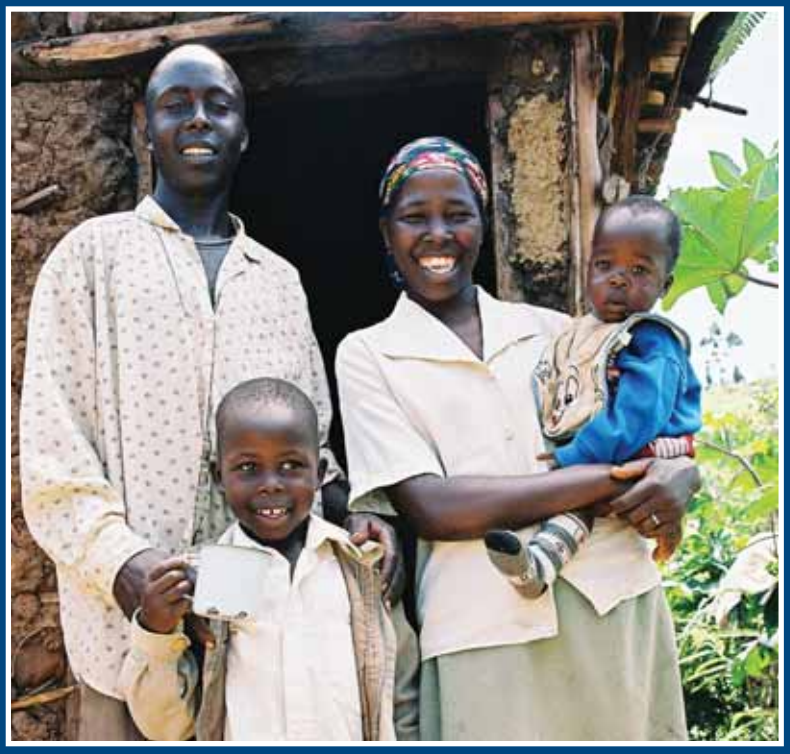
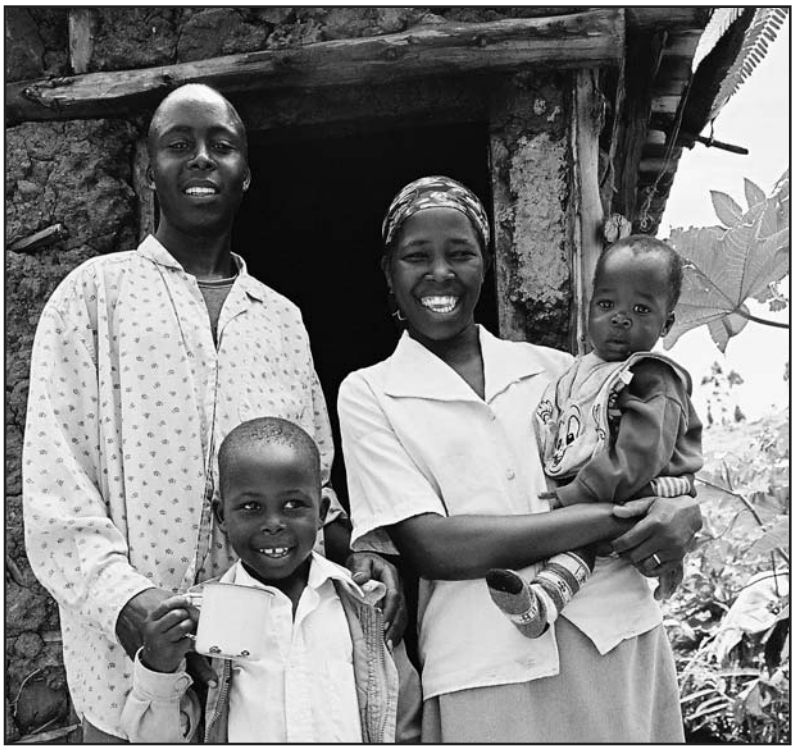


The Power of Partnerships:

The President's Emergency Plan for AIDS Relief

Overview of the Third Annual Report to Congress



The Power of Partnerships:

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Cover Photo

Through HIV counseling and testing for couples at the U.S.-supported Kericho District Hospital, Joyce and David found out they are infected with HIV. Joyce was four months pregnant with her second child at the time of diagnosis. Thanks to the clinic's program to prevent mother-to-child HIV transmission, Joyce delivered a baby boy who is HIV-negative. After a year of antiretroviral treatment, David has also gained weight and feels healthy – enabling him to provide for his family.

Photo by Doug Shaffer

This report was prepared by the Office of the United States Global AIDS Coordinator in collaboration with the United States Departments of State (including the United States Agency for International Development), Defense, Commerce, Labor, Health and Human Services (including the Centers for Disease Control and Prevention, the Food and Drug Administration, the Health Resources and Services Administration, the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, and the Office of Global Health Affairs), and the Peace Corps.

President George W. Bush and Mrs. Laura Bush tour the Pasteur Institute in Ho Chi Minh City, Vietnam November 20, 2006.

"Our work in the world is also based on a timeless truth: To whom much is given, much is required. ... We must continue to fight HIV/AIDS."

President George W. Bush
State of the Union
January 23, 2007

Overview - The Power of Partnerships:

The Impact of Partnerships Between Host Countries and the President's Emergency Plan for AIDS Relief in Turning the Tide against HIV/AIDS

The Transformational Power of Partnerships

The President's Emergency Plan for AIDS Relief (Emergency Plan/PEPFAR) is part of a broader renaissance in partnerships for international development. Under the leadership of President George W. Bush, and with the bipartisan support of Congress, this renaissance – with a particular focus on Africa – has represented both a massive commitment of treasure and a change of heart. The United States is changing the paradigm for development, rejecting the flawed "donor-recipient" mentality and replacing it with an ethic of true "partnership."

Partnership is rooted in hope for and faith in people. Partnership means honest relationships between equals based on mutual respect, understanding and trust, with obligations and responsibilities for each partner. Partnership is the foundation of PEPFAR's success and of what Secretary of State Condoleezza Rice has called "transformational diplomacy."

All told, the President has presided over a tripling of development support for Africa, and this has meant not only dollars but a new ethic of partnership. The $15 billion PEPFAR commitment joins other key initiatives: a doubling of U.S.-Africa trade, the $5 billion Millennium Challenge Account, the $1.2 billion President's Malaria Initiative, the $600 million Africa Education Initiative, and the $55 million Women's Empowerment and Justice Initiative.

The Emergency Plan is central to U.S. efforts to "connect the dots" of international development. Emergency Plan programs are increasingly linked to other important programs – including those of other U.S. Government agencies and other international partners – that meet the needs of people infected or affected by HIV/AIDS in such areas as nutrition, education and gender.

It is important to note that PEPFAR is not the only international partner of host nations. Other key international partners include: the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); the World Bank; United Nations agencies, led by the Joint United Nations Programme on HIV/AIDS (UNAIDS); other national governments; and – with growing commitment – the businesses and foundations of the private sector. All have vital contributions to make to the work of saving lives in the field.

While impressive results are reported here, they are not fundamentally the work of Americans. They are the work of courageous people in nations devastated by HIV/AIDS who are saving the lives of their countrymen and women.

The American people, through the President's Emergency Plan, have provided resources and support for communities around the world to meet the challenge of this pandemic. These partnerships are having a global impact and transforming the face of our world today.

There is a growing consensus that the world's response to global HIV/AIDS has undergone a transformation in recent years – and that new U.S. partnerships with hard-hit nations have been the catalyst.

At the end of the 20th Century, there was scant basis for hope on global HIV/AIDS. The predominant reactions to the emergency were sadness and fatalism – a sense that this problem, in these places, was beyond our collective ability to address in more than a marginal way.

Given the reality at the time, this view was understandable – and it was wrong. The seeds of a transformation from despair to hope existed all along in hard-hit nations; what were lacking were genuine, effective partnerships with the developed world. The people of many developing nations, joined by the people of the United States, are making these partnerships a reality. The history of this pandemic in the 21st Century has taken a course that was impossible to foresee just a few years ago.

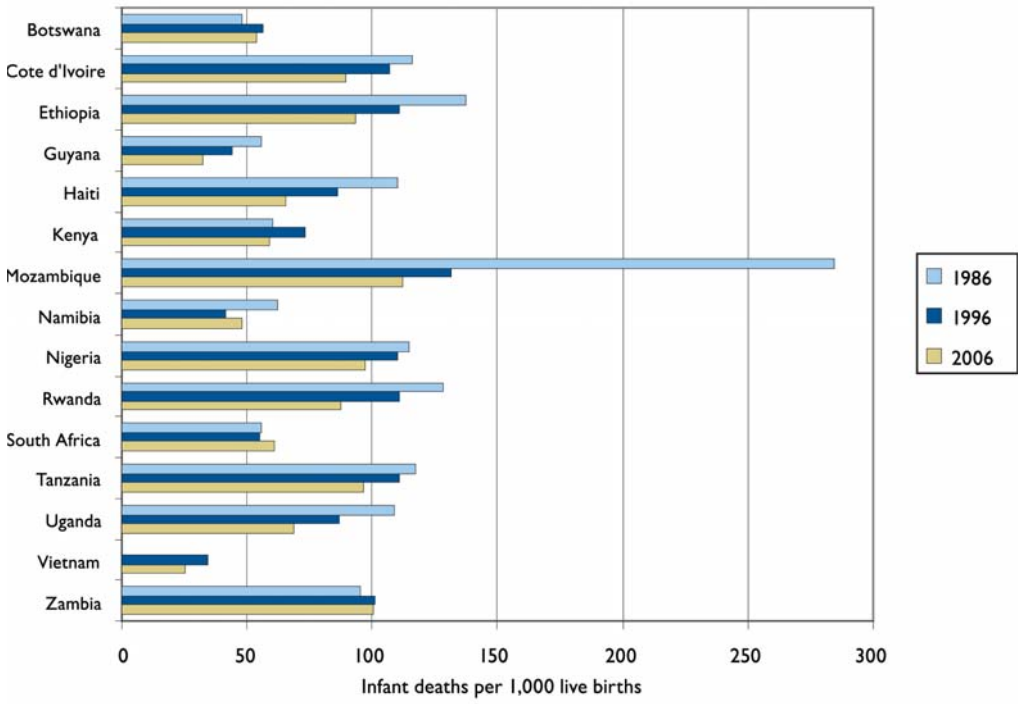
This transformation from despair to hope will be a project of a generation or more. While we are in its early days, many lives have already been saved, and the way forward to save many millions more is now clear.

Trends in Health

The developing world faces a wide range of health and development issues, and some have questioned whether HIV/AIDS merits the intensive focus that the Emergency Plan has brought to it.

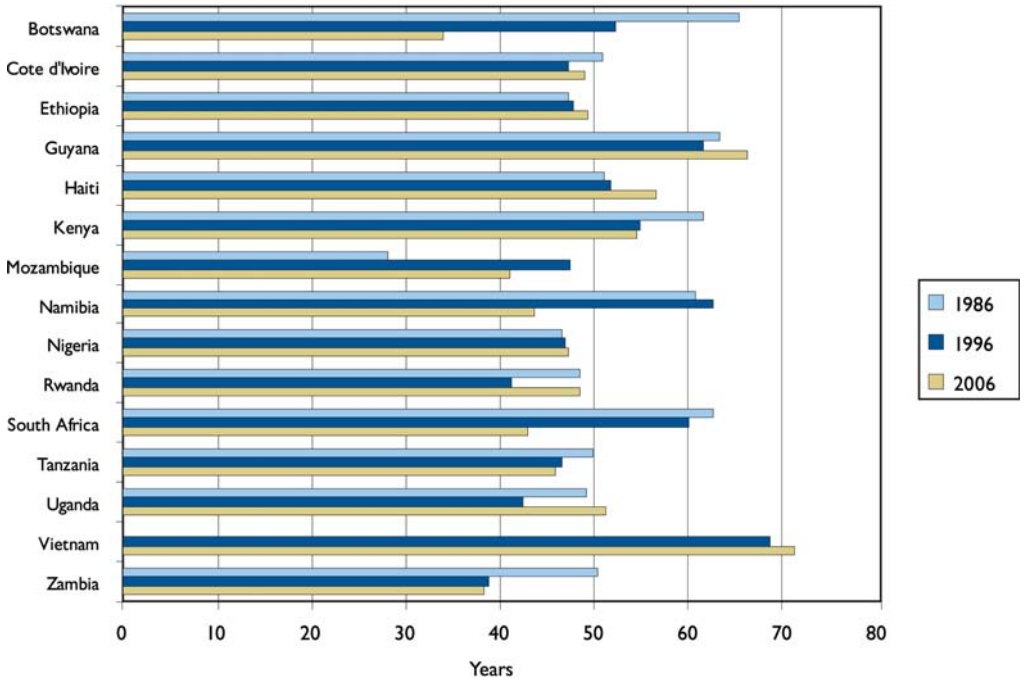
In the 15 PEPFAR focus countries, home to approximately half of the world's infected persons, valuable perspective is gained by examining changes in infant mortality over the past two decades. As seen in figure 1, infant mortality has declined in 12 of the 15 focus countries since 1986; in most of them, the decline has been very substantial. This is a major achievement for these nations and one that might be expected to reflect an overall improvement in health.

Figure 1: Changes in Infant Mortality Rates for PEPFAR Focus Countries: 1986-2006



Source: U.S. Census Bureau, 2006
Note: 1986 results for Vietnam were unavailable.

Figure 2: Changes in Life Expectancy for PEPFAR Focus Countries: 1986-2006



Source: U.S. Census Bureau, 2006
Note: 1986 results for Vietnam were unavailable.

Yet, figure 2 shows that strikingly few of these countries have experienced significant improvements in life expectancy. Tragically, seven of the 15 have actually seen life expectancy drop – a shocking state of affairs in the 21st Century. Those declines have been especially dramatic in Botswana, Mozambique, Namibia, and South Africa – the four focus countries in southern Africa, where HIV prevalence is the highest in the world. Even if nations are having success in improving some health indicators for their people – and many are – the impact of HIV/AIDS is offsetting, or far more than offsetting, those improvements. The message is clear: an effective response to the unique challenge of HIV/AIDS is an absolute necessity for real progress on health in the developing world.

Trends in HIV/AIDS

By now, the statistics of the human cost of the HIV/AIDS pandemic are familiar: more than 39 million infected. Sub-Saharan Africa remains the epicenter of the pandemic: approximately 25 million of those infected – more than 60 percent – live in the region.

Even as some African nations are experiencing success in slowing the spread of the pandemic and expanding the availability of treatment and care to prevent AIDS-related mortality, those successes are being offset by growing challenges elsewhere in Africa and in other regions.

According to UNAIDS estimates, the number of people living with HIV worldwide in 2006 was roughly 2.6 million more than in 2004. Approximately 400,000 more new infections occurred worldwide in 2006 than in 2004 (4.3 million compared to 3.9 million), and 200,000 more people died of AIDS (2.9 million compared to 2.7 million).

Economic and Security Effects of HIV/AIDS

It is a mistake to think of HIV/AIDS in terms of health alone. It is among the most serious economic development and security threats of our time – one reason why the President and PEPFAR host nations have made addressing it such a priority.

With prevalence high among people in the most productive years of their life, HIV/AIDS presents a long-term adverse strain on the socio-economic structure of these nations by overtaxing the capacity of both the private and public sectors. Businesses in the developing world are faced with absenteeism, declines in skilled workers, high rates of

turnover, expenses to train new workers, reduced revenue, and increased health care costs.

An International Labor Organization report released on World AIDS Day 2006 provided new information on the economic damage HIV/AIDS is causing. Among those of working age, in addition to 24.6 million labor force participants living with HIV, 11.7 million more persons who are engaged in some form of productive activity, often women in the home, are now living with the virus. Forty-one percent of labor force participants (and 43 percent in sub-Saharan Africa) living with HIV are women. Forty-three countries heavily affected by HIV/AIDS lost a yearly average of 0.5 percent in their rate of economic growth between 1992 and 2004 due to the epidemic, and as a result forfeited 0.3 percent per year in employment growth. Among them, 31 countries in sub-Saharan Africa lost 0.7 percentage points of their average annual rate of economic growth and forfeited 0.5 percentage points in employment growth.

In addition, many nations suffer from high HIV prevalence among defense forces, losing their soldiers – and their leadership – to AIDS. Militaries, fundamental to peacekeeping and protecting civilian populations, are often unable to keep their own personnel alive and healthy. A study done by a Commandant of the Nigerian Army Medical Command in the late 1990s showed that HIV infection rates among peacekeeping troops deployed in Sierra Leone increased from seven percent for those deployed for one year to 10 percent for those deployed for two years and more than 15 percent for those deployed for more than three years. Deaths due to HIV/AIDS are estimated to have reduced the size of Malawi's armed forces by 40 percent. In South Africa, HIV/AIDS accounts for 70 percent of military deaths, and prevalence in the armed forces is estimated at between 17 and 23 percent, with some battalions tested in 2004 showing prevalence rates near 80 percent. In Uganda, more soldiers are believed to have died from AIDS than from the nation's 20-year insurgency.

With PEPFAR support, Army Doctors conduct HIV/AIDS training for members of the Benin Defense Force.

These realities are discouraging. Yet against this background, PEPFAR reflects the recognition of hard-hit nations and the United States that, in this era, confronting HIV/AIDS is fundamental to development and security.

The Power of Partnerships: Impact on Prevention

The most recent UNAIDS report indicates that there were approximately 4.3 million new HIV infections in 2006. Effective prevention is a prerequisite to significant progress against HIV/AIDS; if the number of people newly infected continues to increase, the growing number of people in need of treatment and care – and the growing number of orphans and vulnerable children – will overwhelm the world's ability to respond and to sustain its response.

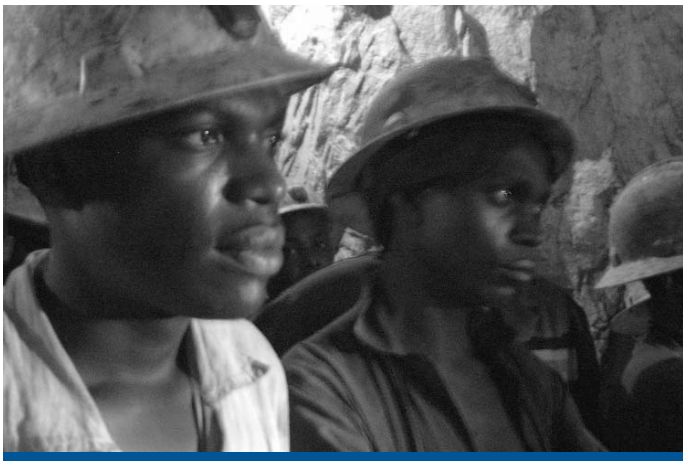
Of the countless developments taking place in the global fight against the pandemic, perhaps the single most important in recent years is the growing number of nations in which there is clear evidence of declining HIV prevalence as a result of changes in sexual behavior. In addition to earlier dramatic declines in HIV infection in Uganda, there is growing evidence of similar trends in other nations, including Botswana, Ethiopia, Haiti, Kenya, Tanzania, Zambia, and Zimbabwe. While the causes for decline of HIV prevalence are undoubtedly complex, these countries have demonstrated broad reductions in sexual risk behavior, suggesting that behavior change can play a key role in reversing the course of HIV/AIDS epidemics.

The Emergency Plan supports the most comprehensive, evidence-based prevention program in the world, targeting interventions based on the epidemiology of HIV infection in each country. PEPFAR supports prevention activities that focus on sexual transmission, mother-to-child transmission, the transmission of HIV through unsafe blood and medical injections, and greater HIV awareness through counseling and testing. The Emergency Plan will integrate new prevention methods and technologies as evidence is accumulated and normative guidance is provided.

Prevention of Sexual Transmission

The vast majority of focus countries have generalized epidemics, meaning that HIV infection is not concentrated in specific and identifiable groups, but touches the general population. Long before PEPFAR was initiated, many nations with generalized epidemics had already developed their own national HIV prevention strategies that included the "ABC" approach to behavior change (Abstain, Be faithful, correct and consistent use of Condoms where appropriate). The new data – from time periods that pre-date PEPFAR scale-up – link adoption of all three of the ABC behaviors to reductions in prevalence. Learning from the evidence, PEPFAR will continue to support all three elements of the evidence-based ABC strategy in ways appropriate to the epidemiology and national strategy of each host nation. In focus countries during fiscal year 2006, approximately 61.5 million people were reached by community outreach programs promoting ABC and other related prevention strategies. In countries with concentrated epidemics where, for example, 90 percent of infections are among persons who participate in prostitution, the epidemiology dictates a response more heavily focused on B and C interventions. The U.S. Government has supplied 1.3 billion condoms from 2004 to 2006, lending support to comprehensive ABC approaches based on the epidemiology of each country.

The Emergency Plan is also ready to support nations that adopt new prevention technologies once clinical trials are complete and guidance from a normative agency, such as the World Health Organization (WHO) or UNAIDS, is available. When new prevention strategies, such as microbicides, are identified by normative agencies as effective prevention interventions, PEPFAR will support them as part of a comprehensive prevention strategy. With respect to male circumcision, in December 2006, two clinical trials of adult male circumcision were halted as interim data revealed that medically performed circumcision significantly reduces a man's risk of acquiring HIV through heterosexual intercourse. PEPFAR is awaiting normative guidance from international organizations or other normative bodies, and thereafter will support implementation of safe medical male circumcision for HIV/AIDS prevention, based on requests from host governments and in keeping with their national policies and guidelines.



Still Life Projects

At Konkola Copper Mines in Zambia, peer educators reach miners with ABC-based prevention messages. This workplace program is part of a greater movement to reach 300,000 migrant workers with comprehensive information on HIV prevention.

Young adults in Vietnam participate in Dance4Life. In addition to dancing, the PEPFAR-supported program teaches young adults how to protect themselves against HIV.

Prevention of Mother-to-Child Transmission

Prevention of mother-to-child transmission (PMTCT) is a key element of the prevention strategies of host nations, and PEPFAR is supporting their efforts. UNAIDS estimates that 12 percent of new infections globally in 2006 (530,000 infections) occurred among children, and that more than 90 percent of these were due to mother-to-child transmission. The Emergency Plan has provided support for host nations' PMTCT interventions for women during approximately six million pregnancies to date. Of these, over 533,700 received preventive antiretroviral drugs (ARVs), preventing an estimated 101,500 infections of newborns to date.

Hard-hit nations have sought to ensure that all women who visit antenatal clinics (ANCs) receive the option of an HIV test through pre-test counseling. By promoting the routine,

voluntary offer of HIV testing – so that women receive testing unless they elect not to receive it – host nations have increased the rate of uptake among pregnant women from low levels to around 90 percent at many sites. A major PEPFAR focus in the past year was to support countries' leadership in scaling up the voluntary "opt-out" approach at as many sites as possible, to reach many more women while improving the performance and efficiency of health workers.

As table 1 indicates, access to vital ANC services varies across the focus countries. For example, Botswana has been able to ensure at least one clinic visit for nearly 100 percent of pregnant women, whereas in Ethiopia less than 30 percent visit a clinic. As a key element of its support for comprehensive programs, the Emergency Plan supports host governments' and other partners' efforts to provide PMTCT services, including HIV counseling and testing, for all women who attend ANCs.

Some countries, such as Botswana and South Africa, had already started their PMTCT programs before the establishment of PEPFAR. Additional nations have made very significant progress in reaching pregnant women with PMTCT services with PEPFAR support in the last three years (please see table 1). In other countries, progress has been slower, and the Emergency Plan is supporting these nations in redoubling efforts to close the gap. When comparing results from the first year of the Emergency Plan in fiscal year 2004 to fiscal year 2006, all countries have scaled up, and most have dramatically improved availability of PMTCT services to pregnant women.

A volunteer counselor discusses prevention of mother-to-child HIV transmission with a mother in Guyana.

Table 1: Prevention: Estimated Coverage of Prevention of Mother-to-Child Transmission[1] with USG support in FY2004 and FY2006

Country	Pregnant women receiving PMTCT services		HIV+ pregnant women receiving ARV prophylaxis	
	Percent Coverage		Percent Coverage	
	FY2004	FY2006	FY2004	FY2006
Botswana[2]	66%	95%	13%	91%
Côte d'Ivoire	4%	9%	3%	7%
Ethiopia	0%	2%	0%	2%
Guyana	36%	69%	17%	25%
Haiti	11%	30%	6%	11%
Kenya	25%	42%	18%	36%
Mozambique	5%	17%	2%	9%
Namibia	14%	57%	12%	55%
Nigeria	0%	2%	0%	6%
Rwanda	14%	61%	21%	59%
South Africa	45%	52%	22%	41%
Tanzania	3%	26%	1%	11%
Uganda	9%	21%	8%	17%
Vietnam	0%	28%	0%	8%
Zambia	4%	9%	14%	24%
Total	**7%**	**16%**	**9%**	**21%**

Notes:

Numbers may be adjusted as attribution criteria and reporting systems are refined.

Coverage based on Upstream and Downstream results from the first and third years of the Emergency Plan. In FY2004 only, it was assumed that 80% of women receiving PMTCT services were counseled and tested.

Percents were calculated by dividing PEPFAR program (upstream and downstream) results by the estimated population eligible for the service. Eligible populations include pregnant women and pregnant HIV+ women and were estimated using multiple sources, including UNAIDS, country surveillance, national surveys, DHS, etc. The same denominators were used for both 2004 and 2006 calculations.

Footnotes:

[1] PMTCT includes activities aimed at providing the minimum package of services for preventing mother-to-child transmission including: HIV counseling and testing for pregnant women, ARV prophylaxis to prevent MTCT, and counseling and support for safe infant feeding practices.

[2] Botswana results are attributed to the National HIV Program. Beginning FY2006, USG downstream contributions in Botswana are embedded in the upstream numbers, following a consensus reached between the USG and the Government of Botswana to report single upstream figures for each relevant indicator.

Addressing Gender Issues

The Emergency Plan recognizes the critical need to address the inequalities between women and men that influence sexual behavior and put women at higher risk of infection. For this reason, many HIV prevention programs also address issues related to gender. While gender equity does not directly reduce HIV transmission, the ABC approach is particularly important for the protection of women and girls. PEPFAR-supported ABC programs address gender issues, including violence against women, cross-generational sex, and transactional sex. Such approaches are not in conflict with ABC – they are integral to it.

The five priority gender strategies of the Emergency Plan (please see table 2) are monitored annually during the Country Operational Plan (COP) review process. In fiscal year 2006, a total of $442 million supported over 830 interventions that included one or more of these gender activities.

Table 2: Number of Activities per Gender Strategic Focus Area in FY2006

Gender Strategic Focus Area	Number of Activities That Include This Strategic Focus Area
Increasing Gender Equity	460
Addressing Male Norms and Behaviors	348
Reducing Violence and Coercion	243
Increasing Women's and Girls' Access to Income and Productive Resources	97
Increasing Women's Legal Protection	80

Note:
Each activity may include multiple focus areas.

Prevention of Medical Transmission

In fiscal year 2006, PEPFAR provided approximately $68 million for medical transmission prevention activities in the focus countries. This included direct support for 3,846 blood safety service outlets or programs, as well as broader efforts to improve management, commodity procurement, infrastructure, and national policies. In order to build capacity for a sustainable response into the future, PEPFAR also supported training or retraining for 6,600 people in blood safety and 52,100 in medical injection safety.

In Kenya, microeconomic activities, such as sewing, help women living with and affected by HIV/AIDS earn income.

The Power of Partnerships: Impact on Treatment

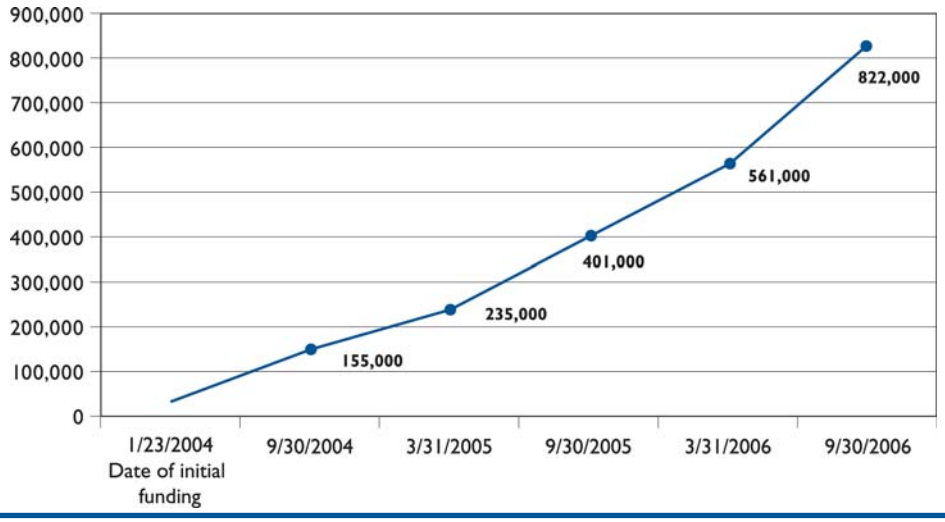
It was just a few years ago that many doubted that large-scale antiretroviral treatment (ART) programs could work in the world's poorest nations. Now we know they can. Hundreds of thousands of people are proving it.

Approximately 822,000 people received treatment in the 15 focus countries with support from rapidly scaled-up bilateral PEPFAR partnerships with host nations. The striking growth of PEPFAR support for treatment in the focus countries is shown in figure 3.

By September 2006 in the focus countries, approximately 50,000 individuals were being added to the number of people benefiting from PEPFAR support for life-extending therapy every month. The number of sites providing treatment increased by 139 percent from fiscal year 2005 to fiscal year 2006, and each month an average of about 93 new ART sites came on line.

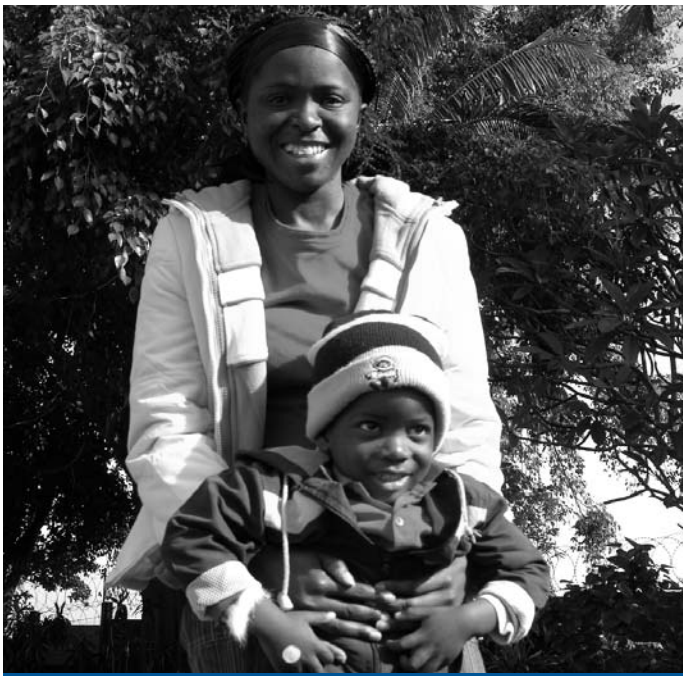
Beyond the focus countries, other bilateral PEPFAR treatment programs supported an additional 165,100 people (more than double the approximately 70,000 a year earlier). Thus the number receiving treatment with support from PEPFAR bilateral partnerships at the end of

Figure 3: Treatment: Number of Individuals Receiving Antiretroviral Treatment in the 15 Focus Countries
(Total of both upstream and downstream USG-supported interventions)



fiscal year 2006 was 987,100 – approximately half of the estimated 2 million on treatment in low- and middle-income countries.

As part of its commitment to ensure treatment availability for children and women, PEPFAR bilateral programs have led all international partners in supporting host nations in tracking clients by age and gender. As shown in table 3, of those for whom PEPFAR provided downstream support for treatment in the focus countries, almost nine percent were children, and approximately 61 percent were women.



With support from PEPFAR, Nompumelelo and Elihle receive antiretroviral treatment at McCord Hospital's Sinikithemba Clinic in Durban, South Africa.

Another way to assess the impact of PEPFAR's partnerships with host nations is to estimate treatment's effect on the life spans of individuals. The World Health Organization has recently developed a methodology for calculating the number of life-years added by ART; when applied to the number supported by PEPFAR, as shown in figure 4, this approach generates very significant results. The more than 822,000 persons who began treatment with support from PEPFAR in the focus countries during fiscal

Table 3: Percentages of Children and Women Among Those Receiving Treatment with Downstream Emergency Plan Support for Focus Countries in FY2006

	Children (ages 0-14)[1]	Women (all ages)[1]
Total	**9%**	**61%**

Notes:

Numbers may be adjusted as attribution criteria and reporting systems are refined.

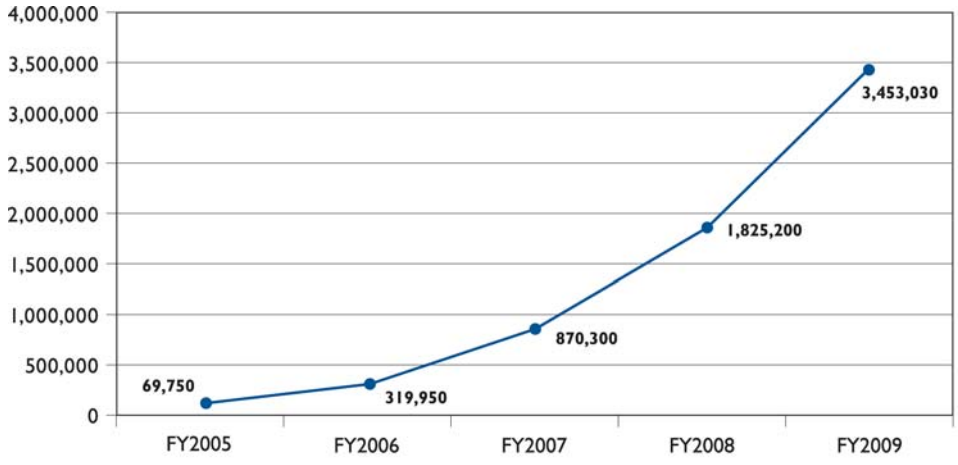
Percentages shown reflect only those receiving downstream support. Data for those who benefit from upstream support cannot be disaggregated by age or sex.

Number of individuals reached through downstream site-specific support includes those receiving services at U.S. Government-funded service delivery sites.

Footnote:

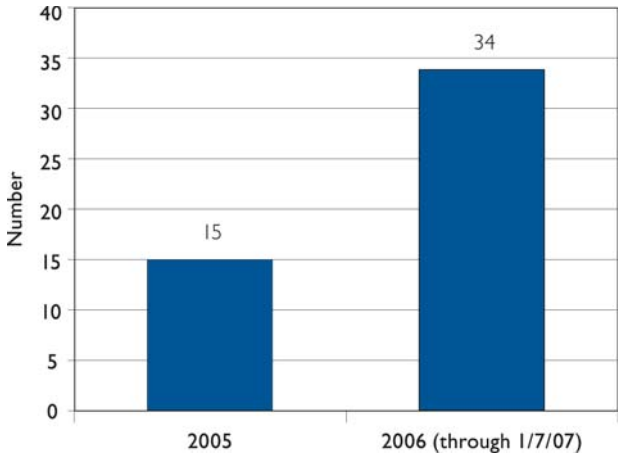
[1] According to the 2006 UNAIDS Epidemic Update, 45 percent of those infected with HIV worldwide in 2006 were women, and 13 percent were children.

Figure 4: Estimated Cumulative Years of Life Added through FY2009, Based on Current and Projected Persons on ART, Due to PEPFAR Support for ART in Focus Countries



Note: Calculations are based on methodology developed by the WHO, 2006. Total person-years-of-life added are based on the actual number of persons on ART in FY2004-FY2006 and projected numbers of people to be on treatment for FY2007 and FY2008.

Figure 5: Cumulative HHS/FDA Approvals/Tentative Approvals of Generic ARVs, Calendar Years 2005 and 2006



years 2004 through 2006 represent approximately 2,200,000 person-years-of-life added through the end of fiscal year 2009 (September 30, 2009). Estimating the additional number of people projected to be placed on ART by the end of fiscal years 2007 and 2008 under current PEPFAR budget plans, an additional 1,250,000 person-years-of-life would be added by the end of fiscal year 2009. In all, PEPFAR support for treatment is projected to save around 3,450,000 person-years through September 30, 2009, alone – and undoubtedly will have much greater effects beyond that time frame.

The Emergency Plan's impact on treatment access extends beyond PEPFAR-supported programs to increased availability of safe, effective, low-cost generic antiretroviral drugs (ARVs) in the developing world. To meet the need for such ARVs, the Food and Drug Administration within the U.S. Department of Health and Human Services (HHS/FDA) introduced an expedited "tentative approval" process whereby ARVs from anywhere in the world, produced by any manufacturer, could be rapidly reviewed to assess quality standards and subsequently cleared for purchase under PEPFAR. As of January 4, 2007, 34 generic ARV formulations have been approved or tentatively approved by HHS/FDA under the expedited review, including eight fixed-dose combination (FDC) formulations (two of which are triple-drug combinations) and eight pediatric formulations. The steady increase in approvals is shown in figure 5. As a side benefit, the process has also expedited the availability in the United States of five generic versions of ARVs whose U.S. patent protection has expired.

In addition to supporting host nations' programs that provide pediatric ART, PEPFAR also has been a leader in expanding a prerequisite to treatment – early infant diagnosis for children under 18 months. Without intervention, approximately half of HIV-positive newborns die before two years of age. PEPFAR supports nations in expanding polymerase chain reaction (PCR) testing of dried blood spots, which require less blood per test than older methods and easily can be transported to central laboratories for testing.

Table 4: Key Policy Changes: Infant Diagnosis	
Country	**Date of policy adoption on infant diagnosis[1]**
Botswana	2006
Côte d'Ivoire	2006
Ethiopia	2005
Guyana	2006
Haiti[2]	-
Kenya[3]	-
Mozambique	2006
Namibia	2005
Nigeria[3]	-
Rwanda	2006
South Africa	2005
Tanzania[2]	-
Uganda	2005/2006[4]
Vietnam	2006
Zambia[2]	-

Footnotes:

[1] Unless otherwise noted, information obtained through correspondence with country teams.

[2] Countries are implementing infant HIV counseling and testing without a policy.

[3] Policy is pending.

[4] Uganda's Counseling and Testing Policy (2005) has a section on Infant Diagnosis, and the Revised PMTCT Guidelines (2006) has sections on Infant Diagnosis and treatment.

PEPFAR has supported country-level policy change to allow PCR-based testing in order to reduce the cost and burden of infant diagnosis. As table 4 shows, most focus countries have now adopted such policies. In some cases, national policy is behind actual implementation, with 14 focus countries reportedly using PCR testing – making accurate diagnosis and management of pediatric ART a growing reality.

The series of maps in figure 6 depicts the steady increase in Emergency Plan support for ART coverage as programs scale up toward the five-year target of treatment support for two million people.

The Emergency Plan is the largest contributor to the Global Fund, providing approximately one-third of all resources to date. The Global Fund has reported support for ART for 770,000 people globally as of the end of 2006; strikingly, 418,000 of those were reported in PEPFAR focus countries.

Table 5: National Treatment Coverage Supported by All Sources			
Country	**% Coverage 2003[1]**	**% Coverage 2006[2]**	**% Change in Coverage**
Botswana	15.2%	80.4%	430%
Côte d'Ivoire	4.1%	24.9%	506%
Ethiopia	1.0%	14.4%	1369%
Guyana	12.6%	64.0%	410%
Haiti	2.9%	23.5%	707%
Kenya	1.5%	35.8%	2214%
Mozambique	1.0%	15.8%	1561%
Namibia	1.3%	64.1%	4871%
Nigeria	2.3%	10.6%	366%
Rwanda	4.4%	61.2%	1278%
South Africa	0.2%	21.4%	10773%
Tanzania	0.1%	14.1%	10905%
Uganda	6.5%	60.3%	834%
Vietnam	14.0%	26.4%	89%
Zambia	0.6%	39.1%	6139%
Total	**1.9%**	**24.3%**	**1212%**

Note:

National treatment coverage includes individuals on treatment as reported by WHO and other multi-lateral agencies and includes all sources of support.

Footnotes:

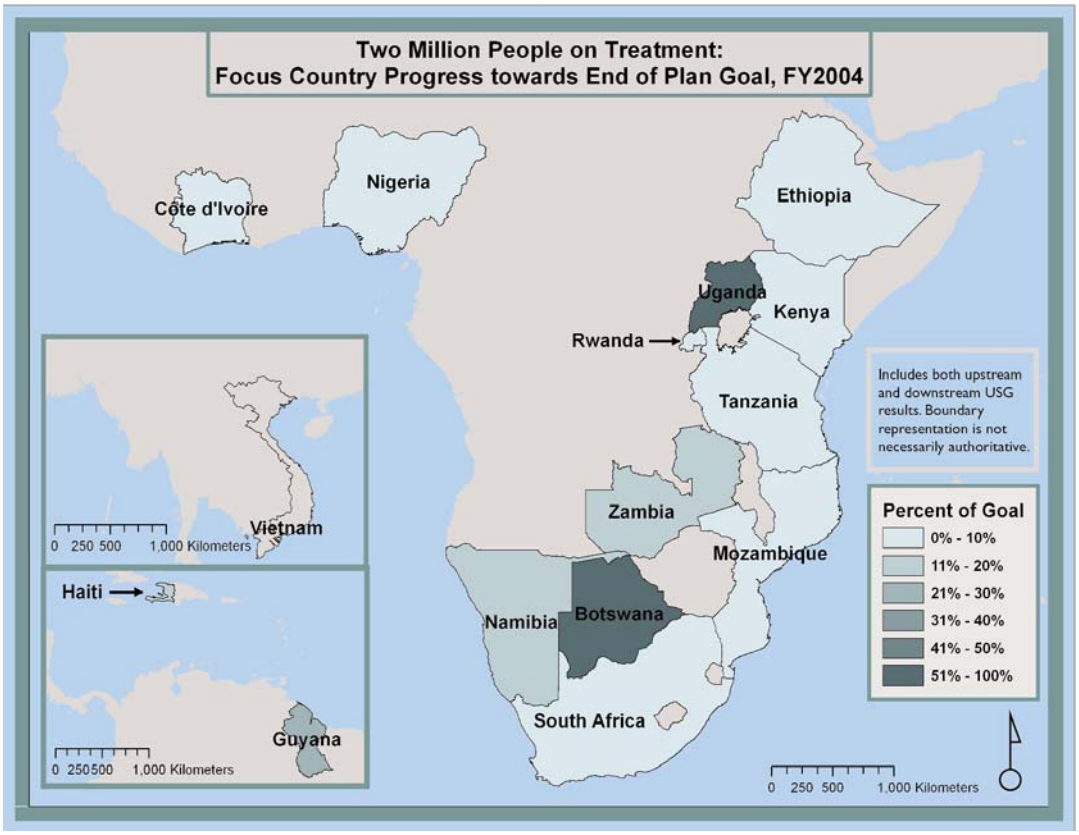
[1] "Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries in 2003," USAID, UNAIDS, WHO, CDC and the POLICY Project, June 2004.

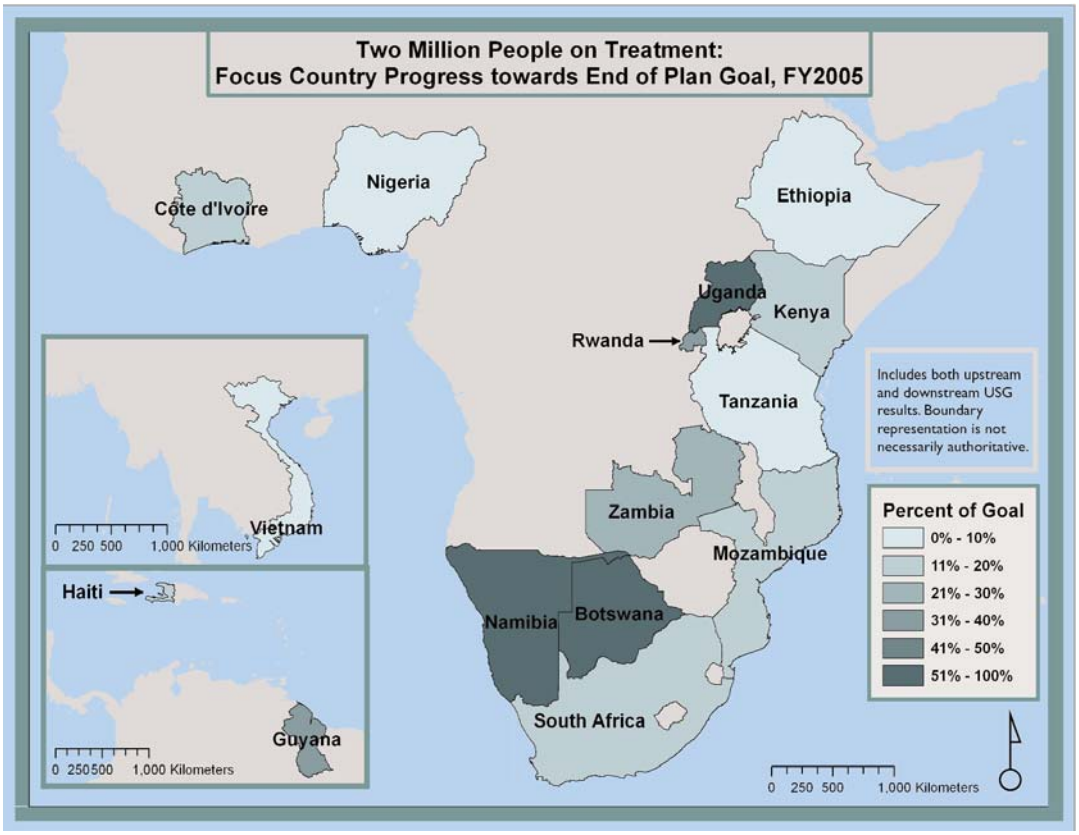
[2] WHO, 2006.

For 2005, it was estimated that 80 percent of those receiving Global Fund support in the focus countries also benefited from Emergency Plan bilateral support; this year, it is estimated that all of them do. This is a testament to close country-level coordination in support of national programs.

Because of the commitment of resources and talented people in-country, many of the focus countries have achieved massive improvements in their national levels of ART coverage in recent years as shown in table 5, and the Emergency Plan has supported their leadership.

Figure 6: Progress in PEPFAR Support for Treatment Coverage in Focus Countries, 2004-2006





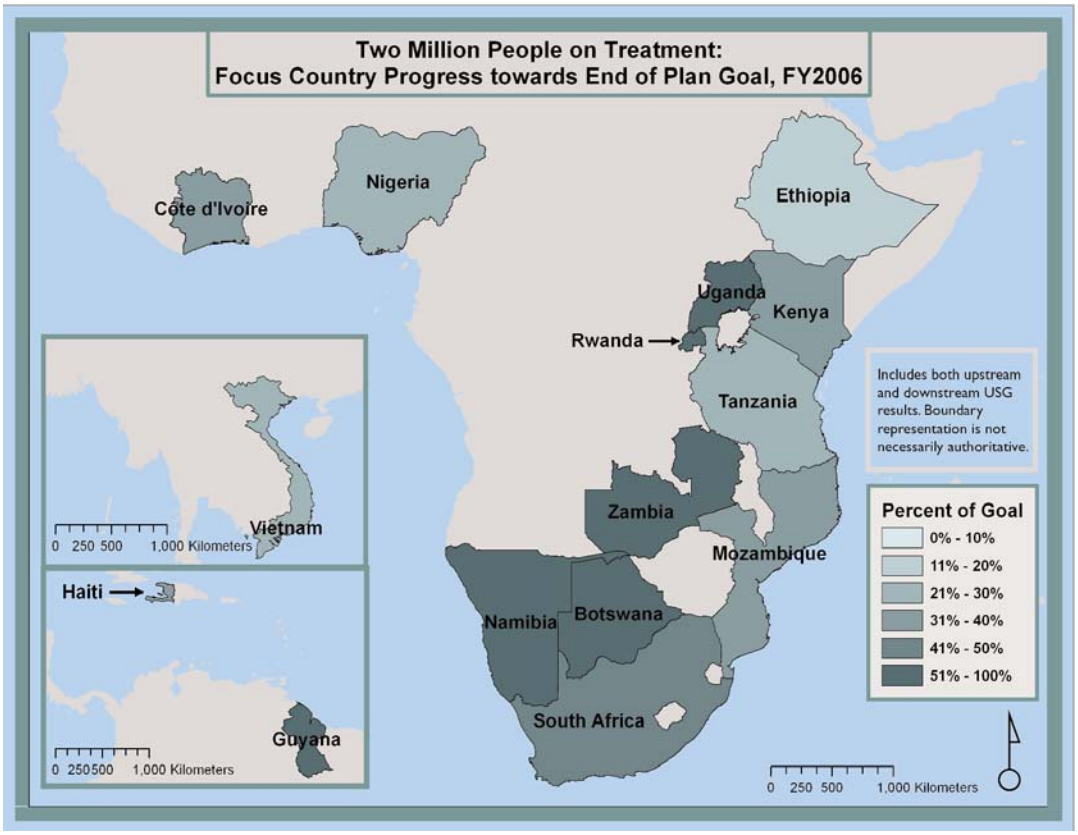


Figure 7: People Receiving ARV Treatment with Support from the President's Emergency Plan for AIDS Relief in Focus Countries through FY2006

EMERGENCY PLAN FOCUS COUNTRY RESULTS = 822,000

INCLUDES
THOSE RECEIVING SUPPORT FROM U.S. BILATERAL PROGRAMS - 100% FUNDED BY THE PRESIDENT'S EMERGENCY PLAN
AND
THOSE RECEIVING SUPPORT FROM THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA – APPROXIMATELY 30% FUNDED BY THE PRESIDENT'S EMERGENCY PLAN

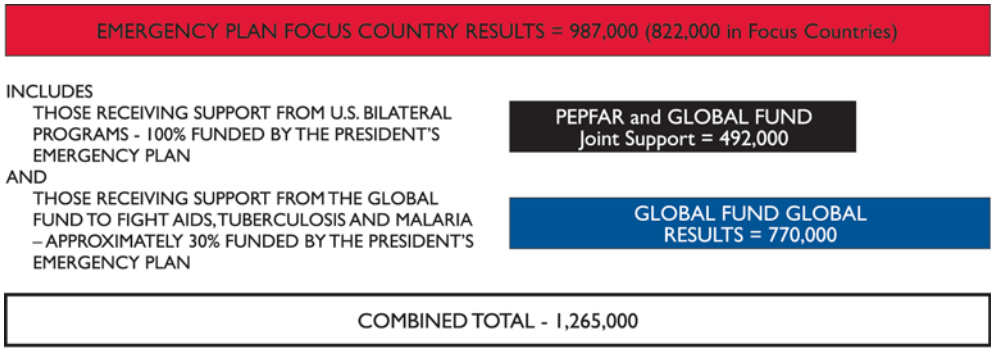
PEPFAR and GLOBAL FUND Joint Support = 418,000

GLOBAL FUND FOCUS COUNTRY RESULTS = 418,000

COMBINED TOTAL - 822,000

Notes: Numbers are rounded off to the nearest thousand. Treatment numbers include upstream and downstream results for the Emergency Plan bilateral programs provided by the Office of the U.S. Global AIDS Coordinator. Treatment results for the Global Fund programs provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria. Overlap estimate based on review of country data with Global Fund and the WHO. Overlap differs by country.

Figure 8: People Receiving ARV Treatment with Support from the President's Emergency Plan for AIDS Relief Globally through FY2006



Notes: Numbers are rounded off to the nearest thousand. Treatment numbers include upstream and downstream results for the Emergency Plan bilateral programs provided by the Office of the U.S. Global AIDS Coordinator. Treatment results for the Global Fund programs provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria. Overlap estimate based on review of country data with Global Fund and the WHO. Overlap differs by country.

The Power of Partnerships: Impact on Care

In addition to efforts to diagnose and treat children infected with HIV, PEPFAR supports host nations' wide-ranging programs to meet the needs of orphans and vulnerable children (OVCs) affected by the pandemic. The following graph shows that, as of September 30, 2006, PEPFAR supported care for approximately two million OVCs (in addition to care for nearly 2.5 million people living with HIV/AIDS).

In addition to scaling up HIV/AIDS programs for OVCs on a larger scale than has been attempted previously, in fiscal year 2006 PEPFAR took an important step forward in ensuring the quality of programs (please see figure 9). OVC programs now are being required to track how many of six key services they provide, and to report accordingly.

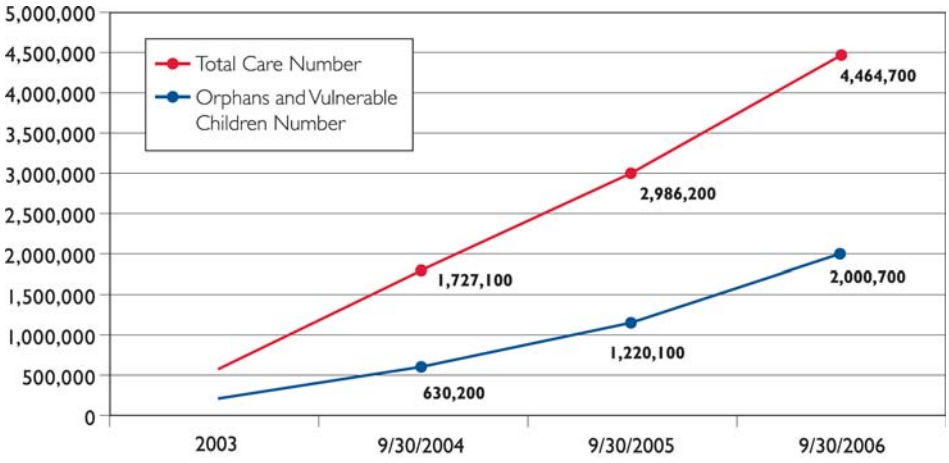
Along with its OVC programs, PEPFAR has scaled up its support for national efforts to provide high-quality care for opportunistic infections related to HIV/AIDS. Especially important in this area is care for HIV/tuberculosis (TB) co-infection, a leading cause of death among HIV-positive people in the developing world. From fiscal year 2005 to fiscal year 2006, PEPFAR nearly doubled funding for HIV/TB, supporting TB treatment for 301,600 HIV-infected patients in fiscal year 2006.

Another key improvement in fiscal year 2006 was the development and dissemination of "preventive care packages" for children and adults living with HIV. These packages can help to keep HIV-positive persons healthy and delay the need for treatment, and were crafted to be adapted to local circumstances. Like many best practices developed by the Emergency Plan, these advances in the area of care for OVCs and people living with HIV/AIDS have the potential to have a wide impact beyond PEPFAR-supported programs. PEPFAR is working to disseminate them broadly.

Knowing one's status provides a gateway for critical prevention, treatment, and care. Millions of people must be tested in order for PEPFAR to meet its ambitious prevention, treatment, and care goals. If countries appropriately target counseling and testing to populations at increased risk of HIV infection – such as TB patients and women seeking PMTCT services – and if health care providers offer coun-

Ambassador Dybul interacts with children at St. Bridget's Preschool in Tonota, Botswana.

Figure 9: Care: Number of Individuals Receiving Care in the 15 Focus Countries
(Orphans and Vulnerable Children and Care for People Living with HIV/AIDS)



Note: 2003 OVC estimate includes all OVCs in focus countries whether or not affected by AIDS.

seling and testing in routine encounters, it is estimated that at least 30 million people will need to be tested in order for PEPFAR to meet its 2-7-10 goals. To the extent counseling and testing is not well-targeted, the number who must be tested in order for PEPFAR to meet its goals will be correspondingly higher. Table 6 shows that PEPFAR supported more than 18 million counseling and testing encounters through fiscal year 2006. Among these, more than 5.7 million encounters were with women seeking PMTCT services, a key population to target.

Malise Swila is breaking new ground in Tanzania, providing HIV counseling and testing to the deaf community.

A key barrier to the universal knowledge of serostatus is the lack of routine testing in medical settings, including TB and sexually transmitted infection (STI) clinics, ANCs, and hospitals. In many focus countries, studies have found that 50 to 80 percent of hospital and TB patients are infected with HIV; many of these patients are in urgent need of treatment. PEPFAR has worked with host nations to build support for the model of routine "opt-out" provider-initiated testing, where, in selected health care settings, all patients are tested for HIV unless they refuse. Several studies presented at the HIV/AIDS Implementers' Meeting in Durban, South Africa (discussed later in this overview) demonstrated the impact this policy change can have. A pilot project in Zimbabwe showed a 54 percent increase in testing rates at urban ANCs after the introduction of routine testing and a 76 percent increase in rural areas. Another study conducted in the maternity ward of a 200-bed hospital in rural Uganda found that moving to routine testing more than doubled the proportion of women discharged from the ward with a known HIV status, from 39 percent to 88 percent.

Table 6: Care: Cumulative Counseling and Testing (C&T) Results, FY2004-FY2006				
	FY2004[1]	FY2005	FY2006	Cumulative C&T to date
Number of women receiving C&T through PMTCT	1,017,000	1,957,900	2,814,700	5,789,600
Number of individuals receiving C&T in other settings	1,791,900	4,653,200	6,426,500	12,871,600
Total	**2,809,900**	**6,611,100**	**9,241,200**	**18,661,200**
Women as a percentage of all individuals receiving C&T in PMTCT and other settings through downstream support				
	66%	**69%**	**71%**	**70%**

Notes:

Numbers may be adjusted as attribution criteria and reporting systems are refined.

Upstream and downstream numbers above 100 are rounded to the nearest 100 and then added to get totals.

Values include the number of individuals reached through upstream contributions to national, regional and local activities such as training, laboratory support, monitoring and evaluation, logistics and distribution systems, protocol and curriculum development and those receiving downstream services at U.S. Government-funded service delivery sites.

The same individual may receive counseling and testing on multiple occasions.

Footnote:

[1]In FY2004 only, it was assumed that 80% of women receiving PMTCT services were counseled and tested.

Table 7: Key Policy Changes: Counseling and Testing		
Country	**Date of policy adoption on provider-initiated testing[1]**	**Date of policy adoption on use of rapid test kits[1]**
Botswana	2003	2006
Côte d'Ivoire	-	2001
Ethiopia	-	2006
Guyana	2006[2]	2004
Haiti	-	-
Kenya	2004	2006
Mozambique	-	2006
Namibia	2004[4]	2005
Nigeria	-	2006[5]
Rwanda	2006	2006
South Africa	-	2006
Tanzania	2006	2006
Uganda	2005	2006
Vietnam	2006	-
Zambia	2005[6]	2005

Footnotes:

[1] Unless otherwise noted, information obtained through correspondence with country teams.

[2] Guyana's provider-initiated testing policy is for labor and delivery wards only.

[3] While Haiti has no official written policy on the use of rapid test kits, the use of rapid test kits is the de facto policy. Haiti's health system adopted rapid test kits early and use of rapid kits is considered routine practice.

[4] Namibia's provider-initiated testing policy is for PMTCT, ANC, and TB only and includes provision for non-laboratory personnel including community counselors to perform rapid HIV testing.

[5] Nigeria adopted an interim testing policy to support the use of rapid tests in 2006 and will draft its final policy after the results of the PEPFAR-supported rapid test assessment.

[6] Zambia adopted a PMTCT-specific provider-initiated testing policy in 2004.

Another key policy trend in many nations that PEPFAR has supported is in favor of the use of rapid HIV tests; use of rapid testing improves the likelihood that those who are tested will actually receive their results. Table 7 illustrates the encouraging recent trends on these issues.

The Power of Partnerships: Building Sustainability

As the name of the President's Emergency Plan frankly acknowledges, HIV/AIDS is a global emergency, and PEPFAR has sought to save as many lives as rapidly as possible. At the same time, it is essential to look to the future and sustaining an effective response. From the beginning, PEPFAR has focused on achieving 2-7-10 in an accountable and sustainable way. Over time, PEPFAR has progressively deepened its activities to ensure a sustainable response by building the capacity of public and private institutions in host nations to lead their responses to HIV/AIDS.

Review of annual COPs includes an evaluation of efforts to increase the number of indigenous organizations partnering with the Emergency Plan. At least one-quarter of PEPFAR resources in fiscal year 2006 were devoted to capacity-building in the public and private health sectors – physical infrastructure, training, and support for workforce. And 83 percent of partners were local organizations, which support more than 15,000 project sites for prevention, treatment, and care.

Reliance on such local organizations, while challenging, is essential for PEPFAR to fulfill its promise to partner with host nations to develop sustainable responses. As another step in the direction of sustainability, COPs for fiscal year 2007 are required to devote no more than eight percent of funding to a single partner (with exceptions made for host government partners, commodity procurement, and "umbrella contractors" for smaller organizations). This requirement will help to expand and diversify PEPFAR's base of partners and facilitate efforts to reach out to new partners, particularly local partners – a key to sustainability.

To increase the number of local organizations, including faith-based and community-based organizations (FBOs and CBOs), that will work under the Emergency Plan, the President launched the New Partners Initiative (NPI) – and the first 23 grants were awarded on World AIDS Day 2006.

Alongside efforts to support community capacity-building, other crucial activities for sustainability include: enhancing the capacity of health systems and health care workers; strengthening quality assurance; improving financial management and accounting systems; building health infrastructure; and improving commodity distribution and control. The Emergency Plan is intensively supporting national strategies to strengthen these critical systems.

For example, PEPFAR's Supply Chain Management System (SCMS) project strengthens systems to deliver an uninterrupted supply of high-quality, low-cost products that will flow through a transparent and accountable system. SCMS's activities include supporting the purchase of lifesaving ARVs, including low-cost generic ARVs; drugs for care for people living with HIV/AIDS, including drugs for opportunistic infections such as TB; laboratory materials such as rapid test kits; and supplies, including gowns, gloves, injection equipment, and cleaning and sterilization items.

Greg Roche

Participants in a stock management training conducted by the Supply Chain Management System (SCMS) in Port-au-Prince, Haiti.

White House photo by Eric Draper

President George W. Bush and Laura Bush meet with leaders of organizations fighting HIV/AIDS in the Roosevelt Room at the White House, on World AIDS Day, December 1, 2006.

The Power of Partnerships: Growing Health Workforce

The building of local capacity depends upon a workforce that can carry out the many tasks and build the systems that are needed. In fiscal year 2006, PEPFAR devoted approximately $350 million to partnerships for workforce and health-system development. This massive effort to support local efforts to build a trained and effective workforce has provided the foundation for the rapid scale-up of prevention, treatment, and care that national programs are achieving. Capacity-building results to date are summarized in table 8.

In addition to training existing health care workers, it is also essential to bring new workers into the health workforce. Policy change to allow task-shifting from more specialized to less-specialized health workers is the one strategy that will have the most significant and immediate effect on increasing the pool of health workers to deliver HIV/AIDS services. Changing national and local policies to support task-shifting can foster dramatic progress in expanding access to prevention, treatment, and care services. The Emergency Plan supports the leadership of its host country partners in broadening national policies to allow trained members of the community – including people living with HIV/AIDS – to become part of clinical teams as community health workers.

Table 8: Emergency Plan Support for Capacity-Building FY2004-FY2006		
	Number of individuals trained or retrained	**Number of USG supported service outlets**
Prevention of Sexual Transmission[1]	863,300	-
Prevention of Mother-to-Child Transmission	85,800	4,863
Prevention of Medical Transmission[2]	85,500	3,848
Provision of Antiretroviral Treatment	100,700	1,912
Provision of Care for Orphans and Vulnerable Children[1]	240,700	-
Provision of Palliative Care for HIV-positive People	216,900	8,019
Provision of Counseling and Testing	69,800	6,466
Total	**1,662,700**	**25,108**

Notes:

Upstream and downstream numbers above 100 are rounded to the nearest 100 and then added to get totals.

Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnotes:

[1] These services are provided in a variety of settings and are often not facility-based.

[2] Service outlets counted under prevention of medical transmission include only outlets that carry out blood safety activities.

The Power of Partnerships: Improving Program Quality

With respect to sustainability, as in other areas, PEPFAR is generating best practices that are being used in the fight worldwide. The U.S. supports full national scale-up of multi-sectoral, results-based, accountable, country-led programs in the 15 focus nations, and the lessons learned from national scale-up are now being shared globally and having an impact far beyond PEPFAR programs.

The Emergency Plan is building the capacity of local people and organizations to evaluate what they are doing and present their findings to their colleagues from around the world. In June 2006, the Emergency Plan convened the first HIV/AIDS Implementers' Meeting in Durban, South Africa. Nearly 1,000 implementers from 50 countries gave more than 500 scientific presentations on their programs, and the vast majority of the presenters were from severely affected nations in Africa, Asia, Eastern Europe, and Latin America. The presenters included representatives from governments and non-governmental organizations, including FBOs and CBOs, and the private sector.

As the Durban meeting demonstrated, constant evaluation to improve programs can be a hallmark of all HIV/AIDS efforts, including those of PEPFAR. Fiscal year 2006 saw the launch of a new program of Public Health Evaluations, including efforts to monitor resistance and toxicities, the effectiveness of various prevention and OVC programs, and many more.

The Power of Partnerships: Creating a Culture of Accountability

With support from PEPFAR, host countries are developing and expanding a culture of accountability that is rooted in country, community, and individual ownership of and participation in the response to HIV/AIDS. Businesses are increasingly eager to collaborate with the Emergency Plan, and public-private partnerships are fostering joint prevention, treatment, and care programs.

This culture of accountability bodes well not only for sustainable HIV/AIDS programs, but also for an ever-expanding sphere of transparency and accountability that represents transformational U.S. diplomacy, as Secretary Rice has described it, in action. While HIV/AIDS is unmistakably the focus of PEPFAR, the initiative's support for capacity-building has important spillover effects that support nations' broader efforts for sustainable development. Organizations whose capacity is expanded in order to meet fiduciary accountability requirements are also in an improved position to apply for funding for other activities or from other sources. Expanded health system capacity improves responses for diseases other than HIV/AIDS. Supply chain management capacity-building improves procurement for general health commodities. Improving the capacity to report on results fosters quality/systems improvement, and the resulting accountability helps to develop good governance and democracy.

A central issue for sustainability is the capacity of host nations to finance HIV/AIDS and other health efforts. At present, their ability to do so on the scale required varies widely. Many deeply-impoverished nations are years from

being able to mount comprehensive programs with their own resources alone, yet it is essential that these countries appropriately prioritize HIV/AIDS and do what they can to fight the disease with locally-available resources, including financial resources. A growing number are doing so. Many other nations do have significant resources, and are in a position to finance much of their own HIV/AIDS responses. Progress is being made by some countries, and a growing number of nations are investing in fighting HIV/AIDS on a scale commensurate with their financial capacity. In some cases, for example, host nations are procuring all or a portion of their own ARVs, while PEPFAR provides support for other aspects of quality treatment. Such developments within hard-hit nations build sustainability in each country's fight against HIV/AIDS.

The Power of Partnerships: The Road Ahead

The people of severely affected nations have accomplished so much in their fight against HIV/AIDS, and the American people are privileged to partner with them through PEPFAR. Yet, we are at the beginning of a long journey. The challenges of this pandemic remain immense, and there is so much more to be done. PEPFAR and its partners recognize the continuing challenges and are confronting them together. Fiscal year 2006 saw a number of critical adaptations, such as the new Public Health Evaluation initiative, enhanced gender programming, improved quality for OVC programs, and much more. In 2007 and beyond, the Emergency Plan will continue to work with its partners to evaluate lessons learned and disseminate best practices to save even more lives – through PEPFAR partnerships and beyond.

Despite the daunting challenges ahead, the United States will remain a partner with host nations in this fight. President Bush's Emergency Plan was the first quantum leap in America's leadership on global HIV/AIDS, and the American people must continue to stand with our global sisters and brothers as they take control of the pandemic and their lives and restore hope to individuals, families, communities, and nations.


UNITED STATES PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF