Ambassador Tobias embraces an orphan girl at the Lesotho Child Counseling Unit during his visit in July 2005. The program provides a variety of services to abused and orphaned children including shelter, education, community and youth activities, training, and life skills development. Emergency Plan funds are helping the organization to grow and reach more children with services.

"A few years ago, a little girl in Namibia was born to a mother and father who both had HIV; she had the disease, as well. The name her parents gave her translates as the phrase, "There is no good in the world." Months ago, the girl was very sick and losing weight and close to death. But today, she and her entire family are receiving life-saving medicine. Now she's a beautiful, shy, thriving six-year-old, with a new life ahead of her, and there's a little more good in the world."

President George W. Bush
June 30, 2005

Chapter 5
Children and HIV/AIDS: Responding to Critical Issues

For further discussion, see the Emergency Plan's September 2005 Report to Congress, "Focusing on Our Future: Prevention, Diagnosis, and Treatment of Pediatric HIV/AIDS," available at www.pepfar.gov.

Issues and Challenges

Approximately 2.3 million children under age 15 are living with HIV/AIDS, and a majority live in the 15 focus countries of the Emergency Plan. HIV-positive children are especially vulnerable: without treatment, the majority of infected children die before they are two years of age.

When prevention fails, the cost is enormous in terms of human suffering, and there are also many obstacles to providing pediatric HIV treatment, which is more complicated and expensive than adult treatment. This is particularly true among the youngest children, who are at the highest risk of death from AIDS, but are also difficult to diagnose and provide with appropriate antiretroviral (ARV) drug formulations.

In addition to those infected with HIV/AIDS, many more are orphans and vulnerable children (OVCs), with one or both parents dead or chronically ill as a result of AIDS. At least 8 million children have been orphaned by AIDS in the focus countries.

In addition to the tragedy an individual child may experience, the increasing needs of millions of vulnerable children are reducing the economic and social resources of families, communities, and entire societies. Inadequate care and protection of children could result in increased social disorder, with profound implications for future political stability. Orphans are especially vulnerable to recruitment by gangs and armed groups, and to exploitation as child labor or trafficking victims.

Without attention to education and vocational training, skills needed for economic development could be lost, condemning nations to continued poverty. One World Bank simulation of the economy of South Africa – a nation with a relatively developed economy – found that without effective intervention to meet the needs of OVCs, by 2020 the average household income would be less than it was in 1960 and would continue to decline thereafter.

Children have distinctive needs that must be addressed in a comprehensive, multisectoral way, with programs of high quality that can be sustained by families and communities for the long term. While there is much left to do, the Emergency Plan has brought an intensive focus to children and HIV/AIDS.

Challenges in meeting the needs of HIV-exposed children

The vast majority of pediatric infections can be prevented through the provision of highly effective preventive short-course ARV regimens. In the U.S., new pediatric HIV infections have decreased by over 95% since the implementation of combination prophylaxis regimens, with less than 50 pediatric HIV infections now reported to occur every year.

In the developing world, however, preventing, diagnosing and treating pediatric HIV/AIDS all present daunting challenges, and scaling up highly effective interventions to prevent mother-to-child transmission (PMTCT) has been challenging. The prevalence of HIV among pregnant women is rising and is above 30% in some regions. The limited capacity of health systems in resource-poor nations affects pediatric HIV/AIDS care, as it does a range of other health issues.

The most effective way to prevent HIV in children is PMTCT. Yet PMTCT is challenging in resource-limited settings, beginning with difficulty in getting pregnant women to access antenatal care and HIV prevention programs in the first place. Even when women are reached with prevention services, there are significant barriers of stigma, reluctance to return for HIV test results, issues related to delivering short-course preventive ARVs in situations where women have their babies at home, and transmission through breastfeeding in settings where replacement feeding is not safe and feasible

Because most HIV-positive children die before the age of 2 without intervention, early diagnosis is essential. Yet diagnosis of children – especially the young children most likely to be infected – is complex and expensive. The traditional tests used for adults are not effective until after the child is 18 months old. Technologies to improve pediatric diagnosis are not yet widely available, and shortages of trained health workers are a major problem.

Long-term combination antiretroviral treatment (ART) for children also poses special challenges. ARVs are often unavailable in pediatric formulations, and they are often much more costly than adult drugs. Pediatric regimens can be difficult to follow because of the complexity of dosing by weight, and few providers are trained in pediatric HIV treatment. Parents often need to reconstitute the formulation, making the instructions more complex, and the formulations often need refrigeration for storage. Treatment of infants is also sometimes subject to higher failure rates than older children due to difficulties in administering these formulations.

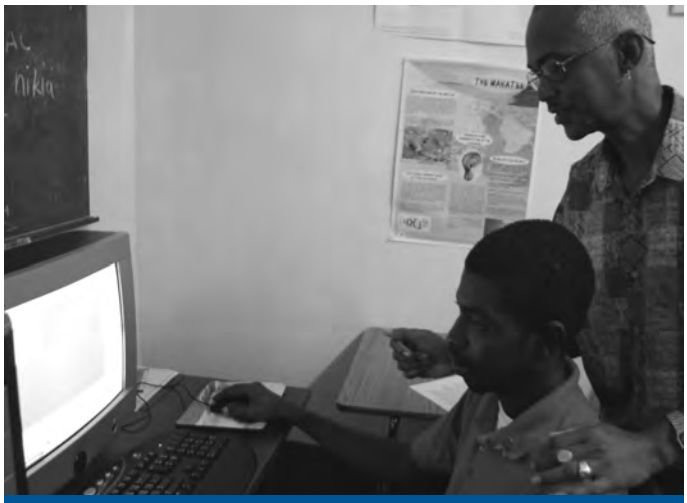
Communities do not always focus on the special issues of children with HIV/AIDS, whose parents may be ill or dead, and their caregivers often lack needed support. Even where there is a community response, older children in particular have issues that may be neglected.

Challenges in meeting the needs of orphans and vulnerable children

All children are vulnerable, simply by virtue of being children. Children whose parents become chronically ill or die from AIDS, however, face an especially daunting array of issues.

Dimensions of risk for children affected by HIV/AIDS may include:

- Survival vulnerability – poor health, nutrition and basic care



Orphans and other vulnerable children face many challenges, including academic vulnerability. At the Linden Care Foundation in Guyana, a student works on schoolwork with a staff member in the "Capacity Building Room."

- Economic vulnerability – loss of income and property, family and community fragility, inability to afford health care
- Academic vulnerability – leaving school due to lack of time, money, and hope for the future
- Psycho-social vulnerability – post-traumatic stress disorder, grief, burdens of caring for sick household members or younger children
- Exploitation vulnerability – abuse and exploitation due to loss of protective parents and community support

It is the interaction of a number of factors in a child's life that determine his or her level of vulnerability. Age and developmental level, gender, geography, and a complex array of social factors all interact to heighten or reduce a child's vulnerability, and effective responses must take these elements into account.

Because of the complex web of needs of OVCs, only some of which are directly addressed by prevention, treatment, and care programs, it is essential to coordinate with providers of resources that address the full range of issues. This coordination must take place among international partners and other providers of resources at both the national and community levels.

Activities must strengthen the capacity of those who take on the burden of caring for OVCs. Partnerships in support of families, communities, and community organizations are crucial. Perhaps the most fundamental way to protect children is to help their parents to stay alive through effective prevention, treatment and care interventions.

Results

The Emergency Plan has brought U.S. leadership to bear on the pediatric HIV/AIDS crisis, as part of the U.S. response to the overall emergency. With governmental and nongovernmental host country and international partners, the U.S. Government (USG) is scaling up a family-based approach to prevention, treatment and care for children infected with and affected by HIV/AIDS.

Table 5.1 summarizes fiscal year 2005 Emergency Plan results in providing a range of prevention, treatment and care services to children in the focus countries. (The terms "upstream" and "downstream," as used in this table and chapter, are defined in the Accountability sections at the end of the chapters on Prevention, Treatment, and Care.)

Support for pediatric HIV prevention

It is estimated that over 90% of childhood HIV infections result from transmission from mothers to their children during and soon after birth. Preventing childhood infections through PMTCT programs has been one of the highest priorities of the USG in the fight against AIDS. The President's International Mother and Child HIV Prevention Initiative launched some of the first programs in this critical area, and provided the foundation for current work under the Emergency Plan.

PMTCT programs offer preventive ARVs to mothers and infants to prevent HIV transmission to their babies during labor and delivery. While short course single-drug prophylaxis to mothers and infants beginning during the onset of labor can reduce transmission by over 40%,

Table 5.1 - Children: Summary of Child Prevention, Care, and Treatment Results in Focus Countries, 2003-2005

	October 2002 - March 2004	October 2003 - September 2004			October 2004 - September 2005			October 2003 - September 2005		
	2003	**FY04 upstream results[1]**	**FY04 downstream results[2]**	**2004 total results[3]**	**FY05 upstream results[1]**	**FY05 down-stream results[2]**	**FY05 total results[3]**	**Upstream results: cumulative total of FY04 and FY05 results[1]**	**Downstream results: cumulative total of FY04 and FY05 results[2]**	**Total results: cumulative total of FY04 and FY05 results[3]**
Total number of infant infections averted[4]	6,400	14,700	9,100	23,700	5,800	17,500	23,300	20,500	26,500	47,100
Number of pregnant women receiving PMTCT services	355,300	671,100	600,200	1,271,300	724,200	1,233,700	1,957,900	1,395,300	1,833,900	3,229,200
Number of women receiving ARV prophy-laxis for PMTCT	33,800	77,400	47,700	125,500	30,700	91,900	122,600	108,100	139,600	248,100
Number of OVCs served[5]	N/A	78,700	551,500	63,100	404,900	764,400	1,169,300	N/A	N/A	N/A
Total number of chil-dren (0-14) on ART[5]	N/A	N/A	4,800	4,800	N/A	17,700 **(7% of total ART patients)**	17,700	N/A	N/A	N/A

Notes:
Reporting in 2003 was for an 18-month period, from October 2002 through March 2004 as the (MTCT) Mother-to-Child-Transmission) Initiative was integrated into the Emergency Plan. Reporting in FY04 was from October 2003 through September 2004. There is thus some overlap in reporting during the months between October 2003 and March 2004. For this reason, results from the 2003 period are not included in Total Results for FY04.
Footnotes:
[1] Number of individuals reached through upstream systems strengthening includes those supported through contributions to national, regional, and local activities such as training, laboratory support, monitoring and evaluation, logistics and distribution systems, and protocol and curriculum development.
[2] Number of individuals reached through downstream, site-specific support includes those receiving services at U.S. Government-supported service delivery sites.
[3] Total results are the sum of upstream and downstream results.
[4] The number of infant infections averted was calculated by multiplying the total number of pregnant women who received ARV prophylaxis (upstream and downstream) by the efficacy rate of ARV prophylaxis, currently estimated to be 19%. The same method was used to calculate total results for infant infections averted, and results are rounded to the nearest 100. Therefor, total results may not equal the sum of upstream and downstream results.
[5] It is assumed that there is substantial overlap in the OVCs served and the number of people on treatment from one fiscal year to the next. For this reason, cumulative totals are not present for the period between October 2003 and September 2005.

more effective combination regimens have now been developed which can reduce transmission from around 30% to as low as 2% in a non-breastfeeding population. The Emergency Plan has been working with countries to help them revise national guidelines to incorporate these more effective regimens and develop plans to scale up implementation in coming years.

Emergency Plan programs took the first step in addressing HIV/AIDS in environments where long-term ART was not available. These programs were also among the first to address the critical need to treat mothers and fathers who were sick with AIDS and needed long-term ART, as well as children who may have become infected in spite of short-course ARVs, in order to preserve families and prevent a generation from being orphaned.

PMTCT results to date are described in the chapter on Prevention. Beginning in fiscal year 2004, the first year of Emergency Plan implementation, emphasis was placed on supporting national strategies to expand PMTCT programs as well as ART for pregnant women and their families. This required strengthening health care systems, including infrastructure and human capacity, and improving monitoring of PMTCT programs. In fiscal year 2005, PEPFAR supported training for approximately 28,600 health care workers in PMTCT services, and provided support for approximately 2,500 PMTCT service sites in the focus countries.

Through September 2005, the Emergency Plan provided support for PMTCT services for approximately 3.2 million pregnant women, including over 1.9 million in fiscal year 2005 alone. Approximately 248,100 HIV-positive pregnant women in the focus countries have received short-course preventive ARVs, including 122,200 in fiscal year 2005.

Under internationally accepted standards for calculating infections averted, the Emergency Plan has supported

programs that have prevented the infection of approximately 47,100 estimated newborns, including approximately 23,400 in fiscal year 2005. In addition to short-course preventive ARVs, PEPFAR-supported PMTCT services include follow-up after birth to ensure that exposed children receive adequate diagnosis and treatment for opportunistic infections.

The Emergency Plan has continued to support countries in moving toward the routine offer of voluntary diagnostic HIV testing, sometimes called the "opt-out" approach, in PMTCT and other health care settings. Progress has also been made in increasing the proportion of women who receive their results through expanding rapid testing to many USG-supported PMTCT sites. As these approaches are scaled up, they will allow the Emergency Plan to reach many more women in future years.

Support for pediatric HIV diagnosis

The Emergency Plan is supporting host country efforts to make diagnostic tests more widely available, improve the capacity of laboratories, and ensure the availability of appropriate technologies for testing children. Efforts to expand a network of laboratory services to rapidly reach the largest possible number of children have initially emphasized development of national laboratory strategies, infrastructure renovations, training of personnel, and development of quality-assured laboratory services. Support has been, and continues to be, provided for these efforts in each of the focus countries.

The USG is supporting efforts to expand availability of polymerase chain reaction (PCR) tests, which can identify HIV-positive children before they are 18 months old and require less blood per test than older methods. In Namibia and other nations, the USG is pioneering the use of dried blood spot tests that can bring down costs and ease the burden of testing.

In addition, the Emergency Plan supports expanding information and training related to testing children and, where testing is not an option, improving clinical diagnosis based on symptoms. As with all Emergency Plan interventions, support is provided with an eye to long-term sustainability by developing local capacity and strengthening systems.

Support for pediatric HIV treatment

Because ARV doses are dependent on weight and other biologic factors that may differ for adults and children, pediatric ARV formulations are necessary, and the Emergency Plan is working to ensure their availability. As discussed in the chapter on Treatment, the USG has created an expedited review process for generic versions of ARVs, including pediatric formulations, and such products are being submitted for review and approval, providing additional sources of high-quality, inexpensive products. As of January 2006, four generic pediatric formulations had won approval or tentative approval from HHS/FDA and were thus available for use in Emergency Plan programs.

Children exposed to HIV or living with AIDS may require a broad range of additional health interventions. The Emergency Plan thus promotes a comprehensive package of other services to prevent infections that can lead to illness or death. This pediatric preventive care package includes life-saving interventions such as cotrimoxazole prophylaxis to prevent opportunistic infections and diarrheal disease; screening for tuberculosis and malaria; prevention of malaria using long-lasting insecticide-treated mosquito nets; and support for nutrition and safe water.

From the outset, the Emergency Plan has recognized the importance of supporting treatment for children and has required the dissaggregation of treatment data so that the number of children served can be determined. PEPFAR is the only major global HIV/AIDS program to require such reporting. Age-specific data are available only for programs for which the USG provides downstream support.

In fiscal year 2005, approximately 17,700 of 249,000 patients receiving ART with downstream PEPFAR support – or 7 percent – were children. This figure likely under represents the actual numbers, as there are a num-

One Young Woman's Story
Rwanda: "I Love Children" means support for a courageous child and her household

How can Marguerite Mukandayisenga, age 17, find the courage to smile, when her life has included such pain and loss? Over 50 family members, including her father, were killed during the Rwandan genocide of 1994. Marguerite and her mother were the only survivors. Her mother went on to have two more children, Maniriho (age 9) and Mushimimana (age 7), but no long term relationship developed with the fathers of the two boys. After the youngest was born, the children's mother became sick with AIDS. Marguerite left school to take care of her mother and run the house. The neighbors ostracized and isolated the family when they heard the news. Her mother joined an association of people living with HIV/AIDS that gave the family some financial assistance, but this support came to an end when she died in 2002. Marguerite became the head of the household, with no one to turn to for help.

Marguerite Mukandayisenga, 17, lives near Gitarama town, Rwanda, with her two brothers, age 9 and 7. She has cared for her brothers since her mother's death from AIDS, and has received assistance through the "I Love Children" program supported by the Emergency Plan.

Marguerite describes the loneliness she faced in the months following her mother's death. Neighbors forbid their children to visit the house. People refused to shake her hand and avoided being close to her. The house was in a terrible state, with a leaking roof and an insecure entrance. Marguerite's health started to deteriorate, with frequent bouts of diarrhea and malaria. Farming the small amount of land surrounding the house was a struggle, and there was never enough food to eat.

Two years ago, the situation changed. The Emergency Plan supported a partner in starting what is known in Kinyarwanda as the 'Nkundabana' (I love children) project, specially designed for child-headed households. Groups of child-headed households nominate a person from the community to be their supporter, known as the Nkundabana. Marguerite's group of houses nominated Pascasie Mukamusoni, who agreed to volunteer. Pascasie's role gives her prestige within the community and she is very proud of all the assistance she provides the children. She received training in HIV/AIDS, 'helpful active listening,' nutrition, and hygiene. She meets the children as a group once a week and visits their homes frequently.

On a visit to Marguerite's house, Pascasie proudly shows the improvements she has been able to make for the family. The project provided new doors, windows and a roof for the house, and Pascasie mobilized the local community to help install them. The children in other child-headed households were also mobilized to help.

With Pascasie's support, Marguerite found the courage to get tested for HIV and learned that she is HIV-positive. Three months ago she started to receive antiretroviral treatment, as well as treatment for tuberculosis and a prophylaxis for malaria. She is also receiving food on a monthly basis from the World Food Program. The Emergency Plan-supported project gave Marguerite a goat, and the manure it provides has resulted in a more productive garden. Her brothers are both going to school now and receive school uniforms and school supplies from the project. Marguerite herself finished literacy training, which qualifies her to start vocational training in tailoring. Marguerite is friends with the other children in her child-headed household association, and meets with them most days. They have created an income and loan club. Marguerite is very proud that she was able to borrow and repay a loan on a small initiative she had to sell vegetables.

As a friend appears through the door, Pascasie opens her arms to welcome her. Ernestine, 21, has been heading her own household for four years since her mother died. "Pascasie is like a mother to us, and without her we would be lost," says Ernestine, standing with her friend and her supporter, surrounded by a house full of life.

ber of sites that have not yet disaggregated patients by age.

Considering the constraints, these numbers represent important initial steps. There are still many more children who need help, and the USG plans to accelerate

progress in fiscal year 2006. Key initiatives include: establishing targets for children on treatment at the country level; working with international partners to ensure affordable pediatric ARV formulations and diagnostic techniques; training health care providers in pediatric treatment; and working at the community level to fight stigma and provide support to children and their caregivers.

Support for orphans and vulnerable children

Recognizing the central importance of preserving families, PEPFAR focuses on strengthening the capacity of families to identify, locate, protect, and care for OVCs by prolonging the lives of parents and caregivers. The Emergency Plan supports efforts – many by community- and faith-based organizations – to provide both immediate and long-term therapeutic and socioeconomic assistance to vulnerable households.

PEPFAR support for OVCs is discussed in detail in the chapter on Care. In fiscal year 2005, the Emergency Plan provided over $62 million in funding OVC activities in the focus countries, supporting care for over 1.2 million OVCs. Of these PEPFAR-supported children, over 815,000 received downstream support, while support for the remainder was provided through upstream PEPFAR contributions to national, regional, and/or local activities, such as training, systems strengthening, or policy development.

Care activities under the Emergency Plan emphasize strengthening communities to meet the needs of OVCs affected by HIV/AIDS, supporting community-based responses, helping children and adolescents meet their own needs, and creating a supportive social environment to ensure a sustainable response. The Emergency Plan supported training or retraining for approximately 74,800 individuals in caring for OVCs, promoting the use of time- and labor-saving technologies, supporting income-generating activities, and connecting children and families to essential health and other social services where available.

After family, the community is the next safety net for children affected by HIV/AIDS, and the Emergency Plan supported 136 activities that included community-based initiatives for OVCs. PEPFAR activities seek to ensure OVC access to other essential services beyond traditional health partners and networks, reaching out to new partners to ensure a coordinated, multisectoral approach. Linkages have been established to basic care for physical survival (including health care and nutrition), economic support, education and vocational training, emotional support, and protection (including birth registration, inheritance protection, and protection from violence and exploitation). The Emergency Plan works with its governmental and nongovernmental partners to increase awareness, seeking to foster leadership that helps to create a supportive environment for OVCs.

Children are supplied with high protein energy supplements. These children are served by Community Care Coalitions, which also make monthly home visits throughout Chipata, Zambia.

Because OVCs are so numerous, the response must include the private sector and donors beyond the USG, and the Emergency Plan provides a vehicle for leveraging resources. While the Emergency Plan is focused on children orphaned and made vulnerable by AIDS, many nations have large numbers of orphans from other causes, and the Emergency Plan is working to foster comprehen-

One Young Man's Story
Botswana: Seychele, age 14

My mother died in 2002 when I was twelve years old and I was left under the care of my grandmother… While at school I was told that I was supposed to attend a five days life skill camp held at Maun Counseling Center on April 2003. Through the camp all the teachings came into my head and that was when I realized that these are the people I have been looking for. So I did not waste any time, during our tea break I contacted one of the counselors and he said he would help me. So I told him the story and went back. During the camp I learnt that "life does not go with the parent who passed away and one should face the fact that life is still there regardless of what might have happened and one should continue with life."

I also attended another camp in Toteng village in November 2004. From the camp I started teaching and telling those who were suffering from grief and loss that there is no giving up in life because you don't know what God's plans are, what might the future have for you... I want to learn and pursue my education without regret. I know I can stand in a gap for my peer age group. I have discovered (the) value of other people's life and I am willing to help my peers on overcoming issues of grief and loss of loved ones, vulnerability to HIV/AIDS, issues of stigma, career development and pursuit thereof, etc.

I am having big dreams for my future. I want to be someone who is helping his country and being someone who is important, trusted and honored by his own people.

sive responses at the community level. As donor commitment to OVCs grows, the U.S. has worked to bring stakeholders together under national OVC strategies, promoting coordination for effective delivery of resources.

Finally, the Emergency Plan seeks to ensure that governments protect the most vulnerable children through improved policy and legislation and by channeling resources to communities, particularly those with disproportionate numbers of OVCs with unmet therapeutic and service needs.

Future Directions

Despite encouraging progress, the challenges in meeting the needs of children at risk of, infected with, and affected by HIV/AIDS are significant. The Emergency Plan is taking steps on several fronts to address these challenges.

Incorporating a family-based approach and increasing the capacity of both adult treatment centers and maternal and child health programs to integrate pediatric HIV prevention, treatment and care is an important beginning. Stronger linkages among providers are key, as progress is made toward seamless PMTCT, treatment, care and community services for children and families.

Through supporting optimal infant feeding and nutrition, ensuring life-saving cotrimoxazole prophylaxis, and linking HIV infected children to core child survival interventions, PEPFAR will seek to ensure that as many as possible survive and can eventually access treatment.

A recently-created, interagency PMTCT/Pediatric AIDS Technical Working Group, drawing on leading USG experts in the area, has developed guidelines for focus countries for fiscal year 2006. These will help country teams to support high quality PMTCT and pediatric HIV programs by implementing more complex PMTCT regimens, improving the postnatal follow-up and diagnosis of infants, identifying treatment targets for children, systematizing infant and childhood HIV testing, and increasing access to treatment.

The Emergency Plan is working to improve assessment of the impact of ART on children and monitoring and evaluation of pediatric programs. Improving reporting of data by age will remain a high priority, and Country

Operational Plans for fiscal year 2006 allow for clearer attribution of which resources are devoted to pediatric programs.

Prevention

Given that PMTCT interventions can dramatically reduce rates of pediatric HIV, PEPFAR will continue to focus its efforts on scaling up high-quality PMTCT services. When one considers the complexity, difficulties, and costs involved in diagnosing and treating children with HIV, it is clear that providing universal access to quality PMTCT services is the most feasible long-term approach to mitigating the tremendous suffering that is being caused by pediatric HIV.

In this coming year PEPFAR efforts will focus on increasing the impact of PMTCT programs by continuing to scale up services, while actively assisting countries to implement the most effective interventions, including combination ARV prophylaxis regimens, rapid testing in antenatal clinics, and the routine offer of voluntary diagnostic HIV testing to all pregnant women (the "opt-out" approach).

Another key priority for PMTCT services is to improve postnatal follow-up of mothers and infants to prevent transmission through breastfeeding and ensure that mothers, fathers, and children enter into a long-term continuum of HIV treatment and care services after delivery. Stronger linkages to the larger health system are essential to ensure that HIV-exposed infants receive life-saving child survival interventions and mothers have access to family-planning services.

Treatment

As PMTCT services are scaled up, there is also an enormous need to scale up pediatric HIV treatment and care services. There are hundreds of thousands of children in immediate need of treatment services in the focus nations, and many of these children are exhibiting clinical symptoms of AIDS and can be rapidly identified through active case-finding in pediatric hospital wards and clinics.

Immediate efforts will focus on promoting active case-finding of such children, most of whom are older than two years and can be more easily diagnosed and treated than younger infants with currently available technology and pediatric formulations. At the same time, the Emergency Plan will continue to support development of systems to enable earlier diagnosis and the use of available clinical methods to diagnose HIV-infected infants.

Although PEPFAR is supporting rapid expansion of care and treatment for children, making liquid ARV formulations more widely available for young children who need treatment remains a high priority. Building on recent successes in this area, in 2006 the USG will work with other partners on this difficult issue. Ensuring that ARVs are available that are appropriate for children to take and easy for providers to dispense will also improve adherence to what will be a lifetime of treatment.

Care

An interagency Technical Working Group also guides PEPFAR efforts to meet the needs of OVCs. As the dramatic scale-up of OVC services takes place, ensuring that the services supported are of high quality is crucial. The Emergency Plan is working to identify and disseminate best practices based on age group, geographic location, gender, and degree of vulnerability.

Given that large-scale OVC programs are a relatively recent development, quality standards are still under development. The Emergency Plan will intensify efforts to develop consistent program indicators and improve monitoring and evaluation, and is supporting host nation partners in developing standard packages of services for OVCs.

Scaling up OVC support to meet the needs of the increasing number of children being affected by HIV/AIDS continues to be a major challenge, especially because many families in hard-hit communities are not in a position to take on additional children. Stigma and a lack of specialized expertise are also obstacles. The Emergency Plan is working through community- and faith-based organizations to bring best practices to scale.

Ensuring sustainability of care services for OVCs is another key challenge that PEPFAR is addressing by focusing resources at the community level. The Emergency Plan will also maintain its focus on improving coordination of care for OVCs at all levels: local, national, regional, and global.