religious beliefs and moral commitment to the poor informed President Bush's foreign policy toward HIV/AIDS. Thus, Moens (2004:2) clarifies that,

In both domestic and foreign policy, President Bush believes ardently in several key values and pursues them consistently. [...] Compassionate conservatism is not a political ploy or campaign spin but contains the key principles he [President Bush] sought in Texas [as Governor] and pursues in the White House. The term includes values of personal responsibility and traditional family, faith-based communities helping the needy and the quest to rebuild American society and culture that respects faith and favors life. [...] He knows from personal experience that simple, honest ideals are what matter the most. Neither policy expertise nor intellectual insight can compete with the moral compass.

This is substantiated through different policy documents. In his Remarks on Senate Action on Jobs-and-Growth and AIDS Relief Legislations on May 16, 2003, President Bush insisted, "We've got a HIV/AIDS initiative that will help – say to the world that the US is a compassionate country – we care deeply about the suffering that takes place in the world." Further, he added, "I will sign it and take it with me as a symbol of the great depth of compassion that our country holds for those who suffer." And on the signing day

of the US Leadership Against HIV/AIDS on May 27, 2003, President Bush remarked, “Our nation sets forth a great mission of rescue.” Furthermore, he brought the policy back into the long tradition of the US foreign service by stating, “The identity of the US is to sacrifice in the cause of freedom, and we’ve got a long tradition of being generous in the service of humanity. We are the Nation of the Marshall Plan, the Berlin airlift, and the Peace Corps and we are a nation of the Emergency Plan for AIDS Relief.” And he would later on write in his memoir that the global public health crisis triggered by the HIV/AIDS pandemic represented a moral opportunity for the United States, which is “too wealthy a nation and too compassionate a nation,” to take a vital step to help those less fortunate. To this moral appeal, President Bush concludes, “I couldn’t stand the idea of innocent people dying while the international community delayed. I decided it was time for America to launch a global AIDS initiative of our own. We would control the funds. We would move fast. And we would insist on results” (Bush 2010:337).

However, to most traditional conservatives, government should not interfere with private lives, especially as guarantor of redistributive justice or provider of universal health care. To correct such an attitude like the one displayed by presidents Reagan and Bush Senior, President G. W. Bush combined his conservative background with a liberal ideal of compassion. He recognized the role and mission of the government in supporting the poor’s social welfare, but he differed from the Democrats’ in regards to how welfare programs should be provided. Compassionate conservatism, Olasky (2000:xi) explains, is “a conservatism [an economic theory] that cares about them [the poor], and makes a concerted effort to help them bring lasting change in their lives.” While still Governor of

Texas, he wrote a preface to Olasky's *Compassionate Conservatism* (2000) in which he summarized the United States' paradox: many citizens remain extremely poor in spite of their nation's great wealth. By endorsing the main thesis of the book, that the welfare state interventionism harms the poor more than it helps them, Bush revealed his belief in compassionate conservatism.

The concept of compassionate conservatism became one of the favorite themes of G.W. Bush during his 2000 presidential campaign. The theme of "compassion" recurs throughout most of George W. Bush's presidential speeches and policy memos on the provision of social welfare support to the poor. The rhetoric of compassion in his inaugural speech on January 20, 2001, as Woodward (2002) remarks, was long compared to that of the principles of conservatism. Again in his 2006 State of the Union Address, President Bush argued,

We show compassion abroad because Americans believe in the God-given dignity and worth of a villager with HIV/AIDS or an infant with malaria or a refugee fleeing genocide or a young girl sold into slavery. We also show compassion abroad because regions overwhelmed by poverty, corruption, and despair are sources of terrorism and organized crime and human trafficking and the drug trade.

Furthermore, he notes in his memoir that his National Security Adviser Condoleezza Rice made it clear to him from their very first meeting, when he had decided he was going to run for presidency, that the humanitarian crisis of HIV/AIDS stood out in Africa above all other problems. In his words,

As Condi made clear in our first discussion, one problem in Africa stood out above all others: *the humanitarian crisis of HIV/AIDS*. The statistics were horrifying. Some ten million people in sub-Saharan Africa had died. In some countries, one out of every four adults carried HIV. The total number infected was expected to exceed one hundred million by 2010. The United Nations projected

that AIDS could be the worst epidemic since the bubonic plague of the Middle Ages. (Bush 2010:335 emphasis added).

Up to 10 million of people had died of AIDS-related disease in Africa between 1981 and 2001 and the spread of the disease was not abating as attested by new HIV infections.

Moved by compassion, President Bush came to frame the HIV/AIDS crisis in Africa in humanitarian terms. He also appealed to the American people's compassion to help meet the social and medical needs of those affected by the disease.

A compassionate government has the duty to intervene without substituting itself for private initiatives, charity agencies, or faith-based organizations that have proved efficient over the years in the history of US welfare provision. A compassionate government is a government that creates an environment within which local armies of compassion – churches, synagogues, mosques, and private charities – can rally and thrive. Because welfare provision is more than handing “big checks” to the poor, as Democrats do, private organizations offer services that also involve an important aspect of changing the lives of those being helped. Besides, as a compassionate conservative, President Bush assumes compassion is not a prerogative of the Democrats. Thinking like that is simply misleading. In addition, while describing the misperception about the difference between welfare provision by liberals and conservatives, Olasky (2000:4) notes,

Conservative politicians have been complaining for years about a spendthrift modern welfare state – but they have been stating the problem backward. The major flaw of the modern welfare state is not that it is extravagant, but that it is too stingy. It gives the needy bread and tells them to be content with that alone [...]. I hoped to see welfare transformed from government monopoly to faith-based diversity. The government of a pluralistic society is inherently incapable of

tending to spiritual needs. So the more effective provision of social services will ultimately depend on their return to private and especially to religious institutions.

Instead, compassion constitutes a basic American value shared by both liberals and conservatives. For Republicans, the compassionate conservative doctrine represents the best way of providing welfare benefits to those most in need without hurtfully impacting them like the liberal big government. As a result, compassionate conservatism advocates a return to the “early American model of compassion,” which involved less government and more private initiatives in the provision of welfare. This conservative approach has proved more efficient in assisting the needy.<sup>2</sup>

Traditional conservatives seek limitation of the government in social welfare provision whereas compassionate conservatives embrace social liberal ideals but enact them through private agencies. But if the welfare state of the past was more harmful than it intended by spending too much money on building large bureaucracies to serve these poor, a compassionate government offers to utilize the resources available through the

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<sup>2</sup> The welfare state has not always been the best way of dealing with public and collective danger posed by diseases. For instance, in “The Politics of Health in the Eighteenth Century,” Michel Foucault investigates the relationship between public and private provision of health care in Europe and observes that the problematization of “noso-politics”; that is, the politics of disease, in the 18<sup>th</sup> century did not coincide with a uniform trend of state intervention in the practice of medicine. Instead, it correlates with the emergence at a multitude of sites in the social body (in the domestic society) of health and disease as problems requiring some form or other of collective control measures. As a result, the control, organization, and initiative as a politics of diseases, “should not be located only in the apparatuses of the state.” A number of distinct health policies as well as various methods for taking charge of medical problems were located and disseminated across different social bodies such as religious groups, charity and benevolent associations, ranging from parish bureaus to philanthropic societies. Yet, these institutions of the civil society operated as organs of the surveillance of one class over others considered to be a source of collective danger and having less power and ability to defend themselves (Rabinow 2010:273-275).

private sector to ensure better implementation of welfare policies.<sup>3</sup> A legislator opposing a welfare spending bill is seen to be cold-hearted and uncaring while a compassionate legislator is one who votes for those such bills although the means of administering it will vary from those of the Democrats (Olasky 2000:2). Hence the compassionate side of conservatism seeks to involve civil society organizations including families, churches, and other faith-based organizations that can help bring about change in a person's character. The government should provide support for this change so that individuals can own responsibility for their welfare.

While the idea of socialism has always been appalling to most Americans, it is in the nature of US democracy to encourage and invigorate private initiatives. This view has dominated the American conservative political landscape and has been a part of the American political culture's resistance to communism and socialized medicine. Increasingly, both Democrats and Republicans, as Nisbet (2004:42 quoted by Tanner 2007:23) argues, claim to share a common dislike of big government – especially a centralized government that would decide policies regarding the organization of society in matters of economic production and the distribution of goods and services, social policies overseeing public welfare, and other regulations affecting citizens' political and intellectual lives. Hence, politicians on both sides of the political spectrum have come to adopt the notion of compassionate conservatism, at least in its application.

Conservatives wish to put the full responsibility of a person's misfortunes and social condition on individual freedom and choices. Tanner (2007:13) explains the

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<sup>3</sup> I shall return to this idea with more details in the second part of this chapter as I analyze the privatization theory, an alternative from which President Bush operated in his foreign aid system transformation and the creation of PEPFAR.

concept of conservatism in the United States as an often-confusing notion. He notes that conservatism in the US is,

[A] sometimes uneasy mixture of two important strains of thought. On the one hand is a profound classically liberal or libertarian tradition that takes its cue from John Stuart Mill's admonition: '[T]he only part of the conduct of anyone for which he is amenable to society is that which concerns others. In the part that merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.' On the other hand [conservatism] is a strong belief in the traditions and institutions of society. Rather than Mill, it is more attuned to Edmund Burke's wisdom: 'We owe an implicit reverence to all the institutions of our ancestors.'

Conservatism is both absolute self-ownership of the individual and reverence and loyalty to tradition. Thorsen (2009:6) explains libertarianism as "an uncompromising concern of individual and commercial liberty above everything else, coupled with a corresponding de-emphasizing of other traditional liberal goals such as democracy and distributive justice." In that sense, economic conservative, libertarianism, and neoliberalism are all synonymous. They involve, as Hackworth (2012: Kindle Locations 68-73) observes, an overwhelming emphasis on the individual:

[First] Individuals are responsible and best able to provide for themselves, solve problems alone, and decide what is best for them. Individuals are responsible for their own failures and successes and should be rewarded and punished accordingly. Second, it consists of an almost religious belief that the market (and the vehicle of property) is the best way to promote an individual's choice. And third, it consists of an almost equally religious belief that the state will inhibit both the market and individual choice.

Conservatives are, therefore, skeptical of state power and its ability to interfere with and infringe on individual freedoms. They see the government as something of a necessary evil. Tenants of this view agree with Robert Nozick (1974) who claims that individuals own themselves fully and are responsible for their individual condition, and share F.A.

Hayek's concern "that central government planning and its outgrowth into the welfare state will ultimately and inevitably lead to the eclipse of liberty" (Tanner 2007:10).<sup>4</sup>

President Bush derived his social welfare preferences from both his religious values and experience, and from his conservative business background. He had come to believe that taking responsibility for one's action and changing one's behavior was a crucial component in correcting and reversing the social problem of HIV/AIDS in poor countries. He admits to being a heavy drinker prior to the age of 40, a condition severely impacting his business ventures. During that time in his life, he lacked focus and seriousness. Presumably, the resultant stress even told on his marriage. He claimed later on that his conversion at age 40 made his life better, easier to understand, and clearer (Andersen 2002). David Frum, President Bush's speechwriter for his first White House years, quotes President Bush as saying that religion helped him overcome his alcoholism problem. An evangelical born-again Christian, President Bush liked to affirm that Jesus was his favorite thinker because he saved his heart. Bush gave up his heavy drinking, smoking, and chewing tobacco, moral triumphs which he attributes to his decision to follow Christ. To a group of representatives hailing from various Protestant congregations, he said, "You know, I have had a problem with alcohol. Right now, I ought to be in a bar in Texas instead of finding myself in the Oval Office. There is only

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<sup>4</sup> It is important to note here how these conservative views are similar to classical liberalism that concurs with the belief that the state has to be minimal, "a night-watchman state." With the exception of law enforcement, force armed, and other non-excludable goods, everything else is expected to be left to the dealing of the civil society – organizations and corporations that citizens choose freely to be a part of (See Thorsen 2009).



one reason why I'm in the Oval Office and not in a bar: I found faith. I found God. I'm here because of the power of prayer" (quoted by Frum 2003:283)<sup>5</sup>.

On the conservative end, President Bush received most of his conservative welfare ideas from such influential authors as Murray and D'Souza. And like most conservatives, President Bush believed that poverty does not stem from social inequalities institutionalized in the current system, but rather from individual responsibility and the absence of moral values. To address issues related to poverty, conservatives propose social programs that rely less on the government than on private initiatives, local communities such as the family, church, or faith-based communities, and the market (Laurent 2004:40). Olasky's influence on President Bush's welfare policy remains uncontested. While Bush read these three major conservative thinkers, it is the concept of "compassionate conservatism" that most gained his favor, becoming the dominant idea that persuaded him concerning the best manner to tackle the poverty issue.<sup>6</sup> As Laurent (2004:40) observes,

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<sup>5</sup> PBS has produced a documentary called "God in America" and compiled a dossier on the faith of American presidents and how their religious beliefs impacted their leadership style. Available at <http://www.pbs.org/godinamerica/god-in-the-white-house/>.

<sup>6</sup> All three authors represent the conservative view of social welfare provision. In *Losing Ground: American Social Policy 1950-1980*, Charles Murray (1984) argues that social welfare provision tends to accrue poverty rather than eradicate it. It creates incentives for the poor's dependency on the government. Instead of graduating from government assistance, the poor develop shortsighted behavior that favors the immediate handouts that cannot be conducive to liberation from poverty. Likewise, Dinesh D'Souza's *The Virtue of Prosperity* (2000) questions the meaning of inequality and the value of techno-capitalism. D'Souza is regarded as an established conservative political commentator who served for one year as a Reagan White House aide. He also contends that rich people are better providers of social welfare, drivers of economic growth, and contributors to charity causes. In short, the rich create new resources for society to prosper and, therefore, can help solve many social problems of the poor and advance the welfare of the nation as a whole. Olasky's *Tragedy of American Compassion* (1992) is another verdict against the welfare state in which the author acknowledges both religion and the orthodoxy of Milton Friedman's economic

The books by Charles Murray and Dinesh D'Souza were among the favorite reading matter of George W. Bush. But the thinker who has most delighted and persuaded him, and whose ideas became one of his favorite themes during the 2000 presidential campaign, is Marvin Olasky, the author of *The Tragedy of American Compassion*.

Kutchins (2001:14) confirms this perspective and claims that Olasky was the originator of this blend of conservative political philosophy and liberal ideals. As such, Olasky holds a moral copyright for the “compassionate conservatism” concept, which he franchised to President Bush for political marketing. For Republicans who advocate a compassionate conservatism approach, conservatism should not equate with opposition to welfare spending. Though compassionate conservatives hold the view that conservative principles are the real engine of social progress through individual change, not government welfare spending as liberals tend to prefer, their understanding of poverty is that it results from poor individual decisions, choices, and the responsibility of the poor who, also demonstrate some form of moral deficiency.

Where liberal government's social welfare programs are seen as a drain on business, compassionate conservatives see business opportunities for new markets wherein social entrepreneurs can turn administrative costs into potentially large profits. This transpired through the Bush agenda to reform the USAID and transform the whole US foreign aid system. As he explained, Bush wanted to move away from the

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neoliberalism as key inspiration. For Olasky, Americans have a consistent tradition of how to overcome poverty, not by promoting the welfare state but by allowing the church and other charity organizations to do the job of helping the poor. Prior to the development of the welfare state in the 20<sup>th</sup> century and before the social welfare interventionism of the government since the New Deal, religious organizations were better able than the government to take care of the poor in the US.

paternalistic legacy of the Cold War era and inaugurate a new model where trade, not aid, is the best solution for addressing Africa's social ills (Bush 2010:349).

But, if we can claim that the President Emergency Plan for HIV/AIDS Relief was motivated by President Bush's humanitarian concerns, the compassionate conservatism doctrine cannot explain the substance, structure, and timing of the PEPFAR policy. Given that the HIV/AIDS global public health crisis was ongoing prior to his coming to power in 2001, some important questions remain unanswered by this compassionate conservatism argument. Why didn't it occur to him that PEPFAR could be created just as speedily as the White House Office of Faith-Based Organizations and Community Initiatives? Was compassion for those suffering from the scourges of HIV/AIDS in Africa really the motivating factor in the decision to initiate PEPFAR? And should altruism be the major factor, could it be enough to warrant the shift in existing patterns of US foreign policy neglect and indifference toward Africa? Answers to these questions remain unsatisfactory when considering the compassionate conservatism doctrine alone. As presidential candidate, when Bush was asked about his future foreign policy priority toward Africa, the HIV/AIDS humanitarian crisis was at its highest peak in Africa. Yet, it did not occur to him then that this issue could become his foreign policy priority.

Like most Conservatives, President Bush believed that the Democrats failed in their welfare policies because they did not focus on the moral dimension and spiritual transformation of the beneficiaries of their social welfare programs. As has been his policy stance while Governor of Texas, he consequently proposed the privatization of the welfare programs at the federal level after taking office at the White House in 2001. As

Jennifer Petersen (1998) notes, “As governor, Bush has supported an increased role for private agencies -- both for-profit and non-profit -- in administering welfare benefits to the needy, a move which has at times pitted the governor's politics against federal policy.”<sup>7</sup> Since his election victory in November 2000, President Bush had a clear idea about what role the government and private charity should respectively play in the provision of social welfare. It became apparent that his welfare agenda aimed at privatizing and outsourcing government’s social welfare programs since social problems are the business of the civil society, families, churches, and charities, not of a paternalistic government as the Democrats insist.

It is no coincidence that among his first Executive Orders – on January 29, 2001, only nine days after he took office – President Bush signed Executive Order 13199 establishing the White House Office of Faith-Based and Community Initiative (FBCI). Besides, President Bush’s Deputy Director of the Office of Management and Budget (OMB), Sean O’Keefe, “ordered federal agencies to prepare annual inventories of their

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<sup>7</sup> In her article in CNN All Politics (August 30, 1998), Jennifer Petersen notes that Bush has applied his anti-big government policy stance by redesigning the state’s welfare programs. He indeed launched his reelection campaign as Governor of Texas on the promise to champion “Tax values” – limited government, local control and individual responsibility.” Backed by Rep. Bill Archer (R-Houston) and Texas Sen. Phil Gramm Bush proposed a plan to privatize the food stamp programs, which he submitted for federal approval in 1997. The Clinton administration rejected the plan, arguing that “needy families should not have to rely on profit-king companies for decisions on Medicaid and food stamp eligibility and benefits. Bush met personally with the president's chief of staff, Erskine Bowles, to dispute the decision as he appealed to Congress to save the plan.” The plan aimed to contract out the administration of the combined programs -- integrate and automate eligibility assessment, enrollment, service referrals and client data for the state's cash assistance, food stamp and Medicaid programs – to private high-tech firms. The contractors would have been responsible for redesigning and running the program, from application to delivery. Available online at <http://www.cnn.com/ALLPOLITICS/1998/08/12/bush.privatization/>.

services, and to identify which ones should be considered ‘inherently governmental function’ [implying the rest] could be privatized” (Stevenson 2003:83).

Obviously, the agenda to privatize the social welfare and to involve families and faith-based organizations in administering care to those besieged by social problems weighed more heavily on his mind than simple giving charity toward African HIV/AIDS patients. He wanted the market, not African governments, to be the most prominent player in the provision of social welfare in the fight against HIV/AIDS. Presidents come to power with their own agenda but the development of events in the international environment can force them to adopt a different policy attitude. For instance, prior to his Washington trip to take the oath of office, newly elected President Woodrow Wilson wrote to a Princeton colleague professor saying, “it would be the irony of fate if my administration had to deal chiefly with foreign affairs” (Ikenberry et al. 2009:10). However, he came to be regarded as one of the most internationalist American presidents.

The compassionate conservatism rhetoric appealed to American public opinion. It reinforced the image of America as a generous nation, a savior nation established through “Manifest Destiny,” and pleaded for such neoliberal ideals as individual freedom and responsibility, development spurred and informed by a tradition of private property, and a compassionate concern for universal human welfare. Because US presidents share the conviction that America is an extraordinary nation, in the flourishing of its political institutions, economic organizations, and individual freedoms a unique example to the rest of humanity, PEPFAR was simply calibrated on the US’s self-interest, measured in economic, ideological, and institutional terms. In this sense, President Bush’s public

health policy approach may be different from his predecessor's, yet it remained in line with the continuation of traditional US neoliberal ideology; that is, its claim was to exhibit US global leadership while it maintained a neoliberal preference for privatization. PEPFAR pursued the US agenda of shunning the welfare state model around the world and promoting the neoliberal market model of welfare provision.

**The presidential politics argument.** The second strand of argument considers presidential politics functioning in both the desire to win re-election in 2004 and the expedience in deflecting attention from the war in Iraq. These motivating factors led to the adoption of social programs that rallied support around a unifying issue within and without the US (Russell 2004; Dietrich 2007). In other words, under the pretense of humanitarian pursuits and the promotion of human dignity in Africa, the Bush administration's Africa HIV/AIDS policy camouflaged politically self-interested calculations, using the rhetoric of compassionate conservatism to hijack a liberal issue and provide social benefits to African victims of HIV/AIDS. While deflecting attention from the controversial unilateral military policy to invade Iraq, this move to create PEPFAR also allowed for wooing the gay constituency and poaching voters from among African-American and Hispanic groups that traditionally belonged to the Democratic Party in time for Bush's reelection in the 2004 electoral cycle (Dietrich 2007; Russell 2004). Bearing in mind the contested 2000 presidential election and the thin margin by which President Bush won crucial Florida votes, the administration needed to come up with a galvanizing strategic effect to lure voters from the opposing party across the political divide. This leads to consideration of the argument that the creation of PEPFAR

was a political ploy to garner influence in both the domestic and international arenas, and to showcase US global leadership in support of the war on terror agenda – given the controversial war in Iraq and the rise of China in Africa.

President Bush's first few months in office were largely unremarkable until after the 9/11 terrorist attacks. Although he scored early legislative successes on domestic issues in his first term – the No Child Left Behind educational reform, two rounds of tax cuts and the launch of a significant Medicare drug plan – the flaws of his administration's relief effort in the aftermath of Hurricane Katrina, and the abuse of detainees at the US-run Abu Ghraib prison deteriorated the public's already significantly lowered confidence in President Bush. With the exception of PEPFAR, George W. Bush's entire presidency has been harshly criticized and his foreign policy seen as a failure. As Gerston (2010:3) remarks concerning President Bush's first term, the US nation was drowning in red ink, thanks to the combination of recently passed mammoth tax cuts and expansive wars in Afghanistan and Iraq; debt soared from \$5.7 to \$8 trillion. By the end of his second term in 2008, a Pew survey conducted among 1,489 adults in Dec. 3-7, 2008, observed how "the American public paints a harshly negative picture of Bush's tenure (...). Among the few bright spots for Bush in the Global Attitudes Surveys were the African nations that had benefited from administration programs to boost economic growth and reduce the spread of AIDS." Nearly two-thirds (64%) say his administration will be remembered

more for its failures than its accomplishments, and a plurality (34%) says Bush will go down in history as a poor president” (*PewResearch*, December 18, 2008).<sup>8</sup>

Numerous constituencies in the US with vested interests in HIV/AIDS were involved in trying to shift the government policy position on the issue. These included the gay, Latinos, and White Christian evangelical right constituencies as well as the Congressional Black Caucus. Because the HIV/AIDS issue had gained accrued salience beyond partisan politics, adopting the issue became politically interesting for the Bush administration, since the president could rally potential voters from non-traditional Republican electorate. By giving in to domestic pressures and international demands to change the US HIV/AIDS foreign policy, the change in US foreign policy toward HIV/AIDS in Africa was intended to reap political dividends.

As a matter of fact, in November 2000, the returns for both Democrat and Republican presidential candidates, Al Gore and G.W. Bush, were only separated by a margin of a few hundred votes. As President Bush’s electoral victory was mired in controversy, given that the final victory was decided on razor-thin margins by a court ruling, it was crucial for the next election cycle to enlarge the voting pool beyond traditional constituencies.<sup>9</sup> Aware that a few percentage points’ difference in a single demographic category can prove decisive, ethnic minorities including the Latinos, Asians, and African Americans have become fertile territory for Republican recruitment because they are “more culturally conservative and religious than traditional Democrats”

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<sup>8</sup> The Pew Research Center is a nonpartisan “fact tank” based in Washington DC that provides information on the issues, attitudes, and trends shaping America and the world. <http://www.people-press.org/2008/12/18/bush-and-public-opinion/>

<sup>9</sup> [http://www.pbs.org/wnet/supremecourt/future/landmark\\_bush.html](http://www.pbs.org/wnet/supremecourt/future/landmark_bush.html)



(Weiss 2001:37). Even faith-based privatization was itself “a political strategy intended to fragment the opposition and to win support from culturally conservative Democrats” (idem).

Besides framing the HIV/AIDS crisis in humanitarian terms, the Bush administration also regarded the HIV/AIDS issue as a security problem. In foreign policy discourse, policy makers related it to global discontent against the Bush administration and global terrorism. HIV/AIDS had simply become a legitimate foreign policy issue in the post-9/11 global environment, as US foreign policy malcontents were easy recruiting targets of terrorist organizations, especially in failed states and poor countries. Scholars observed that post-9/11 US-Africa foreign policy became linked to “national security” because fostering hopelessness, poverty, and disease made people easy prey for recruitment by terrorist extremists. As Donald and Keller (2006:1-2) note, “Security can no longer be presented in geostrategic terms alone. Rather, a conceptual stretching should include aspects of human security, that is, personal wellbeing [in which] poverty, diseases, environment, development, economics, are all part of what makes the human security a crucial issue. State security depends on human security (whether citizens feel secure and protected).”

Senior members of the Bush administration, including Secretary of State Colin Powell also began to refer to HIV/AIDS as a real security threat. As the destructive power of these new emerging infectious diseases came under the spotlight of US foreign policy, Radelet (2003:113) remarks that Secretary of State Colin Powell called the HIV/AIDS pandemic

[A] national security problem, recalling the Clinton administration's decision to classify the pandemic as a security threat. In September 2002, the National Intelligence Council reported that the virus was on pace to spread quickly in several countries of enormous strategic importance to the United States, including China, Russia, and India. In the same month, the administration released its National Security Strategy, which gave remarkable prominence to HIV/AIDS.

As HIV/AIDS and other infectious diseases were integrated in the 2002 *National Security Strategy of the United States* as deserving governmental priority in the wake of 9/11 terrorist attacks, the Bush administration embedded HIV/AIDS in all four functions of foreign policy.

Fidler (2005) identifies the correlation between HIV/AIDS and the four basic functions of traditional foreign policy, which respectively serve to ensure a nation's security from external threats, thus achieving national security as a function of foreign policy; contribute to a country's economic welfare and power by promoting international trade and investment; support economic and political development conducive to the stability of a country; and lastly, promote human dignity.<sup>10</sup> As such, HIV/AIDS constituted an opportunity to pursue strategic interests abroad, which include national

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<sup>10</sup> It is important to understand how the US has traditionally measured its vital foreign policy interests. Kraxberger (2005:49) proposes the concept of "geopolitical code" to assess a region's strategic significance in US foreign policy. He notes, foreign policy strategic significance "can be assessed [...] through analysis of the *geographic deployment of government resources abroad*, including military personnel and assets, diplomatic missions, and foreign aid... Within geopolitical codes, foreign areas and countries are arranged in a loose hierarchy of significance; some places are deemed to be of vital national interest while others are of small or inconsequential importance (*italics added for emphasis*). By defining strategic interest as that for which countries go to war, scholars agree that US strategic interests boil down to economic (investment and trade volume and security), security (military capabilities to annihilate physical threat from outside), and moral interests. Ohaegbulam (1999) clusters these strategic interests into national security, economic gains, the containment of perceived communist and Soviet expansionism – at least until the end of the Cold War – and moral idealism and the promotion of a New World order.

security, symbolic power status as a global leader, economic interests, and the promotion of human rights norms (Fidler 2005; Hunt 2003).

As US policy makers came to establish a nexus between statehood and terrorism, many scholars and policy makers pursued the idea of initiating a massive foreign aid package – a Marshall Plan for Africa – to help boost Africa’s economic development lest the continent turn into a terrorist safe haven due to the continuation of growing poverty. Since poverty may lead to further instability in failed states and was then becoming the groundswell for terrorism recruit, a Marshall Plan for Africa was urgently required. Rothberg (2002:139) notes, for instance, “[N]othing less than a new Marshall Plan [was] needed to mobilize people, money, and ideas for the crucial efforts in (...) the DRC, Sierra Leone, Somalia, and Sudan.”

The Bush administration linked HIV/AIDS in Africa to Africa’s chronic poverty and the failures of development policies. It insisted the pandemic predisposed the continent to the vulnerability of terrorist activities.<sup>11</sup> The Marshall Plan provided massive foreign aid to Europe after the Second World War to help with Europe’s reconstruction, but also expanded the West’s liberal order to include countries in the democratic and free trade exchange framework that were vulnerable to Communist influence. The Marshall Plan combined both neoliberal principles – the democratic and free trade ideals of the US – with strategic containment policy to limit the power and influence of the USSR, its chief rival after the Second World War. As the analogy indicates, President Bush believed foreign aid could be used both to advance the interest of the US and to promote the welfare of the recipients. As a result, the HIV/AIDS public health crisis presented the

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<sup>11</sup> [www.presidencyproject.ucsb.edu/ws](http://www.presidencyproject.ucsb.edu/ws)

US with the opportunity to showcase its humanitarian concern toward those less fortunate than Americans, although the story does not end there.

Scholars advocate that the focus of US foreign policy concern in Africa ought to overcome those post-Cold War humanitarian needs perspectives. As Lyman and Dorff (2007:199-200) put it,

Africa plays an increasingly significant role in supplying energy, preventing the spread of terrorism, and halting the devastation of HIV/AIDS, [its] growing importance is reflected in the intensifying competition with China and other countries for both access to African resources and influence in the region... In sum, it is not valid to treat Africa more as an object of charity than as a diverse continent with partners the United States can work with to advance shared objectives.

Furthermore, these authors proposed that Africa ceases to be reduced to a mere humanitarian case because of the vital strategic interests it represents to the US. Africa now plays an important role as an alternative supply of energy, a vehicle for the containment of terrorism, and ground zero in the fight against HIV/AIDS. More specifically, the continent of Africa is instrumental for US economic and trade opportunities as it was predicted that up to 25% of US oil imports would come from such African countries like Nigeria and Angola by 2015 (Lyman and Dorff 2007:201). Those who downplay Africa's economic importance to US trade interests should not forget the continent's growth potential, since US trade with China and South East Asia in the 1960s and 1970s was also a pittance with an unlikely growth prediction (Chege 2001:232). Boasting 40 out of 185 member states of the World Trade Organization (WTO), Africa represents, in fact, a growing importance not only in the trade negotiation block, but also in global cooperation.

There is a growing recognition that global inequality and the gap between rich and poor nations exacerbate terrorism and threaten US interests abroad. This perception led to global protests against the World Bank, the International Monetary Fund, and the WTO. Foreign aid allows the US to project soft power to accompany its military power. In the spirit of the US foreign aid system reforms initiated under President Bush Senior, and in the context of the New Millennium Development Goals (MDGs) after the assessment of foreign aid provision effectiveness between 1960 and 2000, President Bush's agenda was to reshape the purpose and structure of US foreign aid after coming to office. For Bush, the existing structure of "the foreign aid [was] designed during the Cold War to support anticommunist governments, to maintain friendly regimes in power and not to improve the lives of the ordinary people. [As this paternalistic model of] our foreign assistance programs in Africa had a lousy track record, [consisting of writing] a check and [telling] the recipient how to spend it," the changes that occurred in the world with the collapse of Communism compelled the US to update its programs and apply a new approach (Bush 2010: 350).

Bush remarked that Africa had received \$14 billion in Foreign Aid until 2001, yet economic growth was flat, even worse than in the 1970s. He goes on to conclude that free trade, not aid, is the engine of development.

Free and fair trade benefits the United States by creating new buyers for our products, along with more choices and better prices for our consumers. Trade is also the surest way to help people in the developing world grow their economies and lift themselves out of poverty. According to one study, the benefits of trade are forty times more effective in reducing poverty than foreign aid. (Bush 2010:350).

In March 2002, President Bush proposed the creation of a Millennium Challenge Account (MCA) through which his administration sought to increase foreign aid by 50% over a period of three years. The fund provided \$5 billion per year “to a select group of countries that are ruling justly, investing in their people, and establishing economic freedom. In September [2002], Bush released his *National Security Strategy*, which gave rare prominence to development and aid alongside defense and diplomacy. Then came his 2003 State of the Union address, in which he called for \$10 billion in new funding (\$15 billion total) over the next five years to combat HIV/AIDS in Africa and the Caribbean” (Radelet 2003:104). Not to mention President Bush’s 2004 budget that included two smaller initiatives including \$200 million to fight famine and a \$100 million fund for complex emergencies. Radelet explains that this foreign aid increase under the Bush conservative administration was partly a result of political expedience and partly carried out in response to the 9/11 terrorist attacks. In the first instance, President Bush needed to make such compelling announcements at international summits in March 2002 at the UN International Conference on Financing for Development in Monterrey, Mexico and in June 2002 at the G-8 Summit at Kananaskis in Alberta, Canada.

For President Bush, provision of foreign aid should be determined by the needs of individuals, not to maintain an obsolete Cold War paternalistic system or dictatorships that squandered American taxpayers’ resources. In June 2002, at the 28<sup>th</sup> Kananaskis G-8 Summit, he mentioned his intention to reform the US foreign aid industry to French President Jacques Chirac; a reform that would take a new approach to aid provision based on the needs of the recipients and the results of the implementing agencies. Hence, in the

spirit of the MCA, this would be “a stark departure from the G-8’s tradition of measuring generosity by the percentage of GDP a nation spent on foreign aid” (Bush 2010:349).

However, the compassionate conservative, security, and national strategic interest theories, though compelling, do not provide sufficient grounds for explaining the magnitude of foreign aid increase through PEPFAR, let alone the timing of the policy creation during a time of economic recession. Garten (2005:40) remarks that,

The president came into office facing a projected \$5 trillion budget surplus over the next decade. Today, the ten-year projection is for a more than \$2 trillion deficit, and that is before spending on any of the new initiatives planned for the second term is taken into account. President Bush has said he will make his tax cuts permanent, adding another \$2 trillion to the deficit over the next decade. He also wants to privatize part of Social Security in a way that could add another \$1 trillion to \$2 trillion in transition costs.

It is, therefore, difficult to prove that PEPFAR was simply the result of the Bush administration’s interpretation of security threat posed by poverty discontents and desperate HIV/AIDS sufferers in the aftermath of the 9/11 terrorist attacks. In response to this argument, President Bush admits that poverty in Africa exists and that there was a need to reform and restructure the US foreign aid system, but he rejects the charge that his Africa-HIV/AIDS policies was a political ploy to divert attention from his hard power militarism in Iraq and Afghanistan as preposterous (Bush 2010:339). Indeed, his 2002 MTCI policy and his National Security Strategy document show that his administration’s concern and growing awareness about HIV/AIDS were anterior to the war in Iraq.

Actually, the international pressure and African government-negotiated policies realized through international organizations, including the UN, WHO, and WTO, pushed

the US to adapt its HIV/AIDS global policy to the flexibilities of the TRIPS Agreement allowed by the Doha Declaration. Since the presidency of Ronald Reagan in the 1980s, the Republican approach to the fight against HIV/AIDS had linked the spread of the disease to both the individual moral sexual conduct of HIV/AIDS patients and to the development achievement, economic growth, technological infrastructure, and capacity to fund research and development for more innovative treatment. Likewise, the Bush administration underscored the moral responsibility of African HIV/AIDS patients and established private organizations – the pharmaceutical companies that sought to attract private investment in R&D, the religious and charity organizations, and families – as the primary providers of the care while maintaining prevention, not treatment, as the official US policy before 2003. According to Weiss (2001:36), President Bush proclaimed in 2001,

It is one of the great goals of my administration to invigorate the spirit of involvement and citizenship. We will encourage faith-based and community programs without changing their mission. We will help all in their work to change hearts while keeping a commitment to pluralism.

As a result, President Bush and his administration continued to push for a healthcare policy that removed responsibility from the government to bring it back into the hands of individuals, families, faith-based communities, and private organizations.

Although the presidential politics argument seems plausible since incumbent presidents begin in their first term to prepare for reelection, the desire for reelection can account for the policy timing but may fail to account for the size and the structure of the PEPFAR programs. PEPFAR is regarded not only as a breakthrough US HIV/AIDS foreign policy toward Africa, innovating in its way of bringing together the private and



the public sectors in working toward a common goal, but also in rallying American voters around one nonpartisan issue, the common good of HIV/AIDS patients. The most rational decision with regard to the issue of HIV/AIDS was to consider political calculations with available information, the costs and benefits of paying heed to the demands of different HIV/AIDS stakeholders. Thus, not only for political reasons but also for ideological convictions, the move to support these constituencies – those with entrenched interest in HIV/AIDS, including both not-for-profit and for-profit organizations – was a major determinant of the president's policy preference, because it permitted President Bush to reorient the traditional welfare provision from government to the private sector.

**The domestic politics and the Christian evangelical right.** A third strand of argument contends that the Christian evangelical right, as the most trusted constituency of the Bush administration, possessed a competitive advantage in US domestic politics. Because President Bush was one of them, and because the evangelical vote had significantly determined the outcome of the 2000 presidential election, their ideology infused most of President Bush's policy proposals, behavior, and public rhetoric (Guth 2004). The evangelical Christians, indeed, constitute one of the Republican party's most powerful interest groups; they had the president's ear in the political debate on HIV/AIDS in Africa and also impacted the Bush administration's policy leading to the signing of the Sudan Peace Act in 2002. In a similar vein, they hoped to advance the cause of African HIV/AIDS victims by causing the administration to adopt a human rights approach and develop a comprehensive policy that would protect vulnerable

populations (children and women) (see Table 3) from further contamination and provide health care and treatment to AIDS patients (Hertzke 2004; Behrman 2004).

Those working with this “religious right” paradigm regard evangelical Christians as the possible force adding new impetus to the HIV/AIDS cause, achieving new salience and prominence for it among the Bush administration’s other foreign policy priorities. Burkhalter (2004) regards evangelical Christians’ shift in perception regarding HIV transmission as fundamental in the Bush administration’s changing policy attitude. The prevailing understanding of HIV/AIDS among US conservatives was to regard the epidemic as a divine punishment on homosexual sinners. Burkhalter (2004:8-9) could, thus, conclude that the vital turning point in American AIDS policy occurred when conservative Christians espoused the cause.

Thanks to recent activism by conservative political and religious groups, AIDS has finally started to gain foreign policy attention commensurate with its substantive importance. Prodded by its conservative evangelical base, the Bush administration has pushed AIDS to the forefront of its international agenda, backing record increases in US assistance for AIDS treatment abroad and beginning to address issues such as sex trafficking and the dangers of HIV transmission from unsafe injections and blood transfusions.

In June 2002, President Bush followed up Senator Jesse Helms’ promise to help prevent infection from mother to child during pregnancy and child delivery. He launched the International Prevention of Mother-to-Child Initiative (PMTCI), pledging \$500 million over a period of five years to purchase medicine and train local health-care workers in the most heavily affected African and Caribbean countries. Yet, while he also broadened his religious base by co-opting other mainstream Protestant, Catholic, and Jewish leaders who shared his conservative moral outlook, he appointed openly gay individuals to key

policy positions in his administration to help in the fight against HIV/AIDS, while he simultaneously avoided anti-gay pronouncements in his speeches. Guth notes,<sup>12</sup>

One-third of Bush's votes came from evangelical traditionalists, reflecting their large numbers, strong GOP preferences, and high turnout. Indeed, the entire evangelical community (about 25 percent of the public) supplied almost 40 percent of Bush's votes. Add mainline and Catholic traditionalists, throw in the Mormons, and the total for theological conservatives rises to 60 percent. (And Bush got a few more traditionalist votes from minorities, such as Hispanic Pentecostals, Orthodox Jews, and some Muslims.

Berggren and Rae (2006) believe that one can only understand President Bush's policies – like the foreign policies of Woodrow Wilson and Jimmy Carter – if they account for the impact of religion on his personal beliefs. They also claim that all three presidents have in common a similar leadership style that drew heavily on their evangelical faith. However, the crucial determinant in sparking the 2003 change in US foreign policy toward HIV/AIDS in Africa was the rise of the religious right in American politics during the Bush administration. As Epstein (2005) remarks,

Jerry Falwell called AIDS God's judgment on promiscuity, and former Senator Jesse Helms, a longtime congressional ally of the evangelicals, told *The New York Times* in 1995 that AIDS funding should be reduced because homosexuals contract the disease through their "deliberate, disgusting, revolting conduct." When lawmakers moved to amend the Americans with Disabilities Act to protect people with HIV from discrimination, some evangelical Christians lobbied against them. In a 2001 poll, only 7 percent of American evangelicals said they would contribute to a Christian organization that helped AIDS orphans.<sup>13</sup>

Subsequently, the high HIV prevalence in Africa was explained mostly through heterosexual contact. This shift allowed conservative Christians to shoulder the struggle

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<sup>12</sup> <http://www.pbs.org/wnet/religionandethics/2004/04/23/april-23-2004-james-l-guth-on-george-w-bush-and-religious-politics/11405/>

<sup>13</sup> Available online at: <http://www.nybooks.com/articles/archives/2005/apr/28/god-and-the-fight-against-aids/> Last access, June 23, 2015.

against HIV/AIDS while it also helped galvanize the AIDS policy of the United States. They succeeded in bringing Congress and the White House hearings on some neglected issues involving HIV transmission such as the consequences of unsafe needle exchange and poor health care infrastructure surrounding blood transfusion in Africa. Senator Jesse Helms's "mea culpa" at a meeting convened in February 2002 in Washington D.C. by Franklin Graham, son of Billy Graham and founder of evangelical charity organization Samaritan's Purse, began to transform evangelical opinion about access to HIV/AIDS treatment in Africa. The conference title was "Prescription for Hope"; it attracted more than 800 Christian leaders ranging from American evangelical Protestants and Catholic conservatives to overseas missionaries advocating access to treatment for those sick and dying from HIV/AIDS in Africa.

During the conference, Senator Helms stated his shame for having done so little to help the victims of AIDS, a politician whose voting record on opposing government financing of HIV/AIDS programs was well known. In the days following, he published an op-ed in *The Washington Post* in which he promised to secure \$500 million to help prevent mother-to-child transmission of the disease. He also publicized the fact that in Africa the disease was transmitted through heterosexual relations, dispelling evangelical opposition to government assistance for HIV/AIDS victims.<sup>14</sup> These efforts resonated

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<sup>14</sup> Regarding the Republican Party, most public officials have identified their views of HIV/AIDS with key morally conservative figures such as Rev. Jerry Falwell who correlated AIDS with moral decay and homosexual depravity. Behrman (2004:27) argues that as early as 1983, this pastor proclaimed in a sermon how "AIDS is God's punishment... The scripture is clear; we do reap it in our flesh when we violate the laws of God." Given that "the subpopulations suffering in the United States were not part of Reagan's constituency, AIDS was sexuality and death: not the stuff that politicians are wont to gravitate toward."

with most of the Republican evangelical constituency, which began lobbying the administration to increase its foreign aid to African victims of AIDS. Indeed, the “rise of the evangelical movement and the Christian right and its increasing engagement in national politics and public policy” is an important factor that “has begun to change in American politics that could affect aid purposes in the future” (Lancaster 2007:107).

According to this domestic politics approach, political actors in democratic societies are any citizens, groups, or organizations – not only elected officials – who also control bureaucratic appointees. All these actors in any form of organized group act to influence policy outcomes. They lobby or pressure the government to enact policies in favor of their preferred policies. As Falkner (2008:158) observes, continuity or change is attributed, in the traditional pluralist perspective, to the “shifts in the relative influence of domestic interest groups and bureaucratic units within the institutional setup.” Others claim that the rise of the religious right in American politics echoes in some respects a common theme in the history of the United States (Campbell and Putnam 2012). Religion is certainly present throughout US politics in spite of the constitutional demarcation that mandates the separation of church and state. It should be noted, however, that President Bush was neither the first nor the only US president to incorporate the influence of religion into his governing style.<sup>15</sup>

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<sup>15</sup> For instance, March and Olsen (1989) contend that personal character is shaped by cultural environment and that the existing institutions, including religion, play an important role in defining values, norms, interests, identities, and beliefs. Because “the US was founded on the proclamation of ‘unalienable’ rights, and human rights ever since have had a peculiar resonance in the American tradition,” as Forsythe (1990:435) suggests, it has shown a consistent moral commitment to human rights. From the drought in Ethiopia, Kenya, and South Sudan to alleviating famine in Somalia or providing resources in cases of natural catastrophes, the US foreign policy in Africa has consistently sought to address these social problems. As a result, both

McCartney (2004) and Judis (2005) relate this historical evangelical influence on US foreign policy to such concepts as “Manifest Destiny” or “Special Providence” that have enjoyed a special place in the US self-perception. As totalitarianism was so contrary to American values and posed a threat to international peace and the national security of the United States, during the Cold War the Truman Doctrine offered to stop totalitarian regimes and to support all free people who were resisting multiple subjugation attempts by armed minorities or outside pressures. Most American presidents have pursued grandiose humanitarian and moral goals in their foreign policy. The belief in promoting the human rights and freedom can be traced in twentieth century US presidencies from Woodrow Wilson and Harry Truman to Ronald Reagan, George W.H. Bush, and Bill Clinton. All these presidents regarded the United States as a savior nation with universal moral objectives (Ikenberry 2009).

Religion has always played a role in US politics in spite of the political imperative to demarcate state from religion and keep established religion at bay. James Guth (2004) laments, however, a dearth of research in the political science literature on the role of religion in foreign policy. Nonetheless, as he observes, a pool of research does exist, carried out mostly by sociologists such as Weber (1919) and Derber and Magrass (2008); by diplomats like Carter (2005) and Albright (2006); and by religion scholars like Urban (2006) and March (2007). Political scientists are only beginning to produce works on the influence that religion played in US foreign policy specifically during the Bush

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personal experience and US political culture contributed towards shaping President Bush’s HIV/AIDS policy preferences and direct involvement in the creation of PEPFAR to address the global public health crisis affecting Africa.

administration.

However, the Christian evangelical right argument alone can neither explain the policy's timing – why the Bush administration chose to initiate the PEPFAR policy at this specific point in time – nor the policy's substance and structure. Critics of this approach argue that the FBCI was an assault on the general welfare system, eroding the collective spirit so vital to a genuine democracy and replacing the postwar government safety net with a system of charity that transformed the political right into the major dispenser of arbitrary altruism (Willis 2001; Press 2001; Waldman 2001). As only “one-third of its AIDS-prevention funding [was directed] toward programs urging abstinence before marriage” while the bulk of the fund went to purchase antiretroviral drugs, the religious constituency argument also cannot account for the policy's substance (Burkhalter 2004:12). If only one-third of the total budget earmarked for prevention programs was allocated to ideological programs – the ABC where A stands for Abstinence, B for being faithful in marriage, and C for Condom use in case the two previous strategies failed – it is hard to explain the entirety of PEPFAR's initiatives based on the religious right theory alone.

Finally, if the faith-based welfare organizations are better equipped than the state's to address social issues, it is clear that the privatization model has its positives; nonetheless it reduces citizens with civic obligations and moral rights to mere clients of arbitrary philanthropy, mere objects of charity. The privatization model also divorces poverty from its historical and structural underpinnings while it enshrines the moral character of the victims as the main culprit for their social misfortunes. It should be noted

that both poverty and HIV/AIDS in Africa are the result of many historical and institutional factors, not only of individual decisions. To that extent, the emphasis put on privatization surreptitiously succeeds in shifting the embeddedness of causal histories and the structural injustices away from the state's responsibility, a displacement that subordinates the state obligation and citizens' welfare rights to the arbitrariness of private philanthropy.

### **A Brief Overview of US Foreign Policy Toward Africa**

Conventional wisdom in the literature on US foreign policy toward Africa treats Africa as the 'stepchild' and 'backwater' in the hierarchy of U.S. foreign policy priorities. Scholars of US foreign policy toward Africa argue that the lack of consensus "within the policy-making establishment over Africa's importance to U.S. national security interests," has bolstered the marginalization of the African region in the post-Cold War era, which is left at "the bottom of foreign policy concerns" (Schraeder 1994:2-3; Moss 1995:195). The assumption that Africa is lacking in strategic significance for U.S. national interests in comparison with other regions is well entrenched among Africanist scholars (Pham 2005; Schraeder 2006). As Pham (2005:19) explains, "Most foreign policy realists wrote the continent [of Africa] off as little more than a source of trouble, albeit one that could be safely ignored because it rarely if ever impinged on America's strategic national interest." Others also corroborate this view such as Nicolas Van de Walle (2009) who suggests that belief in the absence of core vital interests in Africa has been a longtime staple within foreign policy circles. Thus, a stranger to in-depth presidential attention, Africa has remained the province of bureaucratic routines unless a



crisis erupts to pull the President back into the foreign policy-making process. In case the crisis drags on, Congress also becomes directly involved while the domestic interest groups compete to impact the congressional process (Schraeder 1994a; Clark 1998; Cohen 2000).

For many, the absence of vital interests did not allow the U.S. to be adept at forming a coherent African policy after the Cold War's ending. Resultantly, Africa's political neglect persists – with some degree of variation – regardless of which president occupies the White House, or the nature of his party affiliation. This is a direct result of the ingrained perception that Africa's strategic worth is unconstructive to the United States' vital interests. While these interests have yet to be explained, the history of the U.S. relations toward Africa is significantly marked by the persistence of neglect and indifference, which reached the lowest point in history in the mid-1990s. For instance, some scholars remark that despite ambitious rhetoric and overarching discourse on democracy promotion and human rights protection, President Clinton's Africa foreign policy was characterized by timidity and retrenchment (Rosenblum 2002; Alden 2000; Ottaway 2001; Van de Walle 2009). Therefore, one can question whether the perception of the US interests in Africa changed during the Bush administration or if US interests do change over time. If so, what explains the US foreign policy's variation and selective engagement toward Africa? To address the above question, it is important to understand how foreign policy is conceptualized and how US policy makers have defined American vital interests in Africa.

By foreign policy, we refer to how state entities use their sovereign power to influence the behavior of other sovereign states to attain or achieve their own interests. The concept of interest has many definitions. For the sake of this analysis, focus will centralize on Merriam Webster's definition that emphasizes 'interest' as "a concern for one's own advantage or well-being," in other words, the advantage or benefit a person or group derives from the selfish pursuit of one's welfare. Snow and Brown (2000:6) frame political 'interests' as strategic, that is, "those interests for which a state would go to war; that cannot be voluntarily forfeited without *altering the state's identity*: they are properties of states alone. Domestically, they subordinate interests of individuals and groups to those of the state and, internationally, they are too important that states prefer legal anarchy to a global authority" (emphasis added). They conclude, "The need for foreign policy arises because all states have interests – conditions that are important to their well-being or, in some cases, even their existence – and because the interests of different states sometimes conflict. When conflicts of interest arise (situations where two or more states cannot simultaneously pursue their interests), foreign policy attempts to resolve those disagreements" (idem).

To avoid confusing the goals of foreign policy and the means of achieving these goals, it is equally important that we agree on what justifies states' international behavior. While the liberal tradition claims that international promotion of American values, such as democracy, human rights, and free trade, has an overwhelming importance in the foreign policy decision-making process, scholars with a conservative bent suggest that material strategic interests – such as oil, natural resources and security – are the only

important factors that determine US behavior abroad. Bock and Berkowitz (1966), however, contend that US strategic interests encompass the decisions and actions that the government deems of *greater importance in protecting domestic core values against external threats*. For Leffer (2004:123), the very concept of national strategic interests is attractive, due to “its synthetic qualities [which] stem from the fact that it is not a specific interpretation that focuses on a particular variable as much as a comprehensive framework that relates variables to one another and allows diverse interpretations in particular periods and contexts.”

The notion of strategic interests has, thus, allowed for the reconciliation of liberals and conservatives in the U.S. foreign policy tradition. Kraxberger (2005:49) proposes the concept of “geopolitical code” to measure a region’s strategic significance. A geopolitical code, he argues,

can be assessed [...] through analysis of the *geographic deployment of government resources abroad*, including military personnel and assets, diplomatic missions, and foreign aid... Within geopolitical codes, foreign areas and countries are arranged in a loose hierarchy of significance; some places are deemed to be of vital national interest while others are of small or inconsequential importance (*italics added for emphasis*).

By defining ‘strategic interest’ as that for which countries go to war, scholars and policy analysts tend to cluster strategic interests into national security, economic gains, moral idealism, the containment of perceived communist and Soviet expansionism – at least until the end of the Cold War – and the promotion of a New World order (Ohaegbulam 1999). Yet, any objective analysis of the broad sweep of US–Africa relations indicates that two sets of interests, security and economics, have competed for pre-eminence in US foreign policy toward Africa, as Schraeder (2011:304) contends. Before and during the

Cold War, policy makers abandoned their interest in African policy in favor of Europe's, afterwards using U.S. ambassadors to aggressively serve as diplomatic advocates for the facilitation of U.S. business abroad. In the words of former Assistant Secretary of State for African Affairs, Herman Cohen, "The time has passed when Africa could be carved into spheres of influence, or when outside powers could view whole groups of states as their private domain [...] We must accept free and fair competition, equality between all actors" (Schraeder 2000:404-406). Where does Africa fall on the spectrum of US strategic interests or, more specifically, how do US policy makers frame the strategic significance of Africa in terms of U.S. foreign policy?

The neglect of Africa in the history of U.S. foreign policy can be explained through the history of the politics of the US and Africa being geographically removed and separated by an ocean. The US developed an isolationist attitude in the years immediately following the formation of the new Republic. In his 1796 farewell speech, President Washington cautioned his fellow Americans about getting entangled with European politics.

The great rule of conduct for us in regard to foreign nations is in extending our commercial relations, to have with them as little political connection as possible. So far as we have already formed engagements, let them be fulfilled with perfect good faith. Here let us stop. Europe has a set of primary interests, which to us have none; or a very remote relation. Hence she must be engaged in frequent controversies, the causes of which are essentially foreign to our concerns. Hence, therefore, it must be unwise in us to implicate ourselves by artificial ties in the ordinary vicissitudes of her politics, or the ordinary combinations and collisions of her friendships or enmities.<sup>16</sup>

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<sup>16</sup> "Washington's Farewell Address 1796," Available at the website of the Yale Law School Avalon Project, 2008, accessed on October 19, 2013. [http://avalon.law.yale.edu/18th\\_century/washing.asp](http://avalon.law.yale.edu/18th_century/washing.asp)

This strategic posture grew out of the need to shield the young Republic from violent happenings on the world stage and avoid being entangled in European conflicts and wars. In one sense, it aimed at protecting the new republic's integrity from the depredations of European power politics, as European states were more powerful than the U.S. until the mid-twentieth century and "fought according to the rules of amoral power politics, which elevated state interests and survival above everything else" (Dobson and Marsh 2006:6). An established geopolitical tacit agreement among Western powers permitted the US to leave Africa to European colonial powers until the end of the Second World War, and granted the U.S. the right to intervene in the Western hemisphere to restore order and protect its own economic interests, according to the Monroe Doctrine in 1823 and the later belief in a Manifest Destiny. Hence, the attitude of most US policy makers in the early part of the 20<sup>th</sup> century – even until the end of the Cold War – consisted of treating Africa as a "chasse gardée" (or the sphere of influence) of Europe.

Obviously, this policy attitude contributed to the continued neglect of Africa in U.S. foreign policy while enforcing the belief that Africa is strategically insignificant to the U.S. The U.S. concern for Europe's economic recovery led the adoption of "enlightened self-interest," which saw Europe's access to Africa's resources functioning as an adjuvant to the Marshall Plan. During the entirety of the Cold War, the U.S. deferred the task of intervention to former European colonial powers, which were seen as custodians of Western interests in Africa until the end of the Cold War. This is not to claim that Africa's policies among Western allies were at any time monolithic even though conflicts rarely surfaced in public and remained at a manageable level. However,

the U.S. always sided with its European allies in case of difficult choices between African nationalist interests or Europe and her postcolonial interests after the independence in the 1960s (Marcum 1972; Jackson 1984; Clough 1992).

Between 1945 and 1960, the U.S. reversed its decolonization commitment signed in The Atlantic Treaty by President Roosevelt and Prime Minister Churchill in the fall of 1941.<sup>17</sup> It also reviewed its definition of Africa's strategic significance after the Second World War and reorganized its strategic interests in Africa around four priorities, including the containment of communism wherever it erupted, protection of U.S. shipping lanes, access to Africa's minerals, and the promotion of American values, especially human rights (Moss 1995:193-194). After the independence obtained in the early 1960s, determinants of U.S. foreign policy toward Africa boiled down to concerns about the vulnerability of newly independent African states to the lures of communism.

During the 1960s, despite rhetorical support for decolonization, self-determination and development, "The United States, which hoped to replace the imperial powers as the dominant external force in Africa, bridged the decolonization and Cold War processes.

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<sup>17</sup> An illustration of this reversal can be seen in the U.S. shift from supporting colonial nations' independence and self-government to what Assistant Secretary of State for Near East, South Asian and African Affairs, Henry A. Byroads called an 'enlightened self-interest' in dealing with the colonial question. In an address to the World Affairs Council of North California at Asilomar, on October 31, 1953, entitled: "The World's Colonies and Ex-Colonies: A Challenge to America," he argued that the U.S. should continue to support European colonial powers who happen to be "our allies" and who share "many common interests with us. In his words, "We cannot blindly disregard their side of the colonial question without injury to our own security" nor can we "forget the importance of these interests to the European economy which we have contributed so much to support." A premature independence – he argued – could lead to a power vacuum and invite internal disorder and external (Soviet) intervention (Baptiste 2005).

Wavering between its European allies and moderate nationalists, the United States strove to keep both radical nationalism and communism at bay.” (Schmidt 2013:7). Africa was supposed to continue playing the role it had maintained under Europe’s colonial rule, which consisted of supplying strategic resources to preserve America’s economic and industrial supremacy. Herbst (1992:4) cites a 1961 memo by African experts at the Policy Planning Council to the Kennedy administration that describes the perception of Africa in the eyes of U.S. policy makers – concludes that if African countries try to industrialize, “scarce resources will tend to be misdirected into parallel and overlapping investments; and the possibility of attracting foreign capital from abroad will be reduced.” In the 1970s, the Church Commission detailed the pattern of covert operations and assassinations of democratically elected foreign leaders, including Congolese Prime Minister Lumumba. Congress opposed the inchoate self-proclaimed morality of U.S. foreign policy and legislated that respect for human rights should be incorporated into foreign policy (Forsythe 1990:440-439, note 16).

In the 1980s, realists contested the idea that moral ideals and human rights should drive U.S. foreign policy. Kennan (1985), for instance, argues that decision makers hurl such semantic challenges to their foreign counterparts in order to derive political benefits from establishing themselves in domestic American opinion so positively by contrast. Instead, the U.S. should unapologetically and without moral pretension recognize its national interest is the legitimate motivator of its foreign policy. Besides, “Where measures taken by foreign governments affect adversely American interests rather than just American moral sensibilities, protests and retaliation are obviously in order; but then

they should be carried forward frankly for what they are, and not allowed to masquerade under the mantle of moral principle” So, why bother with moral standards when “there are no internationally accepted standards of morality to which the U.S. government could appeal if it wished to act in the name of moral principles?” (1985:207-211).

Africanist scholars believed that once freed from anticommunist conceptual and ideological frameworks, the end of the Cold War would, finally, push U.S. policy makers to consider African realities as central to the policy-making process. Meernick et al. (1998:64) writes, for instance, “[w]ith the passing of the Cold War, security-driven goals have become less critical and ideological goals more important.” Given the changes that were occurring in the international environment, scholars refuted the material strategic interests argument that characterized the Cold War guiding principles of U.S. foreign policy. While ensuring America’s economic and physical security lies at the heart of U.S. foreign policy, the self-interest approach does not tell the whole story of U.S. foreign policy because U.S. ideals were also a crucial part of the U.S. identity and played an important role to begin with in sparking the Cold War (Kegley and Wittkopt 1987:78).

Paradoxically, the 1990s were characterized by further retrenchment and came to be known as the lowest decade in U.S. involvement in Africa since the Cold War. That situation lasted throughout the first eight months of the Bush administration (Schraeder 2011:301-3; Clough 1992:15). In fact, as Schraeder (1994a: 251-252) notes, the post-Cold War tendency within the U.S. policy-making establishment consisted in ignoring Africa in favor of other regions of greater concern, an attitude justified by the fact that



Africa's strategic significance was synonymous with geopolitical competition with the Soviet Union during the Cold War – that is, vying for political allegiance of African states in the United Nations voting system and access to the continent's natural resources. As US Policy makers lacked an “overarching policy framework for coping effectively with the continent's long-term problems of conflict, disease, and poverty,” Africa receded to its traditional area of policy neglect (Rothchild 2001:179).

Attitudes, speeches, and actions of officials during the 1990s tended to confirm the notion that strategic economic resources and security threats interests have been the primary driving force behind U.S. foreign policy. Clinton former Secretary of State, Madeleine Albright (1998:50) notes that U.S. foreign policy has not changed for more than 200 years. Summarizing its goals, she contends that U.S. foreign policy aims at “ensuring the continued security, prosperity, and freedom of our people.” In his 1995 State of the Union Address, President Bill Clinton warned the American people against the temptation to believe that all security issues were becoming domestic, with the exception of trade. As he concludes, “[W]e can't be strong at home in the new international environment unless we are strong abroad.” And other U.S. post-Cold War policy makers – like North Carolina conservative senator Jesse Helms – went as far as to suggest terminating U.S. foreign assistance altogether in the absence of strategic interest, and to dissolve the federal agency in charge of foreign aid (Schraeder 2011:302-303).

After the Cold War raised hopes concerning a U.S.-Africa foreign policy focused on African realities, Herbst (1992:15) observed the irony “that just as the Cold War is ending and political calculations are receding in the determination of aid policy [as]

whole new issues threaten to distract American policy-makers from the central problem of promoting growth and education.” Trying to predict the likely source of threat to U.S. economic and security interests, scholars argued that the rivalry and competition would come from former allies such as France, Germany, and Japan. The U.S. “will still be uncomfor with any nation rising to disproportionate power in Asia or Europe” As (Garten 1992:220). More recently, scholars have called on policy makers to abandon such moralism in foreign policy and go beyond humanitarian categories to conceptualize Africa in more realist terms. The focus of U.S. foreign policy concern in Africa, Lyman and Dorff argue, ought to overcome the post-Cold War humanitarian needs perspective because of Africa’s growing importance to the U.S. and the rest of the world. As they write,

“Africa plays an increasingly significant role in supplying energy, preventing the spread of terrorism, and halting the devastation of HIV/AIDS, [its] growing importance is reflected in the intensifying competition with China and other countries for both access to African resources and influence in the region... In sum, it is not valid to treat Africa more as an object of charity than as a diverse continent with partners the Unites States can work with to advance shared objectives.” (2007:199-200).

### **Neoliberalism and Privatization in US Foreign Policy**

The task of policy analysis consists in determining the hermeneutical framework or philosophical underpinning from which the decision makers operate and the ideology that shaped public attitudes toward the issue of interest. Kotz (2002) is right to affirm that neoliberalism has dominated economic policy-making for quite some time. Neoliberal resurgence in US foreign policy during the 1990s, he argues, resulted from changes in the competitive structures of world capitalism that altered the political posture of business,

turning it from a supporter of state-regulated capitalism into its opponent. As an economic theory and a policy stance, neoliberalism sought to revive classical liberalism when the state regulatory and interventionist measures since the Great Depression were no longer accepted beliefs for tenants of American capitalism in the 1970s. To neoliberals, the unregulated capitalism system – that is, the free market economic system – is the best way to achieve democracy and collective welfare. Kotz (2002:64-79) argues, “the optimal economic performance as related to efficiency, economic growth, innovation and technical progress, and distributional justice requires a minimal state whose functions are reduced to defining property rights, enforcing contracts and regulating the money supply.”

Most neoliberalism policy recommendations have been concerned with the abolition of state's welfare interventionism and the promotion of the privatization ideology. It is noteworthy to underscore two important facts that propelled the neoliberal agenda in US foreign policy. The first is the demise of the notion of state sovereignty in the age of globalization; the second was democratic rhetoric and the promotion of human rights. While international relations until the end of the Cold War traditionally focused on the state as the basic unit of analysis, post-Cold War foreign policy analysis cannot overlook the reality of globalization. A state-centric approach that would simply ignore how the international environment has changed may either miss the point or grossly undervalue “an important part of what is shaping today's world and will shape tomorrow's” (Rothkopf 2012:30). Globalization has offered a new international context and ideological framework for foreign policy, as transnational actors – such as

international organizations (IOs), international nongovernmental organizations (INGOs), the international financial institutions (IFIs), multinational corporations (MNCs), and international banks – challenged the notion of state sovereignty. A gradual shift occurred in foreign policy whereby the U.S. focused less and less on dealing with governments as *de jure* international actors than on consolidating civil society. Indeed, even at the domestic level, non-state actors – such as nongovernmental organizations, churches, community-based and faith-based organizations, and individual citizens – increasingly play an undeniably significant role both in the provision of welfare and the definition of international issues.

Hence, the focus is put less and less on state attributes and more on human security and individual freedoms. The democracy and human rights promotion agenda is a part of the neoliberal rhetoric, becoming central to global perspective in the Cold War's aftermath. American neoliberal ideals, i.e., democracy, liberalization, and human rights – became the major determinants of U.S. foreign policy toward Africa (Hilgers 2011, 2013). U.S. foreign behavior sought to reward those states that performed well by adopting and implementing neoliberal ideals with foreign aid. Meanwhile, assistance to former strategically important nations under the Cold War simply dwindled. Ideas and ideals, indeed, matter in shaping and justifying foreign policy. They also shape identities and preferences; steer actions of both state and non-state actors; and create the framework for interpretation. As a result, ideals and material interests cannot be separated since ideologies always underpin both the creation of symbolic meanings and also the justification of action.

No other institution embodies so well these two sides of the same coin in American foreign policy than multinational corporations. Indeed, from the beginning they have played an important role in shaping American politics. While writing the US Constitution, James Madison expressed concern about factions of men who by intrigue, corruption or other means could “betray the interests of the people.” Indeed, the early debate whether to create a central Bank, and whether the Bank should be private or public, demonstrated the sharp business cleavage between U.S. domestic and foreign politics. Secretary of the Treasury, Alexander Hamilton advocated for the creation of a private bank – given his mercantile relations with Great Britain – against the views of Secretary of State Thomas Jefferson, whose economic ties and allegiance lay with the Southern cotton growers. While he preferred that the nation honor its international obligations like the treaty signed with France during the War of Independence, President George Washington warned in his 1796 farewell speech that combinations and associations were likely to rise and “direct, control, counteract, or awe the regular deliberation and action of the constituted authorities” (Davidson 2009:24).

Most U.S. presidents and statesmen have alerted American opinion to how corporations aggregate power into the hands of a few private individuals, jeopardizing the welfare of the American democracy. Interestingly, the political and economic welfare of the U.S., as well as its military power, have gone hand in hand with the MNCs. Not only were corporations initially understood to be “creatures of the state, figments of the legal imagination of the public sector” and were not initially seen as “part of the society of individuals that the U.S. Bill of Rights or its British forbearers were meant to protect,”

but they have also come to play an important role in preserving the belief in private property rights so dear to American democracy (Rothkopf 2012:182). And yet, corporations have acquired the status of “artificial persons” and are treated as individual persons who share the same privilege granted by the First (free speech), Fourth (privacy), Fifth (double jeopardy), and Fourteenth (due process) Amendments. Regarding historical perspectives, President Lincoln wrote to Col. William F. Elkins in 1864,

I see in the near future a crisis approaching that unnerves me and causes me to tremble for the safety of my country... corporations have been enthroned and an era of corruption in high places will follow, and the money power of the country will endeavor to prolong its reign by working upon the prejudices of the people until all wealth is aggregated in a few hands and the Republic is destroyed (quoted by Shah 2002, electronic version).<sup>18</sup>

Shortly after, however, MNCs acquired the status of a natural person under the U.S. Constitution according to the Supreme Court’s ruling in 1886, granting them the same rights and protection extended to persons by the Bill of Rights, including the right to free speech, and the right to use their wealth to influence the government in their interest.

In subsequent years, other presidents and statesmen have referred to the conflict of interests between the state’s public welfare and the MNCs’ private interests (Rothkopf 2012:181-2). Testifying before Congress in 1915, U.S. Supreme Court Justice Louis Brandeis compared MNCs to Frankenstein monsters created by the state, “Through their size, corporations... have become an institution which has brought such a concentration of economic power that so-called private corporations are sometimes able to dominate the state. Such is the Frankenstein monster which states have created through corporation laws” (Davidson 2009:14). Later on, President Franklin Roosevelt lamented the risk that

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<sup>18</sup> Anup Shah, “The Rise of Corporations,” *Global Issues*, 2002, available at <http://www.globalissues.org/issue/50/corporations> (consulted December 10, 2013)

corporations posed to the state and how they had come to dominate and control the government to the extent that it resembled an oligarchy more than a democracy. In his words, “The liberty of a democracy is not safe if the people tolerate the growth of private power to a point where it becomes stronger than their democratic state itself. That, in its essence, is fascism – ownership of government by an individual, by a group” (ibid).

As recent as 2010, however, in *Citizens United v. Federal Elections Commission*, the U.S. Supreme Court overturned the ban that prevented corporations from using their own money to support candidates for public office. Dissenting voices like that of Justice John Paul Stevens argued, “The Court’s ruling threatens to undermine the integrity of elected institutions around the nation,” (quoted by Krista Gesaman in the *Newsweek* Jan. 22, 2010). While this landmark case allowing corporations and unions to spend limitless amounts of money on presidential and congressional political campaigns may result in foreign businesses emerging as the real winners, President Obama has recognized that the decision gives “a green light to a new stampede of special interest money in our politics.” Yet, because corporations are conceptualized as legal ‘persons’ according to the U.S. law, pro-business lobbies viewed the decision as honoring the First Amendment right to free speech.

Multinational corporations are not to be regarded as mere interest groups. In American society, they have acquired the status of “artificial individuals,” existing as something halfway between the state and its citizens. They are the perfect embodiment of the idea of a civil society crucial for the flourishing of liberal democracy. As Davidson (2009: 24-7) observes, “individuals with similar interests and goals [...] have learned that

it is advantageous to come together and... pool their financial resources and, if available, their voting numbers” to influence the government and shape policies to their benefit since “Any political system of much size or scope is likely to contain within it a population sufficiently diverse to provoke the formation of factions, each pursuing its own interest.” For this reason, Greider (1992) regards the U.S. policy-making structure as a coalition of government elite working hand in hand with a few wealthy businessmen to enact and implement laws that will advance their economic interests. In the same vein, Bueno de Mesquita (2002:4) suggests that because leaders are “motivated by their own well-being and not by the welfare of the state,” they would rather provide exceptional opportunities to their cronies to get rich while expecting the support and resources in return that they need to maintain themselves in office.

This old tension, which Alexis de Tocqueville recognized in the nineteenth century, is characteristic of the U.S. political identity. Observing the American democracy, he acknowledged the difficult business of conducting foreign policy in a democracy since the masses in their idealism, ignorance and passion may lead foreign policy making astray when, in fact, the pursuit of power should be the guiding principle. Countering U.S. democratic ideals, Tocqueville (2006:188) suggests that the primacy of the elite’s corporate interests constitutes the core of U.S. foreign policy. He argues that, “All the nations that have exercised the influence upon the destinies of the world by conceiving, following up, and executing vast designs – from the Romans to the English – have been governed by aristocratic institutions.” Yet, the interests of MNCs, at some point in American history, coincided with the definition of national interest as epitomized



in the expression “what is good for General Motors (GM) is good for America.” MNCs represented the long arm of the US government’s foreign policy by competing for economic advantages abroad. As a result, the real question in U.S. domestic politics has been how to balance the public interest of the Republic with the private claims and power of corporations.

The pluralism of American society stresses competition among nongovernmental actors to make their views heard by the government and to get their favored policies enacted. While U.S. politics is described as a marketplace with more or less perfect competition among different actors and interest groups, scholars agree that the business community as an interest group enjoys a comparative advantage in lobbying to change foreign policy, given its economic resources that provide more political clout (Gibbs 1991). The democratic pluralism in U.S. politics, Davidson (2009:24) claims, is more about interest groups than individuals. In fact, “Any political system of much size or scope is likely to contain within it a population sufficiently diverse to provoke the formation of factions, each pursuing its own interest.” While MNCs have contributed to keeping alive the belief in liberalism and exceptionalism so engrained in American collective thought, they are not only active interest groups, but also have become international actors in their own right. They have the capacity to lobby the government and steer policies; they also have grown in power to the extent of challenging the very power of the government they are supposed to lobby.

Hart (2004:48) contends, however, that although they might fit the definition of an interest group, understood as “organized group that promotes a common political or

policy goal,” MNCs are not just interest groups in the traditional sense. Unlike most interest groups that are usually voluntary associations of citizens trying to influence public policy for the common good, MNCs are hierarchically organized and can easily overlook the pursuit of the common good since their primary goal is seeking to maximize profits. Brown (2012:19) concurs with this view and adds the fact that MNCs’ structural capacity to organize gives them more political clout and leverage to lobby the government more than other interest groups. Not to mention their social capital, intellectual and economic resources, and the multiple venues through which they can access and influence the decision making process.

Even as an interest group, MNCs’ influence is unmatched by nonbusiness interest groups in the way they affect the foreign policy-making process. They not only possess tremendous resources and capacities to create, shape, and impact political preferences but also are regarded as full-fledged international actors. These behemoth firms are seen as taking over the nation state since some of them possess resources exceeding those of nation states themselves. Hence, they cannot be regarded as interest groups given that they present significant ontological, structural, and methodological differences in the way they organize themselves to influence policy. As Shah (2002) suggests, 51 of the largest 100 economies of the world are corporations while 49 are countries. Using their economic power, corporations are undermining the national sovereignty of states and challenging the Westphalian nation-state system, weakening sovereignty and traditional borders. Although not all agree with this point, some argue that MNCs should be treated, in their own right, as independent international actors (Nicholson 2002).

In the post-Cold War era, a subtle shift has occurred thanks to the dominant belief in neoliberalism and the redefinition of the state's function in international relations. In fact, many concur today that the public power of the state needs to be limited to allow the private sector to flourish. This evolution in international politics and the change brought about by the globalization phenomenon have led to focusing democratic transformations in foreign policy on the role of civil society, not the state per se, in following in the American model's footsteps. Thus, international regimes and foreign policy are becoming more and more dominated by private nongovernmental organizations in a reflection, if not a continuation, of U.S. domestic politics (Haass 2013; Donald and Brown 2000; Bull 1977). Multinational corporations have, indeed, had a privileged position granting them access to the government and the power to constrain its regulatory role in favor of the free market.

### **The Private Corporations' Influence on US Foreign Policy Toward HIV/AIDS**

A fundamental assumption of this dissertation regards the creation of PEPFAR as a logical outcome of the evolution of the patent regime and the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement that protected US pharmaceutical companies' economic interests, thus limiting African AIDS patients' access to ARV drugs treatment. The repercussions of the crisis on Africa's development were devastating. President Clinton's Executive Order 13155 attempted to shift the neoliberal market approach bringing the public health responsibility into the hands of official governments. The 4<sup>th</sup> World Trade Organization Ministerial Conference held in Doha in November 2001 confirmed this need to prioritize public health interests over the private

economic interest of pharmaceutical companies. Yet, in the view of conservatives, allowing the compulsory licensing and parallel importation of generic drugs provisos of the TRIPS Agreement undermined the interest of the US pharmaceutical R&D-based industry. As a result, the Bush administration chose a third way solution that increased the provision of foreign aid to allow African HIV/AIDS patients greater access to ARV drugs treatment. By sending foreign funds to African governments to purchase American products, this neoliberal market solution would preclude the implementation of President Clinton's Executive Order 13155 – and thus expand the job market for US goods and services through PEPFAR. Without the evolution of the crisis in the international patent regime and the US trade policy that regulated access to antiretroviral (ARV) drug therapy, the Bush administration's creation of PEPFAR would not have been possible.

A neoliberal policy approach to the welfare provision offers a comparative advantage in organizing the complex phenomenon of the international HIV/AIDS crisis and in explaining the rationale, timing, and substance of the PEPFAR policy. The creation of PEPFAR was the net result of the interplay between these ideological, political, and economic interests represented by the different, competing demands of various stakeholders and actors. This converged in the clash of interests between African governments, the developing countries' generic producers, and the US R&D-based pharmaceutical industry that respectively sought to provide the public health welfare for a greater cost, the breaking up of the market monopoly by patent holders, and the control of international treaties to maintain existing international IP regimes liberalizing the global market of ARV drugs and HIV/AIDS-related technology. The dominance of the

pharmaceutical industry's worldview on eradicating the HIV/AIDS global crisis through the neoliberal market approach – incentives for investment in R&D in order to promote the society's welfare as a whole through economic growth and medical technology – came to be challenged in international organizations by African governments and the global civil society leading to the Clinton policy change through Executive Order 13155.

Although in its early days the Bush administration promised to abide by the same Clinton HIV/AIDS policy, thus allowing African governments to either purchase cheap generic drugs to meet their public health needs or issue compulsory licensing to produce their own drugs, PEPFAR overturns this position by providing financial resources to avoid the conflict of interests between US pharmaceutical companies and African governments' demand for greater access to treatment. As a matter of fact, the generic producers would acquire a greater market competitive advantage given the saturation of the HIV/AIDS drug market in the West and the expansion of the market in developing countries where more than two-thirds of HIV/AIDS patients are found. This protracted conflict continued to fuel the debate over the benefits of the TRIPS Agreement and IP patent regime in developing countries.

The HIV/AIDS crisis during the first two years of the Bush administration reflected an ideological divide between Republicans and Democrats on the best way to provide for public health welfare. In spite of the strong pro-market foreign policies shared by both parties, the Clinton Democratic administration responded flexibly to the demands of human rights interest groups that had the ear of the Democrats. It relaxed its pro-

market policies by adopting Executive Order 13155. The Bush Republican administration, on the contrary, maintained strong conservative ties with business interest groups leaning more toward market-oriented solutions. As the crisis had evolved along the lines of IP patent regime and Trade-Related Aspects of IP Rights, private R&D-based pharmaceutical companies in the US tirelessly lobbied the government to protect the patent regime, thus denying developing countries the possibility of using the flexibility provisions to develop generic products under the compulsory licensing proviso or importing them from competitive prices around the world under parallel importing measures. Instead, President Bush chose to increase US foreign aid to the developing countries and to transform the foreign aid delivery system so as to provide support to US private corporations and nongovernmental organizations. By using these private entities instead of traditional government-to-government bilateral channels, he applied a neoliberal privatization model to reflect what he called a results-based approach simply because in his conservative belief, government agencies were obsolete and underperformed. This is how much the private business power had influenced ways of thinking concerning what the state can achieve according to the neoliberal world order.

A definition and measurement of business power, though a contested area, is necessary in order to understand how the US pharmaceutical industry has exerted influence on the making of HIV/AIDS foreign policy. Borrowing a definition from social psychology literature, power is understood as the “potential to influence others in psychologically meaningful ways” through the giving or withholding of rewards and/or punishments (French & Raven 1959; Fiske, 1993; Keltner et al., 2003)” (Guinote and

Viscio 2010:2). These authors explain the three components of power entailed in this definition. First, they refer to power as one's "potential" to influence others; second, the psychologically "meaningful" influence includes, but is not limited to effecting how people feel, think, or behave; and third, power may be exerted by means of "soft" influence tactics (e.g., rewards, charisma, knowledge) and/or "hard" tactics (e.g., physical punishment). A dictionary definition of influence clarifies the word as "the capacity to have an effect on the character, development, or behavior of someone or something"; and "the power to shape policy or ensure favorable treatment from someone, especially through status, contacts, or wealth." Using these definitions, how should we measure the power and influence that US pharmaceutical companies exerted on the Bush administration's HIV/AIDS foreign policy decision-making process?

Fuchs (2007) suggests a three-dimensional scale for measuring the power of business on political processes. First, he introduces the instrumental dimension of power as the availability of resources (soft power) that can be used to buy political influence. Because it is in the nature of things that individuals or groups "have a basic need to control their own outcomes and be effective in their relationship with the environment in attempts to secure basic resources and valued outcomes," as Guinote and Vescio (2010:3) note, the power of US private corporations, in this case of pharmaceutical companies, served to advance the notion that private profit incentives were more important than the sovereignty of the nation state to regulate markets. In fact, incentives are necessary to invest and produce innovative drugs that will advance the social welfare of all, including the victims of HIV/AIDS. In other words, this is the understanding that the self-interest of

US private pharmaceutical companies determined the conditions for the public welfare of HIV/AIDS patients even in poor countries. This belief combines availability of resources for investment into R&D for private pharmaceutical companies with availability of both medical and financial resources in developing countries to access new medicines.

Second, Fuchs refers to the structural dimension of power, which concerns the relationship between US pharmaceutical MNCs and the structures of US government. This is the area wherein the business interest group offers to meliorate the general public welfare by producing goods, creating new jobs, bringing in foreign direct investment (FDI), promoting technological innovation, and advancing economic growth. The focus here is on the instrumental influence of US pharmaceutical companies. For instance, they are able to utilize and profit from the privileged status of US global technological competitiveness and the prestige of US leadership in innovative medicine. The US Trade Representative has acted to promote the interest of US pharmaceutical companies in international forums and to secure these interests through international treaties.

Third, Fuchs claims power also entails a normative dimension that consists in the capacity of US pharmaceutical companies to generate and disseminate new ideas – the framework for development, for instance – but also to initiate new modes of thinking (i.e., neoliberalism vs. welfare state). As a result, new international regimes and institutions (i.e., the TRIPS Agreement) are negotiated and enacted to constrain the behavior of states in the international environment (McFarland 2004; Falkner 2010). Given this triple dimension of power – instrumental, structural, and normative –to



influence the US foreign policy, the power of the business on the behavior of states is undeniable. In fact, there is a recognized tendency of the US government to depend on the business community, a model that is more and more exported and adopted abroad under the neoliberal global order. The dependency of states on producing public welfare involves this triple dimension of power; the influence of US pharmaceutical companies as states demand economic resources, social and political organizations, and normative and ideological beliefs to advance their own participation in the public welfare provision.

That is, US private pharmaceutical companies exert instrumental power through their economic resources, i.e., through contributions to political campaigns or capital investment or capital flight. They also exert structural influence through interlocking government and business communities – that is, through the revolving door that impacts the government, as the business sector provides the government with the staff to key advisory and decision-making positions and vice versa, a system that allows both politicians and corporate leaders to align their preferences and implement joint strategies with their governments (Dumhoff 1996; Hart 2004). Besides, the private sector offers job creations while it supports charity organizations or contribution to foundations, universities, or research institutions. Finally, the normative influence of the business industry is felt through production of knowledge, collaboration with academic institutions or think tanks, and by controlling the policy image that filters into the media, public opinion over certain issues, and the definition of any situation prevailing among policy makers.

Scholars contend, however, that the unity and strategy of the business interest should not be taken for granted. This is, instead, not a matter of theoretical conjecture but of empirical study (Falkner 2010). Foreign policy scholars may agree that change in international environment brought in a set of new nonstate actors including NGOs and MNCs, but Neo-pluralists like to emphasize both the political agency of specific firms and the potential for conflict within the business community (Gibbs 1991). There are countervailing forces in the global environment that compete with and limit the business industry's power, preventing a monopolistic control of power. For instance, a multitude of nonstate nonbusiness actors, including human rights advocacy groups, environmentalists, and health workers have emerged to challenge the moral authority and political legitimacy of business actors in the public policy-making process. Also, even if MNCs are eroding the Westphalian system of sovereign states in times of globalization, the very survival instinct of states constitutes a countervailing force whereby the latter attempt to retain their "status as loci of authority not only in core state functions such as security, but also remain powerful gate keepers and providers in other policy areas that are more open to the influence of non-state actors" (Falkner 2010:5).

The business sector is not always unified regarding the political strategy to achieve specific interests. The business conflict theory does not focus on the business industry as a monolithic unit in competition with equally powerful interested groups. Instead, it considers that there are as many inherent conflicts, rifts, and cleavages within any given industry as there are conflicts across industries. That is, the dynamics of conflict of interest within the HIV/AIDS industry – pharmaceutical drug producers, civil

society and human rights activists, governments – reverberates on foreign policy-making. As Falkner (2008:160) puts it, the “fragmentation of the business community and the ability of sectoral or individual corporate interests to form alliance with state actors are seen as central determinants of corporate influence in foreign policy.”

Although structural constraints still play an important role in the foreign policy-making process, and while challenges stemming from other nonbusiness nonstate actors in the global environment are non-negligible, a source of influence in domestic politics, it just so happens that the post-Cold War neoliberal environment has given more prominence in the privatization of policy (Davidson 2009).

The global market dynamics played a crucial role in shaping the IP global governance standards, which are a strategy to improve firms’ market opportunities. Roemer-Mahler (2013:131) argues that the US pharmaceutical industry lobby group PhRMA (1999) acknowledges that Indian patent system and generic competitiveness was the direct motivation for US efforts to enshrine the TRIPS Agreement in the Uruguay Round negotiations. If we accept the definition of the situation as a conflict opposing African governments (as flag bearers for all developing countries) against US pharmaceutical multinational companies, which had introduced a court lawsuit against South Africa for overlooking the TRIPS Agreement for the sake of public health, then it is easy to place PEPFAR in continuity with the US foreign policy toward HIV/AIDS in Africa, and to understand this innovative policy as a solution provided for the global crisis in the public health sector in most developing countries where interests of private companies were given precedence over the needs of HIV/AIDS patients in poor

countries. After the international image of the US was tarnished and the definition of the HIV/AIDS issue started to slip out of the control of US pharmaceutical companies, the US urgently needed to salvage its public stance on this crucial problem that was provoked by the monopoly held by US anti-AIDS drugs patent holders who restricted the market to rich buyers only through the international IP regime.<sup>19</sup>

As Ellen 't Hoen (2009:1) notes, “a patent is the right granted to an inventor by as State, or by a regional office acting for several States, which allows the inventor to exclude anyone else from commercially exploiting his invention for a limited period, generally 20 years.” Many scholars regard this gap in access to treatment as an aggravating factor of the HIV/AIDS crisis in Africa. Fisher and Rigamonti (2005:2) contend, for instance, that the “uneven spread of the pandemic [was] aggravated by the fact that in those regions of the world where the burden is highest, the coverage of antiretroviral treatment is the lowest.” Ellen 't Hoen (2009:xv) also observes, “the high cost of AIDS medicines has focused attention on the relationship between patent protection and high drug prices.” Concerns were raised about the effects of the TRIPS as the developing countries experienced difficulties in accessing the new medicines. As part of the multilateral trade agreements, the TRIPS require protecting both the rights of Intellectual Property (IP) owners, and, in the case of HIV/AIDS treatment, those of

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<sup>19</sup> In 1998, a number of US Representatives wrote a letter to the US Trade Representative under the Clinton Administration, Ms. Charlene Barshefsky, to urge the US government to take steps to force South Africa to rescind its decision, as it overlooked the WTO framework for the protection of the patent over HIV/AIDS drugs. As they remark in their letter with regard to South African public health reform, “The new law contains at least two egregious provisions. First it permits the parallel importation of patented products and second, it allows for the administrative expropriation of patented technology [compulsory licensing]” See Fisher and Rigamonti (2005:35).

private US pharmaceutical companies. The TRIPS Agreement also impose global minimum standards for the protection of IP rights and harmonization of patent terms for at least 20 years before generic formats can enter the market competition. As Sell (2003:9) notes,

States are required to provide adequate and effective enforcement mechanisms both internally and at the border. The Agreement makes the WTO's dispute settlement mechanism available to address conflicts arising under TRIPS, and significantly provides for the possibility of cross-sectoral retaliation for states that fail to abide by WTO's Dispute Settlement Body's (DSB) rulings. Infractions in intellectual property can lead to sanctions on goods. The WTO is empowered to monitor compliance to ensure that defendants carry out their obligations within a reasonable time period. If the defendants fail to comply, the WTO will authorize the complainant to impose retaliatory trade sanctions if requested to do so.

Pharmaceutical companies in the US were very active in shaping and influencing the US government policy toward the global market management of HIV/AIDS pharmaceutical products and medical technology. These business interests coincided with US foreign trade interests and clashed with African governments faced with a severe public health crisis caused by HIV/AIDS. While the former intend to protect their drive for free market for greater incentives by investing in R&D to discover new innovative treatments, the latter's insistence on sovereign use of their political power in addressing the public health crisis affecting their citizens led to a conflict of interests and differing interpretations of the HIV/AIDS global crisis. On the one hand, the American interpretation of the situation – the crisis in Africa's public health sector caused by the virulence of the HIV/AIDS pandemic – used historical analogies and stereotypes of Africa's cultural habits and sexual stereotypes to divert attention from the gap in access to treatment.

The three dimensions or aspects in which US pharmaceutical companies were able to leave their imprint – instrumental, structural, and normative – also reflect US strategic interests related to economic, political and ideological pursuits of US foreign relations as spelled out in the Bush administration’s document *The United States National Security Strategy of 2002*. The normative or ideological level involved removing the responsibility of social welfare provision – or the task of dealing with HIV/AIDS care – from the government and putting it into the private sector and the realm of the civil society – family, faith-based organizations, and community neighborhood as the primary providers of care and welfare. The family culture, religious faith, and business background within which President Bush was raised and socialized informed his personal beliefs and fore-structure, which simply refers to “antecedently developed, already entrenched, cognitive systems, or merely heuristic structures awaiting testing and deployment” through which an image is created and a relationship established (Heelan 1984:79). Thus, an enduring image of Africa as a developmental failure, mired in chronic poverty, combined with the critical statistical evidence of HIV/AIDS infections as compared to the rest of the world allowed President Bush to apply his compassionate conservative approach to promote his idea of development through privatizing the welfare system and adopting of free trade policies in opposition to the traditional Democratic practice of governmental interventionism.

The structural or political level implies the interdependence of the American society with multinational corporations as the expression of freedom, democracy, and entrepreneurship characteristic of US values. Thus, President Bush brought to his office

the agenda to reform the federal government, to overcome the bureaucratic turf war, and to measure government performance by results. In a pluralistic society, the decision maker has to hear and accede to the claims and demands of different constituencies and interest groups. Scholars and analysts of US foreign policy decision-making like to emphasize the importance of domestic politics and the nature of American society as key independent variables of foreign policy. Thus, as Falkner (2008:158) notes, continuity and change in US foreign policy is attributed, in the traditional pluralist perspective, to the “shifts in the relative influence of domestic interest groups and bureaucratic units within the institutional setup.”

The economic level was crucial since it represents the struggle between African nations and US trade interests, materialized in the global crisis around the IP governance regime and TRIPS Agreement. Gilpin (1975) and Casper (2011) have shown how the organization of the international environment reflects the interests and strategy of powerful states. Thus, by institutionalizing its global trade preferences into the multilateral agreement on the basis of intellectual property rights and the management of pharmaceutical products and other knowledge-based industries, the US was simply protecting its own economic interests. The developing countries, along with human rights NGOs, challenged the Intellectual Property (IP) patent regime and the trade aspects of IP rights policy that permit production and access to certain pharmaceutical goods and services. As the crisis intensified upon the advent of the New Millennium, the US government under the Clinton administration made a strategic move, which consisted of abandoning its staunch support of US pharmaceutical companies’ intellectual property

rights and promoting human rights goals instead. Before leaving office, President Clinton tried to resolve this problem by issuing Executive Order 13155 allowing African governments to overlook the TRIPS Agreement for the sake of public health welfare without fear of US economic sanctions. Some critics contend that even this shift did not imply that President Clinton abandoned the strategic national interests of the US, but simply meant that the interests of the state are not necessarily material and that material interests do not always trump humanitarian interests (Katzenstein 1996; Abdelal et al. 2010; Casper 2011).

At the normative level, Ikenberry (2009:5) argues, “The Bush administration did herald a remarkable turn in American foreign policy: a conservative president – perhaps the most conservative in the postwar era – who campaigns for office seeking a return to a realist philosophy of foreign policy but who, in the course of events, invoked liberal internationalist ideas to justify a controversial war and an expansive global agenda.” President Bush neither brought to office a delineated HIV/AIDS global health policy nor did his administration think of the HIV/AIDS global crisis as reason enough to give Africa prominence as a region of foreign policy priority. Instead, given Bush’s White House inner circle’s realist tendencies, policy analysts expected to see Africa further marginalized. Second, the political ploy argument, whether to divert attention from Iraq or to promote development, seems contingent on the 9/11 security concerns of the United States. However, the post-9/11 economy of foreign policy decision makers’ attention and public resources would, instead, decrease rather than increase Africa’s strategic significance in US foreign policy. While the issue’s impact on domestic electoral politics



seems a more plausible reason for adoption, a strong move as an incumbent president in this first term began to prepare for reelection, it is likelier that the role of business in American politics, both domestic and international, was the strongest determinant in the development of the PEPFAR policy.

### **PEPFAR as a Paradigm of Neoliberal Welfare Privatization**

The privatization theory of the welfare provision, simply put, is a theory that advocates the shift in the production and distribution of goods and services from public to private sector. As Starr (1989:22-26) explains, this is a part of the neoliberal rhetoric on what constitutes a good society. Neoliberal inspiration derives from the laissez-faire individualism and free-market capitalism, an economic theory that promises that greater prosperity in society will ensue from less governmental interference with personal choices, private property rights, and market forces. This neoliberal economic theory of a good society is reinforced by its justification by social conservatism which looks for a decrease of government overreach following a return of power to the private sector in family, churches, voluntary organizations, and other forms of associations in civil society. Hence, greater reliance on the private sector and communities in the provision of social welfare is more efficient than the “nanny government” of the welfare state.

Thus, the idea and theory of privatization is grounded in economic, social, and political warrants; first, the laissez-faire individualism and free-market economics, second, the return of power to smaller communities; and third, the political strategy of diverting social demands from government, and by the same token, reducing government overload. There are, however, different forms of privatization that need to be spelled out.

Privatization can mean the cessation of public programs and government engagement in their production and distribution of goods and services; it can mean the transfer of public assets to a private ownership; it can also be synonymous with transfer of expenditures from public funding to private funding – that is, the financing of private services instead of direct government service production and distribution (Table 3).

Table 3. Privatization Influence at Different Levels of the Policy-making Process

Privatization influence	Factors determining the policy process
At the individual level of policy process	<p>The presidential belief in Compassionate Conservatism as a strategy to implement the privatization of welfare provision</p> <ul style="list-style-type: none"> <li>• A humanitarian crisis - President Bush avoids the language of “human rights” but uses, instead, the concept of “human dignity” to divert care from state obligation to religious charity.</li> <li>• His proposed medical Marshall Plan for Africa seeks revisions in the foreign aid delivery system, incorporating private and nongovernmental actors</li> </ul>
At the state (institutional) level	<p>Convergence of domestic politics and bureaucratic structures</p> <ul style="list-style-type: none"> <li>• Competition (public-private) for access to government funds to provide welfare: creation of the White House office of Faith-Based Organizations and Community Initiatives</li> <li>• Circumvent the traditional bilateral government-to-government channel of aid provision and use Agencies, NGOs, and CSOs for aid delivery.</li> </ul>
At the international level	<p>Regimes and international organizations:</p> <ul style="list-style-type: none"> <li>• The Bush administration’s mistrust of the UN, and the Global Fund</li> <li>• Global competition between US R&amp;D-based companies and generic producers (India, Brazil, Thailand, South Africa); the US commitment to protect the “patent” regime that ensures US neoliberal order and economic interests</li> </ul> <p>Other superpower involvement such as:</p> <ul style="list-style-type: none"> <li>• The growing presence of China in foreign aid provision in Africa</li> </ul>

The U.S. domestic political structure and pluralist model has become the most dominant one to be found in global politics, offering multinational corporations as the factor for democratic and economic takeoff. This has led scholars to consider MNCs not only as having a major influence on the American foreign policy but also as being instrumental in the spread of the very neoliberal rules present in the post-Cold War globalized world (Page and Jacobs 2005). This evolution in international politics and the change wrought by the globalization phenomenon brought focus on democratic transformations to the role of the civil society, not the state per se, following in the footsteps of the American domestic society model. Thus, international regimes and the foreign policy of the US are becoming more and more dominated by private nongovernmental organizations as a reflection, if not a continuation of U.S. domestic politics (Haass 2013; Donald and Brown 2000; Bull 1977).

Obviously, President Bush had the desire to reform the US government's bureaucratic structure, especially in regard to the delivery system of US foreign aid. While this goal led to the creation of the Office of the Faith-based and Community Initiatives at the White House in the domestic realm, in the international realm it arguably transformed the foreign aid organizational system from a paternalistic model into a neoliberal model of aid provision, which was expressed through the creation of the Millennium Challenge Corporation (MCC).<sup>20</sup> PEPFAR was just that, a logical offshoot of the MCC and an

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<sup>20</sup> The creation of the Millennium Challenge Corporation (MCC) was the Bush administration's approach to providing foreign aid to African countries under new conditionalities. Unlike the structural adjustment programs of the World Bank and the International Monetary Fund that were decried for their perverse impacts on social welfare in most developing countries, the MCC adopts new incentives defined as good governance to qualify for aid donation. In an op-ed in the New York Times on the first anniversary of the 9/11 terrorist attacks, President Bush notes,

experiment in the implementation of the “Chari Choice” model in the international realm (Olasky 2000; Bush 2010). Hence, many conclude that the recent policy activism – PEPFAR, the Millennium Challenge Corporation (MCC) and the AFRICOM – suggests that the U.S. will likely get involved in Africa when strategic interests that are taken for granted are being challenged by a rival power, in this case, the growing influence of and competition with China as well as the threat posed by global terrorism.

This agenda to reform US welfare assistance can explain why the Bush administration needed to create a new policy PEPFAR, and a new agency, the Office of the Global AIDS Coordinator, to manage the programs. However, PEPFAR is still a federal government program and one does not simply shun existing big government systems or bureaucracies only to create new ones that will grow to repeat the same old mistakes. Instead, the creation of PEPFAR was thought of as a remedy for existing bureaucratic inefficiency. To that extent, the choice of former Eli Lilly, a pharmaceutical company CEO with a background in business, to run this newly created institution proves that President Bush wanted to bring new insights from the private sector into the administration’s daily business.

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“Through the Millennium Challenge Account, the United States will deliver greater development assistance to poor nations that govern justly, invest in their people and encourage economic freedom. And we will continue to lead the world in efforts to reduce the terrible toll of AIDS and other infectious diseases” (The National Security Strategy of 2002, p.vi). Governing justly is, of course, a euphemism for adopting the neoliberal approach that favors privatization of public services, deregulation of trade, and liberalization of the market. President Bush, “Securing Freedom’s Triumph” *New York Times*, Issue of September 11, 2002, A 33, available at, <http://www.nytimes.com/2002/09/11/opinion/securing-freedom-s-triumph.html> (last view, August 1, 2015).

The speed with which President Bush established, through Executive Order 13199, the White House Office of Faith-Based and Community Initiatives which expands and implements the “Charity Choice Welfare Reform Act of 1996” shows that the issue of how to reform the government was one of the Bush administration’s paramount priorities (Olasky 1995; Moens 2004:2; Laurent 2004:40).<sup>21</sup> This was the first step in the implementation of the compassionate conservative approach to the welfare provision. Weiss (2001) affirms that the institutionalization of the OFBCI at the White House was a strategy of the Bush Republican administration to expand the “Charity Choice,” a provision of welfare reform law sponsored by Republicans in Congress during the Clinton administration that allowed religious charities to compete with other nonprofit providers for grants from the Department of Housing and Urban Development for the provision of social services.

The “Charity Choice” represents section 104 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) or simply P.L. 104-193. The law provides that states can operate their welfare programs through contracting out with charity, religious, or private organizations (Stevenson 2003:89). As Republicans controlled Congress in the second term of President Clinton, such Senators as John Ashcroft, Dan Coats, Rick Santorum and Congressmen Steve Largent, JC Watts, and Jim

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<sup>21</sup> Mark Chaves (1999) conducted a scholarly research on the likelihood of religious congregations to take advantage of government monies for social services. To some extent, the research was supported and funded by the US private pharmaceutical companies funds such as the Lilly Endowment and the Nonprofit Sector Research Fund of the Aspen Institute. The findings conclude that support of the “Charity Choice” for welfare provision is likely to come from African Americans and conservative evangelicals, given the entanglement of race and religion in the US history. As such, it is diverted from political leaders and outsourced to religious leaders.

Talent sponsored this law. The debate leading to this reform was fevered, according to Olasky (2000). While the “charity choice” and President Bush’s FBCI assume that religious groups and faith-based organizations do a better job in the provision of social services than many secular agencies, the concept allowed for decreasing reliance on the government to take social action and enabled the president to present the traditional message of values in a nontraditional, caring, non-judgmental fashion (Ebaugh, Chafetz, and Pipes 2006; Leonard 1999:A1; Neal 1999: A14; Mink 2001:6).

The law allowed religious charities to compete with other nonprofit providers for grants from the Department of Housing and Urban Development to provide social services. This way, conservatives believed that individuals would own responsibility for their health and not become dependent on the government. As Weiss (2001:37) contends, the objective in expanding the Charity Choice was for the Bush administration to reduce dependence of the poor on the government. The Bush institutionalization of the Office of Faith-Based Organization and Community Initiatives at the White House was the “Third Stage” of reform of the US welfare system, after the first and second stages that began respectively with Democratic predecessors Lyndon B. Johnson’s Economic Opportunity Act of 1964 and Bill Clinton’s Charity Choice reform, in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

### **Research Methodology**

A sound analysis of the PEPFAR policy cannot overlook a number of important variables, including the decision makers’ action and its underlying ideology, the values and political philosophy operative in the decision-making process, and the processes

leading to the policy of interest. For that reason, a method and methodology are crucial as parts of the research. Method simply refers to a set of procedures and scientific techniques for the collection and analysis of data while methodology concerns the underlying philosophical assumptions that guide the research process and provide it with an overall sense of vision and guidance (Strauss and Corbin 2008). In other words, because PEPFAR is regarded as a decision made by President George W. Bush, it is important to understand not only the framework and personal beliefs that shaped Bush's interpretation of world events but also the bureaucratic culture and institutional structures within which he made that decision.

The framing of the issue or definition of the situation always contributes greatly to the decision-making process and the shaping of policy outcomes. Thus framing refers to what Schraeder (1994) calls the interplay between the nature of events occurring on the continent of Africa and the part of the bureaucratic establishment (President, Congress, or bureaucracies) involved in the policy making process; or what Baumgartner and Jones (2009) term as the interplay between "policy image" and "policy venue" or the decision making unit. This is what determines the policy substance. All these scholars agree that "the way in which a given problem and set of solutions are conceptualized" and the "set of actors or institutions that make decisions concerning a particular set of issues" are crucial in the adoption policy preference (Walt et al. 2008:3011-312).

This brings to mind two questions: What definition of the situation did the Bush administration use to understand the global HIV/AIDS crisis? Was the administration condoning or repealing existing U.S. HIV/AIDS foreign policy toward Africa, and why?

This dissertation is a qualitative case study that uses process-tracing method for data collection and analysis (George and Bennett 2005; Mahoney 2010; Collier 2011). The choice of case study process-tracing method is motivated by the deviant nature of the phenomenon under investigation. While process-tracing analysis suggests “the passage of time plus continuous changes in relationships – including the conditions underlying change and its consequences,” as Snyder, Bruck, and Sapin (2002:55) recall, it also allows explaining the operations “by which various initial conditions are translated into outcomes”; that is, “by going back in time and identifying the key events, processes, or decisions that link the hypothesized causes with the outcomes,” process-tracing explains the outcome of interest using a theory from the onset to solve the problem of establishing a *terminus a quo* without which the process tracing would go on *ad infinitum* (George & McKeown 1985:35; Faletti 2006).

Mahoney (2000) sets the starting point at contingent events that trigger path-dependency processes while Collier and Collier (1991) suggest establishing it at moments of critical junctures. Not all historical critical opportunities, however, have translated into markers or starting points of particular processes. Since PEPFAR deviates from the historical neglect and indifference of US foreign policy toward Africa and fails to fit into existing theories of foreign aid provision, process-tracing can play a heuristic function by generating new hypotheses on the basis of sequences of observed events. For instance, PEPFAR did not occur in the first or second year of the Bush administration but in the third year of his first term. Does the timing of the policy creation have political



significance at all? Why was the policy created in the aftermath of the 4<sup>th</sup> Ministerial Conference of the WTO at Doha or after the 9/11 terrorist attacks?

Unlike too abstract general theories or what Carl Hempel calls “covering laws” that look only at regularities and correlations between the start and finish of a phenomenon, George and Bennett (2005:7-8) suggest another comparative advantage of the process tracing method is that of a nuanced middle-range theory, which can contribute more to theory testing while providing policy-makers with more contingent and specific generalizations. In other words, process tracing can help address aspects of multiple causalities; that is, the issues of equifinality and endogeneity in causal relationships. The former is concerned with the plurality of causes when the combination of different independent variables cause variation in the outcome of interest and the latter refers to the fact that it is difficult to retrace history to verify the direction of causation beyond simple correlations, since covariance is not causation (George and McKeown 1985:23; Mahoney & Terrie 2008).

As a fundamental tool of qualitative analysis, process tracing is also sui for identifying causal mechanisms. George and Bennett (2005:137) define causal mechanisms as, “ultimate unobservable physical, social, or psychological processes through which agents with causal capacities operate, but only in specific contexts or conditions, to transfer energy, information, or matter to other entities. In so doing, the causal agent changes the affected entity’s characteristics, capacities, or propensities in ways that persist until subsequent causal mechanisms act upon it.” Process tracing, thus, allows examining “histories, archival documents, interview transcripts, and other sources

to see whether the causal process a theory hypothesizes or implies in a case is in fact evident in the sequence and values of the intervening variables in that case” (George & McKeown 1985:35).

This work relies primarily on archival resources. Most documents relative to PEPFAR creation, Congressional hearings, and academic analyses are now available to the public through public and electronic libraries such as the Library of Congress and the online National Archives and Records Administration (NARA). Nonetheless, document analysis is not enough because official policy documents do not reveal the hidden agenda and motivations of actors. On the other hand, while they offer the official side of the story, some primary documents are often designated “limited access” and it may take years before classified documents get released. However, a good number of these documents including Presidential State of the Union Addresses, Executive Orders, speeches, directives, memos as well as congressional letters to the Bush administration and transcripts from hearings of the House and Senate Committees and Subcommittees are freely accessible through the Internet and governmental libraries.

To understand the context and public opinion around the issue of HIV/AIDS leading to the creation of the PEPFAR policy, this dissertation makes an extensive use of secondary documents. It sifts through memoirs, academic books and articles, and NGOs’ archives and analyzes articles from the *New York Times* and the leading British weekly peer-reviewed medical journal, *The Lancet*, during the period between 2001 and 2004. Other secondary sources related to the implementation of PEPFAR come from annual reports by US government agencies, including the OGAC, US Accountability Office

(GAO), USAID, the CDC, and Institute of Medicine (IOM). Other international organizations (IOs) such as the United Nations, the World Health Organization, the World Bank, or Think Tank and Research Foundations whose libraries on HIV/AIDS policy contain also useful information about PEPFAR. More specifically, the University of California at San Francisco (UCSF) has created an online database on HIV/AIDS treatment, prevention, and care policy that contains extensive statistics, regional information, and useful analysis of PEPFAR. Avert.org as well as actupny.org are two other important online databanks that provide structured reports and information about the contexts surrounding the creation, progress, and implementation of the PEPFAR policy.

To compensate for the difficulty of accessing first hand resources and deciphering the primary motivation of policy actors, in-depth elite-interviews have been conducted with key policy-makers, human rights activists and corporate lobbyists. These interviews constitute an important source of data, especially since the goal of this study is to identify implicit and explicit influences in the making of the policy. Because there is a natural tendency among policy officials to harmonize their rhetoric based on their shared culture and ideological paradigm, in order to conceal their real political motivations, or for the sake of consistency – this research concurs with Gibbs (1991:6) that “in most cases we can only infer motivations from circumstantial evidences” and, thus, this dissertation employs supplementary official sources to attend to marginal voices from activists and non-governmental organizations. These will provide a relevant alternative source of information in the analysis of implied motivations or hidden interests.

I conducted focus interviews with key policy officials from the Bush administration. Former second PEPFAR Coordinator and now Director of the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria, Ambassador Mark Dybul, has provided an insider view of the policy making process. Former ONAP director Dr. Joe O'Neil, Andrew Natios, former USAID director under the Bush administration, and staff members of the PEPFAR task force and the US Committee on Foreign Relations have provided invaluable insights about influences within and outside the Bush administration during the creation of PEPFAR. While it is expected that official discourse is going to remain consonant with what has been written in memoirs and official documents, I requested an interview with President Bush himself but this was not possible given his busy schedule. His office apologized and delegated Dr. Doyin Oluwole, the executive director of the cancer and AIDS policy at the George W. Bush Presidential Center to handle my interview on behalf of the president. Other interviews have been conducted with staff members from the Senate subcommittee on Africa Affairs and from the House subcommittee on Africa, global health, human rights and international organizations, some of whom preferred to talk on condition of anonymity. John DiLulio, the first director of the Faith-Based Organization and Community Initiative at the White House has been contacted at the University of Pennsylvania, where he teaches in the Political Science Department.

I traveled to Toronto to meet with Stephen Lewis, former UN Secretary General HIV/AIDS Special Envoy to Africa and Canadian Ambassador to the UN, and with Dr. James Orbinski, former MSF director and 1999 Nobel Prize laureate, currently professor

in global health at the Balsillie School of International Affairs, Wilfrid Laurier University in Waterloo, Canada. Other interviews could only be conducted by phone given the difficulty of traveling expenses and visas processes. Yet, appointments for these subsequent interviews are being secured, including one with former UNAIDS director Peter Piot, currently director of the London School of Hygiene and Tropical Medicine. Given the role played by the global civil society, non-governmental organizations, and human rights activists in changing US HIV/AIDS attitude toward Africa and in challenging the pharmaceutical companies' monopoly over the ARV drug market, this work relies also on archival research in NGOs libraries, often available online, including Doctors Without Borders (known by its French acronym MSF) who conducted a successful "Access Campaign" to turn around global perception of HIV/AIDS medicines from a market-oriented approach to the human rights framework for universal ARV treatment. The Yale AIDS Network campaign was crucial in changing the US pharmaceutical companies' patent monopoly attitude toward generic production of essential medicines in developing countries.

It remains crucial to understand how US pharmaceutical private companies exerted power and influence to lobby the Bush administration's decision-making process at every stage from the designing to the implementation of the PEPFAR policy. The present dissertation not only enquires about donations these firms made to the cause of HIV/AIDS between 2000 and 2003 but also about the extent to which their political action committees (PAC) contributed to the Bush electoral campaigns in 2000 and 2004. The consumer project on technology ([www.cptech.org](http://www.cptech.org)) and Public Citizen's Congress

Watch are two invaluable sources of information that compile documents related to pharmaceutical companies' political donations and their relationships to US government. Obviously, US pharmaceutical companies were instrumental in the development of this US official HIV/AIDS policy response under the Bush administration. Adelman and Norris (2004) make the argument that the private sector assistance to the developing world, especially the pharmaceutical industry's philanthropy, by far surpasses the US government official development assistance (ODA).

The aim of this dissertation is to make sense of the President's Emergency Plan for HIV/AIDS Relief (PEPFAR), a conservative administration's global public health initiative to provide social welfare to African HIV/AIDS patients against the backdrop of the US pattern of neglect and indifference toward Africa. The rationale in undertaking the study of PEFAR arises not only because PEPFAR has been acclaimed as one of the few foreign policy successes of the controversial Bush presidency (Stein 2008; Moss 2009; Hindman and Schroedel 2011; Thomas 2001; Sachs 2005) but also because HIV/AIDS is seen as one of the most serious threats to global collective security, Africa's economic development, and human rights (De Cock et al. 2002, Rushton 2010; Gow 2002: 66; Fauci 2001; De Waal 2003a; Sagala 2010; Walensky and Kuritzkes 2010). While it constitutes an impediment to individual life, liberty, productive capacity, and the pursuit of happiness, HIV/AIDS has been identified as an area that deserves special attention and requires urgent action. As MacKeller (2005:303) remarks, one of the Key Findings of the WHO Commission on Macroeconomics and Health gives a special status to HIV/AIDS,

which termed the epidemic as a “distinct and unparalleled catastrophe” that requires “special consideration.”

The devastating effect of HIV/AIDS in Africa predicted since the early 1990s, Dietrich (2005:271) observes, “is now being seen in falling life expectancies, increasing numbers of orphans, and terrible tolls on households, learning, teaching, health systems, agriculture and business sectors across the board.” Because AIDS affects people in their prime who should be working to support their families or serve their nation, it endangers both individual and national economic security. HIV/AIDS’s impact on development prospects public health, political stability, and state capabilities cannot be overstated. The pandemic constitutes one of the greatest moral, social, political, economic, and scientific challenges of our time. Given these political, ethical, and epistemological dimensions pertaining to HIV/AIDS, it is crucial to develop a better understanding of the Bush policy to address the complex phenomenon of HIV/AIDS and the public health crisis in Africa.

One major limitation of this study is that no interviews were conducted with the pharmaceutical companies representatives. Instead, all information on this constituency’s position is derived from archival research and document analysis. I did attempt an interview with Abbott Vice President on Global Affairs. He refused to address my questions and insisted instead that I watch a propaganda video about the company’s philanthropy work in enriching rice production in India and other parts of the developing world. This Abbott senior official inaccurately claimed that his company has never been involved in developing HIV/AIDS antiretroviral drugs although the company used to own the patent for protease inhibitor *Kaletra* (lopinavir/ritonavir). Ethical issues have

tainted the corporate behavior of some US pharmaceutical companies. Lobbying the government thus is a psychologically surreptitious act and no one is eager to reveal the techniques and strategies used.

Finally, the practical policy relevance of this work is tied to prominent debates centered around Africa's poverty, the social welfare infrastructure, political leadership, and moral and cultural values. It proposes a reevaluation of the role that both state and non-state actors should play in the provision of the public good, especially in the face of humanitarian challenges like HIV/AIDS and poverty in Africa. At the beginning of the new millennium, the HIV/AIDS global crisis posed a collective action dilemma. The waning sovereignty and capabilities of national governments in the post-Cold War environment, let alone the private sector vying for more power and autonomy in African failed state, means that it is urgent to devise a new welfare model (Rothkopf 2012; Rosenberg 2005).



CHAPTER THREE: HISTORICAL CONTEXT AND EVOLUTION OF US HIV/AIDS  
FOREIGN POLICY FROM REAGAN TO CLINTON 1981-2001

**Introduction**

This aim of this chapter is to provide the contextual and historical background for the Bush administration's creation of PEPFAR in 2003. To that end, it surveys the evolution of US HIV/AIDS policy under the administrations of Presidents Reagan, Bush Senior, and Clinton from 1981-2001. Beginning with the emergence of the HIV/AIDS epidemic in the US in the early 1980s, the chapter highlights why and how different administrations adopted different attitudes and policy outcomes based on the framing of the issue and entrenched ideological beliefs and interests. For instance, while the Reagan and Bush Senior conservative administrations paid very little attention to the international dimension of HIV/AIDS, not only because of the Cold War context, but also because of their conservative beliefs, the Clinton post-Cold War administration focused attention on multilateral efforts and staunchly pursued a global market liberalization agenda. The representation of HIV/AIDS epidemic thus shifted from the initial conservative sexual moral framing of the Reagan administration, to a public health issue under Bush Senior, and a security threat during the Clinton administration.

The remainder of this chapter is divided into three sections. The first section highlights the origins of the HIV/AIDS disease and the early US response by the Reagan

administration. The second section traces the gradual change in policy attitude and its possible causes during the Bush Senior one-term administration. And the third section focuses on the post-Cold War Clinton administration facing the globalization challenges and delegating most of the responsibility in the fight against HIV/AIDS to multilateral organizations such as the UNAIDS, which it helped create in 1996.

### **The Reagan Administration 1981-1989**

**Origins and evolution of the HIV/AIDS pandemic.** The HIV/AIDS epidemic emergence coincided with the advent of the Reagan conservative administration. The perception of the epidemic at the domestic level played an important role in how the epidemic was handled in foreign policy. The Centers for Disease Control and Prevention (CDC) – which is one of the Department of Health and Human Services federal agencies responsible for tracking the emergence of new epidemics and the incidence of diseases – reported in its *Morbidity and Mortality Weekly Report (MMWR)* issue of June 5, 1981 the five first cases of a rare lung infection, *Pneumocystis carinii* pneumonia, marking the first official reporting of what would become HIV/AIDS. Only one year later, on July 8, 1982, the Public Health Service (PHS) reported a cumulative number of 452 cases of AIDS and 177 AIDS-related deaths and by February 1983, the threshold of the 1,000th case was crossed. The cumulative number of patients with HIV/AIDS amounted to 19,000 cases by the end of 1985. In Surgeon General C. Everett Koop's (1987:4-5) words, “[i]t now takes about a year for the number of victims to double. Today, the total number of AIDS victims is close to 36,000. Over a half of them have already died of the disease and the rest probably will.” At the beginning of the 1990s, Behrman (2004:25) announced that,

“There were almost 115,000 diagnosed cases, and more than 70,000 deaths” in the US alone” and, by the mid-1990s, “roughly 500,000 diagnosed cases had accrued, and more than 300,000 Americans had died of AIDS.” In 2000, HIV/AIDS was considered the fourth largest killer, after heart disease, strokes, and acute lower respiratory infections (Dixon, McDonald and Roberts 2001:381).

The demographics of the disease also seemed to have determined the official policy attitude. Because, in the US, gay men and heroin injecting drug users (IDUs) constituted the highest HIV infection rates, it was logical to infer “an association between some aspect of homosexual *lifestyle* or disease acquired through sexual contact... in this population” (CDC 1981:250-252 italics added). CDC scientists named the epidemic “Gay-Related Immunodeficiency Disease,” or simply GRID. On December 31, 1984, the CDC published a list of patient characteristics showing that gay and bisexual men still represented the highest prevalence rates of 72.8% in the total AIDS population in the US; immediately followed the IDUs who made another 17.3%; Haitians represented 3.5%; and persons with hemophilia made 0.6% of the total AIDS population, sharing in the stigma and blame of this new illness (Lauritsen 1993:14; CDC report of January 6, 1985, Siplon 2002:6).

Although more cases were emerging of the disease affecting other members of society besides the gay community, the blurring of the lines between sexual orientation, race, gender, age, political partisanship, and religious affiliation caused public opinion to shift; due to protests and advocacy organized by the gay community out of fear of stigma and being unfairly associated with the epidemic’s inception, the CDC changed the name

GRID to AIDS in September 1982 (Barnett and Whiteside 2006:30). The Ryan White event also served as a catalyst in changing the American perception of HIV/AIDS. The story of a teenager with hemophilia from Kokomo, Indiana, expelled from school after having been infected with HIV through blood transfusion, had just sent shockwaves across the nation. As more and more parents protested against Ryan White's return to school, fearing that he might become a public health liability in contaminating other kids, the case gained prominence, forcing the president to take a stand.

Also, the death of American idol Rock Hudson on October 2, 1985, caused a national shockwave, leading to a public discussion about raising awareness of HIV/AIDS. As Shilts (1988:588) puts it, "It took a square-jawed, heterosexually perceived actor like Rock Hudson to make AIDS something people could talk about." Another important activist group with roots in the gay community was formed in 1987 in New York City – the AIDS Coalition to Unleash Power (ACT-UP). The ACT-UP had chapters in other major cities and quickly became involved in discussions and debates on HIV policy development. These include "research and pricing of AIDS drug treatments, care of AIDS patients, needle exchanges, preventions and education programs, and most recently, AIDS in the developing world" (Siplon 2002:8). (See Table 4 for the reflection of the distributions of the trends in infection at the end of the year 2000).

Table 4. UNAIDS/WHO Regional Statistics and Features, Dec. 2000

Region	Epidemic started	Adults & children living with HIV/AIDS	Adults & children newly infected with HIV	Adult prevalence rate (*)	% of HIV-positive adults who are women	Main mode(s) of transmission (+) for adults living with HIV/AIDS
SSA	late '70s - early '80s	25.3 million	3.8 million	8.8%	55%	Hetero
MENA	late '80s	400,000	80,000	0.2%	40%	Hetero, IDU
SSEA	late '80s	5.8 million	780,000	0.56%	35%	Hetero, IDU
EAP	late '80s	640,000	130,000	0.07%	13%	IDU, hetero, MSM
Latin America	late '70s - early '80s	1.4 million	150,000	0.5%	25%	MSM, IDU, hetero
Caribbean	late '70s - early '80s	390,000	60,000	2.3%	35%	Hetero, MSM
EECA	early '90s	700,000	250,000	0.35%	25%	IDU
Western Europe	late '70s - early '80s	540,000	30,000	0.24%	25%	MSM, IDU
North America	late '70s - early '80s	920,000	45,000	0.6%	20%	MSM, IDU, hetero
Australia & New Zealand	late '70s - early '80s	15,000	500	0.13%	10%	MSM
TOTAL		36.1 million	5.3 million	1.1%	47%	

- The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 2000, using 2000 population numbers.
- + Hetero (heterosexual transmission), IDU (transmission through injecting drug use), MSM (sexual transmission among men who have sex with men).

Source: UNAIDS, 2000

- SSA=Sub Saharan Africa; SSEA= South & South-East Asia; EAP= East Asia & Pacific; EECA= Eastern Europe & Central Asia

### **The Reagan administration response to the HIV/AIDS problem.**

HIV/AIDS-perceived virulence was beginning to blur the lines between sexual identities, races, and political partisanship, and instead of continuously avoiding tackling a social problem that looked very much a concern of the Democrats, the government had to do something. President Reagan needed an urgent domestic public health policy. The gay community had organized as early as January 1982 to push the administration to do something. Gay men created a lobby group, the Gay Men Health Crisis (GMHC), to educate the government and influence public opinion while protesting the lack of policy leadership and advocating for more funds for research on HIV/AIDS. As a result, the CDC dropped the formerly created name GRID and on September 24, 1982, used for the first time the name Acquired Immunodeficiency Syndrome, or “AIDS” as we know it today.

The Reagan presidency is seen as the most conservative in the US since the end of World War II. Liberal interest groups, for instance, fiercely opposed the nomination of C. Everett Koop in 1981 as Reagan’s Surgeon General because of his conservative religious fundamentalism (Shilts 1988:587). Yet, the Surgeon General’s final report came as a surprise to many, even among Conservatives in the administration, and proved to be a watershed moment in the history of US HIV/AIDS policy. On May 31, 1987, President Reagan made his first major public HIV/AIDS speech at a fund-raising dinner organized by the American Foundation for AIDS Research (AmFAR). On June 24, 1987, the president issued Executive Order 12601, which established the Presidential Commission on the Human Immunodeficiency Virus (HIV) Epidemic. As its task, the Commission

had to investigate the AIDS epidemic and advise the president on national policy. The president appointed Dr. W. Eugene Mayberry, CEO of Mayo Clinic, as chairperson of the commission, an appointment objected to by Jeff Levi, the executive director of the National Gay and Lesbian Task Force, who considered Mayberry to be a person possessing no former experience with the HIV/AIDS disease. As the Kaiser Family Foundation (2006:9) reports, “A series of television public service announcements (PSAs) were created using celebrities and other personalities, including Meryl Streep and Robert de Niro, to deliver messages debunking some of these commonly held myths.” The administration promised to return sexuality to its rightful place within a civilized and democratic society.

Until his 1986 State of the Union Address when he instructed US Surgeon General to work out a public health policy, President Reagan did not address the issue of HIV/AIDS. This tardiness in public policy decision-making – more than five years since the epidemic erupted – was a result of the way in which the administration framed the issue and understood what the role of the federal government should be in dealing with the public health. The Reagan administration’s response to HIV/AIDS, first domestically, then abroad, is summarized in the Surgeon General’s words when he stated that the government should not decide on behalf of the people, but instead enlighten them by providing factual and impartial information so that they can choose for themselves. As Surgeon General Koop puts it, “I have absolutely no desire to quarrel with or change the US non-statecentric system that has served us well for over 200 years... [Besides] Matters of sexual education can only be achieved by the civil society” (Koop 1987:27).

President Reagan's conservative beliefs – a moral condemnation of homosexuals' promiscuous lifestyle – and his political economy regarding any federal welfare policies as proof of the intrusiveness of big government to encroach on individual freedoms – can explain the administration's long silence on the HIV/AIDS issue and policy neglect until 1987. This policy attitude also shaped the international attitude and the absence of HIV/AIDS from the foreign policy agenda during the 1980s. In other words, the traditional way in which HIV/AIDS was conceptualized in the US domestic experience reverberated through US foreign policy during the Reagan, and later, the Bush administrations. Hence, US indifference toward Africa's HIV/AIDS problem during the two-term presidency of Ronald Reagan followed by the one-term presidency of former Vice-President George H.W. Bush naturally flowed from their shared beliefs and the view among US conservative policy makers that HIV/AIDS pandemic did not fit within the strategic interest consisting of defeating the Soviet Union's evil empire (Spectar 2003:507).

Simply put, because the Reagan administration framed HIV/AIDS as a moral issue, not a public health crisis, it could justify its avoidance in developing a domestic public health policy until 1987. As one scholar observes, the administration's strategy during the 1980s, "to the extent there was one at all," was to "avoid the issue of AIDS at all costs because the topic had become a political hot potato" (Behrman 2004:12). It was also easy for the Reagan administration to stave off the looming explosion of the pandemic in Africa because its definition of US national interest was still constrained by the Cold War and HIV/AIDS, understood as an individual moral problem and not a



public health crisis, could be contained through prevention, sexual education – or moral behavioral change (Behrman 2004:24). As a result, the HIV/AIDS epidemic neither received the administration’s attention it deserved nor registered on its foreign policy agenda.

Because AIDS was simply affecting marginalized populations and was seen as a “lose, lose issue,” advisors to President Reagan created a cordon around him and opposed his political engagement with the epidemic. Many observers argue that Reagan was a ceremonial president in foreign affairs, unable to put his stamp on foreign policy “in part because of the attempt on his life and in part because his administration focused on other priorities – the reinvigoration of the economy and of the public confidence in America’s future” (Ohaegbulam 1999:221). Others suggest his understanding of international affairs was defined by his ideological preoccupation with communism and the Cold War, and his perception of American influence as declining in the morass of the Vietnam War and under Jimmy Carter’s weak leadership (Tucker 1988; Greenstein 1998).

Most of the Reagan’s White House staff shared in his conservative beliefs. They also dismissed HIV/AIDS as an issue undeserving of public policy attention. They showed disinterest, “if not aversion, to the effort, and it was notoriously difficult to create any new line item on the budget, particularly in the foreign assistance bucket” and also actively sought a rollback of Soviet gains and an increase in US international leadership through military buildup (Behrman 2004:17). Most Reagan appointees shared the same Republican mindset and made it clear that there would be political consequences if the administration involved itself in any AIDS policy. At the White House, the president’s

aid Patrick Buchanan commiserated with “[t]he poor homosexuals [who] have declared war upon Nature, and now Nature is exacting awful retribution,” while the Director of the Moral Majority, Ronald Goldwin claimed, “What I see is a commitment to spend our tax dollars on research to allow these diseased homosexuals to go back to their perverted practices without any standards of accountability” (Behrman 2004:27). These views were not the minority’s perspective.

US federal bureaus during the 1980s were still insulated from each other and bureaucratic rivalry prevailed rather than cooperation and coordination. The Department of the Treasury that oversees international finance and economic development, and the Department of Commerce that deals with trade policies were not yet as entangled, as they are now, with the idea of interdependence in economic globalization. Also, the Department of Defense was still caught in the Cold War dichotomous definition of security threat, believing that nothing was truly a national security threat besides the nuclear menace to the US. And it was simply an aberration for the State Department that HIV/AIDS, a public health issue, could get on the diplomacy international agenda as concern focused attention on other priorities such as foreign debt, economic development and the structural adjustment programs. Besides, “Leaders at State’s Africa Bureau were shaken by cables that seemed to forewarn of apocalypse,” as the Soviet Union and its pro-Communist acolytes launched a campaign in Africa claiming the Central Intelligence Agency (CIA) had created HIV/AIDS to decimate Africans (Behrman 2004:17-18).

As a result, HIV/AIDS remained confined within the Health and Human Services (HHS) and was handled as a medical public health issue. Back then, HHS and its federal

agencies – the CDC, National Cancer Institute (NCI), Food and Drug Administration (FDA) – did not have an international mandate. The federal government acts through its agencies; and “The Secretary of HHS is responsible for the health of all Americans and must decide which battles to pick when, at any given time, issues around funding for AIDS medical care, requests for social services for HIV-infected patients and their families” (Siplon 2002:16). The Public Health Services (PHS) encompasses the National Institutes of Health (NIH) that, in turn, comprise the NCI and the National Institute of Allergy and Infectious Diseases (NIAID). The NIH is publically funded to conduct research on major diseases. Another important agency of the PHS is the FDA that is essentially designed as a regulatory institution to protect consumers and citizens against food and drug poisoning. The CDC controls new diseases outbreak and handles various public health problems through its many centers, including the Center for Infectious Diseases (CID) under which most of AIDS research took place at the national level. Of course, with relation to foreign policy, other departments play an important role too, mostly the State Department and its USAID agency through which foreign aid money is funneled.

The ensuing HIV/AIDS policy aimed to contain the epidemic through education and support for research and the private sector in order to develop a treatment. Congress, on the other hand, tried to strike the right balance between public demands and private interest. While the executive branch’s policy attention was monopolized by economic reforms and the Cold War, the guilt and stigmatization entailed by the epidemic led the gay community and the people living with AIDS (PLWAs) to constitute an important

lobby to push lawmakers to act on their behalf. As Haitians fought against immigration discrimination that identified Haiti as the origination point of AIDS, people with hemophilia whose infection was caused by errors in the blood industry sought to receive compensation for the many deaths and family disruption that resulted from such blood contamination.

AIDS aroused a lot of passion, fear, controversy and concern in the beginning because it was simply seen as an outcome of the gay lifestyle, generating social stigma against the people living with HIV. “[G]overnments don’t like spending money on sex workers, gay men or drug addicts. Not donor countries, and not scarlet countries either. There are no votes in being nice to drug addict,” as Pisani (2008:27) summarizes. Because the epidemic entailed guilt among the gay men for being associated with the epidemic’s outbreak, they organized to change the mainstream perception concerning HIV/AIDS. The Gay lobby, thus, became an important interest group seeking to influence the Policy-making process during the 1980s.

The US policy makers’ entrenched perception that HIV/AIDS was a “gay disease” created disbelief that it could also spread through heterosexual contacts and encouraged indifference of the Reagan administration to the impacts of HIV/AIDS abroad. However, the CDC had dispatched a team of epidemiologists to collect data about HIV/AIDS in Africa as early as 1982. The team reported that, “HIV was found in a geographic band stretching from West Africa across to the Indian Ocean, the countries north of the Sahara and those in the southern cone of the continent remained apparently untouched” (UNAIDS/WHO 2003:6). The Reagan administration’s response to the

international, like the domestic, dimension of HIV/AIDS came too late and consisted of surveillance, control, and containment. Halfan Mahler, then Director-General of WHO is quoted saying, “AIDS is not spreading like bush fire in Africa. It is malaria and other tropical diseases that are killing millions of children everyday” (Denis and Becker 2006:32). Already, a 1983 WHO internal memo attested to the belief that AIDS was a Western problem and was “being well taken care of by some of the richest countries in the world where there is the manpower and the know-how and where most of the patients are to be found” (Behrman 2004:14).

The contribution of pharmaceutical industry to the US HIV/AIDS policy. The private US pharmaceutical industry has played a crucial role from the early stage of the epidemic eruption, both in the development of the drug for the treatment of AIDS and the US official policy attitude toward HIV/AIDS. Because the private sector is enshrined in US democracy as an instrument in the pursuit of welfare, the private pharmaceutical industry was involved in research and the development of an antiretroviral drug and vaccine that would be able to end the AIDS crisis. To take advantage of the measures created during the 1980s and exploit them for economic gains, Abbott Laboratory, for instance, held the patent monopoly and reaped millions thanks to the first test called ELISA – enzyme-like immunosorbent assay – it had developed in 1985 to measure the level of HIV antibodies in the blood.<sup>1</sup> In 1987, the FDA granted approval to

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<sup>1</sup> Goozner (2004:94-98) discusses the involvement of Abbott Laboratory in HIV/AIDS industry and profit making from its AIDS diagnostic tool kit. However, despite the millions it was making, “Abbott wasn’t spending a dime to combat the disease.” He goes on to suggest that most of the basic research and knowledge on AIDS was produced through academic labs and the NIH. For instance, the NIAID launched the National Cooperative Drug Development Grant (NCDDG) and spent about \$100 million at both nonprofit and private-sector labs to develop drugs to fight HIV.

azidothymidine (AZT) as the first antiretroviral treatment of AIDS. AZT compounds were synthesized at the Detroit Institute for Cancer Research in 1964 on an NCI grant but later abandoned them because they did not appear to have anticancer properties (Angell 2005:26). Burroughs Wellcome – a private pharmaceutical company, which later merged with GlaxoSmithKline – acquired the drug’s patent and claimed it had developed it on its own. Burroughs Wellcome sold AZT under the commercial names of Zidovudine or Retrovir at a monopolistic price of \$10,000 per patient per year. Scientists who had worked on AZT development were appalled at this and reacted to the companies’ claims by releasing a letter published in the *New York Times*, showing that all the stages of testing whether the drug could suppress a live AIDS virus in clinical and pharmacological studies were performed by scientists at the NCI and University (Goozner 2004:103-104).

The industry lobbied the administration to pass a number of measures and enact laws to promote and protect its interests. As one scholar remarks, “From 1960 to 1980, prescription drug sales were fairly static as a percent of US gross domestic product, but from 1980 to 2000, they tripled” (Angell 2005:3). Although this move toward economic liberalization started prior to the Reagan election in 1980, as Reich demonstrates (2007), the Reagan administration provided the necessary environment for the new trend to become the dominant ideology. Not only did the Reagan administration encourage privatization at all levels of society throughout the 1980s but also Congress passed a series of laws designed to speed up the process of privatization as a means to innovation and economic growth. Besides the executive branch, Congress has always played an important role in public policy decision-making process. With regard to the HIV/AIDS

policy, members of Congress distributed up to 12 million copies of the Surgeon General's report to their constituents within a year of its release and also adopted a number of laws during the 1980s giving priority to US pharmaceutical companies in their contribution to the welfare of society, thus de-emphasizing citizens' reliance on the government for public health welfare.

In 1984, Congress passed the "Drug Price Competition and Patent Term Restoration Act," (Public Law No. 98-417, 98 Stat. 1585 codified as amended 21 USC. 355 [1984]), simply known as the Hatch-Waxman Act of 1984. This was an important law that favored private US pharmaceutical companies under the Reagan administration. Named after Senator Orrin Hatch (R-Utah) and Representative Henry Waxman (D-California), the Hatch-Waxman Act of 1984 offered to balance incentives for innovation by research-based pharmaceutical companies with market opportunities for manufacturers of generic drugs. In fact, to compensate for the costs incurred in Research and Development (R&D) as well as clinical trials, pharmaceutical companies charge high prices for their innovative-patented drugs and seek to secure exclusive market rights. This is because exclusivity for the sake of recovering investment costs and the incentive to make profit are believed to be the pharmaceutical industry's lifeblood. By granting marketing monopoly rights to patent holders, generic copies were barred from competition and could expect entering the market only after the patent had expired. Two forms of exclusivity exist in the US, the first that deals with patents is granted by the US Patent and Trademark Office (USPTO), and the second concerns exclusivity and is granted by the FDA.

While the Hatch-Waxman Act intended to “stimulate the foundering industry by short-circuiting some of the FDA requirements for bringing generic drugs to market,” industry lawyers manipulated it to extend the patent monopoly rights for brand-name drugs. As Eurek (2003:2) explains, consumers have always sought alternative cheaper generic drugs because brand name drugs’ price tag is often unaffordable. For instance, the average cost per prescription for brand-name medicines in 2000 was \$65.29 while generic drugs’ average cost was only \$19.33 – almost \$50 cheaper. Hatch-Waxman Act of 1984 established a framework within which manufacturers of generic drugs may seek market entry before the expiration of the patent of brand-name products, via the Abbreviated New Drug Application (ANDA) Process (Strongin 2002:10). Within this framework, manufacturers of generic drugs are required to simply establish the bioequivalence of generic drugs with their brand-name versions without having to repeat the long process of new clinical trials that have already been done by the manufacturers of brand-name products. Once generic drugs pass the test of equivalence in strength, quality, purity, and identity of ingredients and dosage with the brand-name products, they can obtain the FDA’s approval and be made available to patients as soon as the innovator’s patents expire.

The Hatch-Waxman Act of 1984 allowed some provisions for drug innovators who were permitted to delay the FDA approval process of generic drugs under the ANDA framework. The generic manufacturers must certify, “In its ANDA that the patent in question is invalid or is not infringed by the generic product (known as paragraph IV certification) and notify the patent holder of the submission of the ANDA.” If the patent



holders feel generic applicant has infringed on their patent right, they have 45 days to file a suit, which automatically delays the patent application for 30 months to allow litigation of the case. These 30 months are always advantageous to brand name drug patent holders, since they provide them with an additional 2 and a half years of market monopoly. As Eureka (3003:3) notes,

According to a recent study conducted by the Federal Trade Commission [FTC], one of the most common ways that patent-holding companies are able to further delay the market entry of generic drugs is through multiple patent listings in the Orange Book, which is the FDA's official listing of all approved products. The FTC study identified several instances in which brand-name companies listed related patents in the Orange Book after an ANDA had already been filed by a generic manufacturer.

Prior to the Hatch-Waxman Act of 1984, Congress, in December 1980, had already enacted into law a bill sponsored by Senators Birch Bayh (D-Ind) and Robert Dole (R-Kans) "to encourage commercialization of inventions made by government-funded researchers" (Goozner 2004:126). The Bayh-Dole Act of 1980, also known as the Patent and Trademark Law Amendments Act, allowed small businesses, universities, or non-profit institutions to own – in preference to the government – the inventions made using federal funds and to patent their discoveries, although the research was funded by taxpayers' money. The Bayh-Dole Act enables private entities, "to patent discoveries emanating from research sponsored by the National Institutes of Health (NIH), the major distributor of tax dollars for medical research, and then to grant exclusive licenses to drug companies. Until then, taxpayer-financed discoveries were in the public domain, available to any company that wanted to use them" (Angell 2005:7 and 17). This privatization of knowledge produced by public funds was intended to boost the

knowledge-based industry, including the drug industry even when its R&D finds major sources in the public-funded academic community, medical schools, and teaching hospitals. The Bayh-Dole Act allowed drug companies to outsource their R&D and to rely on academia, the NIH, and small biotech start-up companies that conduct the research and contract out with big drug companies to market their findings.

**The Senior Bush Administration 1989-1993.** One significant development in US HIV/AIDS domestic policy under Bush Senior's administration, however, was Congress' enactment of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990. Although President Senior Bush reluctantly signed this bill into law, the Act was the largest federally funded program to improve availability of care for low-income and uninsured victims of HIV/AIDS in the US. Actually, this law was not the administration's initiative, as it resulted from intense activism, protests, lobbying, and pressure by HIV/AIDS organized groups pushing the government to act in favor of the people suffering from AIDS and against the overpricing of first generation antiretroviral treatment drug AZT.<sup>2</sup> The Ryan White programs were "payer of last resort," that is, they provided funds to the victims of AIDS only when other resources were unavailable.

The contribution of the private pharmaceutical companies is obvious from the legacy of the previous Reagan administration. In fact, while President Bush Senior was still Vice President in the Reagan administration, Congress passed one law in 1987,

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<sup>2</sup> See the discussion on the evolution and marketing of AZT by Goozner (2004:103-104) and Angell (2005:26). I shall return to this discussion later on in this dissertation. At this point it will suffice to mention the position held by both authors, who underscore the fact that AZT compounds were synthesized thanks to public funds to the National Cancer Institute although the product was later patented by a private pharmaceutical company, Burroughs Wellcome. The company claimed it had developed the drug all on its own and sold it at a high monopolistic price of \$10,000 per patient per year.

which favored the pharmaceutical industry. The Prescription Drug Marketing (PDM) Act of 1987, which was designed to ensure safety and effectiveness of pharmaceuticals, sought to counter the development of counterfeit, adulterated, misbranded, and expired prescription drugs. It also aimed to establish safeguards against the “diversion market” as prescription drugs prices soared in the US market to unacceptable proportions in comparison with prices in other developed places such as Canada or countries in Europe. As a result, most poor families and uninsured victims of HIV/AIDS were barred from accessing the only therapy treatment existing in the 1980s.

Civil society interest groups like ACT-UP were instrumental in moving the government to address pharmaceutical companies pricing monopoly for a greater access to AZT drug treatment. In fact, conceived as a health care program to provide resources to low-income Americans infected with HIV, the Ryan White CARE Act of 1990 was the culmination of decade-long activist pressure, lobbying, and advocacy to push the Bush conservative administration to act to provide welfare to those patients requiring treatment. The Ryan White CARE Act of 1990 provision of resources for treatment and care of low-income HIV infected Americans simply responded to these domestic forces demanding action from the government. As a result, Congress agreed to scale up resources to address both the issues of treatment and prevention and to provide funds for the development of a vaccine by looking into the social dimensions of HIV/AIDS, both at the domestic and the international levels.

However, the US HIV/AIDS foreign policy toward Africa under the Bush Senior administration did not change that much. Why was this the case? Simply put, as former

Vice-President in the Reagan administration, Bush Senior opted to continue implementing most policies initiated in the years of the Reagan presidency. Princeton Lyman – a former US Ambassador to South Africa and to Nigeria, who then went on to serve as Assistant Secretary of State for International Organization Affairs under the Clinton administration – summarized the Bush administration global HIV/AIDS policy in these terms: “There wasn’t a lot of attention. It wasn’t a big issue to the domestic dimension, but the linchpin of US global AIDS policy through the Bush I years was the policy of keeping people out – keep it away from us. So, there was very little US money going into it” (quoted by Behrman 2004:31). Since the US laws and regulations since 1952 restrict the entry of persons afflicted with any dangerous contagious disease into the country, Congress required in 1987 that the Department of Health and Human Services add HIV/AIDS to the list of diseases significant to public health. In 1993, Congress tightened the restriction by enforcing the border control and asking to send back anyone with HIV/AIDS or bringing anti-HIV medications with them.<sup>3</sup>

Given the understanding of certain historical events in the US and how they had shaped US policies, the total indifference of the Bush administration toward Africa and the lack of federal HIV/AIDS policy was interpreted as a deliberate policy of genocide against undesirable racial minorities.<sup>4</sup> Because of the US history of slavery, segregation,

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<sup>3</sup> i.e., the US government imprisoned Haitians men, women, and children at Guantanamo Bay in the spirit of this law. See [http://www.actupny.org/actions/immigration\\_atn\\_alert.html](http://www.actupny.org/actions/immigration_atn_alert.html).

<sup>4</sup> It is noteworthy to signal here the importance of this shift in the perception of HIV/AIDS in American public opinion. Given the US history of racism, the images of lynching, and the legacy of eugenic science for family planning and population control, the black community was able to exploit the analogy of genocide to stir policy. Horowitz (1997), Fullilove (1999), Reverby (2011), Stillwaggon (2006), and others have dealt with the history of US politics of medical research and

and structural social injustice, African Americans AIDS patients interpreted the Reagan administration policy neglect as genocide, a continuation of eugenic policies and war on the poor (Chicago Committee to End Sterilization Abuse (CESA) 1977; Rosenfeld, Wolf, and McGrath 1973; Macklin 2004; Hawkins and Emanuel 2008; Reverby 2011). Hence, while containment and prevention remained the main policy strategies of the US in the fight against HIV/AIDS – especially in later years when up to 30 million Africans were reported to be HIV infected – preventing access to the available treatment was tantamount to a black genocide, at least according to some interpretations in the African American community. Also indicative were the prohibitive prices of AZT in the US, even years after the drug cocktails were developed and introduced to the market in 1996, during the Clinton era, meaning that fewer than 1 percent Africans and 5 percent Asians had access to these miracle treatments (Burkhalter 2004:9). I will return to this point in the next section.

A recent work by Wellesley University professor Susan Reverby investigates the pattern in US Public Health Service (PHS) of treating vulnerable populations as guinea pigs or targeting powerless non-white members of society as subjects for medical experiments.<sup>5</sup> In her conclusion, she indicates how the US medical foreign policy has

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development at the expense of human lives, especially among the minorities whose lives are of lesser value and expendable as experimental guinea pigs. It is obvious that the HIV/AIDS domestic and foreign policies are indelibly marked with the history of US politics of race, population control, and family planning. This is the context that needs to be spotlighted in order to establish the social dimension of a medical problem.

<sup>5</sup> Susan Reverby (2011) discusses the evolution of ethical requirements such as informed consent, protection of vulnerable subjects, and oversight by institutional review boards as related to policies on medical research in the US in the aftermaths of the Tuskegee experiments. In spite of the fact that heavy-metals treatment or penicillin had proved to be efficient in treating the syphilis

applied different standards of human dignity and rights to human subjects abroad.

Some historical evidence seems to confirm this pattern of US medical interest that utilized non-white human subjects as mere disposables in a slave-like ownership of human beings. These include the infamous “Tuskegee experiment” from 1932 to 1972, the PHS inoculation of heat-killed and virulent organisms at the New York Sing Sing Prison in 1953 for the sake of studying syphilis reinfection, and also the Guatemala case in which US researchers inoculated inmates and prostitutes with the syphilis virus without prior information or obtaining consent. In the early 1970s, many black women were sterilized without their knowledge.

These instances constitute the lenses through which affected African American populations perceived the government’s indifference toward HIV/AIDS, as the pandemic continued faring poorly in US foreign policy toward Africa under the Bush administration. At that time the issue did not gain the international notice that it achieved later on, especially in the early 2000s. In fact, no one in the developing countries protested the prohibitive price tag of AZT treatment or the US foreign policy indifference toward the HIV/AIDS global crisis during the early years of the 1990s.

Several reasons explain this: (1) the global market was not as integrated as it would become in the years following the end of the Cold War; (2) the awareness about global social inequalities in the distribution of goods and services was tolerated based on different national policies and the accepting of national sovereignty trumped the conception of universal human rights; (3) the social stigma associated with HIV/AIDS

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disease, US Public Health Service doctors continued using African Americans as guinea pigs for over 40 years for the purpose of scientific progress.

was morally and sexually induced during the 1980s – not economically or racially based – while everyone still waited for the development and availability of treatment; (4) AZT treatment was still at an experimental phase and the hope was that if these clinical trials were conclusive, the high cost of the treatment would drop as the market expanded to all AIDS patients. It is a mantra of the pharmaceutical companies that innovation depends on market incentives without which investment in research and development (R&D) would simply wither. (5) The shift in the perception of the role of US international aid in the absence of the Communist threat and the push in domestic politics to suppress USAID altogether precluded the administration from focusing on global welfare social policy such as HIV/AIDS in Africa. While US policy makers were preoccupied by the Cold War in the 1980s, establishing the new world order became the major focus wherein the transition to democracy and economic liberalization became the major leitmotiv of US foreign policy during the 1990s.

Given the long history of U.S. foreign policy toward the Third World, population control had become the cornerstone of development policy during the 1970s and 1980s. While still a Congressman, Bush Senior had personally championed the cause of population control so much so that many came to believe that the Reagan-Bush administration HIV/AIDS policy indifference was, in fact, a deliberate omission in order to implement population growth control policy in Africa. To address Third World poverty issues, Bush had proposed to Congress in 1970 measures to control population growth in Africa. He advocated an “urgent need for population control activities to fend off the growing Third World crisis... Our strivings for the individual good will become a

scourge to the community unless we use our God-given brain power to bring back a balance between the birth rate and the death rate” (quoted by Horowitz 1997:546).

In 1987, two CIA officials, Katherine Hall and her colleague Walter Burrows, asked for support to study the booming epidemic on the African continent but were rebuffed by colleagues and the hierarchy within the Agency. “[T]he CIA rejected requests for personnel and resources to study the epidemic [For a three-year period (1987-1990)], arguing it was not an appropriate issue for intelligence agencies” (Gellman 2000, A1; Spectar 2003:508). One official is reported saying AIDS “will be good, because Africa is overpopulated anyway” (Siplon 2002:117; Behrman 2004:67).

Surprisingly, Hall and Burrows eventually received the go-ahead during the Bush presidency in 1990 and were able to produce a classified document, the “Interagency Intelligence Memorandum 91-10005” titled, “The Global AIDS Disaster: Implications for the 1990s.” Some unclassified portions were given to the State Department in an attempt to bring the global health concern to the attention of U.S. policy makers. The document predicted that, “The great majority of the new AIDS cases during the 1990s will occur in Sub-Saharan Africa, with North America a distant second” with estimates of worldwide infections being as high as 45 million. “The AIDS epidemic is at its worst in Sub-Saharan Africa. At least 7 million Africans have been infected with HIV. By the mid-1990s the total probably would exceed 20 million HIV infections, and beyond the year 2000, infections rates will be up to 40 percent for young-adult populations in many urban areas, with life expectancy at birth reduced by 15 years or more” (The State Department 1992:v; Siplon 2002:118; Behrman 2004:30).



However, even in the mid-1980s, the Reagan-Bush administration was “in possession of highly classified reports about the potential scale and scope of the burgeoning AIDS epidemic [but] the reaction was indifference – that’s the right word” (Gellman 2000, A1). The indifference of US policy makers toward the HIV/AIDS epidemic in Africa was, thus, reinforced in international politics, by the post-Cold War focus on economic liberalization and democratic transition, which agenda President Bill Clinton carried out until the activism of a global civil society – alternatively called the world social forum – came to challenge the dominant definition of HIV/AIDS, in medical and epidemiological terms, replacing it with an encompassing approach that integrates social, economic, political, and moral aspects of the HIV/AIDS virus. As a result, new nonstate global actors brought a new understanding of the issue back to the attention of US foreign policy decision makers, presenting it as a threat to “human security” and the ideal object of achieving universal human rights.

The indifference of U.S. policy makers toward the HIV/AIDS epidemic in Africa was reinforced in international politics mostly because of the end of the Cold War and the collapse of the Soviet Union. The post-Cold War focus on establishing a New World Order with its central claim being economic liberalization and democratic transition, which agenda President Bill Clinton will have to carry out in the creation of World Trade Organization and the establishment of the Trade-Related Aspects of Intellectual Property Rights until the activism of a global civil society – alternatively called the world social forum – came to challenge the dominant definition of HIV/AIDS, in medical and

epidemiological terms, replacing it with an encompassing approach that integrates social, economic, political, and moral aspects of the HIV/AIDS.

### **The Clinton administration 1993-2001**

**Evolution of the US response to the HIV/AIDS problem.** President Clinton had less time to spend on the HIV/AIDS issue because his presidency was fraught with political opposition in the beginning and sex scandals toward the end. Instead, from the very first, he chose to delegate the issue to his bureaucratic minions. Actually, following the so-called Newt Gingrich revolution in 1994 and the November 1995 government shutdown budget, President Clinton looked very much like a one-term president. At the same time, North Carolina conservative senator Jesse Helms not only advocated the shrinking of US foreign assistance but also battled to get the USAID abolished altogether. This campaign became a disincentive to supplying US official funds to fight the global threat of HIV/AIDS. As a consequence, as President Clinton became consumed with trying to position himself politically, it was challenging to get global HIV/AIDS on his agenda at all. Clearly, dealing with HIV/AIDS would not help him recover his political capital at home and, therefore, was not a part of his political strategy to recapture momentum (Behrman 2004:103-7). The near-impeachment in 1998 put a tremendous constraint on the Clinton administration's Africa HIV/AIDS foreign policy to the extent of paralyzing its political will and preventing any serious change.

Consequently, President Clinton gave only sporadic attention to the magnitude of AIDS in Africa, both because of the above-mentioned financial constraints and domestic political issues. US HIV/AIDS foreign policy continued focusing on curbing the

epidemic's threat at the domestic level rather than containing its global spread.

Through the creation in 1993 of the Office of National AIDS Policy (ONAP) for domestic policy and the UNAIDS, a United Nations Joint interagency Program he helped to create in 1994, President Clinton simply delegated the coordination of global efforts to multilateral efforts. The first director of ONAP, Kristine Gebbie resigned after 15 months because she could not have access to the president. Sandy Thurman, the third Clinton AIDS czar – as the ONAP director came to be known – was still complaining in 1997 that, despite bureaucratic advocacy to get the president's attention, "Clinton did not move one inch on global AIDS in 1998" (Behrman 2004:223).

Earlier, President Clinton had established the Presidential Advisory Council on HIV/AIDS (PACHA) by Executive Order 12963 on June 16, 1995. Through the HHS Secretary, this body was to provide the administration with information, advice, and recommendations on programs and policies for prevention, treatment research, and services regarding the HIV disease. PACHA produced its final report in September 2000, *No Time to Spare*, in which Richard Holbrooke, then US Ambassador to the United Nations, argued, "AIDS is the toughest and biggest of all issues, not just for Africa (although) Africa is the epicenter... if you ask what the number one problem is in the world today, I would say It is AIDS" (See distribution of global HIV/AIDS prevalence in Table 5). The Clinton Administration's overall HIV/AIDS policy goals were economic recovery from the Bush economic recession and debt, and the consolidation of the US global power status in the post-Cold War international order. His HIV/AIDS policy agenda remained, like that of his predecessors, focused on the domestic dimension.

Table 5. Contrasting Africa's HIV/AIDS Prevalence and Incidence With the Rest of the World, Dec. 2000

	Adults and Children living with HIV/AIDS	Adult and Children newly infected with HIV	Adult prevalence
Sub-Saharan Africa	25.3 million	3.8 million	8.8%
North Africa and Middle-East	400,000	80,000	0.2%
Rest of the world	10.4 million	1.4 million	0.4%
Total	36.1 million	5.3 million	1.1%

(Source: UNAIDS, 2000)

The marginalization of Africa in US foreign policy increased even further as policy makers were frustrated with humanitarian efforts in Somalia. About Somalia analogy, Holbrooke is quoted (by Chollet and Goldgeier 2002:159) as saying that,

[T]wo less pleasant memories still hung like dark clouds over the Pentagon. Phrases like 'slippery slope' and 'mission creep' were code for specific events that had traumatized the military and the nation; Mogadishu, which hung over our deliberations like a dark cloud; and Vietnam, which lay further back, in the inner recesses of our minds.

In fact, in December 1992, US troops were sent to Somalia to back the UN mission of alleviating the scourge of famine, and eventually to disarm the Shaabab troops of Aidid. The "Somalia syndrome" became a limiting factor on President Clinton during the 1990s so much so that his administration felt constrained and failed the humanitarian test to intervene in Rwanda to stop the 1994 genocide (Macqueen 2002; Potier 2002; Schraeder 2001:132). This "Somalia syndrome" refers to eighteen US soldiers and twenty-four Pakistani peacekeepers who were killed in Mogadishu on October 3, 1993. As a result, senior officials saw the region as one of strategic irrelevance – "the perfect place from

which to pare down commitments to secure a ‘peace dividend’ for an increasingly insular American public” (Behrman 2004:71-73).

As foreign aid to Africa was shunned, mostly in favor of former Soviet nations in Eastern Europe, President Clinton sought to promote trade policy in an effort to liberalize the free market during a time of globalization. As a matter of fact, Conservatives in Congress championed the idea of abolishing foreign aid, which, in the late 1990s was perceived as unnecessary waste and an expression of either paternalistic Cold War policies or liberal profligacy with US taxpayers’ money. Many US missions closed down in Africa while a bureaucratic downsizing occurred at the Africa Bureau in the State Department. North Carolina conservative senator, Jesse Helms, as quoted by Behrman (2004:73), epitomized this position when he remarked,

foreign assistance merely siphoned funds from US taxpayers to inept despots or corrupt regimes who would not use funds efficiently or judiciously. The money rarely went to those in need... and when it did, it helped make recipients dependent on American aid, perpetuating a negative cycle that stood against the interests of all involved.

Donald and Keller (2006) summarize the Clinton administration approach to Africa, as the Cold War rationale would no longer viably inform U.S. foreign policy. After the humanitarian catastrophe in Somali and Rwanda, President Clinton not only created three new institutions – namely, the Office of the Ambassador at Large for War Crimes Issues; the Atrocities Prevention Interagency Working Group; and the African Crisis Response Initiative designed to build capacity for peacekeeping with US assistance – but also launched the African Growth and Opportunity Act (AGOA) or The Trade and Development Act of 2000. This is a free trade policy that sought to unleash the potential

of Africa in ways that would lead to prosperity and peace (see also Scheffer 1998; 2002). As Susan Rice replaced George Moose as Assistant Secretary of State for African Affairs, she sought to accelerate the integration of Africa into the global economy by promoting economic development, the democratization process, and conflict prevention and resolution.

However, the major crisis in US-Africa foreign policy during the Clinton administration was the battle to access the newly developed drugs that had achieved the transformation of HIV/AIDS from a death sentence into a chronic disease. The highly active antiretroviral therapy (HAART), or the so-called AIDS “drug cocktails,” was introduced at the XI International Conference on AIDS in Vancouver in 1996. It was proved that HIV/AIDS mortality rate in the US dropped from 48,000 in 1994 to 16,000 in only four years from 1994 to 1998. However, these drug cocktails were patented for at least 20 years, which gave their producers market monopoly to charge, as they deemed it acceptable to recoup the investment in R&D. Against the demands of African and other developing nations to lower the cost of antiretroviral drugs so as to allow them to meet the public health needs of their citizens, the Clinton administration championed the protection of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) that promoted the private interests of US pharmaceutical companies. The US government had, indeed, lobbied on behalf of the American business industry for the incorporation of the TRIPS negotiated at the creation of World Trade Organization (WTO) in 1994. The US government took it upon itself to oppose any government that would undermine these TRIPS, which came to constitute the incentive backbone of the new global knowledge-

based economy to promote investment in research and development (R&D), leading to more innovation and even greater social welfare. However, as Stephen Lewis contends, “it is preposterous to think that so much money is spent on development when you know that the money spent on research and development is dwarfed hugely by the money spent on marketing” (personal interview with the author, January 18, 2013).

An illustration of this can be seen in how the US government actively lobbied international treaties to oppose and block any agreements that would allow production and commercialization of low-cost generic medicines in developing countries (Fidler 2004:120; Casper 2011; Gellman 2000a; Attaran and Gillespie-White 2001). At the WHO meeting in May 1998, the official delegation of the US led by HHS Secretary Donna Shalala continued to pressure the Organization not to accept the African position represented by South African, Zambian, Botswana and Namibian delegations and which voiced opposition to US revised drug strategy protecting private pharmaceutical interests. For the African block, public health should have primacy over private commercial interests under the WTO trade agreements. In fact, the US government showed hostility against the South-African government new law, the Medicines and Related Substances Control (MRSC) Act of 1997, which sought to increase access to affordable generic substitution of off-patent medicines for public health. The brand-name medicines were simply unaffordable at \$10,000 to \$15,000 per patient per year.

MRSC Act of 1997 was the legal framework to reform the apartheid-inherited healthcare system to meet the needs and challenges of its black population infected with and affected by HIV/AIDS. The policy sought to increase access and availability of

affordable generic substitution of off-patent medicines for public health use because brand-name medicines were unaffordable. “As well as 45 percent of its army, more than five million of South Africa’s 39 million people were infected with HIV/AIDS. And yet in the face of this crisis, pharmaceutical companies refused to lower prices for patented ARVs” (Orbinski 2008:355). Instead, 39 US pharmaceutical companies coalesced and launched a lawsuit to force South Africa to repeal its newly reformed public health law. They lobbied the European Union and US government to maintain pressure on South Africa until it reversed its reform. Vice-President Al Gore and US Trade representative Charlene Barshefsky threatened South Africa with sanctions unless it repealed the criticisms of and protests against this US policy stance. Actually, the US government imposed sanctions on South Africa and Vice-President Al Gore travelled to meet with President Mandela in person to signify that the US would not tolerate the legislation. On the other hand, European allies like the vice-president of the European Union Leon Brittan as well as French President Jacques Chirac raised France's concerns' during a state visit while the Swiss president and German chancellor discussed the issue privately with Deputy President Mbeki.

A confidential State Department cable of May 27, 1998 (p.8, emphasis added) to some US Embassies in Europe, Africa, and Latin America, and also to other US officials including the USTR, USAIDS Coordinator, Secretary of HHS, NIH and the CDC Directors – contends that “USG [US government], in consultation with our allies, have both the responsibility and opportunity to develop a position on the revised drug strategy resolution that will *enable health and trade to move together in a compatible manner*, not



to be used to foster a North-South trade dispute using health as a proxy.” The Assistant Secretary of State for legislative affairs, Barbara Larkin, wrote a letter to Congress in 1999 in which she affirmed that the US government would defend the legitimate interests and rights of US pharmaceutical firms.

On 5 February this year, Larkin assured Frelinghuysen that 'we are making use of the full panoply of leverage in our arsenal to persuade the South African government to change its law'. An attached report by the State Department confirms that it is acting 'with the full support of pharmaceutical industry representatives'. The report, obtained by The Observer goes on to describe how the US embassy in Pretoria courted the Swiss and EU member embassies to interest them in a 'joint effort' against South Africa. (The Guardian Dec. 18, 1999).<sup>6</sup>

In the aftermath of the end of the Cold War, the US government, under the Clinton administration, championed a neoliberal policy approach. “A new Approach to Africa was taking shape in U.S. foreign policy decision-making circles,” as Schraeder (2000:406) notes, that aggressively looked at facilitating “U.S. private enterprises in all regions of the world, including francophone Africa. [Meanwhile], most U.S. Ambassadors served as advocates for U.S. business.” The promotion and protection of US private corporations abroad – in this case, trade policy to protect US pharmaceutical companies – became synonymous with US national interest. In fact, while expectations were raised at the end of the Cold War that U.S. policy makers would finally take into account African realities, disappointment ensued when most observers remarked further recession of interest and presidential attention toward African matters. As Africa came to be seen as a neutral terrain where all powers could fairly compete, the deference of the US to its traditional European allies (during the Cold War) in matters regarding Africa

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<sup>6</sup> <http://www.theguardian.com/uk/1999/dec/19/theobserver.uknews6>

ended. In the words of Warren Christopher, “The time has passed when Africa could be carved into spheres of influence, or when outside powers could view whole groups of states as their private domain.” And yet, former Assistant Secretary of State for African Affairs, Herman Cohen, corroborates this view when he affirms, “We must accept free and fair competition, equality between all actors” in post-Cold War foreign policy Africa (quoted by Schraeder 2000:404 and 410).

Many among the developing countries opposed such HIV/AIDS neoliberal policies favoring private business interests over urgent public health imperatives. African delegations represented by South Africa, Zambia, Botswana and Namibia unanimously argued that under the WHO trade agreements public health should have priority over private commercial interests. South Africa had wanted to implement its MRSC Act of 1997 to reform its health care system after the apartheid era to expand universal coverage to its black population. At the 1998 Geneva World Health Assembly discussion, HHS Secretary Donna Shalala and Ambassador George Moose refuted the claim from the developing countries that “public health should have primacy over commercial interests under WTO trade agreements such as the TRIPS. The problem for the US and our allies was not with the sentiment of the statement, but rather the linkage of the specific wording to the TRIPS Agreement itself, thereby potentially undermining Intellectual Property Rights (IPR)” (Department of State cable 1998, § 2, section c). The Clinton administration, however, would change its policy stance that supported the private interest of US pharmaceutical industry in favor of the common good and the public health of the poor. This was the result of international advocacy, negotiations, pressure, and

lobbying to bring awareness to the public opinion about the practices of US pharmaceutical companies.

**The Contribution of US Pharmaceutical Companies.** The introduction to the global market of the Highly Active Antiretroviral Therapy (HAART) in 1996 changed the landscape of the epidemic. It not only transformed AIDS from a lethal to a chronic disease but also reduced significantly the number of deaths among American AIDS patients. “And between 1996 and 1997, HIV/AIDS mortality declined 47 percent, falling from the leading cause of death among 25-44 year olds in 1995 to the fifth leading cause of death in that age group” (The Clinton/Gore administration 1999:4). “The discovery of a drug combination capable of controlling the human immunodeficiency virus (HIV) was one of the great triumphs of biomedical research in the postwar era,” as Goozner (2004:85) puts it. To make these drugs not only available but also accessible to patients in the developing countries where the scourge of AIDS was so great remained the greatest political challenge. The prohibitive costs of the treatment marginalized AIDS patients from the developing world while US foreign policy consisted of protecting private pharmaceutical business interests in the global market over and against the demands of citizens from developing countries by threatening African governments that sought to circumvent international trade agreements with economic sanctions.

Only generic versions of ARV drugs could make access to treatment possible in resource-poor settings. Their cheap costs would allow addressing the scale and scope of the HIV/AIDS problem in Africa. The South-African case illustrates the conflict between African countries’ urgent demand to access generic pharmaceutical drugs due to the

public health emergency and the protectionism of US trade interests tied to the strict observance by all of the TRIPS Agreement. Executive Order 13155 relaxed this US government attitude toward Africa's urgent need to access HIV/AIDS pharmaceuticals. While Africa remained the neglected stepchild of US diplomacy between 1993 and 1999, this was a major shift in the US-Africa HIV/AIDS policy.<sup>7</sup> It was however preceded by measures that remained unsatisfactory and forced by international and domestic advocacy, political calculations, and global activism.

Behrman (2004:78) suggests, “[w]hile there would be roughly 1 million Americans infected during the decade, the United States would come to spend more than \$10 billion per year on the domestic epidemic. In that same period more than 40 million infections would accrue worldwide. The United States would spend little more than \$100 million per year on the global dimension.” In 1999, African governments rejected the Clinton administration's offer of \$17 billion in loans through the US Export-Import Bank for hospitals and medical equipment and pharmaceuticals in Africa.<sup>8</sup> This rejection was

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<sup>7</sup> Among the criticisms the Bush campaign team addressed to the Clinton administration in 2000, Robert Zoellick emphasizes the economic policy flaws, which are demonstrated in Clinton's reversal of his staunch support of neoliberal economic principles. He “started with an encouraging emphasis on trade, perhaps because he inherited a signed NAFTA deal and a partial Uruguay Round agreement that he could not abandon easily. But after 1994, the Clinton administration changed its course: it made pledges for free trade, but the reality of its policies did not match the rhetoric.” This attitude arguably led to the stalemate at the Seattle WTO round of trade negotiations in 1999. Apparently, Washington had the power to shape global economic relations for the next 50 years; an opportunity that was squandered by giving in to international pressures to return to the welfare state allowing the developing countries to continue regulating the market as seen in Executive Order 13155. <https://www.foreignaffairs.com/articles/2000-01-01/campaign-2000-republican-foreign-policy>

<sup>8</sup> The Health GAP coalition sent a letter to President Clinton explicitly denouncing the Ex-Im Bank proposal as an unacceptable step backwards from the administration's commitment not to interfere with TRIPS-compliant compulsory licensing and parallel importation. This policy proposal is actually in consonance with profit-driven agenda of pharmaceutical corporations

grounded on three implications. First, new loans would create more burden on African governments when existing debt was undermining their ability to purchase drugs and provide social welfare; second, all indications showed that the money would be used to purchase brand name drugs from US companies and thus ensure the corporate welfare; and third, the initiative appeared to be a means to trump African governments' efforts to develop cheap generic treatments or import them from other developing countries' markets (Raghavan 2000).

As the year 2000 fast approached, the international community was assessing its development assistance programs. The year 2000 was also a critical year in the US because of the upcoming presidential election. The evaluation of foreign development policies – debt, trade, aid led to a strong global advocacy movement for Africa's sovereign debt cancellation and increase in foreign aid. Since most African countries stand at the bottom of the UNDP Human Development Index, debt relief became an international policy agenda for many UN agencies and nongovernmental organizations. As the World Bank (1997a: 202) noted, "Sub-Saharan Africa accounts for 32 of the UN's 40 'least developed' member countries. Its foreign debt has trebled from US\$84.1 billion in 1982 to US\$235.4 billion (quoted by Barnett and Whiteside 2006:139).

On May 10, 2000, President Clinton signed Executive Order 13155 allowing Sub-Saharan African countries greater "Access to HIV/AIDS Pharmaceuticals and Medical Technologies" despite his administration's record of consistent neglect of Africa's

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rather than with the growing consensus about the consequences of existing economic policies on public health and HIV/AIDS in Africa. See [http://www.iatp.org/files/NGO\\_Letter\\_Against\\_Export-Import\\_Bank\\_AIDS\\_Dru.htm](http://www.iatp.org/files/NGO_Letter_Against_Export-Import_Bank_AIDS_Dru.htm) last accessed March 6, 2016.

HIV/AIDS plight and threat of trade sanctions in case African governments breached the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement. For many years, the Clinton administration had strongly opposed any African governments that attempted to access antiretroviral treatment through the cheap generic drug market for their citizens' treatment. According to the TRIPS Agreement, the generic products were meant for local domestic markets, as a way to protect the patent regime on intellectual property rights, and consequently the business interest of US pharmaceutical companies. As Behrman (2004:113) notes, for most of the 1990s, "it was not deemed particularly cost-effective to devote resources to AIDS prevention in the absence of a vaccine." A chart by Jonathan Quick of WHO of how \$10,000 could be spent shows that in terms of financial cost 9,900 people could be saved from fatal bouts of dehydration or hundreds from pneumonia and tuberculosis while only one person could receive anti-AIDS treatment for the same amount. President Clinton's May 2000 Executive Order 13155 claims,

In administering sections 301-310 of the Trade Act of 1974, the United States shall not seek, through negotiation or otherwise, the revocation or revision of any intellectual property law or policy of a beneficiary sub-Saharan country, as determined by the President, that regulates HIV/AIDS pharmaceuticals or medical technologies if the law or policy of the country: (1) promotes access to HIV/AIDS pharmaceuticals or medical technologies for affected people in that country; and (2) provides adequate and effective intellectual property protection consistent with the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) referred to in section 101(d)(15) of the Uruguay Round Agreements Act (19 USC. 3511(d)(15)).

Furthermore, the above-mentioned policy encourages African beneficiary countries to implement policies that address the underlying causes of the HIV/AIDS crisis, namely, by making "efforts to encourage practices that will prevent further transmission and

infection” and by stimulating the “development of the infrastructure necessary to deliver adequate health services”; but also to provide “an incentive for public and private research on, and development of, vaccines and other medical innovations that will combat the HIV/AIDS epidemic in Africa” (Executive Order 13155, Sec.1, §.b).

Most HIV/AIDS budget increases went to domestic programs for research, vaccine development, MTCT prevention, racial and ethnic minorities care, prevention, and treatment. Clinton deferred international efforts to multilateral organization, specifically the UNAIDS which his administration helped to establish in 1996. The president announced the commitment of \$10 million in USAID emergency relief funding to provide support for AIDS orphans through community-based efforts. In 1999, the 106<sup>th</sup> Congress authorized resources to support a proposal by Vice-President Al Gore to broaden US activities abroad related to HIV/AIDS. On July 19, 1999, the Clinton administration launched a new global AIDS initiative called the Leadership and Investment in Fighting an Epidemic (LIFE), increasing to \$100 million the US spending on HIV/AIDS slated to begin in FY 2000. LIFE AIDS initiative had a heavy focus on Africa and enhanced “US leadership in this area [while making] more resources available to developing countries through such measures as debt relief and concessional loans... LIFE funding – approximately one-half of which went to USAID – enabled USAID to step up its HIV/AIDS *prevention* and mitigation efforts in 13 countries (12 in sub-Saharan Africa plus India) (USAID 2001:21 emphasis added). As Kendall (2011:5) acknowledges, LIFE “represented the first time agencies other than the United States

Agency for International Development (USAID) were included in the US response to HIV/AIDS.”

The crisis in HIV/AIDS and African public health was even more exacerbated by limited access to treatment due to certain economic constraints of most people living in the developing world. The Médecins Sans Frontières (MSF) director, the French international organization that was awarded the Peace Nobel Prize in 1999 for its involvement in the war against HIV/AIDS in resource-constrained countries, argues,

Individual pharmaceutical corporations and the industry’s lobby group, PhRMA (a group of 100 of the biggest drug companies in the world, with seven lobbyists for every congressman in Washington, and hundreds more lobbyist in Europe as well), had lobbied Western governments to oppose measures that would make HIV drugs cheaper and more available in the poorer regions of the world. PhRMA feared that if patented drugs were sold at lower prices in the developing world, people in the wealthier countries would demand the same and profits would be driven down. In 1999, with global pharmaceutical sales at \$337 billion, profits were massive. PhRMA companies were among the largest and most profitable of all Fortune 500 corporations, positions they had held for nearly thirty years.

The HIV/AIDS global crisis and the demand by the internationalists<sup>9</sup> for greater access to pharmaceutical products led the Clinton administration to change the US trade policy and

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<sup>9</sup> By this, I mean to refer to international nongovernmental organizations but also to a whole current in academic scholarship that has adopted a cosmopolitan approach to basic human rights. Where nationalists defend the right of governments to preserve state’s sovereignty and to only care for the right and welfare of their national citizens, internationalists, especially after the end of the Cold War, make a compelling argument that the duty to care for people transcends one’s national boundaries. The collective security impels the duty to intervene wherever human rights are put in jeopardy. In his *Political Theory and International Relations*, Beitz (1999) challenges for instance the traditional realist view that moral principles have no room in a world system of sovereign and autonomous states. Bringing together the mingly estranged fields of morality and international relations, he contends that in a cosmopolitan conception of international morality, state boundaries have merely a derivative significance. Unlike political cosmopolitanism, moral cosmopolitanism does not necessarily entail global institutions conceived on the analogy of the state. Thus, someone like Beitz can extrapolate the morality of the domestic into international institutions, concluding that, “international relations [are] coming more and more to resemble domestic society” (Beitz 1999:128). (See also Pogge 2002; Lu 2005; Brock 2005; Rawls 2001).



adopt a different HIV/AIDS foreign policy stance toward Africa. This change came as a result of a conjugation of factors including protests, pressure, negotiations, and international advocacy by domestic interest groups, international organizations, nongovernmental organizations, and African governments. On June 27, 2000, the Peace Corps announced that all its volunteers in Africa would receive training on HIV/AIDS so that they could educate the African populations they served on related matters (Copson 2005:12). In sum, US official contributions to fight HIV/AIDS global crisis, which amounted to less than \$200 million during the 1990s increased to \$450 million by the end of the Clinton presidency, of which one-third was to be administered by the World Bank and two-thirds through bilateral programs (’t Hoen 2009; Russell 2004:139; Casper 2001:8; Liew et al. 2006).

Spectar (2003:509-511) argues that this transformation in US global leadership on HIV/AIDS global pandemic during the Clinton-Gore administration proceeded from senior officials’ dramatic redefinition of US national interests in light of the new age of bio-globalization and ancillary governance dilemmas. Arguably, in the mid-1990s, the Clinton administration was confronted with the following factors: (1) data about the scope and potential ramifications of HIV infections in Africa and other microbial threats; (2) the quickening of the process of globalization, rendering infectious diseases and bioterrorism a new security threat to the US; and (3) the administration’s belief that “US national interests were affected because infectious diseases are a challenge to health and economic productivity, as well as a danger to economic development and political stability” (Spectar 2003:509-511). In short, US officials were spurred to action not just

because of data availability showing the extent of the pandemic but also because of the growing awareness among policy makers of the increasing interconnectedness between HIV/AIDS, conflicts in the Third World, and US national interest.

This growing understanding of interconnections and articulation of national interest goals shaped the development of US-Africa HIV/AIDS foreign policy as the framework for interpretation by decision makers. The policy change, therefore, was not sudden but gradual from 1995 to 2000 as the Clinton administration intentionally changed the rhetoric through which the government framed the issue in diplomacy and international organizations, thus giving HIV/AIDS issues more international salience. For instance, the Bureau of Oceans and International Environmental and Scientific Affairs at the State Department described the pandemic in 1995 as “one of the most significant health and security challenges facing the global community” (Spectar 2003:512). As a result, the US provided much needed global governance leadership by calling the world to recognize the political and economic security implications of AIDS and scaling up the response to this global challenge. By offering a strong global leadership on the issue and by integrating the HIV/AIDS pandemic with national security interest and diplomatic efforts, President “Clinton placed infectious diseases in his agenda during both his African trips, where he promised assistance to fight AIDS and challenged Africans to take responsibility” (Specar 2003:513 note 250). Secretary of State Madeleine Albright did the same on her visit to Africa while US Ambassador to the UN, Richard Holbrooke, and Vice-President Al Gore lobbied the organization to hold a Security Council on the HIV/AIDS health crisis.

It is less likely that these facts alone provoked the change in the US HIV/AIDS foreign policy toward Africa under the Clinton administration. In fact, many senior officials in international organizations and the Clinton administration report the administration's lethargy in confronting AIDS in Africa. As Behrman (2004:107) observes, Clinton "was looking very much like a one-term president. He was totally consumed with whom to reposition himself in order to win [and] Global AIDS was not a part of that strategy at all." Furthermore, "Even during the last two years of his presidency, once he had secured his acquittal and scandal had dissipated, Clinton had remained inert on the issue [of AIDS]"; thus, "There is a staggering hypocrisy in Clinton's involvement as a shining knight in coming to rescue Africa and elsewhere from the pandemic [... He had] tremendous opportunities when he was a president, and chose to exercise none of them" (Behrman 2004:225). Donna Shalala, Clinton's Secretary of HHS also claims, "Despite the president's apparent interest, there would be no direct follow-up... You can't look at this issue and think that we did enough. Not 10 percent of what we should have done" (Behrman 2004:76).

Executive Order 13155 was an outcome of several factors, including domestic and international pressure, lobbying, and advocacy than a benevolent deliberate initiative on the part of the Clinton administration. The interaction between competing perceptions, conflicting interests, domestic context, and international events led to the redefinition of the global HIV/AIDS crisis as a human security threat and a human right claim. Obviously, the HIV/AIDS global crisis, which reached its peak in the late 1990s, was less about the absolute numbers of AIDS patients or high HIV prevalence in Africa than about

the perception of discrimination and injustice in access to drug therapies available in rich countries yet denied to patients in the developing countries due to their prohibitive monopolistic cost. James Orbinski – then MSF Director – describes the context in his 1999 Nobel Peace Prize acceptance speech, as a situation of injustice existing outside the context of war. “[N]ew life-saving ARV drugs were being used to treat 400,000 people, 99 percent of whom lived in Europe and North America, where mortality dropped by 70 percent. Less than 1 percent of all ARV drugs were sold in Africa, where two million people died of AIDS every single year” (Orbinski 2008:353).

While compulsory licensing allows “a government to force a drug company to license its patent to a local generic producer, which then must pay a royalty to the patent holder.” This is a legal procedure under the TRIPS Agreement, as well as parallel importation, which provides leeway for “a government to shop the international market for the lowest price on a patented drug,” the US government fearing that South Africa’s example might set into motion a domino effect among developing countries, thus undermining the whole TRIPS Agreement regime (Orbinski 2008:353-355).

PhRMA feared that if patented drugs were sold at lower prices in the developing world, people in the developed countries would demand the same, and profits would be driven down. In 1999, with global pharmaceutical sales at \$337 billion, profits were massive. PhRMA companies were among the largest and most profitable of all Fortune 500 corporations, position they held for nearly thirty years.

According to the Department of State confidential cable,

While on the surface this language [primacy of public health over commercial interests] seems innocent, in fact, the specific wording could help to undermine IPR guaranteed under the WTO Trips Agreement; the second difficult section was paragraph 2, section (6) which, in effect, directs WHO to advise member states on interpretation of WTO Agreements. This is a problem, in that we believe that

trade experts at WTO, not health experts, should be the primary interpreters of trade Agreements.” (Department of State cable 1998, § 4, section c).

Given the adamant opposition of the Clinton administration to the South-African government attempt to access the generic versions of the Highly Active Antiretroviral Therapy (HAART) for public health emergency reasons, thus allowing its citizens a chance for treatment, President Clinton’s sudden reversal of existing US trade policy in pharmaceuticals through Executive Order 13155 – even at the expense of the TRIPS Agreement – without fear of US reprisal or economic sanctions remains puzzling. For most of the time he spent in office, President Clinton fiercely promoted trade policies that protected US economic interests.

Arguably, change in both the domestic and international environments played a determining role in Clinton’s enactment of Executive Order 13155. In the domestic realm, Clinton spent most of his time – from the midterm elections through the end of 1998 – trying to survive scandals and to overcome political challenges. In 2000, which was the election year in the US, the signing of Executive Order 13155 shortly before leaving the office could have been prompted by the international campaign against US trade policies as seen in growing protests around the world at WTO and G7 summits. Granting African countries the right to use compulsory licensing or parallel importation for a greater access to ARV drugs treatment, regardless of the TRIPS Agreement – a measure he himself opposed for many years – could strategically serve as a political ploy for the campaign of Vice-President Al Gore in the upcoming election.

While the technological and medical research that led to the manufacturing of the HAART or the so-called AIDS “drug cocktails” allowed the US in four years to reduce

the HIV/AIDS mortality rate by two thirds: from 48,000 in 1994 to 16,000 in 1998, the situation did not abate in Africa. On the contrary, alarming UNAIDS and WHO reports between 1995 and 2000 were calling attention to the statistics of growing infections on the African continent. The US Trade Representative went on to negotiate and secure the patent of this scientific *trouvaille*. Actually, at the creation of the World Trade Organization (WTO) in 1994, the US had negotiated the TRIPS Agreement, a global version of the Hatch-Waxman Act of 1984, to secure patent and encourage investment in R&D for further innovation. As the international context of HIV/AIDS global crisis during the 1990s was defined by the growing numbers of infectious diseases and the threat of terrorism using biological weapons, the development of a new line of drugs to treat patients with AIDS was welcomed as great marker in humanity's progress. However, the treatment's high price, given the monopoly of the market thanks to patent rights, excluded the poor from accessing the benefits of this medical progress. As Goozner (2004:92) writes,

The power of the newest drugs, called protease inhibitors, and the even greater power of those now in the pipeline, is such that a diagnosis of HIV infection is not just different in degree today than, say, five years ago. It is different in kind. It no longer signifies death. It merely signifies illness. Larry Kramer, the radical playwright and founder of ACT UP (AIDS Coalition to Unleash Power), the most militant of the AIDS activist groups, signaled the next phase of the anti-AIDS struggle when he penned a long article complaining about the high price of drugs and their lack of affordability in the developing world, where most AIDS sufferers lived.

A global civil society formed to denounce US pro-market support and its privileging of pharmaceutical companies' greed for profit over the claim of the poor to fundamental rights to health and life. In the words of South-African activist and founder of the

Treatment Access Campaign (TAC), Ashmat (2003:xiv), “Just because we are poor, just because we are black, just because we live in environment and continents that are far from you does not mean that our lives should be valued any less.” In the late 1990s, AIDS activists and international Nongovernmental Organizations (NGOs) such as Médecins Sans Frontières (MSF); Oxfam; Global AIDS Alliance (GAA); Health Global Access Project (Health GAP); Bono’s organization Debt, AIDS, Trade, Africa (DATA); and other organizations coalesced with TAC to garner media attention and more greatly impact lobbying governments to address the global HIV/AIDS crisis. “Specifically, these groups demanded the creation of multilateral global AIDS mechanisms, dramatic reform of intellectual property laws, and sweeping international debt relief as essential elements of effective global AIDS policy” (Global AIDS Action Network 2004:5; McDonnell 2007:4).

The AIDS activists and the global civil society that expressed disagreement with US trade policy on AIDS medicines besieged the WTO meeting in Seattle, Washington, in 1999. In addition, domestic protests ensued at Al Gore’s opening of his Presidential campaign, which provoked the Clinton administration’s embarrassment and led to a change in its HIV/AIDS global policy. Ralph Nader, himself presidential candidate in 2000, along with other activists published open letters to the White House demanding that it drop its threats against South Africa.<sup>10</sup> As Fisher and Rigamonti (2005:8) note, “Ralph Nader openly attacked him for engaging in ‘an astonishing array of bullying tactics to prevent South Africa from implementing policies, legal under international

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<sup>10</sup> Nader, Ralph, “Al Gore bullies South Africa on U.S.-made AIDS drugs,” *Knight Ridder/Tribune* (April 26, 1999).

trade rules, that are designed to expand access to HIV/AIDS drugs.” The campaign was successful in that, “Al Gore reversed his position, insisting that he ‘was not afraid to stand up to the pharmaceutical industry.’ Soon after, President Clinton issued a statement saying that no African country would be sanctioned for using compulsory licensing or parallel importation provisions. Also, Congress had reformed the Hatch-Waxman Act of 1984 only later in 2000 to allow importation of pharmaceuticals for any FDA-approved drug from certain countries where the prices are lower, like in Canada. Although the HHS Secretary has to guarantee that this “re-importing” practice complies with the PDM Act of 1987 and poses no added risk to the public, Americans could now purchase prescription drugs abroad and then import them into the US (Angell 2005:18).

For their part, the PhRMA [a group of 100 of the biggest drug companies in the world, with seven lobbyists for every congressman in Washington, and hundreds more lobbyists in Europe as well] companies backed a new presidential candidate (Orbinski 2008:357). The global access campaign and the election year in the US were, thus, key catalysts in creating change both in the perception and global awareness of AIDS in Africa and the US government’s policy attitude toward the TRIPS Agreement and ensuring the right treatment in resource-constrained countries.

The Executive Order 13155, issued by President Clinton On May 10, 2000, altered the unwavering support he previously showed to US pharmaceutical companies in favor of public health in sub-Saharan Africa. By allowing countries to use measures such as compulsory licensing and parallel importation to either produce or import cheap generic AIDS drugs without fear of US retaliation, and by authorizing increase in US



spending and official contributions from \$200 million during the 1990s to \$450 million – of which one third was to be administered by the World Bank and two-thirds through bilateral programs – President Clinton was responding to what the literature has termed “a perfect storm” (’t Hoen 2009; Russell 2004:139; Casper 2001:8; Liew et al. 2006). That is, the Executive Order 13155 stands out as a response to the global civil society’s international activism and was conceived as a solution to the problem of developing countries’ economic resources constraints and international trade policy to access costly ARV drugs in the face of the HIV/AIDS global public health crisis.

The new global actors representing activist civil society organizations succeeded in challenging the official approach to the political economy of the medicalized health-care approach prevailing in the US and injected into the public awareness the perception that access to treatment was a fundamental human right of the poor and that denying it would be tantamount to genocide. Of course, the pressure put on presidential candidates in an election year, especially given Vice-President Al Gore’s role in intimidating the South-African government, was crucial in causing this strategic change. Yet, if the presidential election constitutes the domestic catalyst in transforming HIV/AIDS into a bipartisan issue and bringing attention to global HIV/AIDS dimension, the TRIPS Agreement constitutes the international context within which access to therapy and treatment for the poor was determined and how the developing countries were affected by this international regime.

This clash of interpretation set the stage for the confrontation between the North and the South, the developed and the developing countries on the right to access anti-

AIDS treatment to which Africans were barred because of geography, politics, economics, and history. That is, different actors used different frameworks to interpret the HIV/AIDS global crisis – that of health and access to treatment as a human right of all as opposed to the economic prevailing model of the market. This battle is personified in the Clinton administration’s support of US pharmaceutical industry in opposition to South Africa’s decision to reform its post-apartheid healthcare system (Gagnon2002). After the apartheid and the first democratic election that brought Mandela to power, South Africa was trying to enact a policy that would allow universal health coverage for its black citizens affected by HIV/AIDS. To do so, importation of generic ARV drugs was necessary under the TRIPS proviso on compulsory licensing and parallel importing to limit the cost (Fidler 2004:120; Dietrich 2007; Casper 2011; Gellman 2000a). However, US pharmaceutical firms that controlled patent rights under the World Trade Organization’s Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) opposed South Africa for fear that other developing countries might follow suit and upset the US drug market. In fact, the generic drugs could trump brand name medicines, in the market, given the price differential.

UNAIDS issued another Press Release on July 20, 2000 in the aftermath of the Durban 13<sup>th</sup> International AIDS Conference calling on G8 for Massive Increase in Resources to Fight AIDS. According to UNAIDS, the pandemic had not only reversed the gains of the past three decades made in social, economic, and political development in Africa but also was aggressively eating up and jeopardizing the continent’s future. “Without AIDS, life expectancy in the year 2010 in Zimbabwe would be 70 years, in

Botswana 66 years, and in Zambia 60 years” (*Worldwatch Issue Alert* of October 31, 2000 quoted by IPI 2000:5). With AIDS, these life expectancies are expected to drop respectively to 35 years, 33 years, and 30 years in these countries. The World Bank Press Release of 14 September 2000 portrays AIDS as the leading cause of death in Africa for the last 20 years. The numbers of new infections yearly were not abating. At least 16 countries had more than one-tenth of their adult population infected with HIV and the infections exceeded 20 percent in 7 countries in the Southern cone of the continent (See Annex 2).

The UNAIDS report released in May 2000 prior to the XIIIth International AIDS Conference in Durban depicted the situation as to a mortgage of the continent’s future and threat to a generation of youthful, productive people. “The devastating effects of HIV/AIDS in sub-Saharan Africa, predicted since the early 1990s is now being seen in falling life expectancies, increasing numbers of orphans, and terrible tolls on households, learning, teaching, health systems, agriculture, and business sectors across the board” (UNAIDS/00.13E, June 2000, pp. 21-36).

### **Conclusion**

The evolution of US HIV/AIDS foreign policy with a special focus on Africa has been outlined for the purpose of expressing two main goals. The first goal was to show that numbers alone and statistical data – however alarming – used to estimate HIV and AIDS prevalence in Africa are not enough to command or explain change in US-Africa HIV/AIDS policy. While they are not always objective and value-free, they seek to portray an image that can steer policy-makers’ course of action. That is, accredited

organizations such as WHO, UNAIDS, the World Bank, and others have tried to influence the policy making process through their production of knowledge for a purpose, which can have political, economic, and ideological repercussions, depending on their bureaucratic interests and the stakes of those stakeholders they seek to represent.

The second goal was to highlight that change in policy always ensues from a challenge to the monopoly of the dominant definition of the situation by those with the power to control the perception and to set the policy agenda. Once information becomes accessible to all, which is often key to maintaining a certain control over a policy image, it becomes possible for other stakeholders, interest groups in the civil society, to demand an alternative policy – in this case, a global public health and welfare policy against the unconditional protection of private economic interests of US pharmaceutical companies. Obviously, the US-Africa HIV/AIDS policy developed along the lines of sexual behavior given the early interpretation of the disease as a ‘gay plague.’

With the change in the international environment, the globalization process, and its strong focus on economic liberalization and political democratization after the Cold War, the US foreign policy toward Africa continued its emphasis on its vital national interest whose definition varies only in rhetoric, not in substance. This historic survey has laid the ground for the analysis of PEPFAR, to which I now turn in the next chapter.

CHAPTER FOUR  
CONTRIBUTION OF US PRIVATE PHARMACEUTICAL  
COMPANIES TO THE MAKING OF US HIV/AIDS FOREIGN POLICY  
TOWARD AFRICA UNDER THE BUSH ADMINISTRATION

**Introduction**

Why would a conservative administration choose a liberal policy and focus taxpayers' money on social issues and the public health welfare of citizens of other nations, and why would Congress provide bipartisan support to such a policy? Many policy observers have questioned President Bush's motivations in creating PEPFAR. Not only did presidential candidate G.W. Bush argue in a 2000 presidential debate with Al Gore that Africa would not figure among his foreign policy priorities since the continent did not "fit into the national strategic interests, as far as I (Bush) can see them" (quoted in Schraeder 2011:308) but also Republicans in Congress advocated the reduction of foreign aid to Africa throughout the 1990s, if not for its suppression altogether in the absence of Cold War geopolitical strategic interests. While the president relegated Africa to the bottom place in the hierarchy of his foreign policy priorities and while officials in his administration showed reluctance to admit access to antiretroviral drugs therapy was a viable solution to Africa's crisis in public health, the granting of these unprecedented financial resources to combat HIV/AIDS pandemic in Africa through PEPFAR is rather puzzling.

Since every new administration inherits leftover crises and unfinished policies, as Cooke and Morrison (2009:10) remark, it would have been much easier for the Bush administration to simply implement President Clinton's May 2000 Executive Order 13155. Actually, this was already an attempt to change the US foreign policy attitude toward HIV/AIDS in Africa in response to domestic and international pressures. To create a whole new policy structure and to provide extraordinary financial assistance to a region of traditional neglect, especially in the aftermath of the 9/11 terrorist attacks, and in the midst of an economic recession in 2002, was indeed perplexing. The ongoing war on terror in Afghanistan and the impending invasion of Iraq that both required parsimonious use of public resources and presidential attention only intensify the PEPFAR mystery.

This chapter provides an answer to this puzzle. The remainder of the chapter is subdivided into three parts. First, it presents the incrementalism that characterized the Bush administration's HIV/AIDS foreign policy toward Africa prior to PEPFAR. Second, it analyzes the sudden policy change and the creation of PEPFAR. And third, it underscores the contribution of the private sector in US pharmaceutical companies and demonstrates the neoliberal privatization theory at work in the implementation structure of PEPFAR.

### **The Bush administration's foreign policy toward HIV/AIDS prior to PEPFAR**

From the moment he took office until the day he announced the creation of PEPFAR, President Bush neither showed eagerness to implement the Clinton Executive Order 13155 nor commitment to fund the international efforts to fight AIDS in general.

During the 2000 presidential campaign, the vision of the Republicans was to “return foreign policy to its traditional emphasis on the management of great power relations and the realist pursuit of the national interest,” not to care for the welfare of African citizens (Ikenberry 2009:6). In an essay published in the January/February 2000 issue of *Foreign Affairs*, entitled “Campaign 2000: Promoting National Interests,” the Bush team National Security Advisor, Condoleezza Rice criticized the Clinton administration’s foreign policy and argued that because of Democrats’ discomfort with the notion of power politics and the belief in international law, norms, or multilateral institutions such as the United Nations, they ended up trading US national interest for the interests of the international community or humanitarian interests.

In the same issue of *Foreign Affairs*, Robert Zoellick, a former banker with Goldman Sachs who was appointed the Bush administration’s US Trade Representative in February 2001 also criticized the Clinton administration’s lack of grand strategy in issues of foreign policy. Advocating a modern Republican foreign policy, he developed five principles around which this foreign policy would be structured. The first is premised on power; the second emphasizes reforms to have an effective U.N. with member states aligned behind responsible interests, alliances, and coalitions. The third principle regards international agreements not as political therapy but as a means to achieve ends. The fourth focuses on America’s promotion of the new spirit of globalization through which markets can achieve results beyond the reach of governments and international bureaucracies. And finally, the fifth principle of a modern Republican foreign policy is the recognition that evil in the world is real and many enemies hold grudges against the

US. Hence, the Bush administration dismissed the humanitarianism of the Clinton era, which it believed did not fit the strategic national security of the United States.

Throughout the 1980s and 1990s, the US official policy attitude toward HIV/AIDS in Africa remained lukewarm as focus was mostly put on the disease's domestic dimension. In the international realm, US foreign policy toward HIV/AIDS focused mostly on prevention programs. Lyman and Morrison (2006:65) remark, "[o]ver the previous fifteen years, the US approach had been almost entirely prevention-oriented." Even the Clinton liberal administration did not think treatment in poor countries was the best way to approach the pandemic. Instead, after the introduction of the Highly Active Antiretroviral Treatment (HAART) to the market in 1996, US foreign policy continued supporting, at the global level, prevention programs and thwarted efforts by African governments to try to control the monopolistic prices drugs imposed by private American drug manufactures and research-based pharmaceutical firms.

During the two years before the creation of PEPFAR, the Bush administration's HIV/AIDS foreign policy was characterized by incrementalism to the extent that the sudden policy change inaugurated by PEPFAR took many by surprise. Baumgartner and Jones (2009:9) view incrementalism as a trial and error strategy that can be, "the result of a deliberate decisional style as decision makers make limited, reversible changes in the status quo because of bounds on their abilities to predict the impact of their decisions"; or it can also be "the result of countermobilization. As one group gains political advantage, others mobilize to protect themselves."



Although HIV/AIDS had received increased international salience in 2000, attributed to increased mobilization by international organizations, domestic constituencies as well as African governments were now committing over \$1 billion annually. White House Chief of Staff, Andy Card, announced on the very first day of the Bush administration that the Office of National AIDS Policy would be disbanded along with the Office of Race Relations, perhaps because President Bush had won less than 10 percent of the African American vote (Behrman 2004:247-8). Critics also underscore the administration's unwillingness to promote the use of condoms for ideological reasons; to collaborate with governments of recipient countries and to cooperate with existing multilateral efforts. While focus was put on increasing spending on expensive ARV drugs from US pharmaceutical companies, no efforts were made to improve the public health infrastructure in Africa; "the program was introduced without adequate prior consultations with recipient governments"; the "overwhelmingly bilateral approach (...) undervalues the integration of US efforts with others and dangerously downgrades fund" (Lyman and Morrison 2006:68).

A succession of major international initiatives also helped bring the HIV/AIDS issue to the foreign policy agenda, most notably the June 2001 UN General Assembly Special Session on HIV/AIDS that approved of the creation of an independent multilateral financing mechanism, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (hereafter the Global Fund or GFATM). President Bush made these remarks following discussions with Nigerian President Obasanjo and UN Secretary General Kofi Annan, on May 11, 2001, about the launching of the Global Fund.

Together we've been discussing a strategy to halt the spread of AIDS and other infectious diseases across the African continent and across the world... UN Secretary General Annan has made this issue an urgent priority... When he visited the White House in March, we talked about the pandemic and agreed on the goal of creating a Global Fund to fight AIDS.

Not only the UN but also the World Bank expanded its activities through its Africa Multi-Sectoral AIDS Program (MAP). Yet, UNAIDS and UN operational agencies (such as the UNICEF, WHO, UNDP, etc.) also contributed in giving the pandemic more international prominence. Other governments donors like the rising financial commitments of the UK Department for International Development (DFID) and multinational NGOs like CARE, Oxfam, World Vision, etc. were instrumental too in giving the HIV/AIDS pandemic the status it achieved (Lyman and Morrison 2006:64). As Secretary of the State Department Colin Powell and Health and Human Services Secretary Tommy Thompson went to the White House to discuss the matter, President Bush observed in his Remarks prior to Discussions with South African President Thabo Mbeki on June 26, 2001 that private donors like the Gate Foundation that donated \$100 million were invited to contribute resources to meet the challenge of AIDS.

A number of US federal agencies also had developed an international interest in HIV/AIDS. The CDC, NIH, USAID, State Department, Departments of Defense, Labor, Commerce, Health and Human Services all contributed to elevating the profile of HIV/AIDS in US foreign policy and consolidated the emergent consensus on elements of multisectoral comprehensive approach to combat HIV/AIDS. Corporate philanthropy was also encouraged. A consortium of US pharmaceutical companies, for instance, had made the announcement in May 2000 that they were ready to negotiate 70-90 percent discounts

in the price of AIDS drugs sold in Africa. These included GlaxoWellcome, Boehringer-Ingelheim, Bristol Myers Squibb, Merck, and Hoffman-La-Roche. Indeed, in the spring of 2001, ARVs prices fell precipitously to the level of production.

In January 2002, the UN Secretary General, Kofi Annan established the new multilateral initiative, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFTAM). Yet, the Bush administration chose a unilateralist approach instead of fully supporting the global multilateral efforts.<sup>1</sup> Whereas donor governments pledged up to \$21 billion, of which only 25% was effectively allocated, the Bush administration continued to weaken UN agencies and pledged an annual contribution of \$500 million, a sum that was criticized as “about one-fifth of what [the administration] spends on one cruise missile, or the budget of one Hollywood blockbuster” (Russell 2004:139; Casper 2001:8). The UN Secretary General Kofi Annan’s former Special Envoy to HIV/AIDS in Africa, Stephen Lewis also remarked that,

The logical thing that the US could have done was to attach itself to the Global Fund and to fund it significantly because it was the most obviously instrument internationally to respond to the pandemic and Malaria and Tuberculosis. But the United States is the United States. [However], it was inevitable that they would insist on doing their own thing. Unless Americans put their own stamp on something, they are not interested... It’s a very patriotic nationalistic society. (personal interview with the author, January 18, 2013).

In fact, the official policy attitude of the US continued thwarting global efforts to expand ARVs treatment to the developing countries. The Bush administration attempted

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<sup>1</sup> Ikenberry (2009:6-9) discusses the Bush administration’s resistance to a wide array of international agreements including the Kyoto Protocol on Climate Change, the International Criminal Court (ICC), the Gem Weapons Convention, and other arms control agreements. While this author acknowledges that unilateralism is not a new feature of American foreign policy under the Bush administration, as the US has often violated rules, ignored allies, and used its military force on its own accord, he agrees that the “new unilateralism” of G.W. Bush was a strategic, sweeping orientation, not just an occasional and ad hoc policy decision.

incremental changes to address the global HIV/AIDS crisis in Africa between 2001-2003. The issue of access to treatment was certainly no priority of its African foreign policy until the creation of PEPFAR.

During a June 29, 2001 Congressional hearing, Bush administration's USAIDS coordinator Andrew Natsios affirmed to the House of Representatives Committee on International Relations that the provision of costly anti-AIDS drugs to Africans would be a sheer waste of resources. According to this senior foreign policy official, undertaking such an action was technically impractical in a continent with obsolete medical infrastructure, whose population was illiterate and lacked even the basic notion of how to read a watch. Hence, any attempts to administer the complex treatment in tri-therapy regimen would encounter not only cultural barriers but also structural difficulties, resulting in further complications such as the mutation of the virus or its resistance to existing drugs (Fidler 2004:120).

HIV/AIDS activists, however, tried to attract global attention to the Bush administration's global AIDS policies by disrupting the speech by Human and Health Services Secretary of Tommy Thompson at the Barcelona 14<sup>th</sup> International AIDS Conference in July 2002. They were protesting what they saw as the administration's underfunding of both the domestic and global HIV/AIDS programs. While the Bush administration had maintained the controversial US neoliberal policy attitude adopted throughout the history of HIV/AIDS, which President Clinton tried to change in 2000 for political reasons, the incremental change of the years 2001 and 2002 proved unsatisfactory.

On June 19, 2002, President Bush launched a policy to address the HIV/AIDS global crisis in Africa from the mother to child infection prevention perspective. The International Prevention of Mother-to-Child Initiative (PMTCI) pledged \$500 million over a period of five years to purchase AZT medicine and train local health-care workers in the most heavily affected African and Caribbean countries. The program was built on the Clinton LIFE legacy that would also help build health care infrastructure to facilitate delivery of these program activities (Shaffer et al. 2004). Indeed, only six months later, President Bush announced the creation of PEPFAR. It was this same International Prevention of Mother-to-Child Initiative (PMTCI) program that became the basis for expanding the program into PEPFAR. This policy incrementalism demonstrates that PEPFAR was formed from gradual revision, adjustment, and improvement of prior policies that had failed to harness public consensus.

### **The process leading to the creation of PEPFAR**

Presidential involvement in US foreign policy toward HIV/AIDS in Africa. Although presidential beliefs are regarded as an important aid in explaining continuity and change in US foreign policy toward Africa, it is obvious that multiple actors were involved, at different stages of policy-making, both among the federal bureaucratic agencies as well as among the nonstate actors in domestic and international arenas. These included faith-based organizations and US pharmaceutical multinational corporations that played an important role either in supplying information that shaped official opinion or in assisting the White House task force and Congress in the development of a consensual policy alternative.

The important actors and stakeholders will comprise (1) the President of the United States (POTUS) as the legitimate foreign policy agenda setter; (2) the Senate and the budget appropriation by Congress to implement his agenda; (3) the bureaucracies and federal agencies that, traditionally, provided vital information to help the president with the policy-making. However, it appears that knowledge and expertise about the HIV/AIDS was located outside the locus of government expertise. Hence, the support of (4) nongovernmental institutions, mostly the pharmaceutical industry in the private sector was instrumental in the development and implementation phases of the policy.

Most observers agree that PEPFAR would not have been possible without President Bush's personal commitment. In this capacity he is entitled to decide on behalf of the nation concerning foreign policy priorities. In most official speeches he gave, President Bush framed the issue either in humanitarian terms or as a security issue. For instance, whereas he used the security framework in a joint statement with British Prime Minister Tony Blair on February 23, 2001, saying, "we support the idea of a new partnership with Africa to address in a systematic way, conflict and disease, especially HIV/AIDS and to promote growth and good governance," his vision when making the same kind of statement with German Chancellor Gerhard Schroeder on March 29, 2001 was humanitarian.

Although the influence on the policy-making processes came not only from the White House advisors but also from other stakeholders in different bureaucracies, the president was PEPFAR's agenda setter. His policy proposal that departed from existing US foreign policies toward HIV/AIDS in Africa was made through his 2003 State of the

Union address. With regard to the policy-making process, Gauld (2001:167) suggests that,

Health is arguably one of the more difficult areas of public policy making and service provision (Palmer & Short, 1994; Peters & Savoie 1994; Wilson 1989). In many areas of public work, say tax collection or immigration services, outputs are relatively easy to measure: it is clear what people are doing, why they are doing it, and what the impact of their actions are... In health, however, policy makers and providers in any country must cope to varying degrees with multiple variables including issues of life and death, questions of equality and justice, information generation and provision, powerful clashing interests, etc.

Personal involvement of the president suggests HIV/AIDS condition in Africa had received enough salience in American policy-making establishments, which made policy change highly plausible in spite of high bureaucratic constraints. There has been debate over whether President Bush was the man in charge. David Frum rejects the prevailing perception that the president was hostage to his Vice-President Dick Cheney or advisors like Karl Rove or Andy Card. As he notes, "I could never again take seriously the theory that someone else was running the administration – not Cheney, not Rove, not Card" (quoted by Burke 2004:109). President Bush argues that his concern for HIV/AIDS and Africa was old, a claim which his early initiatives can prove. He reports in his memoir that "Condi Rice and I spent long hours discussing foreign policy on the back porch of the Governor's Mansion (...). We agreed that Africa would be a serious part of my foreign policy" (Bush 2010:335). As Mark Dybul, the second PEPFAR Coordinator, contends, President Bush decided to create this policy of his own accord and without the influence of anyone else. The president "is a voracious reader [who] knew [a lot] about global HIV without technocrats or advocates providing information – although he has acknowledged that Condi Rice, the top national security advisor to then-Governor and Presidential

candidate Bush, pressed engagement in Africa during the 2000 campaign” (Dybul 2011, personal communication with the author).

President Bush’s personality, beliefs and values determined the rationale, timing, and substance of PEPFAR. According to social psychology theory of the decision maker, that is, personality, intellectual skills, professional affiliation, working theories of knowledge, are considered important factors that determine the way in which information is processed and decisions are reached. The interpretation of the situation, thus, has been the most crucial element of the agenda setting as it is dictated by the perception of stimulus-situation that compels a response-action on behalf of the government. Several studies do not only refer to President Bush as a dyslexic, as Ron Suskind (2004:149) writes, but also that he “did not read reports and memos but delegated and relied on aides” for lack of intellectual curiosity. John DiLulio (2002), who served as President Bush first director of the White House Office of Faith-Based and Community Initiatives, also suggests that,

Bush’s more practical bent may have led him to tune-out more intellectually sophisticated analysis. What Bush really dislikes are academic or other elites who, as I heard him phrase it on occasion, are or come off as smart without any heart, who look down on average Americans who just believe in this great country and its great goodness (...). Thus, the Bush administration is largely bereft of policy intellectuals. (quoted by Burke (2004:110).

Deputy Director of Domestic Policy, Jay Lefkowitz, stresses President Bush’s personal involvement in the policy formulation from start to finish and argues that this commitment showcases the degree to which the HIV/AIDS crisis in Africa was an issue close to the president’s heart. As Lefkowitz puts it, President Bush’s consistent effort to develop this HIV/AIDS emergency policy, as he doggedly lobbied Congress to pass the



bill, is clear evidence that he had humanitarian concerns for the victims of HIV/AIDS in Africa. It is witness to his earnest dedication to resolve the global HIV/AIDS crisis.<sup>2</sup> His earnest commitment to the plight of HIV/AIDS in Africa and dissatisfaction with existing policies – including the one he just made six months earlier, on June 19, 2002, the International Prevention of Mother-To-Child Transmission (PMTCT) – encouraged him to think bigger and expand US commitment to meet the need of African resource-constrained nations (Bush 2010).

Others concur that PEPFAR would not be possible without President Bush's personal commitment. The president was the agenda setter based on his convictions and moral values. At the moment when “[l]eaders in international organizations and the US government thought treatment was not possible,” the president took the initiative because “he felt deeply that it was the right thing to do” (Dybul personal communication with the author, Georgetown University, November 27, 2011). Thus, both friends and foes admire Bush as a moral leader, a godly man, and a highly admirable person of enormous decency who truly feels deeply for others and loves this country with a passion (Laurent 2004; McAdams 2011).

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<sup>2</sup> In “AIDS and the President – An Inside Account” in *Commentary*, January 2009, available at <http://www.commentarymagazine.com/article/aids-and-the-president-an-inside-account> (last consultation July 24, 2013), Jay Lefkowitz argues that President Bush had already delineated his foreign policy moral vision in his first inaugural Address in January 2001, using the Good Samaritan metaphor and pledging the nation's goal to show compassion to the poor. However, there are lots of controversies about this HIV/AIDS humanitarian policy toward Africa when the Bush administration failed to meet other humanitarian goals around the globe. Alex Hindman and Jean Reith Schroedel, for instance, discuss the US Justice Department memos under the heading “The Torturer's Manifesto,” available through the *New York Times* online archives, at <http://www.nytimes.com/2009/04/19/opinion/19sun1.html>. The complex character and personality of President Bush, pursuing apparently contradictory goals under the same humanitarian motive, requires a theory that can disentangle and explain the different motives at work in the PEPFAR policies.

Framing the situation in humanitarian terms allowed the Bush administration to fit HIV/AIDS among its different foreign policy objectives – as defined above by Fidler (2005) (see Table 6). By providing the poor with the opportunity for greater access to antiretroviral medicines, the Bush administration was able to implement its policy preferences that consisted in restructuring the role of the government in social welfare. For instance, President Bush acknowledged the important role of pharmaceutical companies.<sup>3</sup>

We attach particular importance to the fight against HIV/AIDS. We want the G7/8 to intensify their efforts to ease the suffering of millions of people who are afflicted by this disease. We consider it to be of particular importance for the pharmaceutical industry to take additional measures so that the HIV/AIDS patients in affected countries can be supplied with medication at affordable prices.

He not only sought how to “bring the private sector back in” but also how to include other nonstate actors, by way of privatization of the government’s service delivery. Thus, the framing of the situation by the Bush administration focused the attention of the American public on ideals and values within the compassionate conservatism as discussed in chapter two. However, the religious images and personal beliefs are important variables whose impacts on President Bush’s welfare policy decision-making process need further analysis. The president likened the US work of mercy in helping to bring hope and life to the dying Africans to Jesus bringing Lazarus back from death to life (Bush 2010:334).

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<sup>3</sup> Available online at: <http://georgewbushwhitehouse.archives.gov/news/releases/2001/02/20010226.html>; and <http://georgewbush-whitehouse.archives.gov/news/releases/2001/03/20010329-5.html>. Last view on January 6, 2016.

Table 6. Conceptualizing U.S. Response to HIV/AIDS in Africa at Different Levels of Analysis

Level of analysis		U.S. foreign policy interests		
Independent variables		Humanitarian	Security	Economic
Individual:	Presidential beliefs => compassionate conservatism and the welfare provision through “mediating private institutions”	Global moral leadership; concern for human dignity, government subsidies to support private initiatives		
National:	Bureaucratic and domestic politics => Agenda to reform bureaucratic system and accommodate competing interests		Foreign aid increase to foster development and preempt global terrorism	
International:	The push for US global neoliberal agenda => (a) privatization with the assumption that efficiency depends on private incentive; (b) challenge to and competition over IP governance regime by other actors			Change in the structure of foreign aid: creation of MCA => promote free trade, not aid, to bring about economic growth

Epstein (2007) suggests this was a strong signal the President wanted to send about his foreign policy that was both compassionate and tough. The administration, thus,

framed the HIV/AIDS public health issue as – and related the creation of PEPFAR to – the US concern for Africa’s development. Both the framing of the issue and the policy solution flowed from President Bush’s humanitarian ideals embodied in his compassionate conservative doctrine and embedded in the American culture that concomitantly seeks the promotion of the values of the human rights, democracy, and free trade. These values, for President Bush, are divinely endowed and therefore their lack should motivate US foreign policy action. As a result, PEPFAR reflects President Bush’s compassionate conservative ideology, which offers a third alternative between the Democrats’ liberal welfare programs and the traditional Republicans’ rejection of big government. As the major motivating force behind Bush’s humanitarian concern for victims of HIV/AIDS in Africa, the compassionate conservatism belief is regarded as the core psychological determinants and cognitive framework that the president used to interpret the situation and create the PEPFAR policy (Princeton and Dorff 2007; Orbinski 2008).

Yet, the policy proposal was not a mere reflection of personal fancy of the president since it had to fit in and reflect the very gist of American policy culture and national interest. As President Bush acknowledged, time was opportune – and it was only morally right for “too wealthy a nation and too compassionate a nation” to not take this step and help those who are less fortunate than we are (Bush 2010:340). Contrasting his results-based approach to the provision of foreign aid with the paternalistic model of the Cold War era – that provided aid to maintain dictators in power for the sake of Communism containment – President Bush used the analogy of a medical version of the

Marshall Plan for Africa. In other words, his foreign aid policy would be consequential in fighting poverty and the measurement for assessing the goals no longer served the US self-interest but was altruistic, seeking to impact lives and serve people.

The federal agencies' influence in the making of PEPFAR. Scholars like to bring up the fact that policy-making is ultimately about human beings while state bureaucracies and organizations are mere tools of people pursuing their self-interests. It is the task of policy-makers to attempt to cope simultaneously with international and domestic imperatives. Their framing or representation of the situation becomes very critical in deciding whether the issue is worthy of policy attention and what alternative solutions are available in attempting to alter the situation. For this reason, scholars concur that “[u]ntil this [integration of domestic politics and foreign policy] is accomplished, not only will our explanations of foreign policy decisions be incomplete, but our theories may often be less useful to policy-makers than we would like (George 1993:7-11; Farnham 2004:441).

For instance, one important aspect of the PEPFAR policy-making process remains the secrecy that shrouded the stage of the policy formulation. Kimone's (2008:41) study of the Nixon administration's revitalization of the National Security Council identified the US's capabilities, interests, and objectives and how to pursue them effectively. He goes on to quote National Security Advisor Henry Kissinger (1973:89) explaining the importance of secrecy in foreign policy decision-making process,

Our reason for keeping the decisions to a small group is when an unpopular decision may be fought by brutal means, such as “leaks” to the press [reference to the Pentagon Papers] or to Congressional committees. The only way secrecy can be kept is to exclude from the making of the decision all those who are theoretically charged with carrying it out [federal bureaucratic agencies]. In consequence, the relevance of the bureaucracy might continue to send out cables

with great intensity, whereby distorting the effort with the best intentions in the world. You cannot stop them from doing this because you do not tell them what is going on.

President Bush equally justified this secrecy surrounding the laying of the policy groundwork as a preventive measure to avoid a bureaucratic turf war since different agencies would hamstring the process had they known about the plan. As President Bush later put it (2010:340),

Only a few people knew about the plan. I instructed the team to keep it that way. If word leaked out, there would be a turf war among government agencies for control of the money. Members of Congress would be tempted to dilute the program's focus by redirecting funds for their own purposes. I didn't want PEPFAR to end up hamstrung by bureaucracy and competing interests.

While a negative connotation of big and inefficient government persisted in the minds of most Republicans in the Bush administration, given President Bush's business background it is obvious that consultancy with Business, which in turn outsources most of its academic knowledge production to think tanks, universities, and other private institutions that maintain close ties with the pharmaceutical industry became the major source of information for the Bush administration, thus removing the authority and influence from traditional bureaucratic venues.

The US domestic bureaucratic structure reflects the political polarization between Democrats and Republicans, and also the conflict of interests existing in the HIV/AIDS domestic and global communities. The Constitution gives leverage to Congress to compete with, and balance, the power of the president. Even the staunchly defended policies of the executive branch can be overturned, modified, or filibustered. Indeed, Congress was very instrumental in the making and shaping PEPFAR's outcome. The

earmarking of the policy was therefore a way that Congress used to accommodate different competing interests; to leave its own imprints on the policy; and to distribute the benefits and advantages across a spectrum of different actors and agencies. The development of a new structure and the earmarking of the budget tried to integrate different aspects of the domestic debate around the issue of HIV/AIDS. That is, if federal bureaucracies attempt to maintain certain leverage over the provision of information, because they possess the expertise and knowledge, different independent individuals, foundations, or interest groups in the civil society seek to exert pressure or make an impact on the policy decision outcome through Congress. As a result, policy change ensued as a result of tug-of-war between the executive and the legislative branches.

The State Department saw the US involvement with the global HIV/AIDS crisis as an opportunity to engage a new kind of diplomacy. The 2002 *National Security Strategy of the United States of America* incorporated the issue of HIV/AIDS among the strategic national interest of the US in a way that dispersed the interest – or framed the issue – across federal agency bureaus, including the Department of State diplomatic interest, the USAID’s development and humanitarian relief mission, the Department of Defense with its military and security concerns, and the Department of Health and Human Services with its multiple agencies including the research at the National Institutes of Health, and surveillance and containment at the CDC.<sup>4</sup>

However, domestic constituencies – AIDS activists, gay community, civil society, and even the Congressional Black Caucus – were more than aware of the Bush administration’s unwillingness to engage the HIV/AIDS and reluctance to include the

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<sup>4</sup> Available online at: <http://www.state.gov/documents/organization/63562.pdf>, pp.19-23.

issue on its policy agenda. From the moment he took office on January 20, 2001, the White House Chief of Staff, Andrew Card, revealed during an interview with *USA Today* on February 7, 2001 the intention of President Bush to close the Clinton administration's Office of National AIDS Policy (ONAP) and the Office of Race Relations, One America, created in 1997 to improve race relations – all this a mere three weeks after assuming office. Instead of shutting down the ONAP program, the Bush administration recanted the idea of removing HIV/AIDS from the policy agenda as this announcement by Andy Card was met with a barrage of protests. HIV/AIDS activists overwhelmed the White House with phone calls, e-mails, and faxes from activists and legislators, including members of Congress – the Congressional Black Caucus that had been involved with the issue of HIV/AIDS and race in American and other Democratic Senators and Congressmen such as Tom Daschle of South Dakota and Dick Gephardt from Missouri. After Card's interview in *US Today*, the White House Press Secretary Ari Fleischer went out to clarify that, "A mistake was made, there is nothing that is closing. That office [ONAP] is open. He [Andy Card] made a mistake. It happens" (quoted by Behrman 2004:248).

Yet, Secretary of State, Colin Powell cancelled last minute to attend the Africa's Summit on HIV/AIDS, Tuberculosis, and Other Infectious Diseases held in Abuja, Nigeria. And in July 2002, at the Barcelona International AIDS Conference, activists to protest the Bush administration's underfunding of domestic and global AIDS programs decried and disrupted the speech of Bush's Human and Health Services Secretary (HHS), Tommy Thompson. Although the USAID published an important report in 2001, *Leading the Way: USAID Responds to HIV/AIDS 1997-2000*, claiming the agency's decades of



experience in, knowledge of and expertise about African issues, including dealing with HIV/AIDS, the Bush administration completely overlooked input from the agency's administrator in its policy making process. Given President Bush's business background, and the fact that a negative connotation of the big and inefficient government persisted in the Republican mind, contracting, consultancy, think tanks, academia, and other private institutions became the major source of information, thus removing the authority and influence from traditional bureaucratic venues. The Bush administration's US Agency for International Development (USAID) Administrator Andrew Natsios was able to testify before Congress but maintains that the Bush decision-making establishment consulted him on many other issues except the one related to HIV/AIDS policy (Personal communication with the author, Georgetown November 30, 2011).

Farnham (2004:229) remarks that domestic constraints might still be an important source of influence but "the role of the decision maker remains critical in reconciling competing values [since] politicians are a critical key to aggregation." President Bush was able to concentrate his policy-making structure within the hands of his National Security Council with an ad hoc Task Force created to work out policy details. President Bush understood the importance of staff work and the value of advisory network for his deliberation. He did not micromanage policy making process like Jimmy Carter had done. Burke (2004:108) reports President Bush saying, "I am the kind of person who trusts people. And I empower people. I am firm with people. On the other hand, I am a decider. I do not agonize. I think. I listen. And I trust my instincts and I trust the advice I get. And I am an accessible person."

While it is expected that leaders in modern societies will depend “heavily on advisors in departments and bureaucratic structures for expertise and information so vital to decision-making processes,” traditional bureaucratic structures have come to be seen as the very reason behind government inefficiency. Such theorists like Rourke (2009) and Hill (2003) have debated the bureaucratic inertia; they contend that bureaucratic slowness may save leaders from rash decisions, path-dependency and increasing return. As J.L. Gaddis (1992/1993:55) remarks,

International Relations [as a discipline] is about individual, conscious entities capable of reacting to, and often modifying, the variables and conditions they encounter (...). It is no wonder that the effort to devise a molecular approach to the study of politics did not work out [because] the simple persistence of values in politics ought to be another clue that one is dealing here with objects more complicated than billiards boards.”

Hence, President Bush was able to circumvent what he regarded as bureaucratic sluggishness and to address the problem at stake through the creation of a new structure. Despite the fact that the influence of domestic politics on foreign policy is mediated on the policy-making process through structural constraints and political bargaining, it is still not enough to articulate the bargaining process in two-level games theory but also to understand the context within which policy-makers operate and how this context affects their thinking (see also Lamborn 1997; Bennett 1981).

The president created, instead, an “ad hoc” Task Force at the White House level, involving a few select insiders of the Bush administration, to develop the PEPFAR policy. The task force was headed by President Bush’s Deputy Chief of Staff for Policy, Josh Bolten, and comprised other senior policy officials. Bolten was Deputy Chief of Staff for Policy at the White House from 2001-2003 before serving as Director of the

Office of Management and Budget (OMB). His prior experience as Executive Director for Legal and Government Affairs at Goldman and Sachs London office from 1994-1999, before becoming George W. Bush's Policy campaign director in 2000, and as General Counsel to the office of the US Trade Representative for three years under the senior Bush presidency, gave him a good knowledge of the business trade laws and policies.<sup>5</sup> Another important figure was Gary Edson, Deputy National Security Advisor and Deputy Assistant to the President for International Economic Affairs from 2001 to 2004. Edson served also as the Bush administration's chief negotiator for all presidential summits such as the G-8, US – EU, or US Summits of the Americas.

Known as “sherpa,” referring to Nepalese guides who help tourist to climb and reach the summit of the Himalayan Mountains, Edson's bureaucratic experience and private sector affiliation were notorious. He not only served as Chief of Staff and General Counsel to US Trade Representative during the Bush “41” administration from 1989 to 1992 but also was the chairman of the board and head of the private equity firm, the Engineering Consultant Group, Inc. Other members of the Bush White House inner circle

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<sup>5</sup> It should be noted that the first appointee as US Trade Representative of the Bush administration, Robert B. Zoellick, was a former banker at Goldman Sachs. During the 2000 presidential campaign, Zoellick wrote along with then Bush team National Security Advisor Condoleezza Rice against the foreign policy of the Clinton administration that pursued humanitarian goals at the expense of US national interest. As Zoellick put it, America should promote its geopolitical agenda by linking its economy to regions of key importance. “The history of U.S. foreign policy is full of examples of private parties—from missionaries to engineers—who forwarded America's belief in the future by helping others face the challenges of the day. The very nature of the “new economy”—with its rapidly adapting technologies, fast-paced change, and innovative spirit—will elevate the role of private parties; they will often surpass the government in their ability to resolve inevitable disputes. These parties are not zero-sum thinkers. The U.S. government should create a climate in which citizens can serve both the private and the public good. Prosperity with a purpose is an idea that reaches far beyond U.S. borders.” In *Foreign Affairs*, January/February 2000 special issue on presidential campaign 2000.

on the PEPFAR task force include, Kristen Silverberg, Deputy Assistant to the President for Domestic Policy and Jay Lefkowitz who served as General Counsel at the OMB before becoming Deputy Director of Domestic Policy at the White House. Among scientific researchers with HIV/AIDS expertise were Head of the National Institutes of Health (NIH), Anthony Fauci, who was later joined by Mark Dybul, a medical doctor and key staffer of Fauci's at the NIH and Dr. Joe O'Neill of the Department of Health and Human Services. Because PEPFAR involved a lot of money, then Associate Director of the OMB, Robin Cleveland, was delegated to the team in charge of developing the PEPFAR policy groundwork.

Testifying before the House of Representatives Committee on International Relations on June 7, 2001, the Bush administration framed the HIV/AIDS crisis in Africa according to its agenda and echoed the business framework that sought to divert attention from the Intellectual Property rights regime as an impediment to Africa's access to treatment. In fact, Andrew Natsios downplayed the priority and urgency of HIV/AIDS arguing that this was only one among Africa's many problems, and not even the greatest health problem. If Africans had been fighting to access antiretroviral drugs, Natsios claimed,

That [the mining business in Botswana] *causes a lot of sex workers and that spreads the disease very rapidly* in a country that actually has infrastructure. So the biggest problem, if you look at Kofi Annan's budget [the Global Fund estimates \$7 to 10 billion needed to meet the global crisis], half the budget is for antiretrovirals. If we had them today, we could not distribute them. We could not administer the program because we do not have the doctors, we do not have the roads, we do not have the cold chain. (emphasis added)

For Natsios, provision of costly anti-AIDS drugs was a waste of resources and technically impractical on a continent with illiterate patients, few clinic infrastructures, and cultural difficulties in respecting a complex treatment and managing a complicated drug regimen. “The US government need not spend millions of dollars on anti- retroviral drugs for Africa. In the process, he delivered a shocker” (quoted by Fidler 2004:120). “Many people in Africa have never seen a clock or a watch their entire lives. And if you say, ‘One o’clock in the afternoon,’ they do not know what you are talking about. They know morning, they know noon, they know evening, they know the darkness at night” (Mutume 2001).<sup>6</sup> In spite of the Agency’s longstanding engagement with African issues, Natsios declares a “big war over turf” had erupted around the US foreign policy on HIV/AIDS involving USAID and the State Department on the one hand, and the USAID and the Department of Health and Human Services (HHS), on the other hand. Secretary of HHS Tommy Thompson, a former Governor of Wisconsin and a very senior member of the Bush administration “wanted to get HHS into doing international health program in the developing world. I don’t want to question what his motivations were. But I told him, ‘that’s what we do.’ The principle focus of HHS should be domestic, not international. We don’t need help in this area.” Eventually, Secretary of State Colin Powell stepped in to clarify that, “we are not going to run this through HHS – no, no, no! We are going to run the program through the State Department and the AID” (personal interview with Natsios, Georgetown University, December 5, 2012).

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<sup>6</sup> <http://www.ipsnews.net/2001/06/development-in-fact-and-fiction-us-officials-play-games-with-aids-in-africa/>

From his business background, President Bush did not believe that humanitarian intervention was necessary in fighting HIV/AIDS abroad; nor did he think that provision of foreign aid was the best way to eradicate poverty in Africa. On the contrary, the president contends in his memoir,

Projects like these [encouraging liberalization, market, and promoting the free trade] were catalysts for countries to develop markets that foster private-sector growth, attract foreign capital, and facilitate trade, which was another cornerstone of my development agenda. Free and fair trade benefits the United States by creating new buyers for our products, along with more choices and better prices for our consumers. Trade is also the surest way to help people in the developing world grow their economies and lift themselves out of poverty. *According to one study, the benefits of trade are forty times more effective in reducing poverty than foreign aid.* (Bush 2010:350). (my emphasis)

The president came to the White House with a stated intention to reform the big government foreign aid system inherited from colonization and the Cold War. For the president, “Our foreign assistance programs in Africa had a lousy track record. Most were designed during the Cold War to support anticommunist governments. While our aid helped keep friendly regimes in power, it didn’t do much to improve the lives of ordinary people” (Bush 2010:335). This lousiness manifested not only in the ineffectiveness and inefficiency of US foreign aid system but also in the partitioning and tug of war among federal programs that lacked coordination and duplicated the work of HIV/AIDS at the global level. “When PEPFAR began, six US Government Departments and Agencies were active in global HIV,” including USAID that controlled more than 60 percent of the resources, the Global AIDS Program (GAP) of CDC with offices in 25 countries and a budget of approximately \$150 million, the Department of Defense with a

\$10 million yearly dedicated to military programs, the Peace Corps volunteers, the Department of Labor, and the State Department (Dybul 2011:6).

President Bush urged Congress to pass the Bill before he left for the G-8 Summit in June 2003 in Evian, France, so that he could have something to present to his peers and show US leadership in foreign aid (Bush 2010:341). President Bush has also emphasized the need to keep control over the funds through bilateral programs instead of working through multilateral institutions. “I decided it was time for America to launch *a global AIDS initiative of our own*. We would control the funds. We would move fast. And we would insist on results” (Bush 2010:337). Thus, as an instrument of US foreign policy, PEPFAR needed to harness a bipartisan support. Foreign aid has always been used to pursue a variety of national goals such as diplomacy, development, Humanitarian Relief, democracy, market expansion, conflict prevention and resolution, state capacity building, etc. (Lancaster 2008:3)

Congress’s influence in the making of PEPFAR. Yet, even if the president was the agenda setter, he did not decide alone and was in need of information and expertise from bureaucrats or experts outside his administration. Also, he would still need approval of the Senate and budget appropriation from Congress to be able to implement his agenda. As Ripley and Franklin (1991) note, policies are the outcomes of the interaction between a variety of governmental and non-governmental actors in the process of affecting decision over the issues that matter. The president must be able to convince Congress because the US Constitution gives leverage to Congress to balance the power of the president. Congress takes each opportunity to overturn presidential initiatives when in

disagreement with the policy, especially those staunchly defended policies of the executive branch. Hence, the executive branch continued lobbying Congress during the legislative process. As Dybul (2011:9) remarks, “[w]hen Congress was slower to act than was desired, President Bush held an event in the East Room of the White House to encourage swift action with the leaders of the key Congressional committees from each chamber, and a large representation from civil society who could put pressure on them.”

In the political context of democratic consensus – the act of bringing others to agree with the administration’s interpretation of the situation – becomes a crucial condition for any given issue to receive public policy attention, support, and resources. Secretary of State James Baker (1995) observed, for instance, “in a democracy any foreign policy that cannot attract a domestic consensus will have difficulty succeeding” (Farnham 2004:444). As such, the role played by Congress in the making of PEPFAR cannot be overstated. First, the PEPFAR bill was introduced to the Foreign Relations committee where it was met with a favorable vote of 37-8 and submitted to the full body of the House of Representatives on March 17, 2003 where it was voted in with an astounding vote of 375-41 thanks to the active lobbying of Representatives Henry Hyde (R-IL) and Tom Lantos (D-CA). The bill underwent several amendments. “One amendment established priorities for the distribution of resources based on factors such as the size and demographic characteristics of populations affected by HIV/AIDS, TB, and malaria; the needs of that population; and the existing infrastructure or funding levels to cure, treat, and prevent HIV/AIDS, TB, and malaria” (IOM 2006:63). These amendments mostly reflect the ongoing debate in the society about HIV/AIDS. The final policy



outcome recommended the President, first to appoint the Global AIDS Coordinator whose mission would consist of coordinating and collaborating with civil sector organizations “to plan, fund, implement, monitor, and evaluate all programs addressing HIV/AIDS” (IOM 2007:64).

The policy also earmarked the program funds, including 55% of the total budget allocations for “therapeutic medical care of individuals infected with HIV, of which such amount at least 75% should be expended for the purchase and distribution of antiretroviral pharmaceuticals and at least 25% should be expended for related care”; 20 percent for prevention of 7% new infections, of which such amount at least 33% should be expended for abstinence-until-marriage education programs. Of the remaining 25%, 15% was to be spent on palliative care of 10 million individuals with HIV/AIDS and 10% for assistance for orphans and vulnerable children (OVCs) affected with HIV/AIDS, “of which 50% shall be provided through non-profit, nongovernmental organizations, including faith-based organizations, that implement programs on the community level” (ibid, 67).

As early as 2001, the 107<sup>th</sup> session of the U.S. Congress received two different bills dealing with issues related to the global HIV/AIDS crisis. The first bill demanded an increase in funding of \$200 million for prevention of HIV infection from mother to child and was known as the International Infectious Diseases Control Act of 2001 (S.1032). The money was to be administered through the Global Fund to Fight HIV/AIDS, TB, and Malaria. Senators Kerry (D-MA) and Bill Frist (R-TN) introduced the second bill known as the U.S. Leadership against HIV/AIDS, TB, and Malaria Act of 2002. While neither of

the two bills passed, elements of both were integrated into the P.L. 108-25 of May 27, 2003. On June 19, 2002, for instance, he announced his new program providing \$500 million for International Mother and Child HIV Prevention initiative. This money aimed to provide antiretroviral drugs to 1 million women yearly in 12 African countries and 2 in the Caribbean region to *prevent infection* from mother to child and *build health care infrastructure* to facilitate delivery of these program activities (Shaffer et al. 2004).

In spite of early assault by conservative advocacy groups and threats by Democrats in Congress, a coalition formed in the House led by Representatives Henry Hyde (R-IL) and Tom Lantos (D-CA) and in the Senate under the leadership of Bill Frist (R-TN), Richard Lugar (R-IN), John Kerry (D-MA), and Joe Biden, (D-DE) who lobbied fellow legislators to pass the bill (Lancaster 2008:24). At the Senate level, Democrats Richard Durbin (D-IL) and Diane Feinstein (D-CA) threatened to introduce further amendments such as the elimination of abstinence funding or an unconditional funding of the UN Global Fund. After a session that lasted until 2 a.m., the bill was passed by voice vote on May 16, 2003 and with no further changes. Returned then to the House as the procedure requires, it received another vote by voice thus authorizing the President prior his travel to the G8 Summit in Evian, in France, to sign “Leadership Act P.L. 108-25,” into law, making PEPFAR the largest international health initiative in history created to combat a specific disease. As Sorrells (2003:1056) suggests, a vote by voice is a White House and Congressional Leadership strategy to provide cover to members of Congress and avoid record and accountability on both sides of the issue.

This bipartisanship about foreign policies reflects the axiom that “politics ends at the water’s edge” because the country needs to present a united front to the world and speak with one voice since several voices could undermine and weaken the ability of the U.S. to succeed abroad (Snow and Brown 2000:3). As the Senate Majority Leader Bill Frist (R-TN) put it, passing the bill “might be of some benefit to our President in his diplomacy and advocacy as he approaches the other wealthy countries of the world (Congressional Record-Senate, 2003: S6479). And Senator Tom Lantos (D-CA) summarizes this “soft power” diplomatic approach in his remarks during a hearing on PEPFAR before the Committee on Foreign Affairs, on April 24, 2007, “those who occasionally complain that we have lost our moral authority better take notice of this [\$15 billion] figure. There is no nation on the planet, which would have made a remotely comparable effort. Our groundbreaking legislation, the United States Leadership against HIV/AIDS, Tuberculosis, and Malaria Act, was comprehensive in both scope and scale.”<sup>7</sup>

The pharmaceutical companies’ influence in the making of PEPFAR. The private pharmaceutical companies played an instrumental role in defining the Bush administration’s policy attitude toward the global HIV/AIDS crisis. Between the moment President Bush took office in January 2001 and the day he announced during his State of the Union address in January 2003 that he was changing the US foreign policy toward HIV/AIDS in Africa, a chain of contingent events had occurred that can explain the contribution of the private pharmaceutical companies in the development of PEPFAR. The creation of PEPFAR in the aftermath of the 9/11 terrorist attacks took account of several aspects of the domestic and international environments, including the conclusion

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<sup>7</sup> <http://democrats.foreignaffairs.house.gov/110/lantos042407.htm>

of the 4<sup>th</sup> Ministerial Conference on TRIPS Agreements and Public Health (hereafter, the Doha Declaration) held on November 14, 2001 in Doha, Qatar; the activism of different interest groups such as the evangelical Christians, domestic and international human rights activists, African governments, and pharmaceutical companies. As a result, the policy makers sought to include not only the international pressure to increase access to ARV treatment in developing countries but also to comprehensively integrate prevention and care advocated by domestic constituencies. The African nations' claim focused on the patent regime and trade rules which they viewed as the main hindrance to their public health welfare and access to ARV treatment.

It is customary to explain the influence on the foreign policy decision-making process based on psychological, structural, or epistemic determinants. In a study of the source of influence on US government officials in each of the three separate institutional arenas – the executive branch, the House and the Senate – regarding the foreign policy decision making, Jacobs and Page (2005) conclude that neither public opinion nor the epistemic communities in academia, think tanks, and bureaucracies are the strongest predictor of officials' preferences but rather, of business preferences. The business role in the making of US foreign policy, however, provides us with a multicausal conceptual framework that organizes the messy process and complex reality of US HIV/AIDS foreign policy decision-making. The role of business in the making of US foreign policy can help articulate better the nexus between domestic forces and the international context of this specific US HIV/AIDS foreign policy. That is, it helps clarify the rationale of the Bush conservative administration's undertaking of a liberal public health policy to benefit

African HIV/AIDS patients while the history of US-Africa relations predicted further neglect and indifference. In fact, the creation of PEPFAR and the increase of foreign aid stand in total contradiction to the most fundamental political philosophy of a Republican administration. Obviously, the global governance in the production and distribution of social goods and services such as health and anti-AIDS pharmaceuticals products pushed the Bush administration to uphold and bolster the neoliberal global market framework.

These events include the terrorist attacks in New York City and Washington DC on 9/11, the consequence of which was to traumatize the whole nation and reshaped its perception of security. Another event consisted of the Indian generic manufacturer, CIPLA's breakthrough development of Triomune, a generic version of the antiretroviral (ARV) drug cocktail combining three basic antiretroviral drugs, stavudine, lamivudine, and nevirapine for approximately \$300 per patient per year. A third element consisted of the UN Secretary General Kofi Annan's creation in July 2001 of a multilateral program, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), to marshal resources from wealthy donors around the world to finance access to treatment in developing countries. A fourth event concerned the November 2001 World Trade Organization Ministerial Conference in Doha, Qatar on the TRIPS Agreements and Public health. And finally, a fifth event was related to the March 2002 UN Summit on Financing for Development held in Monterrey, Mexico; and the Barcelona International Conference on HIV/AIDS in July 2002. All these international events, along with lobbying and advocacy from NGOs and international organizations, increased pressure

on the Bush administration to compel the US government to change its foreign policy approach toward access to ARV treatment in developing countries.

Although President Clinton administration's legacy of HIV/AIDS foreign policy toward Africa, embodied in his Executive Order 13155 issued in May 2000, agreed to a state-centric approach to the provision of ARV to African patients, President Bush overturned this welfare state model of public health since it undermined the neoliberal foundation of the international trade system embedded in the TRIPS agreement. In 2000, Condoleezza Rice who then went to become President Bush's national security adviser (2001-2005) and Secretary of State (2005-2009), made a remark about the Bush administration's attitude toward international treaties and agreements. In her words, "a treaty that does not include China and [which] *exempts 'developing countries from standards* while penalizing American industry cannot possibly be in America's national interests" (Rice 2000:48 emphasis added). Hence, a global treaty or international policy to eradicate the HIV/AIDS pandemic is not sustainable for the Bush conservative administration if it undermines the US economic interests embodied in private interests of US pharmaceutical companies.

The Pharmaceutical Research and Manufacturers of America (PhRMA) constitutes a powerful interest group composed of 100 of the biggest drug companies in the world to lobby the US government and Europe on policies related to health and drugs in the global market. With seven lobbyists for every congressman in Washington and hundreds more lobbyists in Europe, the PhRMA interest group has been deeply entangled with the government in the processes of policy making, especially those affecting the

pharmaceutical business interest. In the case of the anti-AIDS pharmaceutical industry, US pharmaceutical companies became the crucial determinant affecting continuity and change in US HIV/AIDS foreign policy toward Africa. Private US pharmaceutical companies were, in fact, at the heart of the HIV/AIDS global crisis given their role in the making of new ARV drugs, monopolistic control of the market prices, and the patent weapon to threaten or punish those who infringe upon their rights. Thus, the political economy of HIV/AIDS and the global context of TRIPS Agreement can help illuminate the role that pharmaceutical companies in the US played in the development of PEPFAR.

To this end, the Bush administration's policy sought to implement reform of the US foreign aid provision system and, by the same token, an instatement of neoliberal business-oriented model of welfare provision. The very design of PEPFAR was a conservative subtle repeal of the Clinton HIV/AIDS global policy that permitted African countries to overlook, if need be, the TRIPS Agreement for the sake of public health welfare provision for their citizens. Actually, the US Trade Representative (USTR) Robert Zoellick pledged that the US would not rescind President Clinton Executive Order 13155 (Behrman 2004:267). Yet, from the very beginning of the US HIV/AIDS foreign policy, pharmaceutical companies constituted the most powerful force behind official preferences, beliefs, and values. They wield considerable power – financial, technological, epistemological, and symbolic – that allowed them to exert a strong influence on the Bush administration to adjust its HIV/AIDS foreign policy according to US national interests.

The global crisis in HIV/AIDS reflected a crisis in the representation of the pandemic. While the African countries that claimed the patent regime rendered access to anti-HIV treatment impossible given their limited budget and the monopolistic prices that US pharmaceutical companies fixed, US policy makers interpreted the African HIV/AIDS public health problem as rather a direct result of the continent's chronic poverty and lack of adequate public health infrastructure. The business conflict theory can, thus, help uncover the structural interdependency of US politics and business interest while also bringing into historical perspective the institutionalization of the intellectual property (IP) global governance and the patent regime regulating the production and distribution of antiretroviral pharmaceuticals.

Although the US pharmaceutical economic interest may not exhaust the explanation on the creation of this policy, given other nonbusiness influences, organizing PEPFAR policy making process around the political economy of HIV/AIDS helps reveal the role that private pharmaceutical companies played, and the power they exerted, in the continuity and change of US HIV/AIDS foreign policy toward Africa. This political economy theory of US HIV/AIDS foreign policy provides us with a framework for interpreting both the domestic forces and the global crisis in a dynamic and dialogical interaction. Unlike the traditional pluralist theory that focuses on domestic interest groups competition and the business community as one interest group among others, a reading of the role of private US pharmaceutical companies as MNCs in the time of globalization has a theoretical comparative advantage, which consists, first, of distinguishing the



business community's influence from other nonbusiness interest groups' contribution to the shaping of the PEPFAR policy.

Scholars have underscored the privileged position of the business interest group over nonbusiness interest groups since the economic power is fungible (Dahl 1960; Baumgartner and Leech 1998; Coen and Grant 2005; Roemer-Mahler 2013). In fact, a state's capabilities, stability, and survival depend on its economic performance. Because of its significant ontological, structural, and methodological differences, the business interest group is not just like other nonbusiness interest groups. It is hierarchically better organized to overcome the collective action dilemma – unlike most nonbusiness interest groups that are usually voluntary associations of citizens to influence public policy for the common good – and can easily overlook the pursuit of the common good as their primary goal is seeking to maximize profits (Hart 2004:48). However, unlike traditional pluralist theorists who focus on an egalitarian conception of the distribution of power among interest groups, neo-pluralist theorists like to emphasize the fact that the business interest group stands in a privileged position as compared to nonbusiness interest groups and also that it is not a monolithic unit with coherent interests, as the conflict theory advances.

Thanks to the structural interdependence between the business community and the state, the business interest group often trumps other interest groups. The business industry, indeed, wields a great amount of power and influence that by far outweighs the power of nonbusiness interest groups (Lindblom 1977; Falkner 2010). The remark by Arnove (2008:165), thus, acquires more pertinence when he notes,

The US, in fact, is not engaged in programs of international good will than any other state has been (...). The US foreign policy is designed and implemented by narrow groups who derive their power from domestic sources – in our form of state capitalism, from their control over the domestic economy, including militarized state sector (...). Top advisory and decision-making positions relating to international affairs are heavily concentrated in the hands of representatives of major corporations, banks, investment firms, the few law firms that cater to corporate interests, and the technocratic and policy-oriented intellectuals [in academia and think tanks]”

Greidner (1997) and Strange (1996) conclude that while the power and influence of MNCs on foreign policy decision-making process have become immeasurable, the business influence on the behavior of states has tightened even further. Yet, in the age of globalization, businesses are becoming international players in their own respect wherein some MNCs carry out foreign policies in global governance (Hall and Biersteker 2002; Haufler 2001). On the issue of HIV/AIDS, the influence of US pharmaceutical multinational companies that transcends the domestic realm of politics impacts the global governance of production and distribution of goods and services through international regimes (TRIPS), international organizations (like the WHO), nongovernmental organizations (i.e. Médecins Sans Frontières or MSF) or even individual philanthropists like Bill Gate and Bono.<sup>8</sup> Through these nongovernmental actors, US pharmaceutical companies have attempted to constrain the behavior of government to conform to certain expected international standards. As a result, states always tend to accord preeminence

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<sup>8</sup> Andrew Natsios regards Jeffrey Sachs as a good publicist who knows how to get on the front page of influential newspapers. His propaganda about HIV/AIDS as the most serious threat to Africa won over the Harvard University Kennedy School of Governance, against the view that food security and agricultural issues were more urgent in Natsios' view. For Natsios, it is a question of tradeoff. Focus and priority should be given to agricultural development, and in case of dealing with health issues, malaria, not HIV/AIDS should receive priority. However, this is not the opinion that was shared by most people. Besides, Natsios recognizes the power of media and the public opinion in the US democracy as in the example of U2 Singer Bono, an outspoken advocate for humanitarian issues.

and privileges to the business interest group as compared to others such as ideological nonbusiness groups.

Hence, the economic aspect of PEPFAR and the business role in American foreign policy can allow us to integrate the different levels of analysis and the multiple independent variables that concurred in the development of the Bush administration's response to the African HIV/AIDS crisis. The business approach of US HIV/AIDS foreign policy toward Africa also allows for a better articulation of the power of US pharmaceutical companies as the most important source of influence in both the domestic and the global realms of HIV/AIDS politics. In theory, this approach encompasses the compassionate conservatism personal belief of the president, the bureaucratic influence on the Bush administration's HIV/AIDS foreign policy agenda, and the global contingent situation that revolved around the business of producing and providing pharmaceutical products and medical technology in an effort to address the threat posed by HIV/AIDS to the global community public health. The nature of the crisis, therefore, can be interpreted as a clash of claims between US pharmaceutical companies, anxious to conserve their market competitiveness that was protected by the patent regime and the TRIPS Agreement on the one hand, and, on the other hand, the developing countries willing to promote their sovereign right to control the public health of their citizens. As a result, US policy makers interpreted the African HIV/AIDS crisis in line with the policy image propagated by the US pharmaceutical industry. While different stakeholders had different incentives and wielded varying degrees of power and influence, the dominant view among US policy makers was generated by private US pharmaceutical companies, hence

explaining the inception of the Bush administration's HIV/AIDS foreign policy, and its timing and scope, which all depended on the evolution of the global conflict over the production and distribution of patented brand-name antiretroviral drugs versus generic pharmaceutical products to meet the needs of the public health in resources-constrained countries.

**The role of privatization in implementing PEPFAR policy recommendations.**

To be able to meet its goals, Congress required the president: first, to appoint a Coordinator whose primary responsibility would consist of harmonizing and overseeing all U.S. HIV/AIDS policies and international activities dispersed across different federal agencies. Thus, a new and complex implementing structure (Table 7), the Office of U.S. Global AIDS Coordinator (OGAC), was created to coordinate and administer the policy and was placed directly within the Department of State. President Bush appointed Randall Tobias, former CEO of Eli Lilly & Co., as the first PEPFAR coordinator with the mission to provide strategic direction for program, approve activities and work plans, and ensure monitoring and evaluation. This choice, however, quickly raised controversy within the international AIDS community, given the conflict of interest between the pharmaceutical industry and the developing countries' campaign for greater access to treatment. Ironically, although President Bush's 2003 State of the Union speech announcing the creation of PEPFAR mentioned the ARV drugs' lowering cost as a primary incentive for the developing of his global HIV/AIDS foreign policy, the U.S. Food and Drug Administration (FDA), a federal agency of the HHS responsible for the

protection and promotion of public health approved Tobias' first decision to remove generic drugs from the list of PEPFAR funds (Dietrich 2007).

Table 7. PEPFAR Policy-making Process

Definition of the Situation	Agenda Setting	Policy Formulation	Implementation
Framing the issue:  As a humanitarian crisis	Issue salience:  After 9/11, A redefinition of US national interest	Policy alternative:  A neoliberal approach to foreign aid provision: new conditionalities in the Monterrey Framework	A new implanting structure: OGAC  (1) Interagency coordination  (2) Public-Private partnership  (3) Harmonization: one framework, one authority, one monitoring and evaluation system
Key independent variable: Privatization, US pharmaceutical industry and Faith-based organization  Frame Africa with poverty stereotypes; set the agenda to fit the US interest; formulate a policy that sustains “a winning domestic coalition”; implementation (business model)			

It remains crucial to understand how US pharmaceutical companies exerted power and influence on the Bush administration's decision-making process at every stage from the designing to the implementation phases of the PEPFAR policy. They not only successfully lobbied the US government to maintain and protect a neoliberal approach to the IP governance and market-based solutions to the public health crisis but also shaped the very global environment within which official US HIV/AIDS foreign policy position – at both the executive and the legislative levels – had to find grounds and means for

implementation. That is, the very nature of the problem and the way in which the Bush administration framed it reflected the position held by US pharmaceutical companies rather than the one held by African governments, the Médecins Sans Frontières (MSF) NGO, and other civil society organizations at the global level. Unlike Clinton Executive Order 13155, President Bush chose a policy solution that favored philanthropic private charity to the regulation of the market by the state in order to access pharmaceutical products. While the former is the privileged model of redistribution in the private sector, the later would empower African governments to regulate the ARV drugs market distortions maintained by monopolistic pricing controlled by patent holders.<sup>9</sup>

In the global context of economic globalization, issues of trade, debt, and foreign aid provision, the influence of US private pharmaceutical companies was manifest in the pressure they exerted on the HIV/AIDS global agenda. While PEPFAR seems to have raised Africa at a foreign policy normalcy level, as some scholars such as Cooke and Morrison (2009) and Banjo (2010) contend, US private pharmaceutical companies shaped the policy makers' ideological preferences and domestic political constraints, as well as international regulatory mechanisms and public opinion. All of these variables are reflected in the Bush administration's relationship to the private property, and how the IP regime and the TRIPS Agreement guarantee the interests of the US pharmaceutical

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<sup>9</sup> The US version of the free market has been debated in international forums to expose the imbalance of power in regulatory mechanisms and distortions existing in the system. For instance, whether it is agriculture, automotive, or the pharmaceutical industry, it is documented that the US government has always supplied subsidies to the private sector to bolster its competitiveness in the global market. For instance, Brazilian Ambassador to the WTO, Celso Amorin pointed out that the US provides "vast amount of subsidies to its pharmaceutical corporations to research drugs and so forth, and yet when other developing countries try this, the US complains via the WTO about it" (Interview with Amy Goodman, February 15, 2001 available at Democracy Now, [www.democracynow.org/index.pl?issue=20010215](http://www.democracynow.org/index.pl?issue=20010215)).

industry against the claims to implement parallel importation and compulsory licensing. The evolution of the Clinton Executive Order 13155 in favor of African and developing countries, and the Doha Declaration in confirming the priority of the public health over private profit appeared to undermine the position of US R&D-based industry.

While this change in the global environment played a significant role in raising HIV/AIDS on the Bush administration's Africa foreign policy agenda, the policy outcome expresses a strategic move that restored the pharmaceutical rights to profit while accommodating Africans' claim to access treatment. US pharmaceutical companies claimed they had withdrawn their lawsuit against South Africa because South Africa had committed to protect the patents, "AIDS activists celebrated the withdrawal as a direct result of their efforts to create negative publicity for the pharmaceutical companies by pitching the conflict as one of putting profits before people" (Fisher and Rigamonti 2005:10). The shift in policy attention resulted from a conjugation of factors in both the domestic and international environments, including the role of the US pharmaceutical industry, civil society organizations advocacy leading to the Doha Declaration, as well as "other forms of grassroots activism and policy work [that] forced the White House to express commitment to scaling up the United States government's response to the crisis" (Russell 2004:135; Cohen 2002; Fernandez 2002).

Bearing in mind the development of the debate whether access to treatment in Africa was hindered by the prices of antiretroviral drugs under patent protection in the developed world; and aware of the changes occurring in the international perception of the crisis in HIV/AIDS and the public health in Africa, the US pharmaceutical industry

circulated two reports to contest the view that the patent regime had deleterious consequences in the developing world. The reports were meant to influence the upcoming November 2001 WTO Summit as well as the policy makers in the White House. If the reports failed to change the outcome of the WTO Summit as expressed in the Doha Declaration, it remains evident that the views from the report constituted the primary source of information for the Bush administration's policy-makers. As argued earlier, USAID Administrator rejected the idea that Africa's HIV/AIDS problem was about access to treatment, just as the reports attest. And yet, the Bush PEPFAR policy creation, which came after the WTO Doha Declaration and the Monterrey Summit on Financing for Development, is a reflection of neoliberal approach to development that overlooked the state-centric approach of the past for a neoliberal private-public partnership model. To be able to establish the parallel, it is important to understand how the PhRMA reports summarized their findings about the patent system and the limited access to life saving drugs in the developing countries.

Information is very crucial for policy-makers to make the decision that they make. Stone (2011:28) reminds, also, that politics is driven by how people interpret information. "Because politics is driven by how people interpret information, much political activity is an effort to control interpretations." Since information is the staple for decision-making, it becomes the best-kept secret of decision-making. Decision makers need to gather, weigh, and eventually act upon the information they possess. In old days, as Kaufman (2006:17) notes, "the president [had] to rely on information supplied by US diplomats and emissaries who traveled and lived abroad, representing the United States, as well as



the representatives of their countries here.” Today, bureaucracies no longer represent the only repository of information. It cannot be assumed that the information is always coherent, perfect, or exhaustive. The control over the production and the dissemination of information related to HIV/AIDS crisis had become an area of conflict among business and nonbusiness interest groups. Besides, policy makers “cannot be simply assumed to have a fixed and immu preference set, to be blessed with extensive often perfect information and foresight and to be self-interested and self-serving utility maximizers (Hay and Wincott 1998:954).

As a result, President Bush and his administration gathered and process the information related to the HIV/AIDS less from his federal bureaucratic agencies and more through the work of private organizations, think tanks, especially the policy document produced by the Council on Foreign Relations (CFR) in collaboration with the Milbank Memorial Fund.<sup>10</sup> The CFR and Milbank Memorial Fund produced a report in 2001 presenting the views from different stakeholders in the HIV/AIDS issue including the pharmaceutical companies and corporate sector, senior US government representatives and members of Congress, think tanks researchers and university academics, international institutions and nongovernmental organizations. Those stakeholders involved in policy discussion and in shaping the policy perspective

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<sup>10</sup> Kassalow, Jordan S., “Why Health Is Important to U.S. Foreign Policy,” *Council on Foreign Relations*, April 19, 2001. This important document shows the variety of governmental and nongovernmental actors who were involved in shaping the Bush administration’s HIV/AIDS policy image. A list of members of the government and those from the private sector who were interviewed by the CFR provided at the beginning of the document show the overwhelming presence of the private sector in the shaping of the official policy framework.

overwhelmingly represented the private sector's view on how to interpret the production and provision of public goods and social welfare (see the stakeholders list in Annex 1)

Another study sponsored by the private sector investigated the patent status of 15 ARV drugs in 53 African countries. The research led by Amir Attaran and Lee Gillespie-White and entitled, "Do Patents for Antiretroviral Drugs Constrain Access to AIDS Treatment in Africa?" concluded that these anti-retroviral drugs are patented only in a few African countries (See Table 8).

Table 8. Overview of AIDS Drugs With Patent in Africa <sup>11</sup>

Generic Name	Brand Name	FDA	Marketing Firm	U.S. Patent Holder	SA Pat.
Zidovudine (AZT)	Retrovir	1987	GlaxoSmithKline	Burroughs Wellcome	Yes
Didanosine (ddI)	Videx	1991	Bristol-Myers Squibb	United States	Yes
Zalcitabine (ddC)	Hivid	1992	Roche	United States	No
Stavudine (d4T)	Zerit	1994	Bristol-Myers Squibb	Yale University	Yes
Lamivudine (3TC)	Epivir	1995	GlaxoSmithKline	IAF Biochem Int'l	Yes
Abacavir Sulfate	Ziagen	1998	GlaxoSmithKline	Burroughs Wellcome	Yes
Sequinavir Mesylate	Invirase	1995	Roche	Roche	Yes
Saquinavir	Fortovase	1997	Roche	Roche	Yes
Ritonavir	Norvir	1996	Abbott Laboratories	Abbott Laboratories	No
Indinavir Sulfate	Crixivan	1996	Merck & Co.	Merck & Co.	Yes
Nelfinavir	Viracept	1997	Pfizer	Pfizer	Yes

<sup>11</sup> Cf. Fisher & Rigamonti (2005:20).

Mesylate					
Amprenavir	Agenerase	1999	GlaxoSmithKline	Vertex	Yes
Nevirapine	Viramune	1996	Boehringer Ingelheim	Boehringer Ingelheim	Yes
Delavirdine Mesylate	Rescriptor	1997	Pfizer	Pfizer	Yes
Efavirenz	Sustiva	1998	Bristol-Myers Squibb	Merck & Co.	Yes

Sources: Consumer Project on Technology (<http://www.cptech.org>); Amir Attaran & Lee Gillespie-White, "Do Patents for Antiretroviral Drugs Constrain Access to AIDS Treatment in Africa?," *Journal of American Medical Association*, Vol. 286, No.15, 2001, pp.1886-1892; U.S. Food and Drug Administration, *Orange Book* (<http://www.fda.gov/cder/ob/default.htm>)

The final report published on October 17, 2001 in the *Journal of American Medical Association* (JAMA) claims that geographic patent coverage does not appear to correlate with antiretroviral treatment. As they argue,

A variety of de facto barriers are more responsible for impeding access to ARV treatment including but not limited to the poverty of African countries, the high cost of ARV treatment, national regulatory requirements for medicines, tariffs and sales taxes, and above all, a lack of sufficient international financial aid to fund ARV treatment.

A second report by the Pharmaceutical Research and Manufacturers of America (PhRMA) entitled "Facts and Figures on Patenting and Access in Africa" also reached the same conclusion that only a few antiretroviral drugs are patented in African countries. Hence, the result of this August 2001 PhRMA Survey on patents in Africa found that the patent system is not a hindrance to access to treatment in Africa. Tom Bombelles, the Director of International Governmental Relations at Merck, presented the findings at the American Society of Law, Medicine & Ethics on September 30, 2001 and argued that patents are not a barrier to access ARV drugs in Africa but, instead, poverty and lack of

foreign donors' commitment are the main culprits. The report contends that patents are virtually non-existent for the two of the biggest killers in Africa, namely, Malaria and Tuberculosis. Besides, patenting levels are minuscule with regard to drugs treatment for opportunistic diseases related with HIV/AIDS that appear to be a huge source of suffering and hardship in Africa. Finally, concerning the HAART that are designed to stop the progress of HIV/AIDS infection, Africa is a patent desert.

The last category includes the newest and most innovative drugs our companies have developed - drugs used in antiretroviral therapies designed to stop the progression of HIV infection. Three of these drugs are ordinarily combined to treat those infected with HIV (the so-called triple-therapy cocktail). In roughly half of the 52 African countries surveyed, no patents exist related to any of these drugs. In the other half of the countries patents cover a minority of the products in each of the three categories from which triple-therapy cocktails are drawn. Thus even in those African countries where our companies have obtained some patents, more than a dozen different combinations of drug cocktails for treatment of HIV infection are not subject to patents. According to the latest available data - based on company reporting - the patenting level for 16 ARV drugs in 52 Sub Saharan African countries does not exceed 18% (150/832). *For these drugs, Africa is a patent desert.*<sup>12</sup>

Hence, they advocated for increased foreign aid to Africa so that these resource-constrained countries can afford market prices for ARV treatment. By the turning of the new Millennium, foreign aid provision had not been in favor of reports given the worse condition of foreign debt incurred by African countries. As the Cato Handbook on Policy (2004:696) notes, foreign aid is “an excellent method for transferring money from poor in rich countries to rich people in poor countries (...). Today, most researchers agree that economic growth depends on market-oriented domestic policies.”

As Kasper (2001) suggests,

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<sup>12</sup> Available at <http://www.cptech.org/ip/health/africa/phrmasurveytext.html>, last consultation November 10, 2014 (emphasis added)

The decision to drop the South African court case, and some recent announcement of price reductions on antiretrovirals can be seen as attempts by the pharmaceutical industry to avoid having HIV/AIDS catalyze an international movement seeking to address the problems in TRIPS Agreement. The companies seem to be increasingly willing to sacrifice the (already marginal) sales generated on HIV drugs in Africa in an attempt to forestall the development of a larger social movement that might ultimately lead to the TRIPS Agreement being significantly altered or even removed from the WTO.<sup>13</sup>

As the Doha Declaration shows, the international community had come to align its sympathy with the developing countries in their fight to access ARV drugs treatment. In fact, the European Union, the World Health Organization, and the UN supported the South African position (Swarns 2001; Gagnon 2002). Fisher and Rigamonti (2005:15) note that Doha Declarations acknowledged that WTO Members with insufficient technology to implement the compulsory licensing could use the parallel importation to meet their needs. However, they have

[T]he right to grant compulsory licenses and the freedom to determine the grounds upon which such licenses are granted; [...] to determine what constitutes a national emergency or other circumstances of extreme urgency (the HIV/AIDS crisis is explicitly recognized as a case of emergency or urgency), and [are] free to establish [their] own patent exhaustion regime without challenge (and thus free to allow parallel imports).

CEO of GlaxoSmithKline Company, Jean-Pierre Garnier led high-level diplomatic negotiations, involving UN Secretary General Kofi Annan to broker a deal with South Africa's president Thabo Mbeki. While, the US R&D-based pharmaceutical industry came to be presented as the most crucial player in the provision of public health welfare and the implementation of a global HIV/AIDS public health policy, the crisis provoked

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<sup>13</sup> Quoted by Anup Shah, *Global Issues*, available at <http://www.globalissues.org/article/52/pharmaceutical-corporations-and-medical-research> Last viewed on November 14.

by the anthrax scare in 2001 proved that the US government itself was ready to break the patent international agreement in favor of public health protection. Both the US and Canada were ready to extract a whopping 80% discount for Cipro, the patent-protected anti-anthrax drug by the German pharmaceutical Bayer, if not override altogether the patent for compulsory licensing if the situation could not be solved to their satisfaction. Although PhRMA – the Pharmaceutical Research and Manufacturers of America, the organization that lobby the government policies on behalf of US private pharmaceutical companies' interests – opposed the move, the message was already received. To ensure public health, as a fundamental human right, the state can override international agreements.

US pharmaceutical companies represent an important constituency of the Republicans and President Bush's White House had every reason to lobby the Congress in favor of its policy proposal that favored the pharmaceutical industry's interest. This can be summarized as the protection of the US private sector competitive advantage against greater regulatory mechanisms in the developing countries and emerging economies, given that the HIV/AIDS market was expanding to these regions and the production of generics undermined the patent monopoly of US pharmaceutical firms, and their control over the pricing of the HAART.

The controversial selection of Randall Tobias, former chairman and CEO of the pharmaceutical firm Eli Lilly & Co., as the first PEPFAR Coordinator in spite of his lack of specific experience of AIDS and African politics presents a conflict of interests, as US pharmaceutical companies also sought to overturn the Clinton Executive order 13155 and

preclude its implementation. The Food and Drug Administration (FDA) backed down from purchasing generic ARV drugs with American taxpayers monies in the immediate aftermath of the establishment of PEPFAR. This reversal from the 2003 State of the Union Address – ascertaining that ARV drugs have become cheaper thanks to generics – speaks volumes about the Bush administration's intention. Although the comparatively low price of generics drugs was a primary reason for why the policy was created in the first place, it was no longer possible to purchase them with PEPFAR money.

In fact, PEPFAR drugs procurement required that drugs used by the program be approved by the FDA and not by the WHO prequalification program. French President Jacques Chirac criticized this measure during the IAC as the US blackmailing developing countries to barter their right to produce generic HIV drugs for free-trade agreements (Lynch 2004). While US private pharmaceutical companies pushed the Bush administration to foster a new impetus in enforcing the TRIPS international regime as the 2004 Botswana meeting shows, the PhRMA also lobbied the WTO to impose limitations on compulsory licensing and outlaw parallel importing, pushing for even tougher IPRs provisions that would restrict further access to medicines in the developing world.<sup>14</sup>

On March 24, 2004, in a joint letter, Ohio Democratic Senator Sherrod Brown and California Democratic Representative Barbara Lee urged PEPFAR coordinator Ambassador Randall Tobias to comply with international standards and accept generic drugs already prequalified under the WHO prequalification standards. Two days later, on

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<sup>14</sup> Orbinski (2008); also the CEO of the generic trade association, Bill Haddad's Letter of March 16, 2004 available at: <http://www.cptech.org/ip/health/aids/fdc/haddad03162004.html>

March 26, 2004, California Democratic Representative, Henry Waxman, also wrote to President Bush stressing,

It is no secret that US pharmaceutical companies, which make brand-name drugs, do not want funds to flow to generic drug companies in India. These pharmaceutical companies are among your strongest political supporters, having contributed over \$40 million to your political party in the last five years. They should not be dictating policy on US efforts to fight HIV/AIDS in Africa and elsewhere.

Other leading Senators, including Ted Kennedy (D-MA), John McCain (R-AZ), Russell Feingold (D-WIS), Dick Durban (D-IL), Chaffee (R-R.I), Olympia Snow (R-ME) also lamented in a letter to President Bush dated March 26, 2004 how delay in disbursing the funds to provide low-cost medicines to Africa was having deadly consequences on HIV/AIDS patients.<sup>15</sup>

In multiple public statements, President Bush showed his support for the private pharmaceutical companies while acknowledging the need to help Africans with HIV/AIDS access the ARV treatment. For instance, after he pledged US support to the Global Fund on May 11, 2001, he concluded, “we understand the important of innovation in creating lifesaving medicines that combat diseases. That’s why we believe the Fund [Global] must respect IPRs as an incentive for vital research and development.” On June 14, 2001, his News Conference with European Union Leaders in Goteborg in Sweden, President Bush made it clear to Prime Minister Goran Person about the necessity of going ahead with a new round to liberalize trade; to help Africa to lift itself out of poverty with trade and open markets. He claimed that we have realized “a clear linkage between Uruguay Round and good economic growth in consecutive years.” While he invited

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<sup>15</sup> Other documents can be found at the following source:  
<http://www.cptech.org/ip/health/aids/fdc/senate03262004.pdf>



European leaders to support the Global Fund, he went on to assert his views on how to fight HIV/AIDS.

We share important challenges, as the Prime Minister mentioned: Fighting HIV/AIDS, Malaria, and Tuberculosis in Africa (...) We agree on the need for an integrated and comprehensive approach to confront these diseases, particularly in Africa, emphasizing in a continuum of treatment and care, and spurring research and development (R&D). We support the establishment of a Global Fund to fight these diseases. We welcome the steps taken by the pharmaceutical industry to make drugs affordable. In the context of the new global fund, *we will work with the pharmaceutical industry and with affected countries to facilitate the broadest possible provision of drugs in an affordable and medically effective manner.*” (my emphasis).

The prevailing neoliberal market ideology is consonant with President Bush’s business background and with the US cultural hegemony that came to monopolize the public space of representation on how the HIV/AIDS pandemic should be fought in Africa. While academic institutions, foundations, and think tanks have contributed to disseminate the idea that the private sector is the ultimate way to go about the provision of the public welfare, the belief has become hegemonic that protection of private property and investment in research and development are the engine of innovation and progress.

The neoliberal free market ideology influenced not only public opinion but also the policy makers’ perception on the roles of the private and public sectors in the production and distribution of public health welfare. This epistemological framework bolstered the patent right of US pharmaceutical companies at the expense of African governments’ demand to change the rules of the game. This is not new. Throughout Africa’s postcolonial history, relations between the developed and developing countries have consisted of finding the right balance between Western technological economies and African raw material supply economies. One preoccupation of the US after the

collapse of Communism and the end of the Cold War has consisted of developing strategies to maintain a global leadership and superpower hegemonic status.

Garten (1992), for instance, noted that the coming world order would consist of hegemonic competition among the three most influential nations of the day, namely the United States, Japan, and Germany. Ten years later, unlike scholars' predictions in the early 1990s, it is China's activism in Africa that became a greater challenge to US global leadership and strategic access to Africa's resources.<sup>16</sup> However, despite China's rise to a great power status, it is a fact that the US remains the sole superpower in the world to this day. While China has achieved prerequisite elements of global power – a sovereign state, an global and industrial economy, a nuclear-armed military, a permanent seat on the UN Security Council – it is unlikely to play any role in one of the most dominant issues of foreign policy in the post-Cold War world such as democratization and the fight against global HIV/AIDS pandemic. Some in the West have even proposed a G2 – the United States and China – as a new partnership to address the world's most pressing issues, as Minxin Pei argues (Pei 2009).<sup>17</sup>

While China's ideological power and global influence is as yet limited, its increasing presence in Africa could be seen as a tacit claim to become a superpower and a

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<sup>16</sup> Scholars thinking within the Western liberal paradigm of foreign aid donation to help improve the welfare of developing countries are critical of the Chinese approach to aid activism in Africa, which appears poorly organized and to be lacking in transparency (Brautigam 2010). Obviously, the literature on China's involvement in Africa is alarming to the West not only because China's approach defies the existing norms, institutions, and international aid architecture but also because it is hard to predict the future of the world order that rests in part on international financial institutions should China become the world superpower (Beri 2007; Jacques 2009; Jiang 2009)

<sup>17</sup> <http://carnegieendowment.org/2009/12/29/china-s-not-superpower/1rgl> (accessed on September 6, 2014)

wish to project its power globally, a challenge to the US hegemony. As Beri (2007:300) notes, “The Chinese concern with American hegemony has clearly been among the important motivations which led it to forge strategic partnerships with African countries.” As the largest developing country, China likes to boast of its symbolic role in the South-South cooperation against historical ties between Africa and the West. Yet, in its overview of America’s international strategy, the opening chapter of the *2002 National Security Strategy of the United States* recognized this global hegemonic superpower status and the US intention to maintain it. As stated in the *2002 National Security Strategy of the United States*,

The United States possesses unprecedented—and unequaled—strength and influence in the world. Sustained by faith in the principles of liberty, and the value of a free society, this position comes with unparalleled responsibilities, obligations, and opportunity. The great strength of this nation must be used to promote a balance of power that favors freedom.

However, the worrisome question that many have been asking about China’s growing power and involvement in Africa consists in predicting whether it will integrate the existing international system or transform it to fits its own image. China’s rise poses a threat to the existing Western-dominated global system, as Jacques (2009) observes. He challenges the prevailing assumption that the international system will remain unchanged as China will comply with the existing order by embracing Western values since China’s power is primarily economic, and not political or military. These views rely on faulty assumptions such as Fukuyama’s convergence theory that the world is converging toward Western liberal democracy. As it grows economically – Goldman Sachs predicts that China will overtake the US as the world largest economy in 2027 – it will also be as great

politically as it will culturally, since China refuses to Westernize. By rejecting Western cultural values such as the promotion of Human Rights, embracing democracy, or humanitarian intervention, China will reshape the global system to its own liking. Besides, the IMF, the World Bank, the WTO, and other international institutions that define the current global system are undemocratic, dominated by the West and Japan, and it is the Chinese view that they should be reformed. Many Third World countries support this argument, a perspective that makes the West feel disoriented as it will not dictate the measure of everything any longer (language, skin color, furniture, sport, culture, etc.) and new values will come into being.

Other scholars have begun to analyze the ways in which the international world order is changing given the rise of China to a superpower status and its involvement in Africa. Brautigam (2010), for instance, analyzes China's growing foreign aid donation and export credit program in Africa and concludes that China's understanding of foreign aid provision differs from the Western countries' definition. For its diplomatic, business, and development objectives, China does not discriminate recipient countries based on political, social, or the level of GDP achievements. This difference heralds an element of change in the international aid architecture. Likewise, Jiang (2009) argues that while Africans regard China as an opportunity and an alternative to Western neocolonial relations, the West shows more and more concern about China's growing influence in Africa. Critics of China's resource-driven foreign policy in Africa like reminding Africans that China is not there to serve local interests, as its extractive behavior props up repressive regimes at the expense of individuals. In fact, as the West continues warning

Africa to avoid the resource curse given China's elite-oriented approach that overlooks civil society and ordinary people, it challenges China's superpower leadership for disregarding the liberal values such as the protection of human rights, environmental rights, social rights, and democracy in its Africa's policy. However, China considers its involvement in Africa and provision of foreign aid to improve the welfare of Africans as a win-win development solution (through road and clinics building, telecommunication, low or zero-interest loans, etc.<sup>18</sup> Obviously, the challenge posed by China's growing involvement in Africa poses a threat to what the US came to take for granted after the end of Communism, that Africa which had ceased to be a "chasse gardée" of Western Europe and the playground of the Cold War competition would simply align behind the interest and preferences of the sole winning superpower.

Third, the creation of a new federal bilateral structure for the implementation of the policy instead of using and strengthening existing bilateral (USAID) or multilateral venues (World Health Organization; UNAIDS, and the Global Funds) is very telling. The Bush administration downplayed multilateral institutions such as UNAIDS, the World Bank, the WHO, and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTM). If fighting HIV/AIDS in high prevalence African poorest countries determined the

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<sup>18</sup> To explain China's behavior in Africa, Jiang (2009) like many others, concludes that the domestic context and state identity characteristics, more than any bilateral grand strategy can help understand this drive for natural resources (Alden and Hughes 2009). China's foreign policy behavior in Africa is the result of the interplay between China's domestic context – the demand for energy and natural resources to sustain the development model it has adopted – and its non-interference norm and historical role as a champion of the Third World's demand for an alternative economic world order is a better predictor of China's relations with African countries. However, China's January 2006 White Paper on African Policy defines the principles upon which it builds its bilateral relations with African countries. These include sovereign equality and non-interference, mutual benefits and friendship, solidarity and international cooperation, common win-win development, and sincerity (See also Beri 2007:300).

humanitarian drive of PEPFAR, why should it matter which institution, bilateral or multilateral, carries out the work as long as the result is the same? Why did PEPFAR allocate resources to middle income economies like South Africa whose governments could easily provide for their own citizens while countries like Zimbabwe were left out of the focus countries? The creation of two lobby groups – the Corporate Council on Africa’s Task Force on AIDS and the Coalition for AIDS Relief in Africa – in the immediate aftermath of the announcement of PEPFAR to advance the interests of US pharmaceutical industries at the Congress level is another bit of proof that economic interests and considerations were of major importance in the making of PEPAR. All the above factors raise questions about the real motives and intentions of US policy-makers in creating this Africa HIV/AIDS policy.

Multinational corporations (MNCs) have contributed in shaping the US domestic society, its democratic arrangements, and its foreign policy. The MNCs influence in foreign policy is not new given the existence and operation of such predecessors like the Hudson Bay Company and the British East India Company over 300 years ago. For a definition of MNCs, Bartholomees, Jr., (2006:5) notes that they constitute a form of nongovernmental organizations (NGOs) that

[E]xecute commercial activities for profit in more than one country. Estimates are that the largest 500 MNCs control more than two-thirds of world trade. [...] Contemporary MNCs such as General Motors or IBM have been able to take advantage of advances in technology and communication to become truly global in nature, with only a corporate headquarters in a single given country. Production no longer has to be located at the headquarters. With their enormous wealth, the impact of MNCs on the global economy is immense. Much of this influence comes in the arena of international commerce. In addition to being credited as a modernizing force in the international system through the establishment of

hospitals, schools, and other valuable infrastructure in the Third World, MNCs are also charged with exploiting underdeveloped states in their conduct of free trade.

Since “Any political system of much size or scope is likely to contain within it a population sufficiently diverse to provoke the formation of factions, each pursuing its own interest, individuals with similar interests and goals [...] have learned that it is advantageous to come together and... pool their financial resources and, if available, their voting numbers” to influence the government and shape policies to their benefit (Davidson 2009: 24-7). To that extent, MNCs have had a significant role in US foreign policy by shaping the culture, i.e., beliefs and values from which decision-makers operate and by pushing for the institutionalization of norms and arrangements within which policy decisions are made. As a result, MNCs have contributed in keeping alive American Exceptionalism and the belief in neoliberalism so engrained in the US collective thought. Hence, the primacy of the elite’s corporate interests constitutes the core of US foreign policy. “All the nations that have exercised the influence upon the destinies of the world by conceiving, following up, and executing vast designs – from the Romans to the English – have been governed by aristocratic institutions,” he suggested, opposing the democratic ideals (Tocqueville 2006:188).

MNCs embody the idea of a civil society so important for the flourishing of a liberal democracy. Initially, corporations were not seen as “part of the society of individuals that the US Bill of Rights or its British forbearers were meant to protect” but they were understood as “creatures of the state, figments of the legal imagination of the public sector” (Rothkopf 2012:182). Today, they have come to play an important role in

preserving the belief in private property rights so dear to the American democracy. In fact, they have acquired the status of “artificial persons” in the US and are treated as individual persons who share the same privilege granted by the First Amendment about free speech, Fourth Amendment about privacy, Fifth Amendment about double jeopardy, and Fourteenth Amendment about due process. In the eyes of the courts, MNCs are not regarded as interest groups but as “artificial individuals.” They enjoy a status halfway between the state power and the individual citizens.

Shortly after MNCs acquired the status of a natural person under the US Constitution by the ruling of the Supreme Court in 1886, granting them the same rights and protection extended to persons by the Bill of Rights, including the right to free speech, and the right to use their wealth to influence the government in their interest. In historical perspectives, most presidents and statesmen have alerted the American opinion about how corporations aggregate power into the hands of a few private, thus putting the welfare of the American democracy in jeopardy. Interestingly, the political and economic welfare of the US as well as its military power have grown hand in hand with the MNCs. In 1864, President Lincoln already wrote to Col. William F. Elkins,

I see in the near future a crisis approaching that unnerves me and causes me to tremble for the safety of my country... corporations have been enthroned and an era of corruption in high places will follow, and the money power of the country will endeavor to prolong its reign by working upon the prejudices of the people until all wealth is aggregated in a few hands and the Republic is destroyed. (quoted by Shah 2002).<sup>19</sup>

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<sup>19</sup> Anup Shah, “The Rise of Corporations,” *Global Issues*, 2002, available at <http://www.globalissues.org/issue/50/corporations> (consulted December 10, 2013)



In the subsequent years, other presidents and statesmen have referred to the conflict of interests between the state's public welfare and the MNCs' private interests (Rothkopf 2012:181-2).

Testifying to the Congress in 1915, US Supreme Court Justice Louis Brandeis compares MNCs to Frankenstein monsters created by the state, "Through their size, corporations... have become an institutions which has brought such a concentration of economic power that so-called private corporations are sometimes able to dominate the state. Such is the Frankenstein monster which states have created through corporation laws" (Davidson 2009:14). Later on, President Franklin Roosevelt lamented the risk that corporations posed to the state and how they have come to dominate and control the government that it almost looked no longer a democracy but an oligarchy. In his words, "The liberty of a democracy is not safe if the people tolerate the growth of private power to a point where it becomes stronger than their democratic state itself. That, in its essence, is fascism – ownership of government by an individual, by a group" (ibid).

As recently as 2010, in *Citizens United v. Federal Elections Commission*, the US Supreme Court overturned the ban that prevented corporations from using their own money to support candidates for public office. Dissent voices like Justice John Paul Stevens argued, "The Court's ruling threatens to undermine the integrity of elected institutions around the nation," (quoted by Krista Gesaman in the *Newsweek* magazine of Jan. 22, 2010). While this landmark case allowing corporations and unions to spend limitless amounts of money on presidential and congressional political campaigns may set foreign businesses as the real winners, President Obama recognized that the decision

gives “a green light to a new stampede of special interest money in our politics.”

Because corporations are conceptualized as legal ‘persons’ according to the US law, pro-business lobbies viewed the decision as honoring the First Amendment right to free speech.

Hart (2004:48) contends that although MNCs might fit the definition of an interest group, understood as “organized group that promotes a common political or policy goal,” they are not just interest groups in the traditional sense. Most interest groups are usually voluntary associations of citizens joined together to influence public policy for the common good. Unlike them, MNCs are hierarchically organized and can easily overlook the pursuit of the common good since their primary goal is seeking to maximize profits. Brown (2012:19) concurs with this view and adds the fact that MNCs’ structural capacity to organize gives them more political clout and leverage to lobby the government more than other interest groups. Not to mention their social capital, intellectual and economic resources and the multiple venues through which they can access and influence the decision making process.

The influence of MNCs in foreign policy-making process is unmatched by nonbusiness interest groups because they possess tremendous resources and the capacity to create, shape, and impact political preferences. As some of them possess resources exceeding by far those of many nation states, they are even regarded as full-fledged international actors, rivaling the nation state. For instance, they possess resources exceeding those of nation states. Should countries and corporations be ranked together, as Shah (2002) suggests, 51 of the largest 100 economies of the world are corporations

while 49 are countries. With their economic power, corporations are undermining the national sovereignty of states and challenging the Westphalian nation-state system, weakening sovereignty and traditional borders. Although not all agree with this point, some however argue that MNCs should be treated, in their own right, as independent international actors (Nicholson 2002). Hence, MNCs cannot be regarded as interest groups given that they present significant ontological, structural, and methodological differences in the way they organize themselves to influence policy.

The scholarship on MNCs coming from outside the US prior to the end of the Cold War was dominated by the view that described them as neocolonial agents of the West for the exploitation of the developing world natural resources. Scholars underscored the multiple nationality or cross-border operations as the major characteristic of MNCs, which are agents to maximize profit. In the post-Cold War era, a subtle shift has occurred due to the dominant belief in neoliberalism and the redefinition of the state's function in international relations. In fact, many concur today that the public power of the state needs to be limited in order to allow the private sector to flourish. The current process of economic globalization has created "conditions in which the territorially defined logic of the Westphalian States system is being sidelined by a global logic of economic production and exchange" (Falkner 2008:160). This evolution in international politics and the change brought about by the globalization phenomenon have led to focus democratic transformations in foreign policy on the role of the civil society, not the state per se, in following in the footsteps of the American model. Thus, international regimes and the foreign policy are becoming more and more dominated by private

nongovernmental organizations in reflection, if not a continuation, of the US domestic politics. Indeed, MNCs have had a privileged position granting them both access to the government and the power to constrain its regulatory role in favor of the free market.

This has justified the considerable amount of power concentrated into the hands of MNCs, giving them political clout and policy influence in American foreign policy decision-making process. Also, they have been very instrumental in spreading the very rules of neoliberalism in the post-Cold War globalized world (Page and Jacobs 2005). The US domestic political model has become, thus, the dominant model in global politics, offering MNCs as a factor determining democratic spread and economic growth in the developing world. This evolution in international politics and the change brought about by the globalization phenomenon caused to focus democratic transformations on the role of the civil society, not the state per se, in the image of the US model. Consequently, international regimes and foreign policy dominated by private nongovernmental organizations are more and more reflecting the US ideals of pluralism in its domestic politics.

### **Conclusion**

The assumption that Africa is neglected in American foreign policy for its strategic significance is problematic. Continuity and change in US foreign policy toward Africa has obviously fluctuated between greater commitment – when US stakes are high and competition with another superpower is available – and retrenchment whenever the challenge to US interests is low. Political statements are often a posteriori rationalization

or justification to conceal US self-interested motives. While policy-makers' actions, motivations, interests, preferences, influences, and other hidden variables are daunting to analyze, it is a good idea to begin by investigating the US domestic social structure, as Noam Chomsky (2008:160) contends, when theorizing about US foreign intervention. That is, it is crucial to question who are the actors are involved in the agenda setting and policy formulation; what are the interests they represent; and what is the domestic source of their power.

Since social science is different from the physical sciences "in that what is analyzed possesses agency. Neither description of an act of agency, nor assertion that natural law was operative in a particular case of the use of agency, can fully satisfy, for we know that agency means the agent could have acted otherwise" (Hudson 2007:7-8). For instance, different US administrations could have different policy approaches to the same issue affecting Africa. Also, African countries might have possibly developed a strategically docile, nonresistant attitude vis-à-vis the US and aligned their interests along those of the superpower whenever fitting whereas resistance and confrontation are used whenever African stakeholders feel they impact the course of US foreign policy implementation.

To simply assume that distribution of foreign aid or military and diplomatic personnel constitutes an objective measurement of any region's strategic place or international significance might miss the point. Although economic and security interests constitute the two major poles of US strategic interests, it should be borne in mind that economic capabilities are primordial and fungible while, for the same reasons, military

capabilities are ancillary to economic pursuits. That is, the global distribution of US foreign policy instruments – both in soft and hard power – does not apply equally to all the regions of the world because the US does not encounter an equal degree of penetration or resistance with friends or foes. In assessing continuity and change in US foreign policy, account must always be taken of the context, historical trajectories, and identities of each specific region.

Finally, if the US taxpayer's dollar spent in foreign aid serves strategic purposes of buying allegiance of the recipient country to American interest, it remains misleading to measure a country's international strategic significance simply by looking at the amount of foreign aid allocated. Mathematically, the dollar-value varies across countries since not all of the world's regions are economically on par or expect an equal absolute distribution of foreign aid that would ascertain this kind of equality. In fact, political rationality is always bounded to relative gains. Assuming an "absolute value" for each dollar spent on foreign policy issues, regardless of the regional differences, means forgetting one fundamental reality. A dollar's value is always measured within any given social system. In other words, if a dollar could buy one loaf of bread in a European country, it would perhaps be worth three loaves of bread in a Middle Eastern country, five loaves of bread in an African country, or ten loaves of bread in South East Asia. For instance, more US foreign assistance flowed to the newly formed states in Eastern Europe after the Cold War, including Russia, as the US government sought to lure them with its global benevolent influence. Why should the US continue providing the same amount of aid to African countries whose allegiance was inescapable once the Cold War

competition was over? Hence, the retrenchment from Africa during the same period was only consequential during the 1990s while the resumption of US policy activism after terrorist attacks on US interests became a reminder that US involvement in Africa is primarily for the protection of US interests.

It was not a coincidence that the Bush administration avoided going through existing bureaucratic structures and staffed his PEPFAR task force with members of his White House inner circle administration with close ties to the private sector and business expertise. To overcome existing bureaucratic turf war, a multi-agency coordination (Department of Defense, Department of State, Health and Human Services, USAID, Peace Corps, and Department of Labor) was created under the Office of the Global AIDS Coordinator (OGAC) (Table 9). This marked, in a way, the end of big government, both at home and abroad, in the management of U.S. foreign aid funds. President Bush created a task force team at the White House level in charge of laying the policy groundwork, in total secrecy, in order to avoid bureaucratic turf war and move fast – given the emergency of the African situation.

Table 9. PEPFAR Implementing Structure

1. OFFICE OF THE GLOBAL AIDS COORDINATOR (OGAC) This is a new structure created to coordinate and harmonize the government activities related to HIV/AIDS across different governmental agencies		
2. HORIZONTAL COORDINATION (See below Table 10)		
USAID	HHS Agencies (NIH, CDC, FDA)	Other federal agencies: (DoD, Labor, Peace Corps)
3. INTERGOVERNMENTAL COORDINATION		
US Agency PEPFAR Field Staff (In-country team)		

4. VERTICAL COORDINATION
Prime Partners: International NGOs, Universities, private foundations Sub-partners: local or community-based organizations Programs

The OGAC had a threefold coordination mission:

(1) A horizontal coordination that refers to PEPFAR interagency structure sought to supervise actors across different federal governmental agencies, including the State Department, the U.S. Agency for International Development (USAID); the Health and Human Services (HHS) running different programs under the National Institute of Health (NIH), the Center of Disease Control and Preventions (CDC); the Department of Defense (DoD); the Department of Labor, and the Peace Corps. The mission of OGAC combined provision of direction and guidance of individual agency headquartered in the U.S. but whose personnel were involved in the work of HIV/AIDS.

(2) A vertical coordination that refers to the funding supply chain established the OGAC to oversee the funding mechanisms through which PEPFAR allocates the funds to in-country teams. The supply chain, thus, goes from US Congress and OGAC down to local implementing partners in a model termed “networked government” (Kamarck 2002). The Congress appropriates funds; the US Global Coordinator decides through which programs the money is spent across different U.S. governmental agencies; in their turn, in-country teams that include the US ambassador, who administers representatives from each U.S. government agency working on HIV/AIDS program in focus countries, subcontract with prime partners (basically private sector groups that partner directly with U.S. government); finally, the prime partners also sublet contracts to Subprime partners



or the private sector groups with little contact with U.S. government staff among which are the civil society, faith-based, and community organizations that receive funds and technical assistance from prime partners.

(3) An intergovernmental coordination that refers to the ways in which PEPFAR engages with partner countries' governments seeks to harmonize HIV/AIDS programs with national policies in host countries that are seen both as prime and sub-partners. This is the US government's commitment to principles of alignment and harmonization with national programs, including harmonization with other international partners (Boggiano 2011). It is at this level that PEPFAR can be seen as a tool of U.S. foreign policy because it is used in the foreign aid system to obtain a certain kind of behavior from governments where the PEPFAR activities are hosted.

Table 10. US Federal Agencies Involved in PEPFAR Implementation

Federal Agency	Program Activities
State Department	<p>The US Office of the Global AIDS Coordinator (OGAC) reports directly to the Secretary of State. The State Department support for the Office of the OGAC includes:</p> <ul style="list-style-type: none"> <li>Provides human resources services</li> <li>Tracks budgets within its accounting system</li> <li>Transfers funds to other implementing agencies</li> <li>Provides office space, communication and information technology services.</li> </ul>
USAID	<p>Receives overall foreign policy guidance from the Secretary of State. Implementation of PEPFAR programs extends to nearly 100 non-focus countries.</p> <p>Takes a comprehensive and balanced</p>

	<p>approach to combating the HIV/AIDS pandemic and tailors programs, activities, and interventions appropriately considering the country's context</p> <p>Supports and implements a variety of programs in technical areas critical to fighting HIV/AIDS in the countries USAID operates, which include Treatment, Prevention, Care, Research, Infrastructure strengthening</p> <p>Funded by PEPFAR, and managed by USAID, the Supply Chain Mechanism System (SCMS) project has been helping host nations increase their capacity for delivering essential lifesaving HIV/AIDS medicines and supplies to people in need of treatment and care since 2005</p> <p>Integrating gender across HIV/AIDS prevention, treatment, and care programs with an emphasis on transformative interventions is a key guiding principle in the HIV/AIDS work of SAID in partnership with PEPFAR</p>
Peace Corps	<p>Is involved in the fight against HIV/AIDS, implements Emergency Plan programs in nine of the 15 Emergency Plan focus countries – Botswana, Guyana, Kenya, Mozambique, Namibia, South Africa, Tanzania, Uganda, and Zambia.</p> <p>At least 55 percent of all volunteers report being involved in at least one HIV/AIDS activity (e.g., awareness, prevention, orphans, care, etc.) during their service - a significant increase from the 25 percent reported in fiscal year 2004 (See Global biennial Peace Corps volunteer survey, fiscal year 2006).</p>
Department of Defense (DoD)	Implements PEPFAR programs by

	<p>supporting HIV/AIDS prevention, treatment, and care, strategic information, human capacity development, and program and policy development in host militaries and civilian communities of 73 countries around the world.</p> <p>These programs are accomplished through direct military-to-military assistance, support to nongovernmental organizations and universities, and collaboration with other US Government agencies in each country</p> <p>Members of the defense forces in 13 PEPFAR focus countries have been the recipients of DoD military-specific HIV/AIDS prevention programs designed to address their unique risk factors, in addition to treatment and care programs for their personnel</p>
Substance Abuse and Mental Health Services Administration (SAMHSA)	<p>Works domestically through US State and community programs to treat addiction and dependence, to prevent substance abuse, and to provide mental health services, including supporting an educational and training center network that disseminates state-of-the-art information and best practices.</p> <p>HHS and PEPFAR country teams are applying this technical expertise and program experience to the program areas of drug and alcohol abuse in the Emergency Plan.</p>
Department of Health and Human Services (HHS)	<p>Has a long history of HIV/AIDS work within the US and internationally</p> <p>Implements prevention, treatment, and care programs in developing countries and conducts HIV/AIDS research through.</p>
Centers for Disease Control and Prevention (CDC) Global AIDS Program (GAP)	<p>Works with Ministries of Health and other public health partners, through the President's Emergency Plan for AIDS Relief, to combat HIV/AIDS by</p>

	<p>strengthening health systems and building sustainable, evidence-based HIV/AIDS programs in more than 75 countries in Africa, Asia, Central and South America, and the Caribbean</p> <p>GAP has highly trained physicians, epidemiologists, public health advisors, behavioral scientists, and laboratory scientists working in countries around the world as part of US government teams implementing the Emergency Plan. GAP is uniquely positioned to coordinate with the CDC's other global health programs, such as global disease detection, public health training, and prevention and control of other infectious diseases such as malaria and tuberculosis, as well as with CDC's domestic HIV/AIDS prevention programs in the United States.</p>
National Institutes of Health (NIH)	<p>Is the lead Federal agency for biomedical research on HIV/AIDS</p> <p>Supports a comprehensive program of basic, clinical, and behavioral research on HIV infection and its associated opportunistic infections, co-infections, and malignancies. This research will lead to a better understanding of the basic biology of HIV/AIDS, the development of effective therapies to treat it, and the design of better interventions to prevent new infections, including vaccines and microbicides</p> <p>Supports an international research and training portfolio that encompasses more than 90 countries, through its 27 Institutes and Centers, including coordination and support from the Fogarty International Center.</p>
Food and Drug Administration (FDA)	<p>Manages an expedited review process to ensure implementers can buy safe and effective antiretroviral drugs for the Emergency Plan at the lowest possible</p>

	<p>prices. This process has significantly reduced the cost of treatment by making the quality generic products available for registration and marketing in the 15 Emergency Plan focus countries. The result is that more patients receive treatment at a lower cost with high-quality antiretroviral drugs</p>
<p>Health Resources and Services Administration (HRSA) Global HIV/AIDS Program</p>	<p>Operates its Global HIV/AIDS Program through HRSA's HIV/AIDS Bureau</p> <p>Builds human capacity for scaling up care and treatment based on its more than 20 years of experience in providing quality, comprehensive HIV/AIDS care to underserved communities</p> <p>Global HIV/AIDS strategy focuses on health system strengthening and human resources for health.</p> <p>Implements strategies through activities such as twinning, training and technical assistance, rapid roll-out of antiretroviral drugs, mentoring for nursing leadership, and enhancement of the continuum of palliative care.</p>
<p>Office of Global Affairs</p>	<p>Located in the Office of the Secretary; it promotes the health of the world's population by advancing the Secretary's and the HHS' global strategies and partnerships, thus serving the health of the people of the United States.</p> <p>Coordinates all of the HHS agencies to ensure the Department's resources are working effectively and efficiently under the leadership of the OGAC.</p>
<p>Department of Labor</p>	<p>Implements Emergency Plan workplace-targeted projects that focus on prevention and reduction of HIV/AIDS-related stigma and discrimination.</p> <p>Has programs in over 23 countries and</p>

	<p>has received PEPFAR funding for projects in Guyana, Haiti, India, Nigeria, and Vietnam. As of March 2006, programs that work with the International Labor Organization and the Academy for Educational Development have helped 415 enterprises adopt policies that promote worker retention and access to treatment. These programs have reached more than 2,500,000 workers now covered under protective HIV/AIDS workplace policies. Brings to all these endeavors its unique experience in building strategic alliances with employers, unions, and Ministries of Labor, which are often overlooked and difficult to target.</p>
Department of Commerce (DoC)	<p>Has provided and continues to provide in-kind support to PEPFAR, aimed at furthering private sector engagement by fostering public-private partnerships.</p> <p>The US Census Bureau, within the DoC, is also an important partner in the Emergency Plan. Activities include assisting with data management and analysis, survey support, estimating infections averted, and supporting mapping of country-level activities.</p>

The US government federal agencies listed in this table support a range of activities – from research to technical assistance and financial support to other nations – to combat the global HIV/AIDS pandemic under the supervision of PEPFAR.

Source: compiled from <http://www.aids.gov/federal-resources/around-the-world/pepfar/index.html>.

## CHAPTER FIVE

### THE IMPLEMENTATION OF PEPFAR: THE UGANDA CASE STUDY

#### **Introduction**

The PEPFAR policy was implemented through FY 2004-2008 and it was even reauthorized for another five years in 2008. As a matter of fact, the disbursement for the programs went beyond the initial \$15 billion requested by President Bush to reach a total of \$18.8 billion for the period of 2004-2008 (Dybul 2009:S12). Given that the scope of this study is limited to understanding continuity and change in the US HIV/AIDS toward Africa during the five first years of the PEPFAR, it is important to also look at how the money was distributed and whether the trends it followed is consonant with the goals it adopted. Strategically, PEPFAR focused the bulk of its budget to only 15 focus countries. They include Botswana, Cote d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda and Zambia, Haiti, Guyana, and Vietnam (Table 11). However, as Lyman and Morrison (2006:65) note, PEPFAR programs “are not limited only to the fifteen focus countries; assistance in some form extends to almost all affected African countries.” While the focus countries received two-thirds of the proposed US \$15 billion, the remaining one-third went to support the global fight against HIV/AIDS in more than 120 countries worldwide through such multilateral programs like the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) (IOM 2007:25).

Dybul (2009) explains PEPFAR's success in achieving the goals it had set for the first five years through the willingness of President Bush to implement his new approach to foreign aid provision. While Africa remains the world's poorest continent as it continues to trail the other continents on human development indicators such as life expectancy, infant mortality, literacy, or the incidence of communicable diseases such as HIV/AIDS, it was observed that the per capita income in Africa declined by 11 percent in spite of massive foreign aid allocation between 1974 and 2003 (Mwenda 2006). However, foreign aid advocates continued arguing that the culprit was African leadership and that increasing the volume of aid and writing off the sovereign debt of African countries would boost the continent's economic growth and development. Hence, African countries were encouraged to adopt a new development framework to replenish the confidence of donors while international donors also adopted the "Monterrey Consensus" framework that set new criteria for aid allocation. The former created a New Partnership for Africa's Development (NEPAD) and the latter agreed on new criteria for international poverty reduction and the need to increase foreign aid as essential to achieving the Millennium Development Goals.

Table 11. Funding Trends in PEPFAR Sub-Saharan Africa Focus Countries

Country	Population w/ HIV/AIDS	Adult HIV prevalence (%)	PEPFAR funding (\$US millions)	GDP per capita* (\$US) (2004)	GFATM Funding (\$US millions)	Total Funding Amount (\$US millions)	Funding Per HIV+ Person (\$US)
Botswana	350,000	37.3	67.4	4,829.5	18.6	86	246



Cote d'Ivoire	570,000	7	63.6	903.0	19.1	82.7	145
Ethiopia	1,500,000	4.4	118	136.8	97.3	215.3	144
Kenya	1,200,000	6.7	228.6	462.1	39.6	268.2	224
Mozambique	1,300,000	12.2	92.1	278.8	29.7	121.8	94
Namibia	210,000	21.3	64	3,298.0	26	90	429
Nigeria	3,600,000	5.4	179.8	645.9	28.2	208	58
Rwanda	250,000	5.1	90.6	225.8	23.3	113.9	456
South Africa	5,300,000	21.5	221.5	4,892.0	66.1	287.6	54
Tanzania	1,600,000	8.8	175.5	349.6	134.9	310.4	194
Uganda	530,000	4.1	215.1	286.0	119.3	334.4	631
Zambia	1,800,000	16.5	196.7	556.7	117.1	313.8	341

Sources: adapted from Patterson (2006:166-167), compiled from WHO (2004), OGAC (2004a), UNAIDS (2004b), GFATM (2006a) and World Bank data (2004)

\* The World Bank data are available at:

<http://data.worldbank.org/indicator/NY.GDP.PCAP.CD?page=2> last consultation June 8, 2015.

The NEPAD's conception of development not only places Africa at the apex of the global agenda but also integrates economic growth and political democracy, thus providing an African platform to engage the international community in a dynamic partnership. Its vision focuses on promoting accelerated economic growth and sustainable development to eradicate widespread and severe poverty and halt the marginalization of the African continent in a globalized world. Besides, it targets at empowering women as an important contribution to the labor force to fully participate in the development of the African continent. These objectives have been construed around the assumptions that

good governance, democracy, human rights and conflict resolution are a prerequisite for investment and long-term economic growth. The NEPAD, therefore, appears like an institution seeking to comply with donors' values in order to create incentives for increased investment, capital flows and funding, essential to Africa's economic development and conditions for its regional and international partnership.<sup>1</sup>

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<sup>1</sup> In July 2001, a New Partnership for Africa's Development (NEPAD) was adopted in July 2001 at the Lusaka OAU Summit and received enthusiastic support by Africa's development external partners such as the G7/8 and EU member states. They viewed the initiative as an effort towards development by African leaders, for African states, to be implemented by Africans. To understand NEPAD's momentum and the enthusiastic support it received, it is important to consider the conditions that favored its creation and the problems it offered to solve. NEPAD resulted from the merging of two plans for Africa's economic regeneration: the Millennium Partnership for the African Recovery Program (MAP), and the OMEGA Plan for Africa. The former stems from the mandate given to President Mbeki of South Africa and President Bouteflika of Algeria during the Organization of Africa's Unity (OAU) Summit in 1999 to engage Africa's creditors on the total cancellation of external debt. The following year, at the Havana, Cuba, the Non-Alignment Movement and the G-77 Summit, Presidents Mbeki of South Africa and Obasanjo of Nigeria were mandated to convey concerns of the South to the G-8 and the Bretton Woods institutions. Given that these two mandates were similar in focus and proposed the cancellation of external debt, the three African Heads of State earnestly engaged the G-8 at the July 2000 Summit in Japan to obtain the cancellation of Africa's external debt. In March 2001, at the Organization of African Union (OAU) Summit in Sirte, Libya, Senegal President Wade's proposed OMEGA Plan for Africa evaluated the failures of development in the past years. As he observed, "since the 1970s, Africa has gone through economic and social difficulties that are gradually edging it out of the mainstream of world affairs." The Third World leaders had already tried to negotiate already in the mid-1970s a New International Economic Order, which was met with opposition in the North. The ensuing development programs – such as the Lagos Plan of Action (1980-2000) and the Final Act of Lagos (1980); Africa's Priority Program for Economic Recovery (APPER) 1986-1990, which was later converted into the United Nations Program of Action for Africa's Economic Recovery and Development (UN-PAAERD) (1986); the 1985-1995 Industrial Development Decade for Africa (IDDA), the UN New Agenda for the Development of Africa in the 1990s (UN-NADAF, 1991) – failed to yield the expected development results (Anyang' Nyong'o and alii 2002:3). Joined by the President of Egypt, Mubarak, five Heads of States including South African Thabo Mbeki, Nigerian Olesegun Obasanjo, Algerian Bouteflika and Senegalese Abdoulaye Wade received the mandate to merge the MAP and the OMEGA Plan into one comprehensive framework for Africa's development. The NEPAD was thus born as a combination of a new vision for Africa's development informed by the assessment of past failures. Not only that, but the NEPAD also took into account the new world order and the globalization of economy as well as past failures and plans for development. The NEPAD was designed to address Africa's development quagmires. Its conception of development places Africa at the apex of the global agenda and integrates economic growth and political democracy, thus providing an African platform with which to engage the international

A response from Western donors came one year later, through the new criteria for foreign aid allocation that emerged from the UN meeting on Financing for Development International Conference in March 2002. The “Monterrey Consensus,” as it came to be known includes partnership with the recipient country or the ownership of the programs and proof of good governance, results-based approach and accountability, and a multisectoral engagement that avoids a state-oriented development and takes into account the private sector and different nongovernmental actors and the civil society. By focusing efforts and attention to only 15 focus countries with the highest HIV/AIDS prevalence rates, and by devolving responsibility to the recipient country’s ownership of the programs, the Monterrey Consensus principles came to be enshrined in the very fabric of PEPFAR, according to Mark Dybul (2009).

In other words, focus on results (2-7-10), strong accountability measures (monitoring and evaluation mechanisms), and utilization of the private sector’s expertise and services (nongovernmental organization and faith-based organizations) in the implementation of PEPFAR account for the success achieved in the first five years of the program. Hence, specific countries with the highest HIV/AIDS prevalence rates with the lowest economic capabilities were included among the focus countries (See Table 12).

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community in a dynamic partnership. While the vision consists in promoting accelerated economic growth and sustainable development in order to eradicate widespread and severe poverty and to halt the marginalization of Africa in a globalized world, its targets also consist in empowering women as an important contribution to the labor force that would fully participate in the development of the African continent. As is obvious, these objectives have been construed around neoliberal assumptions as prerequisites for investment and long-term economic growth. The NEPAD, therefore, appears like an institutional framework seeking to comply with donors’ values in order to create incentives for increased investment, capital flows and funding, essential to Africa’s economic development and conditions for its regional and international partnership.

Table 12. Estimated HIV Prevalence in Major Regions (2001-2005):

Region	Adults (15-49)* Millions	Number HIV+* Millions	HIV+ 2001 Percent	HIV+ 2001R* Percent	HIV+ 2005** Percent	HIV + 2005R Percent	Major HIV Risk Behavior Groups
Sub-Saharan Africa	291.3	26.0	9.0	7.6	7.2	6.1	Heterosexual
Caribbean	17.2	0.4	2.3	2.2	1.6	1.6	Heterosexual
South and Southeast Asia	1031.5	5.4	0.6	0.6	0.7	0.6	FSW & IDU
Latin America	262.2	1.4	0.5	0.5	0.6	0.5	MSM & IDU
East Europe & Central Asia	209.0	1.0	0.5	0.4	0.9	0.8	IDU
Western countries**	373.5	1.5	0.4	0.4	0.4	0.4	MSM & IDU
North Africa & Middle-East	180.5	0.5	0.3	0.2	0.2	0.2	---
East Asia & Pacific	833.1	1.0	0.1	0.1	0.1	0.1	IDU
Global Totals:	3198.3	37.1	1.2	1.0	1.1	1.0	
*Adapted from the UNAIDS Global report, July 2002. **Adapted from the UNAIDS Global report, July 2003. ***Adapted from the UNAIDS Global report, December 2005. ****Includes N American countries, Western European countries, Australia and New Zealand. ^Adapted from UNAIDS 2006 report on the global AIDS epidemic (May 30, 2006)							

Source: Chin, James (2007:121)

Other studies and reports by authorized commissions also concluded that as the countries hardest hit by HIV/AIDS were also those with the lowest GDP or income per capita, it was easy to conclude to a correlation between development and HIV/AIDS. As

some argued, “the objective conditions obtaining in Africa in the post-independence era showed quite clearly that underdevelopment was a historical phenomenon in which Western imperialism stood accused of depleting Africa’s resources and labor (...) Any attempts to come to terms with this unequal and structurally under-developing relationship call for drastically new arrangements in international relations in which Africa needed to recapture her role as a subject and not an object of her own history” (Anyang’ Nyong’o and alii 2002:27-28). Dybul (2011) also notes the reaction of “African Heads of State, First Ladies, Ministries of health, and local leaders from every sector [who] have pointed to PEPFAR as a great life saving measure that helped to usher a new era in development.” It had become obvious to the international community that poverty exacerbates a country’s efforts to improve the welfare of its citizens, especially with regard to the public health and that there was no way the Bush administration could tackle the issue of HIV/AIDS in Africa without first addressing the challenges of development and poverty posed to the continent (IOM 2007:49).

**PEPFAR focus countries’ selectivity criteria.** As it remains true that Africa, more than the rest of the world, has suffered the heaviest blow from the HIV/AIDS pandemic, how can we explain this epidemiological difference or the African HIV/AIDS exceptionalism? The PEPFAR focus countries are said, indeed, to represent more than half the world’s HIV prevalence. By the time the program was created in January 2003, Africa and the Caribbean accounted for more than 75 percent of the estimated 42 million individuals infected with HIV or living with AIDS around the world according to the U.S.

Public Law 108-25:712<sup>2</sup> (See Table 1). The IOM describes, in its implementation Report of PEPFAR, the classification of countries by HIV prevalence rates. “The epidemics can be described in terms of geography or subpopulations affected within larger populations, and involve different transmission patterns that result from varying patterns of behaviors conducive to spread of the virus” (IOM 2007:38). This classification by HIV prevalence rates at country-level is put in three categories, with numeric indicators: low, concentrated, and generalized.

The “low infection countries” are those countries where little HIV is measured in any group, and the surveillance systems focus largely on high-risk behaviors. The “concentrated infection countries” are those where HIV prevalence is spread out within subpopulations, largely confined to individuals or groups with higher-risk behaviors. These groups mostly include sex workers, men having sex with men, and IDUs, although the infection is not well established in the general population. “For countries with low-level or concentrated epidemics, HIV estimates are based on studies among key populations who are at higher risk of HIV exposure – such as people who inject drugs, sex workers, or men who have sex with men” (UNAIDS 2013:3).<sup>3</sup> The “generalized infection countries” are those within which HIV infection is firmly established in the general population with the prevalence rate over 1 percent in the general population (IOM 2007:40). A state is low if the HIV prevalence is smaller than 5 percent in the Key populations, which include sex workers, men who have sex with men, and people who

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<sup>2</sup> See the *H.R. 1298 United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003*, which President Bush signed into law on May 27, 2003.

<sup>3</sup>[http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/20131118\\_Methodology.pdf](http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/20131118_Methodology.pdf)

use injecting drugs. It is concentrated if the prevalence is greater than 5 percent within the same population. None of the focus countries is characterized by this state of low or concentrated infection.

The poverty theory of Africa's high HIV prevalence rates insists also on the importance of a person's immune system response to HIV and how malnutrition depletes the system, making the person more susceptible to parasitic infections. In Stillwaggon's (2006:7) words, "[t]he conditions of poverty increase HIV susceptibility, not only to opportunistic diseases after HIV infection but also to HIV transmission itself, just as they increase susceptibility to other infectious diseases." Besides the poverty argument, others have correlated the African high HIV prevalence rates with cultural sexual behavior and insist on behavioral changes for spread containment and prevention of new infections. Hence, to explain how Africa became the epidemics global epicenter in the first place, others regard poverty as the etiological explanation of HIV spread. Stillwaggon (2006:5) contends that although the immediate cause of much HIV transmission in sub-Saharan Africa and other very poor regions is heterosexual intercourse, "the individual transmission and epidemic spread of HIV are not simply mathematical functions of sexual behavior." Poor regions provide a different terrain for the spread of infectious diseases as compared to the conditions in industrialized countries. As she notes,

Durban, South Africa, in 2000 begins with the acknowledgement that HIV disproportionately afflicts poor countries. Rarely is that statement accompanied by an adequate analysis of how poverty contributes to the spread of AIDS, and then only to suggest that poverty can provide the impetus to risky behaviors, which is certainly true, but it is only part of the story (*idem*, 11).

Likewise, Whiteside (2006) contends that due to poor healthcare infrastructure as well as deficit in nutrients and malnutrition that weaken the body's immune system, poverty is the cause of widespread HIV infections in Africa. It creates a favorable biological terrain for infections while depleting the immune responses for lack of proteins, iron, vitamin-A, is conducive to conditions of decrease in disease resistance. Thus, the HIV/AIDS crisis has come to represent one of the strongest factors of Africa's development, welfare, and poverty given the economic consequences of repeated funerals, work absenteeism, and cost of treatment as well as the correlation between AIDS political instability and conflicts, and the social effects on orphans and vulnerable children.

While scholars agree that the most common way of HIV transmission in Africa is through heterosexual contacts, they fail to agree on what might explain the widespread variation in HIV prevalence within the continent. Arguably, up to 80-90 percent of Africa's HIV infection rates come through heterosexual contacts while only 5-35 percent come through mother-to-child transmission infections and 5-10 percent of new infections are accounted for by health care procedures such as blood transfusion and medical injections. There is thus a deep-seated presumption, almost a myth, about the African sexualized society and hypersexual performances, a stereotype that "hijacked the AIDS-in-Africa discourse" and continues to inform the prevention policies on behavioral changes. These general trends, however, do not explain the generalized infection existing within particular regions. In fact, there are particularities and variations of HIV prevalence across Africa that the cultural behavioral explanation may not explain (IOM 2007:63). Either way, whether facilitated by economic poverty or sexual cultural



behavior, it remains undeniable that sound policies that can defeat the HIV/AIDS pandemic in Africa will always have to do with the conditions of Africa's socioeconomic development.

Many Africans and Africanists have reacted to these views, claiming that colonial tropes and postcolonial representations continued to depict Africans as being ruled by base sexual instincts. For instance, Paula Treichler (1999) notes that,

Deeply entrenched institutional agendas and cultural precedents in the First World prevent us from hearing the story of AIDS in the Third World as a complex narrative... In concrete terms, we need to forsake, at least part of the time, the coherent AIDS narrative of the Western professional and technological agencies and listen instead to multiple sources about and within the Third World (quoted by Downing 2005:23).

This view confronts the outcry against South Africa President Mbeki's position that revoked the established theory of Africans' promiscuity and unbridled sexual behavior – a theory that puts the responsibility of the HIV/AIDS public health crisis in Africa on Africans and the HIV, thus diverting the policy attention away from the real issue of history, poverty, politics, and economics.<sup>4</sup> President Mbeki's view sought to include iatrogenic aspects of HIV infections such as contaminated blood transfusions, unsterile medical instruments, malnutrition leading to a natural weak immune system, and the social infrastructures that account for Africa's poverty.

Hence, the policy advocating the altering of African traditions, sexual behavior, or promiscuous lifestyles – as if Africa was that exception with regard to the political and

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<sup>4</sup> President Thabo Mbeki's "Speech at the Opening Session of the 13<sup>th</sup> International AIDS Conference" on July 9, 2000 argues that the story of HIV and AIDS in Africa concerns not only the virus as a causal agent but also should be concerned by other factors including lack of basic hygiene, water, food and nourishment, education, and other social determinants. The speech can be found at the following link: <http://www.dst.uff.br/revista13-1-2001/Cap%204%20-%20Speech%20of%20the%20president.pdf> (last view, July 31, 2015).

social economy of sex – to win the war on the HIV/AIDS pandemic was not only misguided but also contemptuous. While some leaders situated the discourse on HIV/AIDS in Africa in the long line of history of Western representation of Africa as a gloomy place where nothing works – a perspective tainted with Eurocentric colonial biases, others were keen on acknowledging the HIV/AIDS epidemic and on combatting it fiercely. It remains important, therefore, to look at how these two approaches relate to the fight on poverty and the history of development policies toward Africa. In other words, it is crucial to understand how the US global politics of HIV/AIDS embodied in PEPFAR and its focus countries related to the shift in the understanding and the new conditionalities of US foreign aid allocation in the Cold War's aftermath.

**HIV/AIDS and US-Africa development policy.** The idea that HIV/AIDS prevalence in Africa is an outcome of poverty has its proponents and its detractors. When these international financial institutions (IFIs) discussed countries to benefit from this Heavily Indebted Poor Countries (HIPC) initiative in 1996, Africa alone represented 33 out of the initial 41 HIPC worldwide. Chege (2001) notes that *The Economist* of May 13, 2000 rendered the verdict about Africa as a helpless continent. Central Africa was depicted as “the epicenter of gravest inter-state conflict in African history, characterized by a series of interlocking wars from the Horn of Africa to Angola.” Yet, the humanitarian tragedy behind the battle lines defies description. As a result, the gloomy depiction of Africa by the turning of the new Millennium was the argument used by those in favor of revamping the foreign aid structure in spite of policy makers' misgivings about aid efficacy. As the infection rates of While HIV/AIDS in 1999 in four key

countries, i.e., Uganda, Rwanda, Namibia, and Zimbabwe, ranged between 10 and 25 percent of the total adult population, “Poor economic growth rates and anxiety over once-promising states like Kenya, Côte d’Ivoire, and Zimbabwe compound these tragedies” (Chege 2001:225).

In 2001, the WHO Commission on Macroeconomics and Health (CMH) concluded that AIDS, Malaria, Tuberculosis and other preventable diseases had severe perverse effects on African economies and caused further poverty, although it should be recognized that these epidemics were also caused by poverty. Thus, the causation may run in both directions (Sachs 2005:197, 204-8; Dietrich 2005:271; Banjo 2010:146). As a matter of fact, three-quarters of the 12 African focus countries belong to the World Bank and the International Monetary Fund’s (IMF) list of the HIPC. While advocacy groups and the global civil society established an inherent correlation between Africa’s poverty and the widespread HIV infection as a vicious circle, scholars are not unanimous on this correlation between poverty and HIV/AIDS in Africa. Following the strong criticisms voices against Western donor countries on foreign aid conditionalities, enforcing the World Bank and IMF’s Structural Adjustment Programs (SAPs) in Africa, a global movement ensued asking for the cancellation of African countries sovereign debt, it was no coincidence that most PEPFAR focus countries were identified among the heavily indebted poor countries in Africa.

As the whole philosophy underlying the foreign aid system was being challenged within the US domestic politics and in the global community, a new rationalization was needed to justify the continuation of the aid industry. The perverse effects of the foreign

aid allocation from the 1960s to the early 2000s, mostly as a function of the structural adjustment policies since the 1980s, were obviously in direct relation with the sovereign debt incurred by African countries, let alone the persistence of poverty. Given President Bush's conservative outlook, it was clear that foreign aid should not be granted for the sake of aid. Rather, in an effort to move away from the Cold War paternalistic approach, he thought that aid should be used as an instrument in his transformational diplomacy that aimed at incorporating good governance, results delivery, accountability, and partnership of African countries. If we look closely at these conditions, it becomes clearer that they are no different from the neoliberal SAPs of old that advocated deregulation, free market, and the privatization approach. Only the vocabulary was slightly different. As a result, PEPFAR was President Bush's first and best opportunity to implement the Republican's sought-after change in US foreign aid system after the Cold War.

As noted earlier, the fight against HIV/AIDS in Africa is closely tied to issues of Africa's plight of poverty and lack of development. "The relationship between poverty and HIV/AIDS is so blatant although many – the IMF and the World Bank – fail to see it. The IMF doesn't understand the combined ravages of HIV/AIDS and poverty," concludes Lewis (2006:14). Craddock (2010:251) also observes, on the other hand, that designating the HIV/AIDS pandemic as a security and development issue at the beginning of the new Millennium set the stage for US policy makers to increase financial and political attention on regions of Africa heavily affected by the disease. Patterson (2006) also concurs that political commitment of donor countries, in the wake of the world leaders' agreement in 2001 through the United Nations Declaration on

Commitment on HIV/AIDS, is essential in the fight against the pandemic. Indeed, after the lost decade of the 1990s, more and more governmental and nongovernmental actors were showing a growing interest in the global HIV/AIDS pandemic.

In 2000, when the UN Security Council raised the pandemic at the level international security threat, other international institutions were paying heed to the correlation between poverty and the wide spread HIV prevalence in Africa. At the opening of the African Development Forum on leadership and AIDS in December 2000, “Dr Salim Ahmed Salim, Secretary General of the Organization of African Unity, opened the Forum by saying, ‘There is a dire need to reorient the concept of national security to transcend the invasion of borders and threats to government... Our societies, in their entirety, have to enter into a combat mode for liberating themselves from the [HIV/AIDS] pandemic’” (quoted by De Waal 2006:106). The issue of resources was, obviously, one of the most challenging problems of poor countries to finance programs dealing with HIV/AIDS. The Africa Development Forum called for a new financing for HIV/AIDS in Africa, a call that was repeated four months later at the summit of African nations on HIV/AIDS, Tuberculosis, and other infectious diseases, in Abuja, Nigeria. In response to the many calls for a new way of funding for development, debt cancellation, and HIV/AIDS in Africa, the World Bank developed its Africa Multi-Sectoral AIDS Program (MAP) that was committed to provide long-term support to combat HIV/AIDS and mitigate its impacts in as many countries as possible in Africa.<sup>5</sup>

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<sup>5</sup> Oomman, Nandini, “Overview of the World Bank’s Response to HIV/AIDS Epidemic in Africa With a Focus on the Multi-Sectoral HIV/AIDS Program,” (no date), Center for Global Development. Available online at: <http://www.cgdev.org/page/overview-world->

Discussing the reorientation and challenges to foreign policy allocation system in the new Millennium, Donald and Keller (2006) identify the crisis in the sovereign debt as exacerbating poverty, underdevelopment, and the social conditions of the poor including the public health crisis caused by the HIV/AIDS pandemic. On March 24, 1999, the US Conference of Catholic Bishops (USCCB) had issued a statement entitled *A Jubilee Call for Debt Forgiveness*, calling the American government to make sure that resources freed from debt cancellation are used for poverty reduction, economic policy reforms, good governance, and mechanisms that ensured accountability and policy participation to promote sustainable development of poor countries.<sup>6</sup> Summarizing the demands of the Jubilee Coalition, which was the international alliance of religious groups and other activists who have done such a superb job driving the cancellation of debt with regard to the upcoming new Millennium, Stephen Lewis (2006:141) attests that the cancellation of agricultural subsidies, which distort the market in disfavor of African competitors, as well as the cancellation of Africa's sovereign debt incurred as a result of bad Western policies were high priority on the policy agenda. In fact, the World Trade Organization Doha Round in 2001 discussed issues of Intellectual Property Rights and agricultural subsidies as the European Union and the US subsidize their farmers to the tune of \$350 billion a year. Even if trade is presented as the panacea for Africa's development – trade not aid slogan – it is obvious that the international rules already

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bank%E2%80%99s-response-hiv-aids-epidemic-africa-focus-multi-country-hiv-aids-program-map  
Last access, June 11, 2015.

<sup>6</sup> Available at <http://www.usccb.org/issues-and-action/human-life-and-dignity/debt-relief/jubilee-debt-forgiveness.cfm>. Last accessed on June 8, 2015.

favor the developed countries to the disadvantage of African countries. Lewis substantiates this argument by showing how Africa's global trade output declined from 3 to 1 percent during the years under the Uruguay round.

As funding the HIV/AIDS programs in the developing before the creation of the GFATM in 2002 and PEPFAR in 2003 was a crucial problem, there is no way one could talk about issues of funding for international HIV/AIDS programs in Africa without touching on questions related to the history of poverty and the evolution of development policies to eradicate Africa's poverty. Historians, economists, philosophers, and social scientists have tried to understand the causes of poverty and why it persists in some environments and not in others. I limit my overview of their conclusions only to a few scholars for the sake of time and space. Thomas Pogge's (2002) analysis, for instance, considers the sophistication of identifying factors of poverty in certain contexts with such variables like institutionalized corruption and individual laziness in poor countries as fallacious. For this author, the global institutional order is responsible for the persisting poverty and impoverishment of some areas of the world. Likewise, Stephen Lewis observes that the conclusion of a high UN debate on Africa's condition is an outcome of historical forces. "The problems of Africa are explained, in part, by colonialism, and in part by the failings of the African leadership itself" (Lewis 2006:8). The decolonization process not only was rushed, leaving Africa in need of expertise, but also the Cold War support of despots left Africa trapped in international clientelism. As the Cold War was drawing to an end, the IFIs launched the now infamous structural adjustment programs in the late eighties and nineties, making foreign aid allocation conditional to embracing

neoliberal policies. As Lewis contends, this *Reaganomics* expansionism to Africa not only reinforced the international patrimonialism but also ended up shredding the social sector in order to become eligible for the Bank and the Fund's loans. The result of the SAPs was simply to intensify Africa's poverty.<sup>7</sup>

For Pogge, as well as Lewis, it is fallacious to claim that global structures and economic order are benefiting the poor. Instead, they exacerbate poverty while also they permit judging the poor harshly because the details and fixtures of this global order are fixed in international negotiations in which Western industrialized governments enjoy a crushing advantage in bargaining power and expertise (Pogge 2002:20). By the turn of the new Millennium, the major three Western development policies in Africa, i.e., foreign aid, sovereign debt, and foreign trade, were scrutinized by scholars and activists to show how they distorted the very development they claimed to foster. As criticisms debunked the shortcomings of these policies, showing how they rather maintained a global order status quo that skewed Africa's welfare, the generosity and good will of Western donors was called into question. In fact, the very generosity of aid donors had slowed down during the 1990s following the end of the Cold War. As a result, scholars began to reexamine the rationale of Western donors' aid allocation.

Lancaster defines this rationale during the Cold War as "being principally a tool of statecraft, employed to encourage or reward politically desirable behavior on the part

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<sup>7</sup> Michael Kelly observes, however, that none of the criticisms addressed to the World Bank and the International Monetary Fund for their structural adjustment policies is suggesting that these institutions maliciously planned to stifle Africa or caused AIDS. Instead, the insinuation is that "these policies have contributed significantly to consolidating the pandemic's foothold in African countries." Such unintended consequence and unforeen outcomes inadvertently paved the way for conditions that increased the vulnerability of the people to the pandemic that many critics gesture towards (Kelly 2010:144).



of recipients” (quoted by UNCTAC 2006:5). Studies about the foreign aid allocation selectivity criteria in the post-Cold War period showed that economic growth, poverty reduction, or the needs of the recipient countries did not constitute a priority for deciding on the recipient or the volume of foreign aid. Alesina and Dollar (2000:33) find evidence that the pattern of aid giving during and after the Cold War was dictated by political and strategic considerations. A friendly regime, whether democratic or not, receives more aid than an unfriendly regime with similar needs or even with a greater level of poverty. As these authors acknowledge, nonetheless, countries that democratized since the end of the Cold War received up to 50 percent increase in aid although cross-country differences, to a large but not exclusive extent, are still explained by political factors, including colonial ties, alliances, or strategic interests. Another study by Dollar and Levin (2006) concludes that multilateral aid tends to follow selective incentives such as country’s institutions and policies whereas bilateral aid does not.

That is, there seems to be no direct correlation between the overall volume of aid and the recipient’s achievements in terms of economic growth and social development, however, multilateral aid donor institutions favor countries with good institutions and policies that become important determinants of aid. Others have also showed that political and strategic interests competed with concerns for growth, poverty reduction, and other economic objectives in aid allocation, at least until the 1990s. Changes in the global economic order after the end of the Cold War, however, removed the geopolitical concerns while a new approach to development was included in the selectivity criteria. Mostly, this post-Cold War aid allocation approach looked also at private donors and

nongovernmental actors for the implementation of programs. This is visible in policies such as the MDGs, the World Bank's Poverty Reduction Strategy, and the debt relief through the Heavily Indebted Poor Countries Initiative (Claessens, Cassimon, and Van Campenhout 2009).

This brief survey of the foreign aid selectivity literature brings us to cast a fresh look at the shift in the US foreign aid allocation to Africa after the 2002 Monterrey Consensus Financing for Development. Indeed, it is remarkable that global funds for AIDS programs increased from 2 percent to 10 percent of Africa's official development assistance (ODA) (UNAIDS 2004:21; De Waal 2006:114). ODA fixed the amount of contribution of the G7 to 0.7% of their GNP. On the other hand, the campaign for debt cancellation was tied to the aid allocation regime. While Africa acquired \$294 billion of debt between 1970 and 2002, the damage done by the debt service is indescribable. Former Tanzanian President Julius Nyerere is quoted demanding "Must we starve our children to pay our debts?" Yet, although Africa serviced back up to \$260 billion mostly in interest over the same period of time, it still owed \$230 billion in debt by 2002. How was the debt contracted in the first place? Of course through the allocation of loans to African dictators during the Cold War who were maintained in power, for the sake of geopolitical struggles between the West and the East, in spite of poor governance, accountability, and corruption.

Another aspect of the criticism of foreign aid flows to Africa comes from ActionAid, which claims that 60 percent of ODA should simply be called phantom aid since it goes to technical assistance (consultants and expertise from the developed

countries), tied aid (purchase of goods and services from the donor country's own firms), and administrative costs (inflated overhead). Jeffrey Sachs (2008:31) also claims, authoritatively, that only one-third of the pledged money to aid in the US gets disbursed. As it was shaped during the Cold War, foreign assistance could not stir Africa's economic development. As obviously as one Congressional Research Service report puts it, "Most foreign aid is used for procurement of US goods and services" although this may vary by programs. In FY 2004, for instance, up to 87% of military aid financing was spent on procurement of US military equipment and training while the remaining 13% were funds allocated to Israel for procurement within that country (Tarnoff and Nowels 2005:21). PEFAR, which President Bush called a medical Marshall Plan for Africa is no exception even though the time and context had changed from the Cold War era. Still, the US economic interests remained the same.

In spite of unanimous recognition of the deleterious impacts of the SAPs on social development and economic growth in developing countries, Western developed countries responded by reexamining a new framework for the conditions of foreign aid allocation to finance development. The understanding that African economic growth depended on the cancellation of its foreign debt, a sustainable policy to foster development, became evident to many pro-Africa constituencies in the United States. Many analysts and advocates for the African cause also linked the fact that HIV prevalence was higher in African countries, suggesting there is a correlation between HIV/AIDS and poverty. A whole stream of scholarship regards poverty as a crucial factor determining not only the HIV high prevalence in Africa but also the donors' foreign aid allocation preferences.

While the AIDS disease exacerbates the crippling of Africa's development and economic growth, the consequences of poverty compound the progression of HIV/AIDS.

The Human Development Index (HDI) proposes criteria for measuring development including the following indicators: health and the longevity of life measured in life expectancy at birth; education and knowledge measured as adult literacy rate; and decent standard of living measured by log of the gross domestic product (GDP) per capita at purchasing power parity (PPP). While the life expectancy in Africa rose from 36 years in the early 1950s to 52 years in the 1990s, it dropped to 46.7 years in 2000 because of AIDS (Barnett and Whiteside 2006:24). Referring to the 2004 UNAIDS (2004a:25) report, Patterson (2006:7) suggests an even further catastrophic drop below 40 years in some countries, including Botswana, Swaziland, Zambia, Malawi, and Zimbabwe. In short, AIDS causes poverty not only in that illness and deaths are expensive but also because the cost of work absenteeism is high and affect the economic of the family and the growth prospects of the country. As the 21 countries with the highest HIV prevalence are found in Africa, the uneven HIV infections distribution across different geographic locations shows that the epidemic is rather a complex and diverse issue even within the continent. Nonetheless, it remains paradoxical that countries with more resources, such as South Africa and Botswana that are among the highest GDP per capita in Africa, also belong to those with the highest HIV prevalence rates. Actually, 9 of the 12 African focus countries figure among the World Bank's classification of the Heavily Indebted Poor Countries (HIPC).

As a result, allocation of US foreign aid through PEPFAR cannot be understood or interpreted in isolation from the evolution of the US foreign aid system. When African countries and the international community were looking for new sources of funds in early 2000s to defeat the global HIV/AIDS pandemic, President Bush announced the creation of the Millennium Challenge Corporation (MCC) at the 2002 Monterrey Consensus on Financing for Development. Since Africa had received by 2001 up to \$14 billion in foreign aid, yet its economic growth was flat, even worse than in the 1970s, as President Bush notes. In light of the New Millennium Development Goals, the centerpiece of his new approach to economic development were the principles of partnership and accountability in which case eligibility criteria were based on lack of corruption, market-based economic policies, and investment in health and education. This move is the indication that the Bush administration was determined to shift the goals and conditions of US foreign aid allocation. Hence, in answer to the question why PEPFAR attributed the lion's share of its budget to a few selected countries, most of which are based in sub-Saharan Africa, this chapter reveals the Bush administration's determination to adapt the foreign aid allocation selectivity criteria to its neoliberal worldview. That is, the guiding principles used to include some countries and not others among PEPFAR beneficiaries remained the administration's focus on the recipient's alignment with the donor's preferences.

### **The Uganda HIV/AIDS Success Story Showcase**

Uganda has been presented both as an economic success story and a country unique on the African continent and in the global efforts to fight the HIV/AIDS pandemic.

Many studies mention the Ugandan HIV/AIDS prevalence rate in the early 1990s as high as 30 percent, which reportedly dropped to reach as low as 6 percent by 2001. As Kuhanen (2008:316) notes, scholars have debated Uganda's success story.

As the first country in the world to reverse a generalized HIV epidemic, it has become commonplace to praise Uganda as a success story in terms of prevention. As the HIV prevalence fell from about 25-30 percent in some of the worst affected urban areas to 5-10 percent at most rural and urban surveillance sites by 2001, academics and specialists working with AIDS in Uganda remained divided about what actually worked in Uganda and why.

When the HIV/AIDS epidemic during the 1980s and 1990s posed a general threat to the whole of Ugandan society, and when sexual behavior represented a health hazard to the military, the workforce, the youth, women's reproductive health, the decline in HIV prevalence rates tends to confirm the success story of Uganda. Two main reasons are provided to account for the dramatic change achieved by the Ugandan government: first, the political leadership of President Yoweri Museveni in speaking out publically about the epidemic; second, Uganda's prevention policies that underscored abstinence – being faithful – or condom use (ABC) model (Patterson 2006).

Uganda came under the spotlight of international media from the late 1990s onwards, "as the first country in sub-Saharan Africa that has managed to reverse a generalized HIV epidemic" while the epidemic continued to spread and intensify in the early and mid-1990s in Africa and other areas of the world (Kuhanen 2008:301). While Uganda's prevalence rates were reported to be declining, especially starting around 1993, the US National Intelligence Council (NIC) reported a new wave of HIV/AIDS pandemic spreading in countries of significant strategic importance to the United States such as China, Russia, and India. In fact, Uganda had succeeded in bringing down its HIV

prevalence rates from 18.3 percent in rural areas and 30 percent in the towns in 1992 to roughly 6 percent in 2001. Mortality rates for infants under the age of 5 have fallen significantly to 86.1 infant deaths per 1,000 live births in 2013 from 178.0 in 1990 and 102.1 in 2010. Yet, the life expectancy of Ugandans has gone up to 59 years from 47.5 years in 1990.<sup>8</sup> It remains crucial, however, to put the Ugandan showcase in historic context. While other African countries could learn from the Ugandan model, what has been lacking to them that only Uganda was able to successfully follow a path that led to HIV prevalence decline? How can the Ugandan success story be explained?

Kuhanen's (2008) historiography of the epidemic in Uganda constitutes a good starting point as an attempt to explain the evolution of HIV/AIDS in Uganda. This study maps the scholarly efforts to account for the origins, the spread, and the policy response to the HIV/AIDS epidemic in Uganda. In 1982, almost as early as the epidemic was identified in the United States, HIV/AIDS was first identified in Uganda on the shores of Lake Victoria in the Rakai District. Uganda is a landlocked African country that covers an area of 236, 036 Square kilometers. It is surrounded on the east by Kenya, on the south by Tanzania and Rwanda, on the west by The Democratic Republic of the Congo, and by South Sudan on the north. Known in Uganda as the "slim disease," because those with AIDS lost weight considerably, the social and political contexts of the 1980s had exacerbated the spread and virulence of HIV/AIDS. By the late 1980s, the disease had progressed to other parts of the country, even though it remained initially concentrated in urban and semi-urban centers. In fact, the epidemic was mostly concentrated within "the populations occupying the major stopping centers for truck drivers along the trans-

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<sup>8</sup> <http://www.indexmundi.com/facts/uganda/life-expectancy-at-birth>, last visit, May 29, 2015.

African highway” (Tumushabe 2006:9). Along with the context of war in the 1980s, the impacts of social dislocation, political insecurity, and economic crises are cited among others factors explaining the widespread reach of the epidemic. These factors concurred to make Uganda a friendly location for the spread of the HIV/AIDS epidemic.

By 1998, Uganda tallied a total of 1.9 million cases with up to 12 percent of all deaths in that same year attributed to the HIV/AIDS epidemic. In 2001, the Ugandan Ministry of Health reported that AIDS had taken over malaria as the leading cause of death among the population between 12-49 years. Patients with HIV/AIDS-related illnesses “hospital bed occupancy” had increased to 70 percent in 2000 from 55 percent in 1997 and the Ugandan health care system was strained to a breaking point. As a result, more than 800,000 Ugandans had lost their lives to HIV/AIDS by 2002 and almost 2 million children were left orphans to either one or both parents due to the epidemic (McAdam 2003). The devastating consequences of the HIV/AIDS epidemic in Uganda affected not only the lives of ordinary Ugandans and their communities but also it affected such institutions as the military. Hence, Susan Hunter (2003) approached the HIV/AIDS problem in Uganda through one of its gravest social and human consequences, namely the growing number of orphans. Most scholars writing on the subject in the early 1990s like Bond and Vincent (1991) consider the socioeconomic and cultural infrastructure as the major determinants that can help explain the rapid spread of the epidemic in Uganda until 1992. In relation to this view, Kuhanen (2008:310) notes,

Parts of Uganda that had been badly hit by war and state terror already had substantial orphan populations before the outbreak of HIV and AIDS, which then caused the numbers of orphans to explode in areas such as Rakai in southern



Uganda. [In] the communities struck by AIDS, (...) funeral were held nearly every day, weddings had almost ceased, and fertility had declined markedly.

On the other hand, Bond and Vincent (1991) claim that the social context and changing economic structure of the late 1980s, such as the warfare, the emergence of a black market and informal economy known as “magendo,” and the transnational networks of trade and migration between Kampala, Kenya, Tanzania, Zambia, Rwanda, Burundi, and Zaire (now the Democratic Republic of Congo) constituted the most crucial factors that facilitated the transmission of HIV/AIDS in Uganda (Kuhanen 2008:310). Like Tumushabe (2006:9), these scholars conclude that the disease developed mostly along the axes of truck drivers, military warfare, and sex workers.

Others have also identified socioeconomic factors behind the spread of HIV/AIDS in Uganda. Barnett and Blaikie (1992) in their analysis of the Rakai District attest to that the disruption of social structures as a crucial explanation of the spread of HIV/AIDS in Uganda. They describe the social context of the disease, which they call the “ecology of vulnerability,” which was linked to the advent of modern economy in Uganda. This pulled women from their traditional setting and thrust them into a system where they not only could not own land but also were compelled to struggle to support themselves and their children as they were left vulnerable and thus became prey to sexual exploitation. Unlike arguments that correlate high prevalence of HIV/AIDS in Africa with lack of economic resources or with poverty, Obbo (1993) contends that Africa’s HIV infection is associated with wealth, education, and elite status. Accordingly, the African patriarchal culture, wherein ideas of masculinity and femininity were bound to sexual desires, paved the way in its networking to the diffusion of HIV/AIDS. Analyzing the economy of

African sexuality, Obbo demonstrates how men were pushed to show their manhood through sexual conquests and prowess while girls and women were expected to keep their place by being conquered, subjugated to male domination, submissive and faithful in marriage, and guardians of traditional values. In the end, those with power (men and the socially well-off), as well as educated women who possessed multiple opportunities for sexual adventures in towns and in rural areas, were more exposed to contracting the virus.

President Museveni was quick to tackle the issue of HIV/AIDS as soon as he took power in 1986. He openly recognized the HIV/AIDS problem to the dismay of his peer African presidents. In his address at the International Conference on AIDS and STDs in Africa (ICASA) in 1995, he explained why he chose to give recognition to the epidemic as early as he came to power. First, he suggests that he had been made aware of the seriousness of HIV/AIDS by chance. Having sent 60 military men to Cuba for training, 18 were reported HIV positive – that is, 30 percent of the total contingent. “At that time we did not carry out HIV tests because we thought that everybody was all right (...). When I went to the Non-Aligned summit in Harare that year [Cuban President] Fidel Castro took me aside and said: ‘You know there is a big problem in your country,’ and he told me the story” (quoted by Tumushabe 2006:8). In response to that situation, President Museveni arguably quarreled with Ugandan doctors and together they came up with a strategy to educate the people by openly discussing the HIV/AIDS matter. “You cannot leave this kind of problem to the doctors who, in any case, are so few. The political leadership must take the leading role in combating this disease” (idem, 9).

In October 1986, the administration created the national AIDS Control Program (ACP) given the threat posed primary to Museveni's power base – the military. Arguably, "It was perhaps this threat to his power base, more than anything else, that provided the overwhelming motive for Museveni's personal effort." The mandate of the ACP consisted of monitoring the epidemic and establishing safety measures. It organized mass education campaigns about HIV/AIDS in which President Museveni participated personally to promote abstinence and condom use although no condom distribution system was started until 1990. In 1992, the Ugandan parliament mandated the creation of the Uganda AIDS Commission (UAC) to harmonize, integrate, and coordinate efforts to fight HIV/AIDS. However, this national multisectoral approach to implement guidelines and monitor activities on HIV/AIDS in the country was still funded, almost entirely, by international donors.

Parkhurst and Lush (2004) have noted the way that HIV prevalence had been dropping in Uganda, which can be seen as a direct result of Museveni's leadership and the swift response by the government to address the issue. For his efforts and leadership in the fight against HIV/AIDS, President Museveni received international recognition at different forums, including the Commonwealth Heads of Government meeting in Coolumb, Australia, in 2002. As he claimed there, the HIV/AIDS prevalence in Uganda actually declined from the high 30 percent to reach 6.1 percent. These pronouncements assumed unequivocally that Uganda's HIV/AIDS prevalence rates were as high as 30 percent in the early 1990s and the government succeeded in bringing them down through preventive policies. Lack of policy leadership can be a factor compounding the high HIV/AIDS

prevalence in Africa. For instance, Dixon et al. (2001:388) underscore the reluctance of African governments to plan an overall government response, “combined with the fact that fiscal crises and structural adjustment programmes,” which were already having adverse consequences on health budgets and the public health in general. Besides, the prevailing denial of most African leaders for reasons of national pride, social stigma and political interest self-interest allowed the HIV/AIDS epidemic to go rampant in Africa. Obviously, “[n]o politician wants to speak frankly about sex or challenge cultural patterns” (Patterson 2006:2). Yet, as Behrman (2004:45) points out, “[m]any leaders didn’t want to acknowledge the disease for fear it may divert foreign investment, cripple the local tourism industry. If their militaries were infected, they didn’t want their adversaries to know about it. Some leaders’ denial was even more visceral: they were worried that they themselves might be infected and couldn’t come to terms with it.”

Some among African leaders regarded the Western Africa HIV/AIDS discourse as exaggerated and rejected the argument that HIV/AIDS was ravaging entire populations in Africa. They claimed this view to stem from the traditional image of Africa in the Western mind, an attempt to scapegoat the world’s evils on Africa. As Western scientists grandstanding painted “a near apocalyptic depiction of Africa” and inflated HIV/AIDS estimates, this planted the seed of “skepticism that would help breed denial among the continent’s leaders for the next decade and a half. African denial, in turn, would serve as a crutch for U.S. inaction,” as Behrman (2004:16) observes. This Western Afro-pessimism infuriated African leaders. Among African leaders who denied the reality of HIV/AIDS during the 1990s was former Kenyan President, Daniel Arap Moi. In fact,

long before what has come to be regarded as President Mbeki's infamous attitude toward HIV/AIDS, President Arap Moi stated that the West's "African AIDS reports are new form of hate campaign" (quoted by Behrman, *ibid*).<sup>9</sup> As Tumushabe (2006:9) puts it, "[s]ome of Uganda's neighboring countries with strong economic and sociopolitical constituencies were naturally hesitant, albeit fatally, to acknowledge that their populations were dying of the most highly stigmatized human disease in modern times."

Yet, the strongest reaction came, of course, from South African president Thabo Mbeki who has become in the eyes of the international community the epitome of the denialist attitude. In April 2000, after rejecting appeals that the national assembly declare the AIDS pandemic a national emergency, he wrote to "then President Clinton and other heads of state defending dissident scientists who maintain that AIDS is not caused by HIV virus" (Copson 2005:4; Piot 2012:278). President Mbeki questioned both "the accuracy of data and the high degree of false positives that came up in HIV tests" and whether it was scientifically established that HIV causes AIDS. He argued that the "Koch's postulates have not been fulfilled" in the case of HIV and AIDS. Besides, it has not been proven that any one has died from AIDS but rather from opportunistic diseases

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<sup>9</sup> African and Africanist scholars concur that the Western discourse and approach to the complex history of HIV/AIDS in Africa obscures the voice of Africans as well as other dimensions pertaining to the HIV/AIDS issue such as the spiritual, communal, and sociological dimensions of the disease. For instance, Ugandan theologian Emmanuel Katongole (2007:115) affirms that the story of HIV and AIDS in Africa reveals serious disorders within "Africa's modern ways of working, playing, and living." He, too, refers to President Thabo Mbeki's opening speech at the 2000 Durban 13<sup>th</sup> International AIDS Conference (IAC) during which President Mbeki was the only one to take seriously the theme of the conference on "Breaking the Silence." As Mbeki argued, "we could not blame everything on a single virus." Instead, AIDS in Africa and the high prevalence of HIV are the outcome of extreme poverty. Obviously, the difference in the interpretation of the pandemic between Western and African discourses represents the clash of interests and the power differential among HIV/AIDS stakeholders. I shall return to this point in my concluding chapter and policy recommendation.

such as TB. Finally, after Mbeki discussed the efficacy of AZT and Nevirapin as well as the toxicity and side effects of the drugs, he made his point: the real problem is Western pharmaceutical companies that are trying to poison Africans (Piot 2012:279-280). In July 2000, during his speech at the opening of the 13<sup>th</sup> IAC in Durban, he again reiterated the fact that extreme poverty was the biggest killer and the greatest cause of ill-health in Africa, not AIDS. To be fair, President Mbeki was getting to the bottom of the problem and was raising awareness about whether HIV is the sole and only cause of AIDS; whether the epidemic should be defined in medical terms alone.<sup>10</sup> Obviously, there are many co-factors including the context, social environment, and medical infrastructure that have been left out in the Western discourse on HIV/AIDS in Africa. Africans feel these conditions – sociological and historical – should be factored in if any policy to fight HIV/AIDS is to have any relevance and be productive at all (See also Horowitz 1997; Stillwaggon 2006; Patterson 2006).

The variation in infection across the continent, of course, represents the problem about generalizing explanatory theories and policy solutions about HIV/AIDS in Africa. So let us set aside, at least for the time being, the question of HIV/AIDS prevalence statistical distribution across the continent and focus on the Ugandan case study.

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<sup>10</sup> If discussion of the complex reality of HIV/AIDS in Africa is reduced to the sole scientific discourse about the virus infection to explain the pathology and etiology of AIDS, African thinkers believe there is much that we are losing in the discussion. This narrow focus is a result of the development of Western medicine in the 19<sup>th</sup> century that adopted the germ theory of disease beyond the miasma (ecological) and contagion theories that had dominated the field. Louis Pasteur's discovery of the existence of pathogenic organisms gave the contagion theory more prominence than the miasma theory. As a result, the triumph of the contagion theory can help highlight the domination of virus-contagion approach to AIDS as well as the success of the medical and pharmaceutical industry favored by the West over a communitarian and spiritual care of the sick in the African context (Katongole 2007:112-114).

Tumushabe (2006) remarks the timing of the emergency of this Uganda's HIV/AIDS success story rhetoric in the early 2000s as not being innocent. While President Museveni's National Resistance Movement (NRM) – the political wing of his National Resistance Army (NRA) – after fighting the Obote government from 1980 to 1986 was credited for ousting a dictatorship, stabilizing the southern region of the country as well as its economy, Uganda adopted a new nationally accepted constitution in 1995. In the following two years, presidential, parliamentary, and local government elections were successfully held with some degree of credibility. However, at the 2000 Africa Development Forum in Addis Ababa, in Ethiopia, President Museveni, it is argued, was searching for new international credibility given his regional politics, internal governance, and poor economic performance. He thus began presenting the Uganda success story in combatting HIV/AIDS, which President Bush echoed in the ensuing years because the ABC strategy was appealing to his conservative constituency and because Western donors were pressured to demonstrate results lest the money given in foreign aid to HIV/AIDS programs was also considered another foreign aid waste. Arguably, “the term ABC emerged as a dominant theme to represent the approaches that worked best in reducing the prevalence of HIV” in Uganda only around 2002 (Tumushabe 2006:10).

In his speech at the 2000 Africa Development Forum, President Museveni claimed that Uganda had reduced the HIV/AIDS prevalence from 30 percent to 8 percent. This dramatic decline was welcomed and greatly applauded by the international community in search of a positive story to tell about global efforts in the fight on the HIV/AIDS pandemic. In Museveni's words,

Uganda's estimated prevalence rate reduced from around 30 percent in the early 1990s to around 8 percent in the late 1990s: the age of first sex among girls increased from 14 to 16 years; and from 14 to 17 among boys between 1995 and 1998; sex with non-regular partners has also considerably reduced' and condom use increased from 57.6 percent in 1995 to 76 percent in 1998. Next year, we shall require 80 million condoms. Most important of all, the stigma attached to people living with HIV/AIDS has virtually evaporated. (President Museveni at the 2000 Africa Development Forum quoted by Tumushabe 2006:7).

Most available literature in Uganda's fight against HIV/AIDS regards two main factors as possible explanations of the Uganda's success story. First, those who claim that behavioral change played a critical role in bringing about the outcome to be explained includes changes in individual sexual behavior through sticking to one partner, "zero grazing," delayed commencement of sexual activity, or celibacy. Second, those who are critical of the behavioral approach also show skepticism in alleged decline in prevalence because, as they argue, the data are insufficient and unrepresentative of the whole of Uganda. Prevalence decline may well have been caused by different factors that need to be studied. These could include a peak in mortality from AIDS, which might reflect a natural course of the epidemic in its mature stages, a significant increase in the use of condoms, particularly among groups with high risks such as sex workers and men with multiple sexual partners.

The success story had some implications for both the national government of Uganda and the international donor's community. First, at the national level, it affected the ability of the government to minimize global pressure to (i) bring about full democratization, (ii) deal with criticisms of economic mismanagement at home and, finally, (iii) carry out military actions in the region, especially in eastern regions of the Democratic Republic of Congo (DRC). Yet, at the international level, the Uganda's



success story also allowed the government to remain in the good favors of international aid donors who needed to showcase that aid worked where there is good leadership. “International and bilateral aid agencies that provide large sums of money for HIV prevention used Uganda as a example to argue that, with sufficient resources and appropriate prevention messages, HIV/AIDS could be controlled.

Given the domestic and regional political blunders of President Museveni during the late 1990s – the country’s image was tarnished by internal and regional political instability involving President Museveni’s policies – he created the propaganda of the Uganda’s HIV/AIDS success story to gain political dividends and lure international donors. Arguably, the government’s careless interpretation of statistics and numbers, and the international “representation” of Uganda as a prevention showcase is the evidence that President Museveni and his supporters needed to convince donors that their money was worthwhile and well spent. President Museveni’s government maintained a lackluster attitude to the anti-AIDS struggle during the 1990s in spite of early outspokenness about the HIV/AIDS issue. However, he was able to shift rhetoric in the early 2000s for several reasons, using HIV/AIDS as a springboard to restore his country’s international image.

Although Museveni’s leadership was appreciated based on his political and economic achievements besides his social success in fighting HIV/AIDS, many now question these reports and find the Ugandan success stories to be controversial. On the political side, the domestic stabilization of the country and the victory over the Lord Resistance Army in northern Uganda is regarded as one among Museveni’s many

accomplishments. On the economic side, President Museveni was celebrated among the “new breed of African leadership” for his liberalization policies to boost Uganda’s economic growth due to exports in coffee and fish to the European Union. The focus on HIV/AIDS by the year 2000 is justified by the fact that Museveni needed another rhetoric to convince his domestic and international constituencies. Critics of the leadership argument, nonetheless, contend that administrative issues linked to the hierarchical decision-making and bureaucratic complexities as well as the centralization of AIDS programs under the Ministry of Health AIDS Program (ACP) had instead negative impacts on the fight against HIV/AIDS. This was so because the hierarchical power structures, bureaucratic sluggishness, and paralysis in decision-making process, let alone the flow of information, hampered the smooth coordination and work of local nongovernmental actors. Besides, the problem of corruption and lack of accountability had jeopardized the treatment programs (Kasasira 2007). As Tumushabe (2006:6) puts it,

Thus, by 2000, an AIDS success story in Uganda was crucial to a wide spectrum of ‘stakeholders’ who needed to justify further funding of their programs (...). For the government, failure to appease donors would lead to economic collapse and seriously roll back the national HIV/AIDS programme; there was little else to show for the huge donor resources poured into Uganda that an ill-planned and poorly executed Universal Primary Education Program, which was also riddled with fraud at the school and district tendering levels.

Kuhanen (2008:315) notes that, “[t]he main factor behind Uganda’s success is allegedly individual behavioral change, i.e., abstinence from sex and partner reduction, particularly among young females, accompanied by increased condom use, all which would indicate deliberate avoidance of risky behavior by individuals.” This includes changes in individual sexual behavior through sticking to one partner, “zero grazing,” delayed

commencement of sexual activity, or celibacy. While lack of knowledge, qualified personnel, and healthcare infrastructure and medical supplies made efforts to fight the epidemic more difficult in the beginning of HIV/AIDS in Uganda, the bottom line of the national AIDS policy affected people and those at risk focused on the provision of health education, treatment, and care.

This thesis, however, has become controversial as some scholars observe the lackluster attitude of the Ugandan government to the fight against HIV/AIDS between 1993 and 2000. Some scholars believe that the role of the government in Uganda has been overplayed at the expense of other players such as NGOs in the struggle against HIV/AIDS. However, it is still true that the swift response by President Museveni in the 1980s is regarded as a factor that played a major role in reducing the HIV prevalence in Uganda in the late 1990s. How could Museveni's response to HIV/AIDS play a major role in changing attitudes and behaviors in such a short span of time for results to show up, given the lag between HIV infection and AIDS manifestation in a person? Besides, why did Uganda's government fight against HIV/AIDS stigma and discrimination when President Museveni himself continued to discriminate against HIV/AIDS in politics and in the military? For instance, he declared in 2000 that none of the people living with HIV/AIDS (PLWHA) should be offered an opportunity to serve in the armed forces because it is so frustrating to have officers who die of AIDS, not a bullet. He went as far as saying that the army is not a hospital and self-inflicted disease through undisciplined sex should not receive ARVs. About his political opponent, a private medical doctor

named Kizza Besigye, President Museveni implied during the presidential campaign that he was HIV positive and therefore unfit to lead the country.

While President Museveni and First Lady Janet Museveni used the HIV/AIDS issue to advance their political interests, the ABC model they promoted received the support of conservative evangelical Christian groups in the US. Through the ABC ideology, the Bush administration also found the support to the family values it wanted to foster, as seen in the reinstatement of the Mexico City Policy on his very first day in office. As President Bush praised the Ugandan ABC model in public and commended President Museveni for his leadership in the fight against HIV/AIDS, in private he pressed him to explain the role that Uganda played in supplying weapons to militias in the DRC wars that had occasioned 2.5 to 3.3 million deaths (Tumushabe 2006:11). Andrew Natsios also stresses that President Bush personally pressed President Museveni in 2003 to not seek a third term in office and, instead, to democratize his country. Criticisms of the ABC programs and the behavioral change approach adopted by the Ugandan government also show skepticism about the alleged decline in HIV/AIDS prevalence rates as a result of prevention policies. As they argue, the data are insufficient and unrepresentative of the whole of Uganda. For instance, de Waal (2006:95) contends that the prevailing belief that Uganda was able to reduce its HIV prevalence rates “has been more celebrated than analyzed.” While some believe that representations of HIV/AIDS in Uganda are variable and unbalanced because most authors have approached the issue from different perspectives, sources, and agendas, others claim, “Museveni has not been open with the figures. He has overstated the decline in

prevalence, claiming in 2000 for example that national prevalence had come down from 30 percent in 1991 – a figure that is probably twice as high as the reality” (ibid). Not only the statistics used by President Museveni were misleading but also those Ugandans who continued burying their relatives refused to buy the government’s propaganda rhetoric.

Besides, it has been argued that Museveni’s inflated statistics was an extrapolation from the number of military men he sent to Cuba (a very small and non representative sample) to the entire population. The battle over statistical representation of HIV/AIDS in Africa raged, in general, in the ensuing years as criticisms erupted in 2004 about manipulation of data in UN annual reports to steer donors to give more funds to HIV/AIDS programs. Arguably, UNAIDS was “cooking up” the HIV infection numbers in Africa to stir policy makers to donate more money; such adjusted statistics are alarming. Explaining the difference between making up and “cooking up” the numbers, Pisani (2008:22) argues, “[T]o find money for other continents, we had to beat things up a bit. When a journalist talks about ‘beating it up,’ [he/she] mean[s] making a mountain out of a molehill, making a big, interesting, dramatic story out of something that may actually be rather mundane. There is a difference between making it up (plain old lying) and beating it up.” Schaefer (2010:2) remarks, “In 2007, the UN was forced to acknowledge that it had long overestimated both the size and the course of the [AIDS] epidemic, which they now believe has been slowing for nearly a decade.” Despite statistical adjustments, Africa still leads as the continent with the most HIV/AIDS cases.

Botswana and Swaziland HIV estimates are still respectively the highest, at 27% and 22.2% in 2001 while Lesotho's adjusted prevalence rates averaged 23.4% (see Table 13).

Table 13. Africa HIV/AIDS Adjusted Statistical Estimates (2004)

Western Africa				
Country	Adult prevalence ages 15–49	Number of people living with HIV	AIDS deaths	New HIV infections
<u>Benin</u>	1.7%	66,000	6,400	5,300
<u>Burkina Faso</u>	2.1%	150,000	15,000	13,000
<u>Cape Verde</u>	1.0%	2,700	<500	not available
<u>Côte d'Ivoire</u>	6.2%	560,000	50,000	not available
<u>Gambia</u>	0.8%	5,700	<500	1,200
<u>Ghana</u>	2.2%	250,000	18,000	28,000
<u>Guinea</u>	1.5%	72,000	5,100	not available
<u>Guinea-Bissau</u>	1.4%	9,800	<1,000	1,800
<u>Liberia</u>	2.5%	39,000	2,500	not available
<u>Mali</u>	1.6%	110,000	9,700	12,000
<u>Mauritania</u>	0.6%	10,000	<1,000	not available
<u>Niger</u>	0.8%	45,000	3,200	6,200
<u>Nigeria</u>	3.7%	2,500,000	150,000	310,000
<u>Senegal</u>	0.5%	24,000	1,400	not available
<u>Sierra Leone</u>	0.9%	21,000	<1,000	4,500
<u>Togo</u>	4.1%	120,000	8,100	17,000
Central Africa				
Country	Adult prevalence ages 15–49	Number of people living with HIV	AIDS deaths	New HIV infections
<u>Angola</u>	1.7%	130,000	8,200	20,000
<u>Cameroon</u>	5.1%	450,000	28,000	57,000
<u>CAR</u>	8.1%	170,000	16,000	15,000
<u>Chad</u>	3.7%	170,000	13,000	not available
<u>Congo</u>	3.8%	74,000	6,900	7,200
<u>DRC</u>	not available	not available	not available	not available
<u>Equatorial Guinea</u>	2.5%	7,900	<500	not available

<u>Gabon</u>	5.2%	35,000	2,100	4,900
<u>São Tomé and Príncipe</u>	0.9%	<1,000	<100	not available

## Eastern Africa

Country	Adult prevalence ages 15–49	Number of people living with HIV	AIDS deaths	New HIV infections
<u>Burundi</u>	3.5%	130,000	13,000	6,900
<u>Comoros</u>	<0.1%	<100	<100	not available
<u>Kenya</u>	8.5%	1,600,000	130,000	140,000
<u>Madagascar</u>	0.3%	22,000	1,500	not available
<u>Mauritius</u>	0.9%	6,600	<500	not available
<u>Mayotte</u>	not available	not available	not available	not available
<u>Réunion</u>	not available	not available	not available	not available
<u>Rwanda</u>	4.1%	220,000	21,000	19,000
<u>Seychelles</u>	not available	not available	not available	not available
<u>South Sudan</u>	not available	not available	not available	not available
<u>Tanzania</u>	7.2%	1,400,000	130,000	140,000
<u>Uganda</u>	6.9%	990,000	100,000	99,000

## Southern Africa

Country	Adult prevalence ages 15–49	Number of people living with HIV	AIDS deaths	New HIV infections
<u>Botswana</u>	27.0%	270,000	18,000	27,000
<u>Lesotho</u>	23.4%	250,000	15,000	26,000
<u>Malawi</u>	13.8%	860,000	63,000	100,000
<u>Mozambique</u>	9.7%	850,000	46,000	140,000
<u>Namibia</u>	15.5%	160,000	8,600	23,000
<u>South Africa</u>	15.9%	4,400,000	210,000	610,000
<u>Swaziland</u>	22.2%	120,000	6,700	19,000
<u>Zambia</u>	14.4%	860,000	72,000	110,000
<u>Zimbabwe</u>	25.0%	1,800,000	150,000	140,000

(Source: compiled from *UNAIDS Report on the Global AIDS Epidemics 2012*)

An epidemiologist and policy maker at the World Health Organization, James Chin (2007:95) also contends, HIV numbers in Africa are “estimated and projected via

the use of models since death reporting in most developing countries is grossly inaccurate and incomplete.” As far as sub-Saharan Africa is concerned, he notes, “In 2001, UNAIDS estimated that this region had the highest mean HIV prevalence rate (9 percent), with 16 of the 44 countries in this region having an estimated prevalence of more than 10 percent. Two countries (Botswana and Zimbabwe) had estimated HIV prevalence rates of over 35 percent” Chin (2007:121) (Table 14). Although in subsequent debates on Africa’s HIV prevalence rates, the UN acknowledged that the estimates were inflated. Furthermore, he remarks, “the initial 2001 HIV prevalence estimates for SSA countries were overestimated on average by 50 percent.” By 2003, UNAIDS revised its data lowering the prevalence rates from 9 percent in 2001 to 7.6 percent (or 22 million infected people instead of 26 million in 2001) (Chin 2007:122).

As far as Ugandan HIV/AIDS statistics are concerned, a gap in the information reflecting a selection bias in the representation of HIV/AIDS has been observed. Indeed, scholars have underscored the fact that most data collection came from antenatal surveillance sites where only pregnant women would attend. Since most women are not constantly or consistently going to seek antenatal services, it is obvious that the sampling selection will be biased given that the phenomenon is being measured in only at risk group. There is likelihood of decline in prevalence from the early 1990s. All three separate sources of data reporting a decline in seroprevalence observed that the group between 13-19 year-olds was the most affected. These sources included Mulago Hospital, 6 antenatal sentinel sites, and two major long-term community-based research projects in



rural South districts of Uganda. Allen challenges the feasibility of using the antenatal surveillance data to detect national HIV prevalence rates.

Table 14. Estimated Number of People Living With HIV/AIDS in the African “AIDS-Belt” Countries (End of 2001)

	Total Adults and Children	Total Women (15-49)	Adults (15-49) rate (%)
Global Total	40 million	18.5 million	1.2
Sub-Saharan Africa	28.5 million	15 million	9.0
Djibouti	-	-	-
Ethiopia	2.1 million	1.1 million	6.4
Uganda	600,000	280,000	5.0
Kenya	2.5 million	1.4 million	15.0
Tanzania	1.5 million	750,000	7.8
Rwanda	500,000	250,000	8.9
Burundi	390,000	190,000	8.3
Mozambique	1.1 million	630,000	13.0
Malawi	850,000	440,000	15.0
Zambia	1.2 million	590,000	21.5
Zimbabwe	2.3 million	1.2 million	33.7
Namibia	230,000	110,000	22.5
Botswana	330,000	170,000	38.8
Swaziland	170,000	89,000	33.4
Lesotho	360,000	180,000	31.0
South Africa	5.0 million	2.7 million	20.1

(Source: UNAIDS, *Report on the Global HIV/AIDS Epidemic: July 2002.*)

As USAID researchers sought to understand why Uganda and not other countries was able to achieve this success, they concluded that the government’s assumed use of the approach of abstinence, being faithful and condom use (ABC) approach as a combination reduced the HIV prevalence while other countries relied heavily on

condoms only (Epstein 2005).<sup>11</sup> Today, the country's HIV prevalence rate is 6 percent, with a distribution of 8 percent for women and 5 percent for men. The Uganda success story has become a commonplace in debates on the fight against HIV/AIDS as scholars and policy makers sought to explain the determinants of this decline. The epidemic continued to spread and intensify in other parts of Africa and the rest of the world while Uganda became an illustration that with sufficient resources, political leadership, and sound policies, HIV/AIDS could be controlled. However, behavioral studies indicate that there was no significant reduction of sexual partners for either men or women; a threefold increase in condom use among men and women between 13-19 in urban settings and 20-29 in rural settings; a significant rise in the age at first sexual intercourse and age at marriage. The Human Rights Watch (HRW) (2005) organization claims that the ABC as a political tool for Museveni and his wife. In its report on the HIV/AIDS progress in Uganda, "The Less they know, the Better: Abstinence-Only HIV/AIDS Programs in Uganda," HRW argues that ABC was a USAID-marketed strategy to advocate the religious and moral views of the American Christian right.

The heart of the debate, however, was the question of whether a medical solution for Africa, in terms of access of the poor to expensive treatment and the sustainability of drug innovation through financing of the research and development industry, was

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<sup>11</sup> This point will be discussed at length in subsequent sections of this chapter. Suffice it to say here that the ABC model that means to explain the Uganda success story has come under harsh criticism by many scholars who claim the ideology of the American evangelical Christian Right was too pervasive in Uganda HIV/AIDS policy for political and economic reasons. "From 2004 Museveni and his wife, in line with their US Right-wing Republican friends, led a crusade against condom use at national and global levels" Tumushabe (2006:11). And also Epstein (2005) available at <http://www.nybooks.com/articles/archives/2005/apr/28/god-and-the-fight-against-aids/>. Last view July 2, 2015.

achievable. While African nationalists interpreted the Western attitude toward HIV/AIDS in Africa as a disguised form of colonialism, a distortion of international economic order, the Western solution to address the African HIV/AIDS public health crisis was confined to promoting an image of leaders who aligned with the prevention approach that most Western policy makers favored and fostered in Africa. Indeed, all these historical, moral, political, economic, and societal factors are operative in the spread of HIV in Africa and the policy to address the public health crisis.

By the late 1990s President Museveni faced both the domestic and the regional political issues that eroded the reputation he enjoyed and the political capital he had been accumulating since in the early 1990s. On the domestic plane, corruption and cronyism led to mismanagement of foreign aid and the money received from the international financial institutions to support Uganda's liberalization. In fact, Museveni had begun the process of liberalization as early as he got to power in the mid-1980s. After 15 years of civil war under presidents Idi Amin (1971-1979) and Milton Obote (1979-1985), Museveni's National Resistance Army (NRA) seized power in 1986. The following year, he began to get rid of Uganda's Marxist ideological past, an attitude that led to an agreement with the International Monetary Fund (IMF) and bolstered the internal legitimacy of his military government. As one scholar remarks, this rehabilitation enabled "Western donors bankrolled Uganda's rehabilitation programmes to the tune of US\$ 2.017 billion; an average of US\$ 600 million per year in order for the government to deliver basic social services (Tumushabe 2006:4). As a result, Uganda's embrace of the

World Bank and IMF's conditionalities, otherwise known as structural adjustment programs, exonerated the country from other pressures.

Yet, as it will become clear in the ensuing lines, Uganda is the proof that there is no evidence that a positive correlation exists between increased foreign aid and debt forgiveness on the one hand, and poverty reduction and economic growth on the other. In fact, another aspect of Uganda's domestic politics concerns the poor achievements of Museveni's political and economic development during the 1990s. Although observers labeled Uganda an economic success story during this same period of time, it is obvious that the Ugandan image was invented. For instance, the Transparency International's Corruption Perception Index ranked Uganda the 11<sup>th</sup> most corrupt country in the world in 2000, and the 3<sup>rd</sup> most corrupt country in the world only one year later in 2001. In 1995, a new Constitution was completed and elections were held the following year. After two terms in office, the presidential 2-term limit was removed from the constitution in 2005 and the number of districts increased from 56 to 76, thus allowing Museveni a lifeline to continue as president.

The political patronage was accompanied by an economic crisis as exports in coffee declined and the European Union banned the fish exports for one year. The overall Uganda's exports dwindled from \$639 million in 1996 to \$463 million in 1999. It is little wonder that the country's economic prospects were not encouraging following years of corruption, political patronage, public mismanagement, and indebtedness. Apparently, the privatization policies of the 1990s and the SAPs in Uganda had yielded the opposite effects. By 1998, Uganda's foreign debt was \$3.2 billion and the government tendencies

to big spending on military expenditures and the war involvement in eastern regions of the Democratic Republic of the Congo entailed a growing deficit in the government's budget. As Tumushabe (2006:4) notes,

Uganda, the much-touted economic miracle of the 1990s, was identified in 2001 by the World Bank as one of the poorest countries in the world (...). Average per capita income in 2003 was estimated at \$259, life expectancy at birth dropped from 47 years in 1990 to 43 years in 2001, and the population with access to clean water remained a miserable 52 percent in 2000.

In spite of Museveni's reprehensible regional behavior characterized by greed, violence, plunder and the destabilization of the Congo, Uganda was still presented as a good student of the World Bank and the IMF. The world celebrated the World Bank's and the IMF's program for Heavily Indebted Poor Countries that was unveiled in 1996. Uganda was among the first beneficiaries of the World Bank's massive debt relief programs through both the Highly Indebted Poor Countries (HIPC) in 1998 and the HIPC Enhanced Initiative in 2000. When it first qualified as a beneficiary of the HIPC in 1998, the sovereign debt of the country amounted to a total of \$3.2 billion. The total debt cancellation under both programs was nearly two-thirds of the total amount, that is, US\$ 2 billion. The World Bank argued that "Uganda deserved debt relief because government had created a good policy environment through macroeconomic policy reforms that led to impressive and sustained economic growth rates for over a decade" (Mwenda 2005:4). While Uganda's debt from 1962 to 1998 grew to reach a total of \$3.2 billion, after the cancellation of the debt under the pretext that it was unsustainable and would affect the future of the country's economic growth, paradoxically, in the five years

following the debt cancellation of \$2 billion, Uganda's debt rose again to \$4.9 billion.

As Mwenda (2005:5) contends,

Uganda did not accumulate that debt under the brutal regime of Idi Amin. On the contrary, over 90 percent of Uganda's debt was incurred during the implementation of the World Bank – and IMF-sponsored economic reform policies of stabilization and structural adjustment, beginning in 1981. If those policies had worked as their advocates argued, Uganda should have been able to pay its way out of debt.

Unfortunately, Uganda indulged in mismanagement, throwing money at political elite and the military. For instance, President Museveni bought himself a new private jet that cost in public money up to US\$ 35 million.<sup>12</sup> Besides, he involved his military men in Sudan and the Congo wars, adventures that implied high cost of military expenditure. While the defense spending rose from 12.5 percent in 1997 to 19 percent in 1999, there was a 23 percent cuts from other ministries in 2003 in order to increase the military budgets. By 2005, Uganda military budget had reached \$200 million from \$110 million in 2000 (Mwenda 2005). It is precisely at this moment that President Museveni championed his leadership in the fight against HIV/AIDS, when he knew he might face international isolation. This was a new approach to donors in the aftermath of poor economic and political performance in liberalizing Uganda.

The World Bank, the IMF, and international donors have presented Uganda as an economic success story. In its 2004 publication, *Uganda: From Conflict to Sustainable Growth and Deep Reductions in Poverty*, the World Bank remarks that Uganda's economic performance since 1987 has been impressive. Not only was the country able to

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<sup>12</sup> Phillips, Jeff, "IMF Settles Uganda Plane Row," BBC Online, May 2, 2000 available at <http://news.bbc.co.uk/2/hi/africa/732971.stm> last view, July 2, 2015.

reduce the proportion of people living in absolute poverty from 56 percent to 35 percent between 1992 and 2000 but it also sustained an economic growth averaging 6 percent and maintained an inflation rate in single digits. The slowdown in Uganda's economic growth for the last 15 years (1987-2002) is blamed on poor weather, as the poverty rates increased to 38 percent in 2002-2003. However, as Mwenda (2005) contends, Uganda has depended on foreign aid for nearly 50 percent of its budget. If development has to be measured by indicators such as literacy and public health, Uganda's free primary, free basic health care, as well as infrastructure rehabilitation and maintenance are mostly financed by foreign aid monies. Given these guarantees of foreign aid inflows in Uganda, the country has not been keen on implementing sound policies such as good taxation system, fight against corruption and political patronage, and democratic reforms.<sup>13</sup> The Public Expenditure Review by the Ministry of Finance in 2002 showed that Museveni's costs of political patronage raised by 16 percent between 1998 and 2002.

In conclusion, scholars remark that the Ugandan success story was distorted to produce political and economic dividends to different actors and stakeholders involved in the HIV/AIDS industry (Tumushabe 2006; Human Rights Watch 2005; Kuhanen 2008). When Western donors were looking for results and accountability of their capitals invested in foreign aid, a good amount of which was spent on technical advisors, endless

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<sup>13</sup> Mwenda (2005:6) remarks that foreign aid to Uganda acts as a subsidy for government corruption and incompetence. Uganda spent \$200 million or 11 percent of its annual budget in 2004 on the military, of which \$40 million was lost in corruption. In fact, the army payroll includes thousands of "ghost soldiers." While foreign aid has served as short-term humanitarian relief, in the long run, it harms prospects of accountability, democratization, and the strengthening of good governance and sound institutions. In short, foreign aid impedes the emergence of a mutually beneficial relationship between government and citizens.

seminars, and the purchasing of vehicles, the Ugandan government seized the opportunity to present its success story. Besides, at the moment when the Bush administration needed international support for its coalition of the willing to attack Iraq and carry out its war business in the aftermath of 9/11 terrorist attacks, the reported Ugandan success story provided the conservative right wing in the US supported by evangelical Christians with the opportunity to showcase President Bush's humanitarian face. As a matter of fact, Uganda was keen on promoting prevention policies but reluctant to implement access to ARV treatment, for instance. This was the HIV/AIDS foreign policy approach toward Africa favored by the Bush administration in its early days. For instance, when the Global Fund offered a three-year grant of US\$ 52 million to the Ugandan government, the Ministry of Finance Planning and Economic Development (MFPED) refused to lift the budgetary ceiling of the Ministry of Health from US\$ 107 for fiscal year 2002/03. The argument for this refusal was to control government expenditure so as to stabilize the national economy, discourage consumerism, and reduce dependence on donors. Nonetheless, the government appropriated 23 percent of all ministerial budgets for the Ministry of Defense in its alleged unending war against the Lord Resistance Army in the North (Tumushabe 2006:20).



## CHAPTER SIX

### CONCLUSION AND RECOMMENDATIONS

#### **Introduction**

The main goal of this dissertation was primarily to make sense of the creation of PEPFAR, a global public health welfare policy, under a conservative administration seeking to help cope with the scourges of the pandemic experienced by those Africans infected and/or affected by HIV/AIDS. This concern simply stands in contradiction with the assumption of neglect and indifference that characterizes US-Africa relations. Besides, as a humanitarian claim, it does not cohere with the policy timing and earlier assertions of President Bush with regard to his Africa foreign policy agenda. While PEPFAR seems to (1) depart from the general patterns of US foreign policy toward Africa and (2) deviate from the legacy of the Clinton administration's global HIV/AIDS policy as embodied in Executive Order 13155, it appears important to understand the rationale behind this policy in order to explain continuity and change in US HIV/AIDS foreign policy toward Africa. To my eye, it made very little sense that the Bush realist administration that started by downplaying the significance of Africa in the hierarchy of US foreign policy; and which criticized the humanitarianism of the previous administration should adopt a welfare foreign policy in contradiction with and at the

expense of fundamental conservative beliefs and the tradition of US-Africa foreign policy. I adopted a theoretical framework that allowed organizing the overwhelming information about HIV/AIDS, the multiplicity of actors involved in the policy decision-making process, their interests, and the structures and institutions that constrained or enabled the emergence of a comprehensive policy framework. While I was drawn initially toward the US pharmaceutical business power and contribution in the making of PEPFAR, the progression of this research brought me to understand not only the importance of other nonbusiness actors in US domestic pluralist environment but also the role of dominant ideas and beliefs in the policy making process. Hence, the privatization theory of the public health and social welfare as a strategy of the Bush conservative administration was able to bring under a single analytical framework the constructivist role of presidential beliefs (Bush's compassionate conservatism doctrine), the pluralist nature of US domestic politics (religious faith-based groups, pharmaceutical companies, think tanks, university networks, private individuals), and the global environment (international organizations, nongovernmental organizations, developing countries' governments and the rise of China as a global player) within which US global leadership collided with competing claims on international trade agreements and the role of the state in the provision of a solution to the HIV/AIDS global crisis.

As different communities clashed over different interests, meanings, and representations of HIV/AIDS, the framing of the issue that came to dominate the official US rhetoric sought to blend both private incentives and expertise in a public-private partnership model. For some, science and innovation in medical technology is sacrosanct

and needs to be protected. For others, the moral and humanitarian imperative trumps every other consideration and compels the government to act. Yet for others, private initiatives and commercial interests are more important as they foster real democratic societies, “*prise en charge*” of the public welfare by the civil society, and economic growth and development. By overlooking the existing patterns of neglect and indifference in US foreign policy toward Africa, this research sought to uncover the real determinants of US behavior in Africa. Is it the nature of the situation as classical theories contend? If so, how is the nature of the situation defined and whose definition prevails and why? Was the creation of PEPFAR guided by altruistic motives or realist calculations? These hermeneutical questions allowed me to dig deep into the documentary evidence to understand the formation of the preferred official framework as a strategy to implement the neoliberal welfare agenda. That is, while the Bush administration sought to bring the private sector back into the implementation of the social welfare provision, President Bush was eager to concomitantly carry out his agenda to reform the US foreign aid system as well as the role of the government in social welfare provision. PEPFAR’s rationale was, thus, to integrate and accommodate the different claims by different interest groups about the HIV/AIDS pandemic; that is, all aspects including humanitarian, moral, social, political, and economic were considered by the Bush administration in order to leave a conservative imprint on the US HIV/AIDS global foreign policy.

To reach this conclusion, I used the process tracing method in a qualitative single case study approach. As stated earlier in this dissertation, the choice of this methodology

was to help address aspects of multiple causality, equifinality and endogeneity, in causal relationships leading to PEPFAR. Indeed, a combination of different independent variables concurred to cause variation in the US HIV/AIDS foreign policy toward Africa under the Bush administration as during the previous administrations (George & McKeown 1985; Mahoney & Terrie 2008). Besides, since it is difficult to rerun history to verify the direction of causation beyond simple correlations, a close examination of archival documents, analysis of official policy documents, including the transcripts of hearings in Senate and House of Representatives Committees and Subcommittees, as well as other documents in the media and the scholarship were confronted and complemented by interviews with policy makers. These sources permitted to see whether my initial theory was solid to explain the causal process and test my hypotheses. Since much was left out by pursuing my initial theory that the Bush administration policy preference was favoring the US private pharmaceutical companies against the demand of African countries to overlook the international trade agreement and the TRIPS regime, I had to revise my approach to integrate other aspects of PEPFAR including noncommercial interests.

The rationale in undertaking this study was owing to the fact that HIV/AIDS is seen as one of the most serious threats to global collective security, Africa's economic development, and the human rights and because PEPFAR has been acclaimed as one of the few foreign policy successes of the controversial Bush presidency. Yet, these interpretations seem not to be accepted unanimously within the African community. Some disagree, in fact, with the idea that HIV/AIDS is decimating Africa, or affecting the

continent for reasons of cultural behavior or level of poverty. Others reject the claim that PEPFAR is the best policy alternative grounded in humanitarian motive (Katongole 2007; Kelly 2010). While HIV/AIDS incontestably constitutes an impediment to the flourishing of human capabilities, individual freedom, and the pursuit of happiness, how can Africa's voice be heard in the competition for power, knowledge, and the control of resources? Applying the privatization theory has allowed bringing and organizing all these claims, the various sources of influence as well as the different independent variables including presidential preferences, bureaucratic reform, international regimes, and global economic trade competition under a single framework.

### **Research Findings**

Even as a political scientist, I admit that I came to this research with personal biases. Actually, I was wary of the altruism rhetoric in US foreign policy. As an African and as a citizen of the Democratic Republic of Congo, the pattern of selective and limited engagement, and the fact that Africa had lost its strategic significance in US foreign policy led most US policy makers to advocate throughout the 1990s for the suppression of US foreign aid (Kraxberger 2005; Schraeder 2011). As a result, the first post-Cold War decade was characterized by further US retrenchment from Africa that lasted well into the first two years of the Bush Administration. Hence, this analysis of the PEPFAR creation brings a good addition to the existing literature on US foreign policy toward Africa. Not only does the study confirm existing patterns of neglect and indifference with selective engagement at specific moments in history but also it shows that classical theories of foreign policy decision-making – the rational actor model, the bureaucratic

politics, and the pluralism model – need to be integrated to provide a fuller picture of the different sources of influence onto the policy making process. Integrating elements from cognitive psychology can make a significant difference in understanding, for instance, the personal beliefs of the president, bureaucratic pulling and hauling dynamics, as well as the hermeneutical process in the definition of the situation.

In other words, the process of decision-making and the policy outcome consist of many “worlds” colliding and many actors acting simultaneously to contribute to the framing of the issue and the shaping of the response they want to see adopted. Hence, that the policy outcome of US-Africa foreign policy decision-making process has been determined by the interplay between the nature of events happening on the ground and the part of decision-making establishment involved in the decision making process needs to put the emphasis on the hermeneutical side of deciding on the nature of events. Given that social reality and political phenomena are social constructed, this study has insisted on the role of human consciousness in interpreting the facts. Actually, the complex nature of the HIV/AIDS phenomenon and the variety of actors involved in trying to stir the policy direction, let alone the path-dependency in sheer succession of events and occurrences leading to the policy choices adopted by the government, demanded that I opt for a multi-level theory capable of bringing the analysis into a single framework and articulating in one stream the different sources of influence on the policy making process.

Given the multiplicity of claims, voices, and interests in pressuring the government to act, this study finds that the Bush administration’s framing of HIV/AIDS was a calculated attempt to rally opposing voices under one accepted framework.

Although many frameworks were possible, such as the one binding HIV/AIDS to US security in the September 2002 *National Security Strategy* document, or the one relating HIV/AIDS to Africa's development and using the Marshall Plan analogy, President Bush chose to use the "humanitarian framework" that is more accept to either side of the political divide and can rally the public opinion without contest. As such, this study entails obvious theoretical and policy relevance to the literature on US foreign policy toward Africa and the literature on HIV/AIDS pandemic. Against the prevailing assumption that neglect and indifference of Africa in US foreign policy result from a lack of strategic significance, the study is in line with those scholars who contend that US engagement in Africa is rather selective and does not follow a "grand scheme" in an unequivocal way. Like Western (2002) who contests the arguments that the "CNN effect" and moral outrage of President G.W.H Bush pushed to engage American troops in such countries as Somalia where there are no US strategic interests involved, this study is in consonance with the argument that opportunism and political calculations has guided the US intervention in Africa through selective engagement (Keller 2006:4; Iyob and Keller 2005:101). In fact, US intervention in Africa results from the political interplay of competing foreign policy elites with different normative beliefs about when and where to intervene; competing interests in the domestic and international arenas, and the cumulative pressure on the administration to act. Indeed, as Rothchild and Keller (2006) observe, change in US foreign policy toward Africa often shifts in client but not in purpose.

I chose the neoliberal framework and the privatization theory to explain President Bush's policy preference of the welfare provision. This framework permits organizing the different actors and their interests around the individual, national and international levels of analysis. As Sayer (1992:50) remarks, a theory is used in at least 3 senses: first, as an ordering-framework or a set of background assumptions; second, as a conceptualization in which to theorize means to prescribe a particular way of thinking about the world; and third, as a hypothesis, an explanation, or a tested proposition. Since facts or numbers do not speak for themselves, a framework is needed to establish a relationship between empirical observation and theoretical conceptualization (Burnham 2008:3). Because a theory is always for someone and always for some purpose, as Cox (1996:87) famously puts it, my choice of the privatization theory is obvious as it puts an emphasis on President Bush's domestic and foreign policy agenda with regard to the production and distribution of social goods and public welfare. Indeed, the privatization theory has allowed organizing the different key variables, from personal presidential beliefs and ideology to bureaucratic politics to the international environment, and their roles in the framing of the issue and the development of policy alternatives.

This study regards the core assumption in foreign policy analysis (FPA) of the "interpretation of the situation" as an exercise in hermeneutics. The hermeneutic, that is the interpretation of any given datum, in this case is concerned with the framing of the HIV/AIDS global issue in conjunction with the social condition of Africans affected by the pandemic. The representation prevailing among senior officials of the Bush administration is not of an objective reality but rather the outcome of a bounded



rationality. In other words, the nature of the situation (whether defined as a routine, a crisis, or an extended crisis situation) is but only one profile of a multifaceted social reality whose interpretation is a function of entrenched interests and the observer's forestructure. The "datum" of interest, in this hermeneutical approach, results rather from the entanglement of those involved in the measurement activity than from representing an objective reality (Heelan 1997; 2004; Kuhn 1962:4). By this, I mean simply to say that a policy response such as PEPFAR to any given situation like the way in which HIV/AIDS affects Africa's condition and prospects results from the preferred interpretation that policy-makers apply to it. For instance, the Bush administration preferred the "humanitarian" framework to the security framework or the trade and economic framework for several reasons. First, a humanitarian framework is a rallying cry beyond political partisanship. Second, it allows for diverting attention away from the business friendly policy he proposed. And third, it allowed him to pursue his structural and bureaucratic reform agenda without rising suspicion.

In the case of HIV/AIDS in Africa, the privatization framework brings to the forefront the continuous influence of private US pharmaceutical companies in attempting to control the policy image and the policy venue, consequently, in stirring the policy alternative in addressing the public health problem at stake. Indeed, PEPFAR policy solution reflects the competing claims – a scientific solution that requires investment incentives in research and development and the protection of the intellectual property regime and the trade agreements to assure the feasibility of this solution; a moral solution that promotes Christian evangelical values of abstinence and sexual behavior conversion;

and humanitarian solution that include the care of innocent victims such as the orphans and other vulnerable children in the programs – to frame the HIV/AIDS issue. Yet, the dominant framework favored by the Bush administration, a humanitarian emergency situation, can accommodate all these claims without exacerbating antagonism. Thus, the reading and interpretation of the HIV/AIDS global public health crisis by US policy makers in the Bush administration followed a neoliberal market-oriented approach to propose alternative solutions to the provision of the welfare favored by a state-centric approach. As a private and market-oriented policy has become the official US position in the post-Cold War context of economic globalization, this neoliberal privatization approach to the provision of public health and welfare subsumes different theories that focus either on individual beliefs or on structural organizations of the state. The privatization theory includes the pursuit of self-interest political interests measured by the political dividends for the incumbent, focus on the moral leadership in the pursuit of other foreign policy goals, concern for the spread of liberal values of economic trade, the involvement of charity and nongovernmental organizations and public-private partnership in the procurement of welfare, and the accommodation of different interest groups that compete to control the policy images.

The privatization theory has its own inherent shortcomings. The meaning of privatization, for instance, may differ depending on historical experience and institutional contexts. In developing countries, interpreted through colonial and postcolonial lenses, privatization may be seen as an act of betrayal, the political elites selling out the country's national strategic assets to a small class of a powerful interest group for the

sake of immediate financial rewards. Besides, it is important to understand the distinction between the load-shedding approach of the Reagan era and the empowerment of intermediary institutions of the Bush administration. In either model, the African experience has been that of disempowering the government, which gets disengaged from its social responsibility. As a matter of fact, even when the load-shedding of contracting out had allowed African government to spare some extra public money, the general perception of privatization has negative feelings attached to it because, in historical perspectives, the spared funds were allocated either to service back the sovereign debt under the structural adjustment programs or simply disappeared into the pockets of all too powerful dictators, due to lack of democratic control and accountability. Hence, instead of empowering the civil society, privatization may produce unintended consequences in Africa, which is the undermining of the social contract.

Of course, neoliberalism is an umbrella theory that provides a general conceptual framework to encompass beliefs, institutions, and practices of the production and distribution of goods and services in the era of globalization. At the level of beliefs, I analyzed presidential compassionate conservatism doctrine as a driving and organizing concept behind President Bush's social welfare action. At the level of institutions, I analyzed the evolution of IP regime and the TRIPS Agreement and how they affected the developing countries' claim to access the anti-AIDS treatment therapy. And at the level of practices, I recognized the death of the welfare state that used to enact social policies and provide help to the poor for the sake of social welfare and the common good. Hence, the scourges of HIV/AIDS in Africa presented both African governments and the

international community with multifaceted challenges given that the pandemic embodied serious impediments to individual, national, and international community life, liberty, productive capacity and the pursuit of happiness. As a social, economic, political, and moral issue, the HIV/AIDS pandemic will continue to be an area deserving of policy attention and unequivocal political commitment regardless of political partisanship and beyond religious ideologies. HIV/AIDS is simply a human problem.

Scholars of foreign policy analysis emphasize that positivist theories that look for regularities or take the nature of situation for granted may forget the dynamic process of foreign policy decision-making process (Burnham et al. 2008). My theoretical approach contends that privatization of the public health and the social welfare provision, as a result of the implementation practice of neoliberal policies, was deeply engrained in presidential beliefs and his doctrine of compassionate conservatism. As Hilger (2013) argues, neoliberal policies have had a real effect on the way social life is structured, how citizens think and problematize their existence, and how the welfare state, which according to conservative thinking “reduces the poor from citizens to clients,” should be supplanted by the promotion of freedom and self-reliance and (Weiss 2001:36). Besides, the neoliberal approach – understood mental dispositions, social policy practices, and institutional implementation – factors in the sought-after reforms of the foreign aid system and its bureaucratic structure by Republicans in the aftermaths of the end of the Cold War. Their goal is to reduce the role of the government in welfare provision while increasing the responsibility of the private sector in both the production and the distribution of public welfare. Finally, as practice, neoliberalism also sees to it that the

market-oriented welfare provision is promoted and implemented. Since all of the above are alive in this Bush administration's US HIV/AIDS foreign policy toward Africa, I argue that while PEPFAR reflects personal values and beliefs of President Bush in addressing the HIV/AIDS social problems in Africa, it is a policy that was devised to be the conservative model of public-private partnership in the provision of welfare and public health.

To understand why PEPFAR deviates from existing policy tradition of policy neglect and indifference, this dissertation integrated various independent variables including the personal beliefs of the President, the domestic and bureaucratic politics, and the international lobbying, and the global context of the HIV/AIDS crisis in Africa. The interplay between these domestic and international variables, and the pluralism of the US domestic politics, as well as the global expectations about the US behavior given its superpower leadership position all concurred to determine the policy-making process leading to the creation of PEPFAR. I reached the conclusion that the neoliberal privatization framework organizes and better explains the Bush administration policy choice, the decision-making process, and the policy substance of PEPFAR. Neoliberalism as a conceptual framework offers a multilevel and multicausal explanation while it organizes in a more coherent way the messy reality of policy process and the complex reality of HIV/AIDS welfare provision in the African context. As a result, the rationale behind the creation of PEPFAR, obviously, was to devise a conciliatory policy that would accommodate different stakeholders in the domestic and international communities, with

competing moral perspectives and material interests, in addressing the US HIV/AIDS global health crisis.

If intentionality matters, as a motivation of human action, it is clear that PEPFAR did not ensue from pure altruistic motives; it did not mark any substantial departure from existing patterns of neglect and indifference in US foreign policy toward Africa. Instead, it followed and calibrated the Bush administration's policy preferences to the dynamic of both the domestic and international politics. PEPFAR confirms what Schraeder (1994) says about the substance of the policy outcome: that it has been determined by the interaction between the nature of events on the ground – routine, crisis, or extended crisis – and the part of the bureaucratic policy establishment (president, federal bureaus, or the Congress) involved in the policy-making process. Because the president accords some sporadic attention to Africa, especially when a crisis erupts, and because Republicans sought to reform the USAID bureaucracy since the end of the Cold War, then the tendency to relegate the responsibility for overseeing US Africa policies to those national security bureaucracies shifted to the President and his minions in the case of HIV/AIDS foreign policy. Of course, Congress was to play a role in the policy development as it usually gets dragged into the policy making process by interest groups and the public opinion when the crisis situation perdures.

Many competing interests over the issue of HIV/AIDS in Africa involved federal agencies, pharmaceutical companies, churches and other FBOs, universities, think tanks and foundations, international organizations, as well as powerful individuals such as Bono and Bill Gates. Hence, to explain the inception of PEPFAR, I chose to adopt a

multicausal theoretical approach that integrates the variety of stakeholders involved in the business of HIV/AIDS. Indeed, the PEPFAR policy approach coheres with the neoliberal model of welfare provision. Hence, the assumption that self-interested individuals are better performers is overly simplistic. Not only do some politicians act on the basis of national interest, but also individuals can be altruistic as part of self-interest, not to mention the fact that not all governments are poor performers. In advanced democracies, there are mechanisms of check and balance and voters are capable of acting on the basis of their collective interest to vote out leaders who failed to be account for their actions. The faith that privatization theorists give to the market is blind to the fact that markets are not always capable of optimal performance due to imperfect information, externalities, and increasing returns to scale. Finally, the possibility to exploit monopolistic powers by private owners can also legitimize the need to create public ownership.

My primary assumption that private US pharmaceutical companies wield tremendous power and have exerted a determining influence on the continuity and change of US HIV/AIDS foreign policy toward Africa remains valid. Saying this does not invalidate the fact that other actors – both in domestic as well as international structures like governmental agencies or nongovernmental organizations – also played an important role in shaping the direction and the outcome of US HIV/AIDS foreign policy toward Africa under the Bush administration. While nonbusiness interest groups succeeded in snatching the monopoly control over the definition of the HIV/AIDS crisis in Africa away from pharmaceutical companies, it remains certain that US pharmaceutical

companies who received the lion's share of the PEPFAR funds – up to 55 percent of the total budget – were the major player and influence on the Bush administration in matters of health welfare provision and the adopted privatization approach. Yet, it has proved useful to expand the hermeneutical framework beyond commercial and trade interests as it appears that US strategic interests that are sometimes interpreted narrowly in material sense also encompass the moral prestige that the US enjoys as a global leader on the world stage.

Actually, my primary hunch was to dismiss the hegemonic view that Africa – in comparison with other regions – is lacking in strategic significance for the US national interests (Pham 2005; Schraeder 2006). This well-entrenched and undisputed assumption among Africanist scholars is simply inherited from tradition and fails to see the dynamics in world relations as new actors rise to superpower status. While it is conventional to treat Africa as a monolithic bloc and accept the view that it constitutes the backwater in the global hierarchy of US foreign policy, it is believed that this lack of strategic interests explains the relegation of the continent to the backburner of US foreign policy agenda; it is simply another way of saying US interests in Africa are rather s and secure (Kitchen 1983; Jackson 1984; Banjo 2010). Removed from the presidential attention, Africa remains the province of bureaucratic routines unless some kind of crisis erupts to pull the President in the foreign policy-making process or, in case the crisis drags out, Congress also becomes directly involved (Schraeder 1994a; Clark 1998; Cohen 2000). As Pham (2005:19) explains, “Most foreign policy realists wrote the continent off as little more



than a source of trouble, albeit one that could be safely ignored because it rarely if ever impinged on America's strategic national interest."

Realist thinkers such as Hans Morgenthau (1972:389) contend that the US "has pursued a consistent foreign policy" throughout history. Even a former liberal politician like former Secretary of State Madeleine Albright (1998: 50) corroborates this view when she claims that the goals of [U.S. foreign policy] have not changed for more than 200 years. Summarizing them, she declares that they have always aimed at "ensuring the continued security, prosperity, and freedom of our people." While they are the same as those that the US pursues in other parts of the world, the new world order since the end of the Cold War has altered the perception of the US global leadership and mission in the world. When these US interests, both material and moral, are not threatened there is no reason for the US foreign policy to change. Africa has had significant strategic interest to the US throughout even though the US, until the end of the Cold War, deferred Africa's responsibility to its European allies. As I have shown above, this deference was strategic in support of Europe along with the Marshall Plan aid. If the absence of vital interests did not allow the US to be adept at forming a coherent African policy after the end of the Cold War, as many contend, has the perception of US interests in Africa changed over time; and if so, under what conditions? If they do not change, can the variation and selective engagement in US HIV/AIDS foreign policy toward Africa be explained only in terms of the change in the global environment? Are US interests in Africa immutable?

The lack of consensus "within the policy-making establishment over Africa's importance to U.S. national security interests" has bolstered the marginalization of the

African region, which is left at “the bottom of foreign policy concerns” (Schraeder 1994:2-3; Moss 1995:195). The persistence of Africa’s neglect with some degree of variation – regardless of which president occupies the White House or what is his party affiliation – is the result of the ingrained perception that Africa’s strategic worth is nothing to the vital interests of the United States. While these vital interests remain yet to be explained, the history of the U.S. relations toward Africa is marked by the persistence of neglect and indifference, which reached the lowest point in history in the mid-1990s.

Since it apparently represents neither a military threat nor an economic power to challenge US vital interests, Africa might remain the stepchild of US foreign policy, at least in the perception of some. Yet, even when lacking in the military capabilities and the political will to challenge US, the rise of a competing superpower, as was the case with the USSR during the Cold War and might be with China today, capable of challenging the US hegemonic interests has always led to adaption and readjustment of the US presence in Africa. For instance, the terrorist attacks on US Embassies in Kenya and Tanzania in 1998, the rise of terrorism in Africa, or the foreign aid activism of China in Africa may compel the US to quit its neglect and indifference to protect its leadership position on the continent. As Schraeder (2001:404-406) rightly observes, the new competitive international environment after the collapse of communism exacerbated the divergent economic self-interests between the US and its European allies while most US Ambassadors now serve as advocates for US business. Indeed, competition and equality between all actors, even former allies, has become the guiding principle in the international environment. Hence, the challenge posed to the neoliberal global economic

order enshrined in such trade regimes and treaties like the TRIPS may be sufficient to call for a readjustment of US policy attitude and cause the government to be more involved in Africa to secure its liberal values and privileged position.

Since poverty was not a new factor between the moment President Bush came to power in 2001 and the moment he enacted PEPFAR in 2003, it cannot be the variable that determined the timing of this policy. Hence, the need to provide an explanation for what happened during the interim period to impact the change in the Bush administration's HIV/AIDS policy attitude toward Africa. Aware that cultural patterns shape perceptions, choices, and expectations, I began by looking at how the Bush administration defined the situation of Africa, reducing the HIV/AIDS problem to essentialist characteristics such as stereotypes about Africa's chronic poverty, deficiency in the sexual moral character of Africans, or simply treating the problem as an "abstract" with poverty being a mere lack of material capabilities. Such an approach, of course, discards the role of history and institutions as having any role to play both in shaping the current situation and in understanding why HIV/AIDS has come to stand at the heart of all of Africa's social problems. This dissertation sought exactly that. To show that the African condition is not "sui generis" but is a result of multiple interactions between different actors, their interests, the institutions they have set, and the conditions they have created leading to the acceptance of the global capitalism paradigm within which we think, work, play, and make meaning of our lives. The privatization of welfare provision and the policy choice of the Bush conservative administration, I contend, makes it easy to put the blame on Africans for any condition that besieges their lives, such as HIV/AIDS.

The chapter on the history of US HIV/AIDS in previous administrations also reveals a pattern of neglect and indifference based on engrained stereotypes and images of Africa in most Western minds. The change inaugurated in the Bush administration policy approach in 2003 did not seek to break with either the tradition of neglect and indifference or the stereotypes of Africa in US foreign policy. Instead, it was simply an expedient accommodation of the new global environment; that is, the development of the crisis in HIV/AIDS pandemic, the pressure from domestic and international civil society, and the rise of China's activism in Africa as a potential source of foreign aid money. The provision of foreign aid at this specific point in time, especially knowing that the crisis in the HIV/AIDS global health community had already reached a critical mass prior to the Bush election in 2000, did not come as a change of heart for considering the scourges of poverty and HIV/AIDS in a new light. Instead, the response followed a pattern of behavior that reminds us that US foreign aid to Africa is always motivated by multiple factors among which how the situation at stake is interpreted; it may affect one of the vital interests of the US on the continent or the presence and involvement of another superpower that might defy or challenge these US interests. As I have shown above, US interests are defined not only in material terms but also in moral terms, such as the global leadership status it enjoyed since the end of the Cold War. With this in mind, it was easy to understand why Congress lent support, in a bipartisan way, to this policy when trends in its post-Cold War approach to the provision of foreign aid to Africa advocated the reduction or even the suppression of it for lack of geostrategic interests.

While I embarked on this study with the hope of debunking the myth of altruism in US HIV/AIDS foreign aid toward Africa, especially by a conservative administration, it should be noted that although the religious right was truly animated by humanitarian purpose in its lobbying of the President, different interest groups had different goals. The role of private US pharmaceutical companies in the making of PEPFAR remains crucial, however. It did not begin with PEPFAR. Actually, even President Clinton and his administration were pro-privatization and supported the private US pharmaceutical companies prior to the issuance of Executive Order 13155. The policy change even under a Democratic President was a matter of political expedience for the Democrats, not an act of charity toward Africa, especially on the eve of the 2000 presidential elections, cycles, which are very important in US domestic politics. The Clinton administration needed to retreat from its staunch neoliberal preferences for the TRIPS regime and the support of US private pharmaceutical companies in response to domestic and international pressure.

In the ensuing years, PEPFAR became President Bush's best opportunity to overturn the Clinton administration's state-oriented welfare provision embedded in Executive Order 13155 and implement his conservative approach to the public health welfare provision through the continuation of the privatization policy. At the international level, there was a tug of war between governments of the developing countries and the US government's support of the private US pharmaceutical companies on the issue of production and access to anti-HIV/AIDS drugs treatment. This war continued well into the years of the Bush White House tenure. As discontent grew about US foreign policy

and as Africanist scholars disparaged the foreign aid regime toward the end of the Clinton two-terms administration, the Bush administration saw this as a chance to enact changes and implement its policy perspective. PEPFAR was enacted in the wake of the 9/11 terrorist attacks as the implantation of the Bush's Millennium Challenge Corporation (MCC). This approach to foreign aid provision embodied the US attempt to reform the foreign aid system, which President Bush denigrated often as a legacy of the Cold War era and an instrument of neocolonial paternalism, and to harmonize the bureaucratic structure of the government after the Cold War, dictated by the need to comply with the new global world order.

The success of the PEPFAR initiative, acclaimed as one of the few positive legacies of the controversial Bush presidency, has been justified on the basis of President Bush's persistent application of the "Monterrey Consensus" framework, which focuses on neoliberalism pursuit of privatization, partnership understood as a greater involvement of the private sector in the public sphere, coordination between public agencies and private organizations in implementing foreign aid for development, and accountability which stands for results delivery in the sense of the business management model (Dybul 2009; Stein 2008; Moss 2009; Hindman and Schroedel 2011). PEPFAR accommodated the interests of US pharmaceutical companies in their push for more privatization of the welfare system and for a market-oriented solution to public problems. However, it also brought back in other actors of the private sector such as private volunteers, philanthropists, NGOs, and FBOs to address the multifaceted issue of HIV/AIDS. As the pandemic came to present challenges to the security of nations, their economic growth,

the global governance, the moral leadership, and individual human rights, HIV/AIDS became the true gauge of the benefits of globalizations and a globalized economy justice (De Cock et al. 2002, De Waal 2003).

Hence, PEPFAR resulted from a coincidence of multiple influences including the President's ideological beliefs in compassionate conservatism, the pluralist nature of US domestic politics, the bureaucratic organizational culture which President Bush sought to reform, the changing global environment with a mounting expression of discontent with US superpower through terrorist attacks and the increasing presence of China in Africa that challenged the status quo. PEPFAR did not reinvent the wheel of the US HIV/AIDS foreign policy. Instead, it built on accumulated knowledge and expertise with existing biases and stereotypes vis-à-vis Africa, but also possessed the goal of introducing structural changes in US foreign aid system. My primary hunch that PEPFAR was the opportunity for the Republicans in the White House to repeal the legacy of the Clinton Democratic administration embodied in Executive Order 13155 finds support even though I had to enlarge my understanding of the sources of influence. From ideology (Democrat vs. Republican welfare model), to interests (moral, economic, political), to organization (private model of welfare procurement), PEPFAR shows that the President is not the only policy making unit acting or speaking on behalf of the government; nor was the private US pharmaceutical companies the only interest group with access to the President. Instead, the privatization theory applies to the definition of presidential beliefs and preferences, the pursuit of bureaucratic reforms and a redefinition of the role of the government in welfare provision, and the pluralistic competition of the domestic politics.

In this study, I have looked at continuity and change in US foreign policy toward Africa: this is a case study of US HIV/AIDS foreign policy toward that country. To understand and explain the puzzle that the President Emergency Plan for HIV/AIDS Relief poses to scholars of International Relations – that is, the timing of the policy creation in the aftermaths of 9/11 when the prospects of increasing foreign aid to Africa were simply unlikely, the pattern of neglect and indifference that characterized different administrations prior to the Bush administration, the impending war in Iraq, and the 2002 economic recession that would compel the policy makers to spend sparingly taxpayers' money – I analyse the domestic and international contexts as well as the prevailing beliefs in the Bush administration. President Bush surprised the world by creating a policy that allocated \$15 billion to combat HIV/AIDS in Africa. While altruism alone or even realist arguments are insufficient in explaining fully the creation of PEPFAR, I suggest that the convergence of different interests and the need to accommodate them led the Bush administration to create PEPFAR.

Given President Bush's "neoliberal presidential beliefs" embedded in his "compassionate conservatism doctrine, the pluralism of US domestic politics and the agenda to reform the foreign aid structure, and more importantly, given the thrust of Conservatives to protect the interest of US pharmaceutical companies in a globalized economy, were determining in the change in US HIV/AIDS foreign policy toward Africa. Actually, US pharmaceutical companies were crucial determinants of the global health crisis and in the making of the neoliberal solution precluding the resurgence of the welfare state in public health provision. It is only when noneconomic interest groups and



other nongovernmental actors challenged the monopoly they wielded in the definition of the situation that the US government was able to reconsider its HIV/AIDS foreign policy toward Africa and to become more inclusive and more comprehensive of the consequences of the HIV/AIDS pandemic in Africa.

Thus, one important finding of this research is that PEPFAR was the outcome not only of the influence of powerful US private pharmaceutical companies on the policy making process of the government but also of the multiple sources of influence coming from different stakeholders including FBOs, NGOs, think tanks, or private individuals both in the domestic and international political environments. While President Bush's personal beliefs and his compassionate conservatism doctrine, at the individual level, sought for ways to conjoin the liberal value of public welfare provision with conservative emphasis on private initiatives in dealing with social issues, President Bush was able to galvanize bipartisan support on HIV/AIDS, a subject matter that cuts across political, religious, or social polarization. Nonetheless, it is the schooling of President Bush at Harvard Business School that was of significant consequence on his decision making process, as President Bush put it in his memoir. "I came away with a better understanding of management, particularly the importance of setting clear goals for an organization, delegating tasks, and holding people to account. I also gained the confidence to pursue my entrepreneurial urge" (Bush 2010:22).

Besides the individual level of analysis, and the influence from Bush's business mindset, the bureaucratic and institutional sources of influence on the HIV/AIDS foreign policy making process at the national level included the bureaucratic competition and the

federal agencies' infighting to control the policy implementation. Not only the pulling and hauling between executive and legislative branches sought to leave an ideological mark on the policy between Democrats and Republicans but also the State Department and the Health and Human Services and the Defense or Labor Departments involved in steering the policy played a determining role in shaping the PEPFAR outcome. As Andrew Natsios confided to me during my interview with him, for instance, different federal departments fought to control the HIV/AIDS money in spite of their lack of expertise in development overseas (on December 5, 2012). As he put it,

I don't want to go in the political intrigues (...) there was a fight between the State Department and the HHS. Secretary of HHS, Tommy Thompson wanted to get HHS into doing health in the developing world. I am not gonna question what his motivation was but I said, 'that is what we [USAID] do. A third of our budget is health. And it is not just one disease but a lot of it... So there was a fight over turf. Who would dominate this. At some point Colin Powell had to intervene and said 'no no no, we're not gonna run this through HHS but through State Department and AID.'" Natsios recognizes that the USAID was not involved in the drafting of the policy until very late because of this battle over turf. "And so, I told HHS it's none of their business, their focus should be on domestic health in the US, not on international, we don't need any help in this area. AID has hundreds officers with PhDs, they are epidemiologists... I think 300 people have Masters degree in public health... but, I guess that's Washington politics.

Eventually, after bureaucratic infightings for control over PEPFAR money, the US Global AIDS Coordinator was to be located in the State Department (Lancaster 2008:24). Yet, the domestic politics also contributed to the development of the policy as expressed through lobbying and advocacy by competing interest groups (Yale Students Association, ACT-UP, Churches, Universities, and pharmaceutical companies). Among different interest groups, the US government often aligns its policy preferences with those of the business interest group (Schraeder 2000; Jacobs and Page 2005; Brown 2012). They

wield more power and had a significant impact on the decision making process to define US policy outcome or to switch official US policy attitude with regard to HIV/AIDS in Africa. As a result, no one interest group could have shaped the US HIV/AIDS foreign policy as comprehensively as PEPFAR appears to have done unless changes advocated by other stakeholders – with social, moral, financial, and political interests – also entered the game to twist the Bush administration’s arm on the issue of public health affecting the lives of millions of people in Africa.

This leads us to consider the influence at the international level. Schraeder (1993) has rightly identified the levels of external (other powers) involvement in the situation affecting Africa among the important variables determining the US foreign policy toward Africa. With regard to the HIV/AIDS global issue, the involvement of the emerging economies such as Brazil, South Africa, India, and Thailand was an important factor in the US decision-making process. These countries not only tried to impact the whole global IPRs regime or to change the TRIPS Agreement to fit their own public health interest but also represented an important market with technological capabilities to manufacture generic drugs and a growing middle class capable of purchasing goods and services. Yet, one individual country such as Uganda was instrumental in influencing the “abstinence until marriage” proviso in the prevention policy. Uganda’s First Lady Janet Museveni, for instance, made a trip to Washington D.C. to deliver a formal letter to Republican lawmakers in Congress “stating that abstinence was key to Uganda’s success. Her involvement helped secure the \$1 billion abstinence earmark that appears in the final bill” (Epstein 2005; Tumushabe 2006). Besides these countries, different UN agencies

and other international organizations (IOs) including the UNAIDS, WHO and the newly created Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) were involved in high profile lobbying to engage the US pharmaceutical companies to reduce the price of the anti-AIDS drugs. Also, the WTO adoption of the Doha Declaration in November 2001 that affirmed the sovereign right of African governments to take measures to protect the public health of their citizens was a determining moment in the international tug of war between, on the one hand, the developing countries and pharmaceutical companies generic producers and, on the other hand, the US government supporting the US R&D-oriented pharmaceutical companies ('t Hoen 2003 and 2009). Yet, some international nongovernmental organizations, more specifically the MSF and the TAC challenged the monopoly of US political and economic approaches to the global issue of HIV/AIDS.<sup>1</sup>

My choice of using a neoliberal framework and the privatization theory has come as a tradeoff – to be more encompassing as the PEPFAR policy itself – to include not only economic aspects but also social and political in the explanation of the Bush administration's policy outcome. In applying the neoliberal privatization theory, this study demonstrates how PEPFAR was a deliberate choice to implement a series of measures and policies with regard to the new direction that the Bush administration wanted to give to the development of Africa and the foreign aid allocation structure. Neoliberalism, in this sense, different from the theory of neoliberal institutionalism, allowed highlighting of the role of the government and the private actors in welfare provision. Among these private actors, the pharmaceutical industry, but also the faith-

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<sup>1</sup> Cf. *supra*, Chapter 4, note 28.

based organizations, think tanks, and individuals competed with one another to steer the definition of the situation and the policy preference of the US government. In the end, the Bush administration perceived that change to the IP regime and TRIPS Agreement, which makes the foundation of international economic relations and guarantees the stability of the post-Cold War neoliberal world order, posed a threat to the global status of the US superpower as well as to its economic welfare and supremacy.

Brown (2012) has made a significant contribution by studying the role of interest groups, think tanks, and lobbyists during the transition period – that is, the time between Election Day and Inauguration Day – between two administrations. Existing studies on interest groups focused on strategies detached from time (i.e., Hula 1999), coalition activities (Hojnacki 1997), or the so-called ‘outside strategies’ to influence public opinion (Kollman 1998), Brown closes this theoretical gap by focusing on the transition period and shows how the business interest group has provided new presidents with policy ideas, staff, and people appointed to the administration (Schlesinger 1965; Meese 1992; Blasko 2004; Brown 2012). Since guaranteeing private US pharmaceutical companies technological leadership, ensuring continuous investment flows in R&D for innovation (incentive theory), and maintaining the US competitive advantage in trade only reflect the neoliberal American ideals and go hand in hand with the promotion of democracy and the protection of private property, it is logical to deduce that the Bush policy preference derives from the business interest. However, the international human rights advocates presented the problem of HIV/AIDS under new lights to challenge the business framework and monopolistic economic interpretation of the situation. Their efficacy in

changing the framework showed that HIV/AIDS was not only an economic issue but a moral and political problem as well. They challenged continued colonial tropes of relating to Africans almost as lesser human beings, excluded from the benefits of scientific progress based on their social and historical conditions.

The privatization theory shows, in fact, the thrust of the Bush administration to shrink the power of the government in the provision of welfare. That is, both in the US and abroad, neoconservatives sought to decrease the power of the state and to increase the role and visibility of private actors in their approach to welfare manufacturing. Hence, the bureaucratic reforms advocated by most Republicans found their echo and were implemented through PEPFAR. No longer USAID alone, but the coordination of different bureaucratic agencies should intervene on this issue that is complex and encompassing. At the same time, the reforms will allow partnership between public and private while also relying on different sources of financing. Bono. Bill Gates. The earmarking of the policy at the Congressional level is an expression of domestic power politics: different constituencies with different emphases: treatment (Pharmaceutical companies), prevention (evangelical Christians), and care (FBOs).

The devastating effect of HIV/AIDS in Africa predicted since the early 1990s, Dietrich (2005:271) observes, “is now being seen in falling life expectancies, increasing numbers of orphans, and terrible tolls on households, learning, teaching, health systems, agriculture and business sectors across the board.” HIV/AIDS impacts on public health, political stability, the state capabilities and the prospects for development cannot be overstated. The pandemic constitutes one of the greatest moral, social, political,

economic, and scientific challenges of our time. Given these political, ethical, and epistemological dimensions pertaining to HIV/AIDS, a better understanding of the Bush policy to address the complex phenomenon of HIV/AIDS and public health crisis in Africa is in order.

The process tracing method followed by this study allowed identifying key events that contributed to the timing, and attitudinal change of the Bush administration as far as the HIV/AIDS pandemic global crisis was concerned. The development of generic drugs from India, Brazil, Thailand or South Africa paired with other international events such as the September 11 terrorist attacks; the Doha Conference on the TRIPS and Public Health; the creation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and the Monterrey Conference on financing for development were all ingredients that allowed the Bush administration to develop its own comprehensive policy approach. While the key decision making unit shifted to the White House – and its Task Force on HIV/AIDS – thus removing the policy making process from the hands of staunch bureaucrats, Congress was able to earmark the appropriations and thus left its own mark on the policy outcome. While President Bush chose to frame the issue in humanitarian terms to show the urgency of an emergency situation faced by African HIV/AIDS patients, this situation did not become so urgent in his first or second year in office, but only in his third year. Thus, the move was to have some political dividends for a president in search of international legitimacy for his intervention in Iraq.

Finally, it appears that the primary beneficiaries of the PEPFAR policy are Americans themselves. As MSF director described the context by the turning of the new

Millennium, HIV/AIDS embodied a situation of injustice outside the context of war, as 99 percent of the people with access to the life-saving ARV drugs lived in Europe and North America while only less than 1 percent of all ARV drugs were sold in Africa in spite of the continent's greater need for treatment given that millions of people dying of the HIV/AIDS pandemic every year (Orbinski 2008:353). If 11 cents only out of every dollar reached Africa, as ... argues, then US taxpayers monies was meant to fund American organizations and firms. PEPFAR Prime partners are American universities, federal agencies, Embassies, pharmaceutical companies before getting to reach the non-American labor force and NGOs (Lewis 2006; Orbinski 2008).

Unlike the African governments that saw the problem through a neocolonial lenses and interpreted it as a power control, and unlike the global civil society that framed the issue as a question of global social justice and human rights, different actors framed the HIV/AIDS issue differently for different purposes. The policy image that prevailed, however, was the neoliberal that emphasized the role and responsibility of individuals and the contribution of the private sector – charities, families, churches, etc. – in dealing with the disease and caring for those affected by it. Hence, the role of the private sector in the provision of welfare was far better than the old way of government handing over big checks without any control or change of character. The role of the government is to support these private initiatives and actors by creating the institutional framework that will allow the interaction among these different actors.



## **Policy Recommendations**

As for the practical policy relevance, this study surveyed the debate on the correlations between the HIV/AIDS high prevalence rates in Africa and the different arguments on sexual behavior and cultural changes for prevention, access to antiretroviral drugs for treatment, and the challenge that the obsolete medical infrastructure continues to pose in the fight against the spread of the pandemic. The problem of HIV/AIDS, indeed, is a multifaceted one that needs an integrated solution and PEPFAR has attempted to provide this. However, African voices that diverge from Western epistemological and hermeneutical frameworks seem to be excluded from the policy making process. Why has this been the case?

This study claims that the voices by African experts and from within the African cultures need to be heard and must inform US policy makers in Washington DC on matters related to the relationship between the African context of economic, social, development, and public welfare, on the one hand and HIV/AIDS on the other. Downing (2005:12) raises an important question about “why is it so difficult for the West to hear African voices?” He goes on to advance the perception and concern that dominant Western interpretation about HIV/AIDS in Africa is not only an economic problem but also one that reproduces and prolongs neocolonial representations, practices and social politics. In fact, some policy makers in the US with connections (whether cultural, political, or economic) with the dominant biomedical industry, refer often to Africa’s chronic condition of poverty; they have a completely different understanding of poverty from the way in which Africans see and interpret their condition. In Western minds,

poverty is often reducible to the deprivation of material capabilities while, in the minds of African and Africanist scholars and practitioners, poverty is understood in anthropological terms as the deprivation of basic human capabilities.<sup>2</sup> It is unfortunate that the voices from Africa have been received in the West, as always, with a good dose of suspicion. While Thabo Mbeki's controversial stance on AIDS as a disease of poverty has been decried and condemned in the West, for instance, instead of rousing attention to the role of poverty in creating favorable conditions for AIDS, African voices continue denouncing the epistemological ethnocentrism of the West as the "biomedical model" which remains the dominant framework through which knowledge and understanding of HIV/AIDS in Africa is disseminated (Downing 2005:13-15). The power of the Western ideological neoliberal framework is also the power to constrain thought. For instance, in an interview shortly before flying to Washington D.C. where former President of Zambia, Kenneth Kaunda, was invited by President George W. Bush at the PEPFAR signing ceremony, he defended Mbeki's position, saying, "I think that comment [of Mbeki] has been deliberately misunderstood – I shouldn't say deliberately, I withdraw 'deliberately – has been misunderstood'" (quoted in Downing 2005:22).

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<sup>2</sup> Sen's discussion of *Development as Freedom* (New York: Anchor Books, 1999) provides a useful framework of interpreting poverty beyond the utilitarian materialistic and liberal individualistic understandings. His "capabilities" approach regards poverty as deprivation of the substantive freedoms, which combine both social welfare and personal freedoms. In the same way, I believe that the actual conditions of life in Africa, and the opportunities opened to one person, cohere in her "capabilities" endowment. HIV/AIDS, in many respects, attacks and depletes not only the immune system of the person but also his social endowment. Unlike the principle of maximization of social goods proposed by the different welfare provisions in the West, either the utilitarian or the liberal approaches that focus on the possession of basics rights, liberties and opportunities, income and wealth, and the social bases of self-respect, African voices have been calling for an even more holistic approach that centers on the social empowerment and human fulfillment of the person.

An important insight from within Africa remarks that there is lack of evidence in justifying the correlation between national poverty of African countries and their rates of HIV/AIDS prevalence. As Kelly (2010: 109) contends, countries with high HIV/AIDS prevalence rates are not necessarily the ones with the lowest GDP or the ones with a high percentage of people living below the internationally accepted poverty line of less than \$1.25 a day. For instance, Nigeria and Zambia have similar poverty rates of 65-70 percent of people living below the poverty line; yet Nigeria's HIV prevalence is only a quarter of that in Zambia. Namibia may have a high GDP than that of Ethiopia, yet its HIV/AIDS prevalence rate is greater than Ethiopia's. Such countries like Comoros, Madagascar, and Ethiopia do not measure up to the high HIV/AIDS prevalence rates in richer South Africa, Nigeria, Botswana or Namibia. Hence, as Barnett and Whiteside (2006) remark, economic growth alone is not enough and needs to be accompanied by social development and justice. While a reevaluation of the role that both state and non-state actors ought to play in the production and provision of public goods are required, especially in Africa with regard to the challenges posed by HIV/AIDS and poverty, African voices strongly emphasize the necessary link between HIV/AIDS and the practice of social justice. Biomedical or cultural solutions are not encompassing enough to address the multiple levels of the challenge posed by HIV/AIDS.

For instance, the African Catholic Church through the voice of its Synod of Bishops advances the view that AIDS "is not to be looked at as either a medical pharmaceutical problem or solely as an issue of a change in human behavior. It is really an issue of integral development and justice, which requires a holistic approach and

response” (quoted in Kelly 2010:251). The HIV/AIDS global crisis will continue to pose a threat to social cohesion, national sovereignty, human rights of people, and the global collective action unless the aspect of social justice is joined with the cultural and biomedical pursuits. Focus on human rights and social justice can allow for a significant advancement in the suspicion nurtured by diverging interests of Westerns and Africans in a common issue such as HIV/AIDS and public health. Indeed, African voices stress the need to dismantle the unjust structures that permit the flourishing of injustice, of which HIV/AIDS is but one facet. These structures are endogenous as well as exogenous. The former include aspects of poverty that relate to income inequality, cultural norms of gender discrimination translating power imbalance between men and women, and the stigmatization and other forms of social discriminations against PLWHAs. The latter includes the global exploitative economic regimes and practices that have maintained Africa in a minority position in terms of knowledge, technology, and dependency on the West.

A cosmopolitan welfare ethics in the age of HIV/AIDS is not about the distribution of ARVs drugs alone. It should concern respect for the voices from within Africa, not only for political elites who might be pursuing different goals and interests, but also for scholars and the civil society who might be easily overlooked in the US policy-making process. Health is indeed a growing concern in foreign policy and US foreign policy-makers should only pay attention to this issue only in times of crisis. The globalization phenomenon and its corollaries – increased movement of people and goods across borders, bioterrorism and an epidemiologically interdependent world, trade

agreements and treaties, transfer of knowledge and technology to spread development – compel foreign policy decision-makers to take the relationship between global health and foreign policy seriously. Public health is something that needs to be integrated into everyday policy practices and should not be treated at specific critical historical junctures as HIV/AIDS has been. Actually, public health has now become integral to national security, economic development, political stability, and human and public welfare.

There are remaining questions that further research could address. How has the crisis in HIV/AIDS public health affected the possibility for strengthening the democratization process in Africa, especially if trust in the capabilities of the state and in their own governments is reduced and citizens tend to overlook them to search for help abroad? Are African leaders accountable to their citizens if donors are the ones to provide the means for social cohesion, or have the power to control, reward or punish good and bad performers? Does the HIV/AIDS experience in Africa call for a different approach to the welfare provision model beyond the limits of neoliberalism, one that does not undermine the legitimacy of elected leaders or the state as a source of identity?

APPENDIX A

PEOPLE REPRESENTING HIV/AIDS STAKEHOLDERS DURING THE BUSH  
ADMINISTRATION POLICY-MAKING PROCESS

Name	Organization
Harvey E. Bale, Jr.	Director General, International Federation of Pharmaceutical Manufacturers Associations
Judith Bale,	Board Director for Global Health, Institute of Medicine
Erica Barks-Ruggles,	International Affairs Fellow, Brookings Institute
David E. Bell,	Professor Emeritus of Population Sciences and International Health, Harvard University
Kenneth W. Bernard,	Special Adviser for International Health Affairs to the Assistant to the President for National Security Affairs, National Security Council
David E. Bloom,	Professor of Economics and Demography, Harvard University School of Public Health
Stephen B. Blount,	Director, Office of Global Health, Centers for Disease Control and Prevention
Thomas Bombelles,	Director, International Government Relations, Merck and Company, Inc.
A. David Brandling Bennett	Deputy Director, Pan-American Health Organization
Kenneth C. Brill,	Principal Deputy Assistant Secretary, Oceans, International Environmental and Scientific Affairs, Department of State
Gro Harlem Brundtland,	Director-General, World Health Organization
Lincoln C. Chen,	Executive Vice President for Program Strategies, Rockefeller Foundation
Richard N. Cooper,	Maurits C. Boas Professor of International Economics, Harvard University
Susan Crowley,	Director of International Organization Relations, Merck and Company, Inc.
Louis J. Currat,	Executive Secretary, The Global Forum for Health Research
Nils Dauilaire	President and CEO, Global Health Council
Randolph P. Eddy III	Senior Policy Advisor to the U.S. Permanent Representative, U.S. Mission to the United Nations
Laura L. Efos	Senior Advisor for International Health Strategy, Office of Science Technology and Policy
Timothy G. Evans	Team Director, Health Sciences Division, Rockefeller Foundation
Richard G. Feachem	Director, Institute for Global Health, University of California, San Francisco

William H. Foege	Distinguished Professor of International Health, Rollins School of Public Health, Emory University, and Senior Medical Advisor, Bill and Melinda Gates Foundation
William H. Frist	Member, U.S. Senate
Cutberto Garza	Vice Provost, Academic Programs, Cornell University
Helene D. Gayle	Director, National Center for HIV, STD and TB Prevention, Centers for Disease Control and Prevention
David F. Gordon	National Intelligence Officer, National Intelligence Council
Margaret Ann Hamburg	Assistant Secretary for Planning and Evaluation, Department of Health and Human Services
David Hamon	Regional Director for Planning and Policy, Department of Defense
J. Bryan Hehir	Professor and Chair of the Executive Committee, Harvard Divinity School
Donald A. Henderson	Director, Center for Civilian Biodefense Studies, Johns Hopkins University
David L. Heymann	Executive Director, Communicable Diseases, World Health Organization
Sharon H. Hrynkow	Deputy Director, John E. Fogarty International Center, National Institutes of Health
Mickey Kantor	Partner, Mayer, Brown and Platt
Gerald T. Keusch	Director, John E. Fogarty International Center, National Institutes of Health
Melinda Kimble	Assistant Secretary for International Finance and Development, Department of State
Mark Kirk	Member U.S. House of Representatives
Roger M. Kubarych,	Henry Kaufman Sr. Fellow, International Economics and Finance, Council on Foreign Relations
Joshua Lederberg	President Emeritus, Rockefeller University
Thomas Loftus	Washington Representative, World Health Organization Liaison Office
Chris Lovelace	Director, Health, Nutrition, Population, World Bank
Frank E. Loy	Undersecretary for Global Affairs, Department of State
Bernd McConnell	Principal Deputy Assistant Secretary for International Security Affairs, Department of Defense
Jim McDermott	Member, U.S. House of Representatives



Michael Moodie	President, Chemical and Biological Arms Control Institute
Thomas Novotny	Deputy Assistant Secretary and Director, Office of International and Refugee Health, Department of Health and Human Services
Thomas R. Pickering	Undersecretary for Political Affairs, Department of State
Jan Piercy	Executive Director, World Bank
Nancy J. Powell	Principal Deputy Assistant Secretary, Bureau of African Affairs, Department of State
Manphela Ramphela	Managing Director, World Bank
Tim Rieser	Minority Clerk, U.S. Senate Appropriations Subcommittee on Foreign Operations
Joy L. Riggs Perla	Director, Office of Population Health and Nutrition, USAID
William L. Roper	Dean, School of Public Health, University of North Carolina at Chapel Hill
Ellen Sabin	Special Consultant, InterAction;
Jeffrey D. Sachs	Director, Center for International Development, Harvard University
John W. Sewell	President, Overseas Development Council
Donna E. Shalala	Secretary, Department of Health and Human Services
Jason T. Shaplen	Vice President and Senior Advisor, Pacific Century Cyberworks
Nicole Simmons	Dean and Virginia Rusk Fellow, Institute for the Study of Diplomacy, Georgetown University
Daniel L. Spiegel	Partner, Akin, Gump, Strauss, Hauer and Feld
Susan Stout	Principal Evaluation Officer, World Bank
Michele Sumilas	Senior Legislative Associate, Global Health Council
Julia V. Taft	Assistant Secretary for Population, Refugees, and Migration, Bureau of Population, Refugees and Migration, Department of State
Melanne Vermeer	Assistant to the President and Chief of Staff to the First Lady, Office of the First Lady
John P. White	Member of the Board and Preventive Defense Project Affiliate, John F. Kennedy School of Government, Harvard University
Tracey Dunn and Denise Gomes,	Research Associates at the Council on Foreign Relations, provided research and assisted in the preparation of this report.
River Path Associates,	Assisted in the research and drafting of some

Dorset, U.K.,	portions of the report in its early stages
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These persons and organizations participated in CFR and Milbrand Fund meetings and were interviewed by Jordan Kassalow (2001), and/or reviewed this report in draft. They are listed in the positions they held at the time of their participation.

APPENDIX B

LIST OF PEOPLE INTERVIEWED DURING THE COURSE OF THIS RESEARCH

Date	Name	Position
Dec. 5, 2011	Andrew Natsios	Administrator of the U.S. Agency for International Development (USAID) (May 2001- January 2006). Previously, Chairman of the Massachusetts Turnpike Authority; he also served as Secretary of Administration and Finance for Massachusetts and was Director of the Office of Foreign Disaster Assistance at USAID for two years under the Bush Senior administration (1989-1991)
Dec. 14, 2011	Dr. Joseph F. O'Neill	Former Director of the Office of National AIDS (ONAP), he then moved to the HHS as Special Advisor to Secretary Tommy Thompson. He worked closely with the HHS Secretary, who is responsible for the administration's global AIDS policy.
Dec. 16, 2011	Dr. Mark Dybul	Executive Director of the Global Fund to Fight AIDS, TB and Malaria as of November 15, 2012. He began his position at the GFATM on February 2013. Previously, Dybul served as the United States Global AIDS Coordinator, leading the implementation of the President's Emergency Plan for AIDS Relief (PEPFAR) from 2006 to 2009.
Dec. 20, 2011	Chester Crocker	Former Assistant Secretary of State for African Affairs from 1981 to 1989, and Chair of the Board of the United States Institute of Peace (1992-2004), he currently holds the James R. Schlesinger professorship of strategic studies at Georgetown University's Walsh School of Foreign Service
Dec. 19, 2011	Shellie Berlin Bressler	Staff Member of the Committee on Foreign Relations at the United States Senate
Dec. 22, 2011	Sheri Rickert	Staff Member, Subcommittee on Africa,

		Global Health and Human Rights. The United States House of Representatives
January 4, 2012	Carol Lancaster	Former Deputy Assistant Secretary of State for Africa, and Deputy Administrator of USAID, Dean of the School of Foreign Service at Georgetown University, Washington D.C.
January 18, 2013	Stephen Lewis	Former U.S. Secretary-General Special Envoy for HIV/AIDS in Africa; Former Canada Ambassador to the UN, and former Deputy Executive Director of the United Nations Children's Fund (UNICEF) from 1995-1999.
February 4, 2013 (rescheduled)	Dr. James Orbinski	Former President of the International Council of <i>Médecins Sans Frontières</i> (MSF, aka Doctors Without Borders) at the time the organization received the 1999 Nobel Peace Prize; co-founder and Chair of the Board of Directors of Dignitas International, a medical humanitarian organization working with communities to increase access to life-saving treatment and prevention in areas overwhelmed by HIV/AIDS. He is a strong advocate for increasing the availability of anti-retroviral drugs to combat AIDS in poor countries.
Email communications	Peter Piot	Former Under Secretary-General of the United Nations, former Executive Director of the UN specialized agency UNAIDS, director of the London School of Hygiene and Tropical Medicine and a professor at Imperial College London. In 2004, he was awarded the Vlerick Award.
November 21, 2012	Dr. Doyin Oluwole	Executive Director, Pink Ribbon Red Ribbon Initiative at the George W. Bush Presidential Center in Dallas, Texas.

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## VITA

Toussaint Kafarhire Murhula was born in Bukavu, the Democratic Republic of Congo (DRC), on March 19, 1973. After graduating from high school in 1991, he spent one year doing propaedeutic in philosophy and another year teaching high school before joining the Jesuit Order in 1993.

Between 1993 and 1995, he was a novice Jesuit studying Jesuit spirituality in Rwanda and the DRC. After earning a B.A. in philosophy in 1998 from the Jesuit Faculties Saint Pierre Canisius in Kinshasa, DRC, he taught high school for two years. From 2000 to 2003, he went on to study theology at Hekima College, Catholic University of Eastern Africa in Nairobi – Kenya. In 2003, he moved to Berkeley, in California where he received a Licentiate in Sacred Theology (STL) with a specific concentration on Ethics and Social Theories.

He returned to Bukavu in 2005 where he taught in both secondary and post-secondary institutions while also running different social programs focused on HIV/AIDS and education.

In 2008, he joined the M.A. Program in political science at Loyola University Chicago and enrolled in the PhD program in 2010. He received his Ph.D. in International Relations from Loyola University Chicago in May 2016.