

**HEALTH ECONOMICS AND HIV/AIDS RESEARCH DIVISION**

**POLICY BRIEF**

**REVIEW OF 'THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF'  
(PEPFAR)**

**Manyeke Sengwana**

**August 2004**

## Contents

Executive Summary.....	3
PEPFAR: An Overview.....	4
PEPFAR Implementation in South Africa.....	6
PEPFAR Implementation and Analysis in other designated countries.....	7
Challenges of PEPFAR Implementation.....	12
Key Research Areas to Inform PEPFAR.....	13

## **EXECUTIVE SUMMARY**

During his State of the Union Address on January 28, 2003, President George W. Bush of the USA announced to the world the ‘President’s Emergency Plan for AIDS Relief’ (PEPFAR). PEPFAR is an initiative that encompasses HIV/AIDS activities in more than 75 countries and focuses in 15 countries in Africa, Asia and the Caribbean to develop comprehensive and integrated prevention, care and treatment programmes. PEPFAR is offering a total of \$15 billion, of which \$10 billion is new cash, over the next five years. Most of the money will be spent in 15 countries, which are among the most afflicted in Africa, Asia and the Caribbean.

The plan has three goals to be achieved over the next five years in the 15 countries:

- (1) Provide anti-retroviral treatment for 2 million people;
- (2) Prevent 7 million new HIV infections;
- (3) Provide care to 10 million people who are infected or affected by the disease, including orphans and vulnerable children.

It is estimated that in South Africa 5 million people are now living with HIV. The 5-year targets by PEPFAR to achieve the ‘2-7-10 goals’ are that; 500,000 HIV+ people to be receiving treatment; 1,806,271 HIV infections averted; and 2,500,000 HIV+ people under care.

In 2003, the Task Force created the Annual Program Statement (APS), a solicitation for grant proposals. Proposals are reviewed quarterly and multiple awards from the same APS are made. Applications for the APS must come from non-government entities that can manage awards between \$1 and \$30 million dollars. PEPFAR has spent \$70 to \$100 million in-allocated funds in SA during the year 2004.

## **PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF: AN OVERVIEW**

During his State of the Union Address on January 28, 2003, President George W. Bush of the USA announced to the world the 'President's Emergency Plan for AIDS Relief' (PEPFAR). PEPFAR is an initiative that encompasses HIV/AIDS activities in more than 75 countries and focuses on 15 countries in Africa, Asia and the Caribbean to develop comprehensive and integrated prevention, care and treatment programmes. The US Congress passed legislation that authorised the president's plan. In addition, the legislation created a new position at the State Department for a Global AIDS Coordinator, occupied by Ambassador Randall Tobias, charged with carrying out the president's plan.

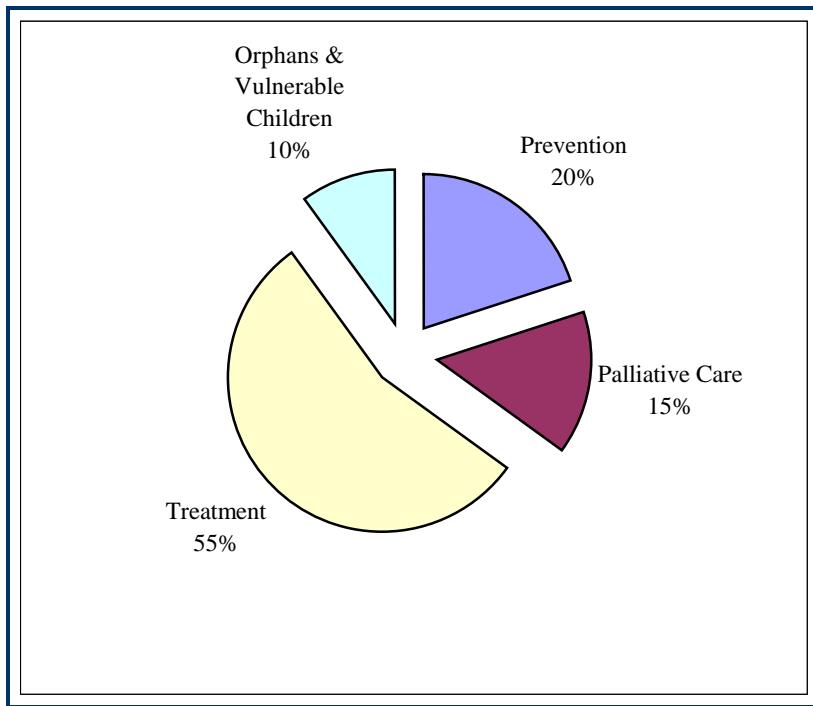
PEPFAR is offering a total of \$15 billion, of which \$10 billion is new cash, over the next five years. Most of the new money will be spent in 15 countries, which are among the most afflicted in Africa, Asia and the Caribbean: Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Zambia and Vietnam. The 14 countries in Africa and the Caribbean represent 50% of the world infections. It was in Hanoi earlier in July when the U.S government decided to add Vietnam in Asia to its list of 15 nations targeted for help under PEPFAR. Vietnam is predicted to have an increase in HIV-infected persons from 130,000 in 2002 to one million by 2010, an eight-fold increase. Although still considered a localised epidemic, emerging trends indicate that HIV infection is spreading to the general population<sup>1</sup>. As stated in the Emergency Plan, interventions through non-governmental organisations could prevent at least 660,000 new infections, and provide care for 65,000 people infected and affected by HIV/AIDS, including treatment for 13,000 HIV-infected people.

The President's Emergency Plan has three goals to be achieved over the next five years in the 15 focus countries:

- (1) Provide anti-retroviral treatment for 2 million people;
- (2) Prevent 7 million new HIV infections;
- (3) Provide care to 10 million people who are infected or affected by the disease, including orphans and vulnerable children.

On February 23, 2004, the first \$350 million in funding for the focus countries of the Emergency Plan was made available and began reaching people in need only two weeks later. The second distribution of funding - \$500 million - will continue to build on prevention, treatment, and care efforts. In total, the Emergency Plan is spending \$2.4 billion on global AIDS this year. The Emergency Plan also devotes \$5 billion over five years to ongoing bilateral programs in more than 100 countries and increase its pledge to the Global Fund to fight AIDS, Tuberculosis, and Malaria by \$1 billion over five years<sup>2</sup>.

In authorising the President's plan, Congress also set specific distribution targets for the \$15 billion in funding for the period 2004-2008 as indicated in the diagram below.



Source: PL108-25

To achieve these goals, the Emergency Plan is built on four cornerstones:

1. Rapidly expanding integrated prevention, care, and treatment in the focus countries by using existing, successful programmes and building new ones that are needed.
2. Identifying new partners, including private sector, faith-and community-based organisations, and building indigenous capacity to sustain a long-term and broad local response.
3. Encourage bold national leadership in every impacted country around the world, and engendering the creation of sound enabling policy environments in every country for combating HIV/AIDS and mitigating its consequences.
4. Implementing strong strategic information systems that will provide vital feedback and accountability, and help to engage in continued learning and the identification of best practices.

## **The Integrated HIV/AIDS Prevention, Treatment, and Care Model**

President Bush's Emergency Plan is based on the established best practice of providing a continuum of care consisting of a full range of integrated HIV/AIDS SERVICES. The availability of each of the continuum's activities – prevention, treatment, and care – strengthens and reinforces the effect of each intervention. Prevention activities such as HIV/AIDS education and awareness, behaviour change, and testing are thus more effective when combined with treatment and restorative or curative care including such services as routine follow-up of HIV-infected individuals prior to receiving antiretroviral therapy, control of symptoms, end-of-life care, and bereavement support. All three interventions are mutually supportive, so that over time, as the availability of treatment (e.g., antiretroviral drugs) grows under the Emergency Plan, the need for palliative care will decrease.

Care for orphans and vulnerable children is another critical component of the Emergency Plan. The strategy emphasises mitigating the consequences of disease to this population and reducing their risk and vulnerability to HIV. The difficulties faced by children orphaned by HIV/AIDS represent some of its greatest short- and long-term consequences. In providing prevention, treatment, care, bereavement, and other support services to children, orphan care further reinforces the synergies of integrated service delivery. Wherever appropriate, services for orphans and vulnerable children will be linked to the health care and human services network.

## **PEPFAR IMPLEMENTATION IN SOUTH AFRICA**

It is estimated that in South Africa (SA) 5 million people are now living with HIV. The 5-year targets by PEPFAR to achieve the “2-7-10 goals” are that; 500,000 HIV+ve people will be receiving treatment; 1,806,271 HIV infections will be averted; and 2,500,000 HIV+ve people will be under care (PEPFAR Country Operational Plan Guidelines for FY04: 1/30/2004).

PEPFAR established a Task Force in South Africa, which is lead by U.S. Ambassador Cameron Hume and includes members from several US government agencies including the Department of State, USAID, NIH, DOD, and CDC. South Africa is allocated \$5 billion over 5 years by Washington and PEPFAR Task Force in Pretoria administer the use of funds

In 2003, the Task Force created the ‘Annual Program Statement’ (APS), a solicitation for grant proposals. Proposals are reviewed quarterly and multiple awards from the same

APS are made. Applications for the APS must come from non-government entities that can manage awards between \$1 and \$30 million dollars. Applicants are assessed based on their program management, technical approach and intended results, past performance and cost effectiveness. Applicants need to demonstrate how their proposed activities are complementary to South African Government programmes, policies and approaches. The Task Force works with the South African government at all levels, and with business and NGOs to meet the objectives of PEPFAR in the areas of treatment, prevention, palliative care and care for orphans and other vulnerable children. It allocates funds to organisations that support the provision of sustainable HIV/AIDS services in South Africa. It does not support research.

PEPFAR has spent \$70 to \$100 million in-allocated funds in SA during the year 2004. Future predictions are that the amount of money allocated to SA will increase dramatically, but the exact figures are unknown yet. PEPFAR is a five-year initiative, whether the Washington will extend the plan beyond five years remains to be seen.

## **PEPFAR IMPLEMENTATION AND ANALYSIS IN OTHER DESIGNATED COUNTRIES**

Activities for anti-retroviral treatment have been approved in Kenya, Nigeria and Zambia; and, in Uganda and South Africa, patients are already receiving treatment from the Emergency Plan. In addition, the Plan outlines that prevention through abstinence messages will reach about 500,000 additional young people in the focus countries through programmes like World Relief and the American Red Cross's 'Together We Can' campaign. However, it has been reported that while recipient governments say they are grateful for the money, officials in Uganda and Rwanda complain that they have not been adequately consulted about the plan's projects for their countries, and are worried this may not fit in with national strategies to fight the disease, though Mr Tobias says that it is PEPFAR's intention to collaborate with local health ministries. The field study, carried out by the Center for Health and Gender Equity, an international reproductive health and rights organization based in Takoma Park, Maryland, claims that the operational strategies in most countries are being set "almost entirely" by US officers without involving those community groups most experienced in AIDS. Local groups are being recruited, but these are mostly faith based, rather than those related to public health<sup>3</sup>.

PEPFAR spokesperson in KwaZulu-Natal, Jack Hillemeier says that PEPFAR in SA works in consultation with the South African Government – Health Ministry to oversee that all organizations/ institutions funded by PEPFAR implement their programs within the framework of the National HIV/AIDS and STD Strategic Plan, 2000-2005. Therefore such complaints have not been received in South Africa. Questions were raised about the political instability in Haiti and other sub-Saharan African countries and how PEPFAR would implement its program effectively. In his press address in Washington early this

year, Ambassador Randall L. Tobias responded by saying that the United States has a good working relationship with those governments and did not anticipate problems.

Approximately 2 million adults and children in Latin America and the Caribbean are living with HIV/AIDS. PEPFAR in these countries aims to provide antiretroviral therapy to at least 600,000 individuals needing treatment by the end of 2005. In some countries of the Caribbean basin, adult prevalence rates are second only to those in sub-Saharan Africa. More than quarter of a million children in the Caribbean have lost one or both of their parents to the disease<sup>4</sup>.

Health officials are trying to figure out how the U.S. money, with its political constraints, could be used effectively in Vietnam, given the drug use and prostitution that are driving the spread of HIV in that country. Congress and the White House generally oppose spending on condoms or on sterile syringes. Condoms are included in the 'ABC' (Abstain, Be Faithful, use a Condom) acronym that describes this part of PEPFAR. But activists fear that the importance of condom use is played down, for religious reasons, rather than played up, as it will need to be if PEPFAR is to achieve its objectives<sup>5</sup>. But according to Hillemeier, the 'ABC' strategy by PEPFAR is inclusive and prevention by using the condom is one of them, therefore none of the organisations or institutions seeking funding in this regard will be rejected. However, abstinence-based prevention is an important element of PEPFAR.

Other claims by the Center for Health and Gender Equity are that the plan, which now has schemes running in 12 African countries (plus Guyana, Haiti and Vietnam) puts excessive weight on abstinence and discriminates against any group that provides information on safe abortion. Jodi Jacobson, executive director of the center, claimed that her staff had found "a huge focus on [sexual] abstinence only". Organisations that object to the plans' emphasis on abstinence see their money withdrawn. One organisation for example, that had had funding from the US government for well over 12 years to do reproductive and social health work with adolescents, and has been favourably reviewed all of that time, has recently been cut off from funding, because they contested the president's plan. In Tanzania, Ethiopia and Namibia, organizations have been told that because they provide information on safe abortion services they won't be able to get money. Mark Dybul, the plan's deputy chief medical officer responded by saying that the programme was soundly based on evidence of successful interventions in countries such as Uganda and Zambia where in Uganda in particular, president Museveni initiated the 'ABC' message. He also said only \$20million of \$865million of the plan's fund was allocated for abstinence in youth and \$700million was for what the field people say they want to support. In contrast, activists refute the statement, saying the success of these two countries was not based only on promoting abstinence as the way to address HIV/AIDS, but they used all types of intervention strategies in consultation with people from the grassroots who live with HIV/AIDS every single day.

It is however, anticipated that the money on abstinence will probably be wasted, it is only one-fifteenth of the total and if its failure is manifest, then there will be pressure for change. In his interview with Jim Lehrer of NewsHour, Mr. Tobias mentioned that there

was enough evidence which shows that condoms have never been effective anywhere in the world in curtailing broad based general epidemics in the broad population; and delaying sexual activity in young people may be the only hope to those affected by HIV/AIDS especially in sub-Saharan Africa.

Also, the Bush initiative has been accused of downplaying other international organisations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria. Because Global AIDS is a global threat, the U.S. cannot beat it alone, so says activists. But Jack Hillemeier says that the accusations were unfounded, as 38% of PEPFAR's fund has been allocated to the Global Fund. In his response to this accusation several times, Mr. Tobias said that the U.S. has been involved in bilateral HIV/AIDS programmes for 20 years and that what is new about the Emergency Plan is the creation of the Global AIDS Coordinator to bring all the activities of the U.S. together under one umbrella. And given this experience, the plan is able to distribute money quickly compared to the Global Fund that takes more time to get money into programmes.

On January 22, 2001, President George W. Bush announced the restoration of the Mexico City Policy, originally announced by President Ronald Reagan in 1984. This regulation prohibits aid being given to international family planning organizations that provided abortion counseling, - or provide abortions, or which advocated abortion access - in as little as one country. They are blacklisted and receive no funds at all - even for family planning counseling unrelated to abortion elsewhere in the world. Regarding the effects of the Mexico City Policy on PEPFAR, in August 2003, the Bush Administration explicitly clarified that PEPFAR funds and USAID bilateral programs in non-PEPFAR countries for HIV/AIDS related services are exempt from the Mexico City restrictions. Restrictions only apply to family planning assistance provided by USAID and the State Department. Family planning counseling and referral services may be supported with HIV/AIDS funds as part of a comprehensive approach to preventing MTCT. However activities that are jointly supported with family planning and HIV/AIDS funds are subject to the Mexico City Policy.

The Director of USAID's Office of Population and Reproductive Health indicated that the Mexico City Policy was responsible for the withdrawal of funding for family planning NGOs that provide counseling, referrals and contraceptive supplies that are important elements of any comprehensive HIV prevention effort. In addition, USAID's Office of Population and Reproductive Health expressed the view that, while HIV/AIDS programs should be informed about family planning, family planning services have been separate for the most part from HIV/AIDS programs. The policies impact on organizations in South Africa that utilize the model coordinated approach to HIV/AIDS service delivery outlined in PEPFAR Strategy may be magnified if a 2-camp split has occurred among family planning and HIV/AIDS NGOS that formerly maximized their impact by coordinating their efforts or if a split has increased obstacles to forging new collaborations.

The response from this approach was that if President Bush denied funding to those groups, then countless numbers of additional people would die from AIDS. This is because in many African and Caribbean nations, family planning services, abortions, and AIDS assistance are often provided by a single agency. Banning of all funding to such groups would cripple AIDS programs.

PEPFAR aims to over a five-year period treat more than 2 million HIV-infected persons with effective combination anti-retroviral therapy, to prevent 7 million new infections and to care for 10 million HIV-infected persons and those orphaned by HIV/AIDS. Activists are not pleased with the plan's arrangements on antiretroviral drugs, which are supposed to reach about 200,000 people by the end of this year and many more in future years. Those groups that have so far been awarded contracts under the plan have no choice but to deploy medicines approved by America's Food and Drug Administration (FDA). These drugs are branded American products. Cheaper (foreign-made) generics are not permitted without FDA approval. That is despite the fact that many have been approved by the World Health Organisation (WHO), as part of *WHO Prequalification Program for Certifying Drugs for Purchase* by U.N. Agencies, and are used in treatment programmes financed by other donors, and that they are more convenient because they combine multiple drugs into a single pill that need be taken twice daily. Branded products, by contrast, involve taking as many as six separate pills a day. But Mr Tobias, in his interview with Jim Lehrer of NewsHour Washington earlier this year, said that the Prequalification program is based on programmes that enable countries that do not have something like the FDA to have a starting point for making informed decisions when they purchase drugs, but was not the same as the FDA. However, in Bangkok he said it would be wrong for his country to give foreigners drugs that have not been approved as suitable for Americans. The HIV Medicine Association (HIVMA) and the Infectious Disease Society of America (IDSA) are urging the Bush administration to adopt the WHO's quality standards for purchasing HIV/AIDS drugs instead of developing its own process that will take up precious time while lives are at stake.

It has been noted, through the plan's review that; the FDA has implemented a "fast-track" review process to allow such combination pills to be bought through the plan. But many people are not convinced that the 'fast track' will be fast enough. Hence the reversal of this position by the Bush administration. Their new system is open to foreign makers of generic drugs, which makes those approved eligible for purchase under the \$15 billion. Under the new plan, the FDA promises special fast reviews that could permit approval of combination or co-packed products within two to six weeks after receiving applications, significantly faster than the usual six-months or longer review. But there is also a question of willingness of generic producers to apply. The HIVMA and IDSA argue that U.S efforts to create a parallel system for regulating drugs in developing countries will limit the effectiveness of PEPFAR resources; unnecessarily delay the expansion of treatment; isolate the United States in its efforts to combat the AIDS pandemic; and impose a U.S.-based system on developing countries that will be unsustainable when PEPFAR resources are withdrawn. Also, it is doubtful that it will be politically possible for recipient countries to sustain health delivery system that is largely geared to the needs of 20 to 30 percent of their populations, however dangerous HIV/AIDS is. There is

likelihood; therefore of political backlash against donor insistence on this priority and a weakening of host countries commitments.

The report that came out of the Bangkok conference showed that this campaign is significantly behind schedule. Perhaps more needs to be spent on the unglamorous task of building new health delivery systems and less on the actual drugs themselves. But PEPFAR's point of view is that the HIV/AIDS pandemic in sub-Saharan Africa has reached crisis level; therefore the focus on building the new health delivery system may divert its objectives of saving millions of lives by providing treatment to those who need it immediately and prevent 7 million new infections over 5 years. This short-term emergency approach is essential. Even though the plan uses this approach, in its outline, it stresses the "network model", whereby the delivery of HIV/AIDS services are shifting from health centres and institutions to communities. Also the US plans to recruit and train health care workers in order to make up the deficit in human capital. These measures are sensible and should yield important near-term results.

In its report (2004), the Milbank Memorial Fund<sup>6</sup> states that the administration's plan in PEPFAR is too near-term in orientation and too narrow in scope to achieve its long-term objectives. The report recommends that the United States adopt a longer-term and broader-based strategy, addressing, in particular, the basic health system that developing countries need and the critical issues that go beyond health delivery. While this strategy will require more resources, it will be more likely to enable the U.S. to reach its five-year goals for PEPFAR, and it will enhance the ability of the U.S to effect long-term, sustainable progress against this and other diseases.

For instance, the plan aims to get 2 million people treatment, there are currently more than 20 million infected people in the 15 countries selected for PEPFAR. A much more robust health infrastructure will be necessary to treat tens of millions of infected people in the year ahead. The same argument holds true for testing. Ninety-five percent of Africans and 95 percent of people infected globally do not know their HIV status. Tens of millions of people will need to be tested in order to get on treatment and to be counseled to avert prevention. Apart of the reason for the lack of testing is the stigma attached to going to HIV/AIDS-specific centre for this purpose. Vast increases in health facilities, clinics, and health care workers will be needed to provide the setting to test, treat, counsel, and care for all who need to be reached.

In their report, Morrison and Hurlburt<sup>7</sup> point out that the comprehensive, multi-sectoral approach that has been adopted in Botswana can be model elsewhere as well. Botswana's experience has produced a number of lessons that should inform the efforts of other countries as well as donor programs such as PEPFAR. Botswana would not have made the progress without the leadership shown by President Mogae at the highest level. The challenges of the responses to HIV/AIDS go well beyond money. Smart approaches such as the train-the-trainer models that have worked successfully in Botswana can help overcome human resource gaps in other countries. The authors conclude that Botswana openness to innovation and its willingness to refine and adapt its response based on an

ever expanding body of evidence and lessons learned will make it an important partner for the United States in the implementation of President Bush's AIDS initiative.

The Milbank report also states that the preoccupation with AIDS threatens to cause other pressing health challenges to be neglected. The strategic statement's noted intention to build delivery services for ARV drug treatment, while vital, is a perfect example. Such delivery system might provide a robust and sustainable part of the overall health system, whereby other drugs for other purposes could also be delivered over time. However, if these services are designed solely to deliver ARV, they will drain resources from other areas of the health system and create a parallel structure. In fact, even where the administration emphasizes integrating HIV/AIDS into every aspect of existing or new components of health systems, history shows that the net effect will be to deliver more attention and resources to HIV/AIDS. The concerted campaign to fight malaria in the 1960s and 1970s drew resources from the larger health systems and from other vital health problems. For the smallpox eradication campaign of the 1970s and 1980s, a separate delivery system was developed and then allowed to dissolve, leaving no infrastructure for later vaccination campaigns. Fighting HIV/AIDS in the same way would have negative effect on health systems capacity to meet other health needs, and it would have disastrous consequences for the long-term health and development of affected countries. HIV/AIDS flourishes in conditions in which health is generally poor. When people are sick, particularly with serious diseases such as TB or malaria, their immune systems are compromised and HIV thus hits them hardest. Improving general health conditions is part and parcel of battling HIV/AIDS.

Although the strategic statement laudably recognises the dearth of health care workers and other human resource problems, such as the "brain drain" – the flight of health care workers to other fields or geographic areas – it is unclear how much impact PEPFAR will have on this enormous problem, given the administration's extreme long list of objectives and limited funds. To truly tackle the human capacity problem, the United States will need to provide a large pool of funds over a long time horizon for wide-scale recruitment and training efforts, which will take many years to produce large-scale results. Jack Hillemeier stated that South Africa has huge capacity to deliver PEPFAR's goals. He cited the Medical School at the University of KwaZulu-Natal and the Nelson Mandela Children's Fund as some of the PEPFAR's beneficiaries. In other sub-Saharan countries where lack of capacity to use the funds effectively was experienced, proposals from other capable countries were accepted and processed in Washington.

The weight of money is certainly having unintended consequences in other countries. American officials themselves have been complaining that the sheer speed with which the money was being pushed into the field was overloading their staff. The question is whether a local health system can handle the largesse being showered on them. There is a possibility that these systems may not be able to effectively deploy the money.

## **CHALLENGES OF PEPFAR IMPLEMENTATION**

The challenges facing the implementation of PEPFAR are mainly:

- 1) Resource constraints and raised expectations;
- 2) Negative impact on other health programs, agency programs, non-focus countries/regional activities;
- 3) Maintaining inter-agency unity;
- 4) Lack of biomedical/biobehavioural knowledge driving programme decisions;
- 5) Use of various agency rules or procedures;
- 6) Managing rapid increase in resources, multiple grantees and complexity with little or no increase in capacity.

In response to these challenges, Gray Handley's (Regional Representative for Southern Africa: U.S. Embassy Pretoria) presentation on the: Challenges of Global Initiatives, stipulated that local teams will have to seek complementary funding to sustain themselves and that regional programmes that use PEPFAR funded activities need to be designed. PEPFAR will fully use local staff and budget for increased management expenses and will seek to expand needed research and research capacity development.

Improving its administration strategy, the U.S. should pursue a two-track approach to building improved health delivery systems. The first track would be a five—year strategy with an emergency posture and time horizon equal to PEPFAR. Concomitantly, though, the U.S. should move just as rapidly and vigorously to enact the long-term strategy of building health infrastructure in the most affected regions and in the rest of the developing world. This long-term strategy requires a greater financial commitment. In addition, both tracks require an extensive response beyond health delivery systems if they are to succeed. The United States and its international and local partners must tackle pressing social and political issues that are fundamental to the spread of HIV/AIDS.

## **KEY RESEARCH AREAS TO INFORM PEPFAR**

- HIV and Co-Infections, particularly TB, Malaria, other tropical diseases and diseases of poverty.
- Nutrition and HIV, particularly impact of nutrition on natural history, treatment outcome and co-infections.
- Pediatric HIV treatment in poor settings.
- Addressing domestic violence and child sexual abuse.
- Targeting male behavior.
- Practical prevention for un-empowered women.

Other questions for future implementation of PEPFAR include:

- 1) How can science better inform the programme and will expertise be more integrated in planning?

- 2) Does each mission have the needed technical, administrative and resource capabilities? How will small missions cope?
- 3) Is competition between countries and programmes beneficial to foreign policy?

## REFERENCES

<sup>1</sup> Fact Sheet: Extending and improving the lives of those living with HIV/AIDS.

[http://www.whitehouse.gov/news/releases/2004/04/20040623\\_1.html](http://www.whitehouse.gov/news/releases/2004/04/20040623_1.html)

<sup>2</sup> PEPFAR Country Operational Plan Guidelines for FY04: 1/30/2004).

[http://www.usaid.gov/our\\_work/global\\_health/aids/pepfarfact.html](http://www.usaid.gov/our_work/global_health/aids/pepfarfact.html)

<sup>3</sup> Bush's AIDS plan criticized for emphasizing abstinence and forbidding condoms.

<http://bmj.bmjournals.com/cgi/content/full/329/7459/192-a>

<sup>4</sup> Global HIV/AIDS Issues. Department of State, Washington, DC.

<http://www.state.gov/s/gac/rl/rm/2004/32367.htm>

<sup>5</sup> The Economist: 15/07/2004.

<sup>6</sup> Council of Foreign Relations and Milbank Memorial Fund. 2004. Addressing the HIV/AIDS Pandemic: A U.S. Global AIDS Strategy for the long term. <http://www.cfr.org>

<sup>7</sup> Morrison JS & Hurlburt H 2004. Botswana's strategy to combat HIV/AIDS – Lessons for Africa and President Bush's Emergency Plan for AIDS Relief: A Conference Report of the CSIS Task Force on HIV/AIDS. <http://www.csis.org>