Celebrating Life:
The U.S. President's Emergency Plan for AIDS Relief

2009 Annual Report to Congress

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South African Hospice Gives Patients and Their Families a Reason to Celebrate Life

The Soweto Hospice in Johannesburg, South Africa, was the last stop made by many HIV-positive South Africans before their deaths. Established as a hospice for the terminally ill, Soweto Hospice provided compassionate care to patients in their final days. Over the years, the hospice lost many patients to HIV/AIDS, which has had a devastating impact on South Africa.

Today, Soweto Hospice is a very different place. Following the introduction of life-saving antiretroviral treatment (ART) supported by the American people through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the hospice has been able to give HIV-positive patients a new lease on life. Patients who were once dying are now living.

"We are trying to get patients to a healthy physical state so they can return to be homemakers and parents of their families," said Ella Danilowitz, the Hospice Associate responsible for the Soweto branch.

Soweto staff members now administer ART, help patients maintain adherence, and provide other medical care and counseling. HIV-positive women who are pregnant are referred to the prevention of mother-to-child HIV transmission program housed within the hospice. Children of patients are thriving at a unique early childhood day care and development center, which the hospice established in the nearby Mapetla suburb.

Soweto Hospice recently opened one of South Africa's first pediatric units to provide specialty care for children living with HIV/AIDS and other life-threatening diseases. This unit has improved the community's attitude towards HIV/AIDS.

"When we opened, people did not want to associate with us. Now they want their children to come here. They see that this is a place where children receive love and care. They learn, get food and medication, and get well enough to return to their homes and go to school," said Nikiwe Dube, the unit's supervisor.

The Soweto Hospice reminds everyone that HIV is no longer a death sentence. To underscore this point, the hospice has turned World AIDS Day — once a time of mourning for the staff and patients — into a day to celebrate life. Thanks to their partnership with the American people, the dedicated staff and patients of Soweto Hospice have proven that the seemingly impossible is possible. And each day, their children, families, and friends celebrate the lives that have been saved.

Cover photo by Reverie Zurba, USAID/South Africa.

CONTENTS

Acronyms and Abbreviations 5

I. Overview: The Role of America's Partnerships in the Worldwide Fight Against HIV/AIDS 7

II. Accountability: Report on PEPFAR Partnerships for Prevention, Treatment and Care 33

Partnerships for Comprehensive Programming 33

Partnerships for Prevention 34

Partnerships for Treatment 45

Partnerships for Care 51

The Future of Partnerships 58

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.

ACRONYMS AND ABBREVIATIONS

ABC	Abstain, Be faithful, correct and consistent use of Condoms
ACILT	African Centre for Integrated Laboratory Training
ACSM	Advocacy, Communication and Social Mobilization
AEI	African Education Initiative
ANC	Antenatal Clinic
ART	Antiretroviral Treatment
ARV	Antiretroviral Drug
BMI	Body Mass Index
CBO	Community-Based Organization
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention (U.S.)
COP	Country Operational Plan
DHS	Demographic and Health Survey
EOC	Emergency Obstetrics Care
FBO	Faith-Based Organization
FDA	Food and Drug Administration (U.S.)
FFP	Food for Peace (USAID)
FHI	Family Health International
FY	Fiscal Year
ITN	Insecticide-Treated Net
HHS	Department of Health and Human Services (U.S.)
IDU	Injecting Drug User
MAT	Medication-Assisted Therapy
MCC	Millennium Challenge Corporation
MDR-TB	Multi-Drug-Resistant Tuberculosis
MoH	Ministry of Health
MOU	Memoranda of Understanding
NGO	Non-Governmental Organization
NIH	National Institutes of Health
NPI	New Partners Initiative
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PCB	Programme Coordinating Board (UNAIDS)

PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief (Emergency Plan)
PHE	Public Health Evaluation
PLWHA	People Living with HIV/AIDS
PMI	President's Malaria Initiative
PMTCT	Prevention of mother-to-child HIV transmission
PPP	Public-Private Partnership
PRH	Office of Population and Reproductive Health (USAID)
SCMS	Supply Chain Management System
STI	Sexually Transmitted Infection
TASO	The AIDS Support Organization
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USDA	Department of Agriculture (U.S.)
USG	United States Government
WFP	World Food Program
WHO	World Health Organization
WJEI	Women's Justice and Empowerment Initiative
XDR-TB	Extensively Drug-Resistant Tuberculosis

Photo by Still Life Projects

In Tanzania, a young woman named Bertha gives back to her community and other people living with HIV/AIDS as a volunteer at Mawenzi Hospital. Bertha explains, "I found out I was HIV-positive two years ago because I was so sick. If it is not these ARVs, I think I was dead long time ago because I use and I am still using these drugs. Now I can do anything. I'm healthy and I'm strong."

I. Overview: The Role of America's Partnerships in the Worldwide Fight Against HIV/AIDS

Introduction: Partnerships Create Hope

For more than 25 years, the global community has witnessed the devastating impact of HIV/AIDS. Until recently, many wondered whether prevention, treatment and care could ever make a measurable impact, particularly in resource-limited settings where HIV was a death sentence.

Just 5 years ago, only 50,000 people living with HIV in all of sub-Saharan Africa were receiving antiretroviral treatment (ART). Recognizing that HIV/AIDS was and is a global health emergency requiring emergency action, President George W. Bush and a bipartisan, bicameral Congress reflected the compassion and generosity of the American people.

Their creation, the U.S. President's Emergency Plan for AIDS Relief (Emergency Plan/PEPFAR), holds a unique place in the history of public health for its ***size and scope***:

- In size, with an original commitment of $15 billion over 5 years, and a final funding level of $18.8 billion, it is the largest international health initiative in history dedicated to a single disease and also the largest development initiative in the world. The first phase of PEPFAR went beyond a commitment to allocating resources to a commitment to achieving results, with ambitious goals to support prevention of 7 million new infections, treatment of 2 million and care for 10 million, including orphans and vulnerable children (OVCs).

- In scope, it is the first large-scale effort to tackle a chronic disease in the developing world. It moves beyond isolated efforts and pendulum swings that led programs to focus on prevention or treatment or care for HIV/AIDS, to sound public health principles — integrated prevention, treatment and care.

The results speak for themselves. On World AIDS Day 2008, President Bush announced that, ahead of schedule, the United States has fulfilled its commitment to support life-saving ART for 2 million people. As of September 30, 2008, the American people have supported ART for more than 2.1 million men, women and children living with HIV/AIDS around the world. Of these, over 2 million people were reached through bilateral programs in PEPFAR's 15 focus countries in sub-Saharan Africa, Asia, and the Caribbean (Figure 1). PEPFAR treatment support is estimated to save 3.28 million adult years of life through September 2009, and many more

Figure 1: Number of Individuals Receiving Antiretroviral Treatment in PEPFAR's 15 Focus Countries

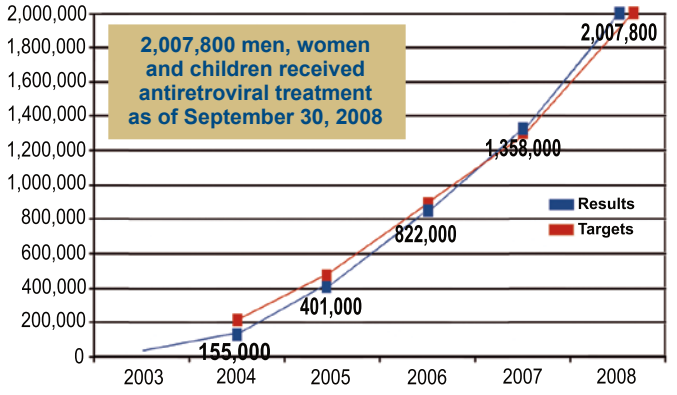


Figure 2: Number of Individuals Receiving Care Services in PEPFAR's 15 Focus Countries

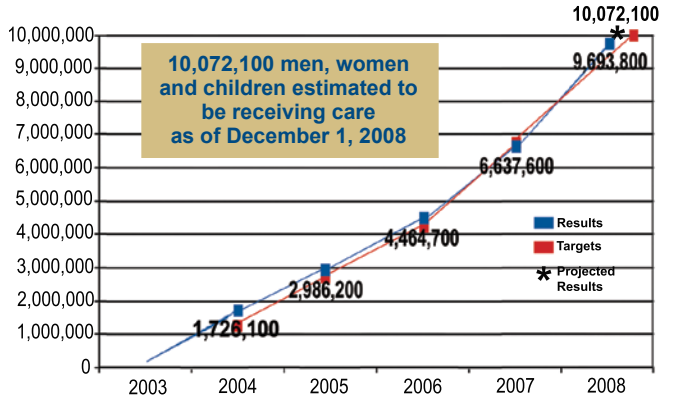


Photo by Still Life Projects

At the Rubengara Clinic and Community Center in Rwanda, people living with HIV/AIDS participate in an income generation project. The women create baskets, bags and other crafts to earn money to help them support their families.

beyond that time frame. These additional years of life are ones in which people can play their vital roles in society as parents, teachers, or caregivers.

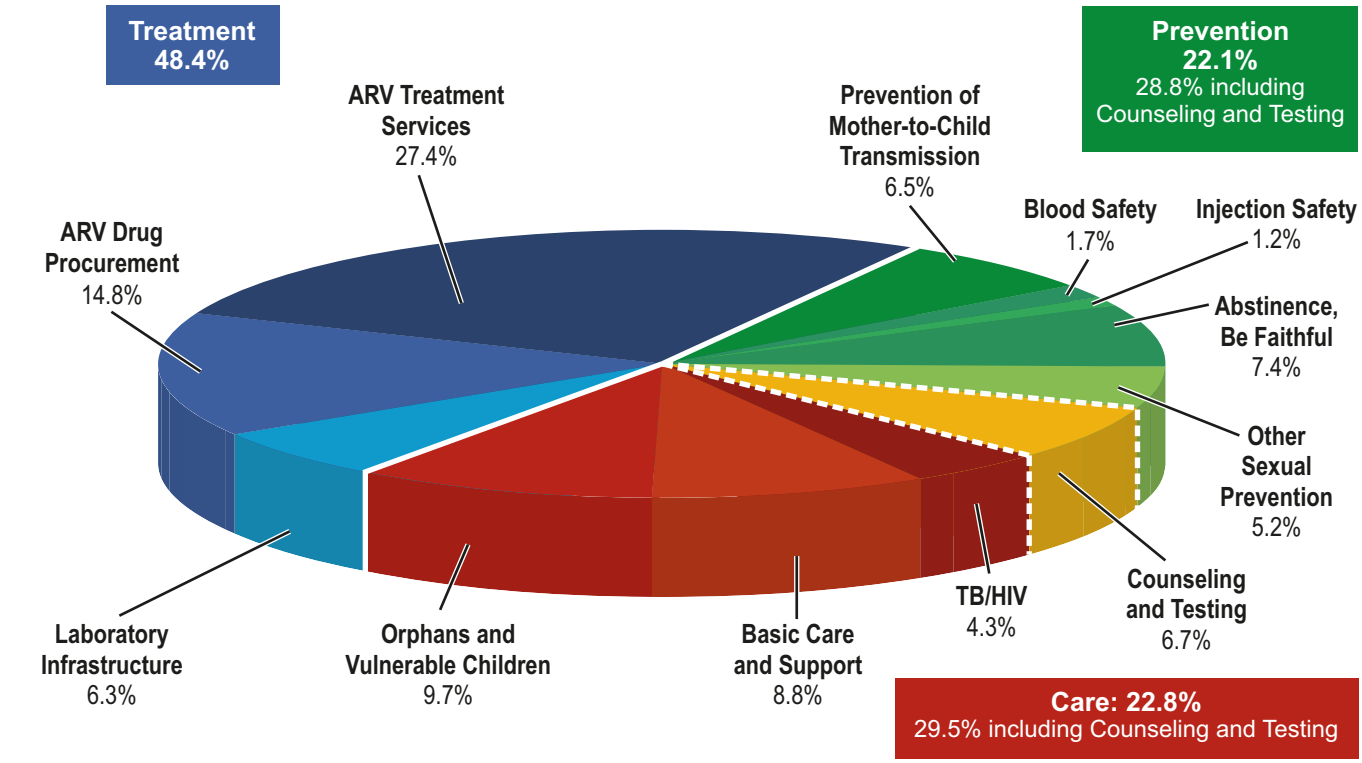
As of September 30, 2008, nearly 9.7 million people affected by HIV/AIDS in PEPFAR's focus countries have received compassionate care, including nearly 4 million OVCs. Using conservative projections, the American people have exceeded the goal of supporting care for 10 million people in PEPFAR's focus countries as of December 1, 2008 (Figure 2). Worldwide, PEPFAR has supported care for over 10.1 million through September 2008.

From fiscal year 2004 (FY2004) through FY2008, PEPFAR has supported prevention of mother-to-child HIV transmission (PMTCT) during nearly 16 million pregnancies. Antiretroviral prophylaxis has been provided to HIV-positive women in over 1.2 million pregnancies, allowing nearly 240,000 babies to be born free of HIV.

In FY2008, PEPFAR-supported programs reached 58.3 million people with support for prevention of sexual transmission using the ABC approach (Abstain, Be faithful, correct and consistent use of Condoms). The U.S. Government (USG) has supplied more than 2.2 billion condoms worldwide from 2004 through December 20, 2008 — as Dr. Peter Piot, former Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS) has said, more than all other developed countries combined. The American people have supported nearly 57 million counseling and testing encounters cumulatively through FY2008. Over the past 5 years, the 14 countries that received PEPFAR support for safe blood programs have seen a decrease in the prevalence of HIV-infected units and are moving progressively closer to meeting their annual demand for safe blood.

The success of PEPFAR is firmly rooted in a commitment to results. Through partnerships between the American people and the people of the countries in which we are privileged to serve — governments, non-governmental organizations (NGOs) including faith-based organizations (FBOs) and community-based organizations (CBOs), and the private sector — we are building sustainable systems and empowering

Figure 3: All Focus Countries: The U.S. President's Emergency Plan for AIDS Relief
FY2008 Planned Funding for Prevention, Treatment and Care



individuals, communities, and nations to battle HIV/AIDS.

Together, we have acted quickly. We have ***obligated 92 percent of the funds*** appropriated to PEPFAR so far, and ***expended or outlayed 68 percent*** of them.[1] Figure 3 depicts the allocation of program resources in the 15 PEPFAR focus countries in FY2008. But success is not measured in dollars spent: it is measured in services provided and lives saved.

On many fronts, the progress to date has been remarkable; as the Institute of Medicine (IOM) noted, PEPFAR has already achieved what many thought was impossible. Encouraged by this progress, Congress came together in a bipartisan way to strengthen the program. On July 30, 2008, President Bush signed into law P.L. 110-293, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, authorizing up to $48 billion over the next 5 years to combat global HIV/AIDS, tuberculosis (TB), and malaria. Through FY2013, PEPFAR plans to work in partnership with host nations to support treatment for at least 3 million people; prevention of 12 million new infections; and care for 12 million people, including 5 million OVCs. To meet these goals and build sustainable local capacity, PEPFAR will support training of at least 140,000 new health care workers in HIV/AIDS prevention, treatment and care.

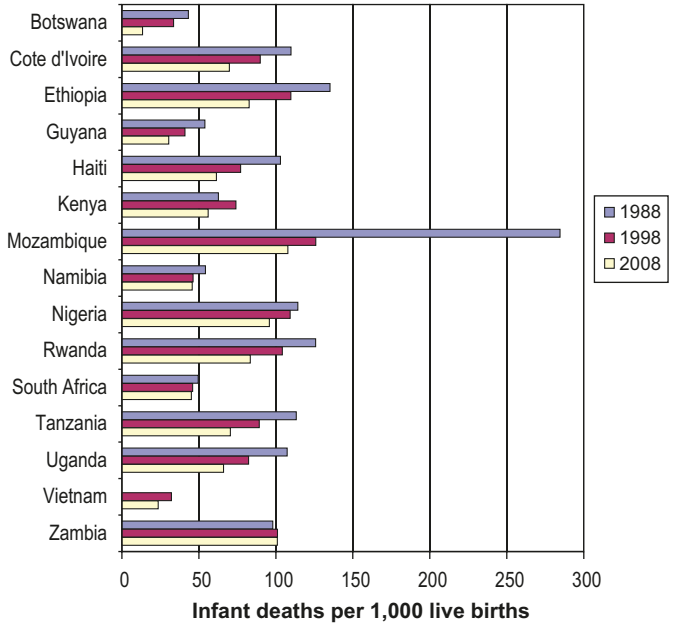
Trends in Health

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

PEPFAR's emphasis on health systems strengthening and local capacity building has benefits that go beyond HIV/AIDS prevention, treatment and care. In the 15 PEPFAR focus countries, home to approximately half of the world's HIV-infected persons, valuable perspective is gained by examining changes in infant mortality over the

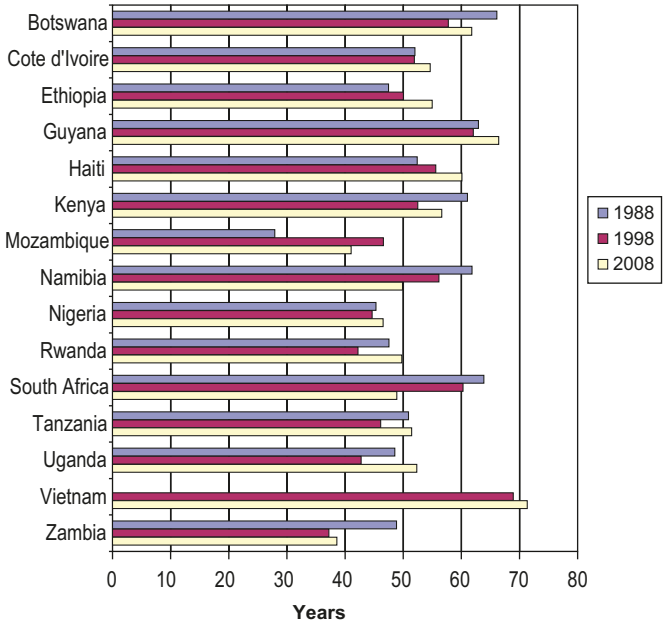
[1] FY2008 fourth quarter data at the time of drafting was still preliminary.

Figure 4: Infant Mortality Rates for PEPFAR Focus Countries: 1988–2008



U.S. Census Bureau, 2008

Figure 5: Life Expectancy at Birth for PEPFAR Focus Countries: 1988–2008



U.S. Census Bureau, 2008

The François Xavier Bagnoud Center, a PEPFAR treatment partner in Guyana, has developed and implemented a clinical mentoring program for local physicians working with Guyana's Ministry of Health. The program works to integrate HIV/AIDS care into doctors' existing clinical practices at local health centers. By bringing clinical mentoring directly into the practices of interested local physicians, the Center is helping to both improve HIV care and treatment and make these services more accessible.

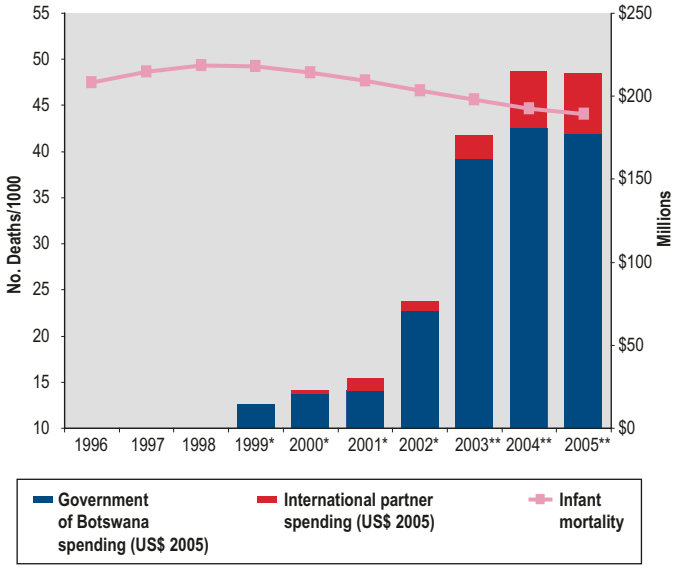
past two decades. As seen in Figure 4, infant mortality has declined in 12 of the 15 focus countries since 1988; in most of them, the decline has been very substantial.

Yet Figure 5 shows that few of these countries have experienced significant improvements in life expectancy. Tragically, many have seen life expectancy drop, with especially dramatic declines 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 those improvements.

In many regions where PEPFAR works, 50 percent or more of hospitalizations are due to HIV/AIDS. In the hardest-hit countries, decades of public health gains have been erased. For example, in Botswana, HIV/AIDS drove an increase in infant mortality despite significant increases in health resources committed by the Government (Figure 6). Similarly, life expectancy in Botswana dropped by 30 percent during the 1990s and early 2000s (Figure 7).

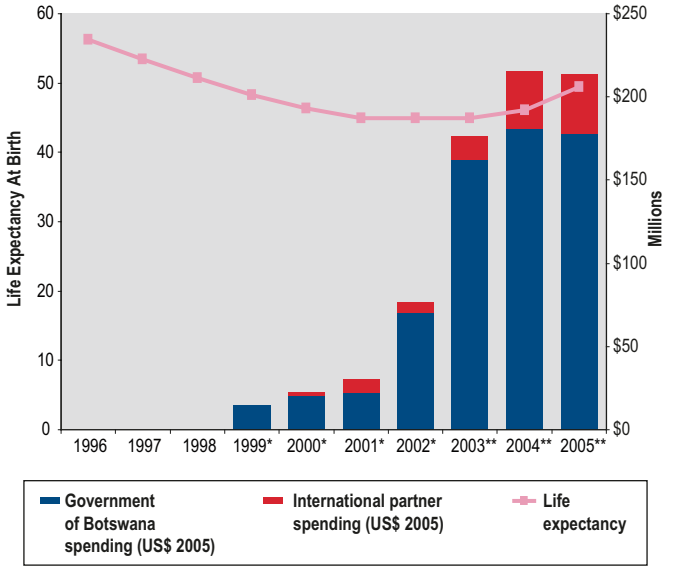
In recent years, the Government of Botswana reports that those trends have turned around, thanks to a major assault on HIV/AIDS funded primarily with its own resources, but also with increased support from international partners. For the first time in more than a decade, infant mortality has decreased and life expectancy has increased there. The correlation between HIV/AIDS programs and improved quality and duration of life for women and children is unmistakable. A study in Uganda shows the expansion of HIV services led to a decrease of 81

Figure 6: Infant Mortality and HIV Spending in Botswana



Infant mortality data provided by U.S. Census Bureau. Funding data is estimated based on data provided by the Government of Botswana and CDC; may not include all funding sources.

Figure 7: Life Expectancy and Spending in Botswana



Life expectancy data provided by U.S. Census Bureau. Funding data is estimated based on data provided by the Government of Botswana and CDC; may not include all funding sources.

percent in non-HIV infant mortality, in part because the number of children orphaned by HIV/AIDS decreased by 93 percent. In other words, parents, including many mothers, are staying alive.

The good news is that growing evidence shows that aggressively confronting HIV/AIDS has a broad impact on the overall health of populations. It is clear that an effective response to the unique challenge of HIV/AIDS is necessary for real progress on health in the developing world. The data are increasingly compelling; as countries scale up their HIV/AIDS prevention, treatment and care programs, they are making progress toward reversing the course of the epidemic. Their efforts are paying off as life expectancy once again begins to rise and infant mortality continues to fall.

Trends in HIV/AIDS

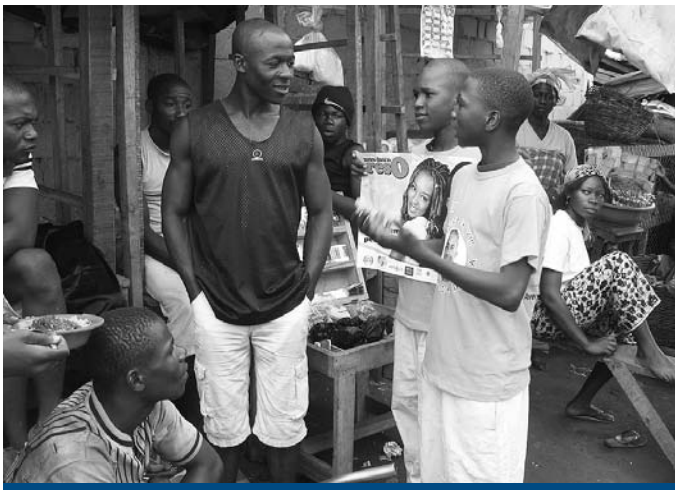
UNAIDS has revised its estimate of the number of people living with HIV/AIDS worldwide downward to 33 million from a previous estimate of 39.5 million. For the most part, the revision reflects the strengthening of HIV surveillance capacity over the past few years, as countries have implemented population-based surveys (in many cases with PEPFAR support) to supplement the antenatal clinic (ANC) surveillance previously used to estimate prevalence. Even with the new prevalence estimates, however, the number of people living with HIV/AIDS worldwide in 2007 was roughly 4.2 million more than in 2001. Prevention remains the central challenge.

Prevention

Sexual transmission

Of the countless recent developments in the global fight against the pandemic, perhaps the most important is the growing number of nations in which there is clear evidence of declining HIV prevalence as a result of changes in sexual behavior. According to UNAIDS' *2008 Report on the Global AIDS Epidemic*: "In sub-Saharan Africa, most national epidemics have stabilized or begun to decline." Zimbabwe, Botswana, Malawi, and Zambia are among those that have seen declines in national prevalence. The report also emphasizes, however, that although most sub-Saharan epidemics have stabilized, they have often done so at high prevalence levels. The report continues: "The rate of new HIV infections has fallen in several countries, although globally these favourable trends are at least partially offset by increases in new infections in other countries."

A key trend in HIV/AIDS prevention is the growing importance of addressing HIV-discordant regular partnerships as a means for transmission. According to Uganda's 2005 National HIV Survey, approximately 50 percent of new infections there occurred within discordant regular partnerships. Many HIV-discordant



Launched in 2006, the PEPFAR-supported Sports for Life program uses soccer as a vehicle to teach Ivoirian youth ages 10-14 how to prevent HIV. Working in collaboration with the Ministry of Education extra-curricular program, Sports for Life has trained 146 coaches and 1,823 peer educators at 48 sites. More than 18,000 young people have been reached through community outreach, and 24,000 youth have been exposed to HIV/AIDS prevention messages during soccer tournaments. In 2008, Sports for Life became the first francophone program to win the Africomnet Award for best multimedia HIV/AIDS strategy in Africa.

couples do not know their HIV status. Several studies in Africa have shown that provision of voluntary counseling and testing for couples reduces HIV transmission by 56 percent and that consistent condom use in discordant couples is associated with an 80 percent reduction in HIV transmission. However, the rate of condom usage in regular partnerships remains low. In Uganda, for example, condom use rose from 0 percent in the early 1990s to 1.9 percent in the late 1990s. Despite massive provision of condoms by the USG and others, increasing usage has proven difficult, even when couples know their HIV status. A promising new prevention approach is safe medical male circumcision, which studies have shown lowers transmission rates where the man is the HIV-negative partner. Discordant couples represent an important opportunity for prevention, so further innovation is needed to address this vulnerable population. For example, antiretroviral (ARV) medications have the potential to be used either as pre-exposure prophylaxis for the HIV-negative partner, or to reduce the level of HIV in the positive partner, thereby reducing the transmission rate in discordant couples.

For all populations, multiple concurrent partnerships remain a significant prevention challenge. On average, an African's number of life-time partners is comparable to that of an American or a European. However, in some areas multiple concurrent partnerships, which could promote more rapid spread of HIV, are common. The challenges of multiple concurrent partnerships parallel those of discordant couples. Data show that decreases in the number of sexual partners — the "B" in "ABC" — could have a significant impact on HIV transmission. This issue will continue to be a key focus for PEPFAR.

As the epidemic changes, the global community must constantly adapt and improve its programs. One of the central themes of PEPFAR continues to be "Knowing Your Epidemic" — understanding where, why and in whom infections are occurring, both in terms of geography and in terms of vulnerable populations, and tailoring programs accordingly. An HIV prevention program in Vietnam, where the epidemic is largely concentrated among injecting drug users (IDUs) and people in prostitution and their clients, requires a different approach from a prevention program in Uganda, where most infections occur through sexual partnerships in the general population (and, increasingly, within discordant couples).

Regardless of the key factors in transmission, in the continued absence of an effective vaccine or microbicide, behavior change must remain the keystone of HIV prevention success. Even with the recent advances in prevention related to male circumcision, maintaining behavior change is essential. Armed with data from UNAIDS and others showing encouraging trends, PEPFAR is promoting life skills and comprehensive HIV prevention programs beginning with the very young, because it is easier to influence behavior if educational programs begin early. Life skills and HIV prevention programs teach youth to respect themselves, to respect others, including the opposite sex, and to practice personal responsibility. Such programs are being scaled up nationally, both in- and out-of-school, in PEPFAR countries. In many countries, adults continue to face elevated risk of HIV infection, and PEPFAR is supporting the expansion of programs for them as well. PEPFAR prevention programs target different age groups with interventions tailored to the risks they face, recognizing that effective prevention is a life-long matter.

Prevention of mother-to-child transmission

Mother-to-child transmission remains the leading source of child HIV infections, and providing PMTCT remains an essential challenge. According to UNAIDS, the global number of children who became infected

When an HIV-positive woman is having trouble accepting her HIV status, it affects the uptake of services to prevent the spread of HIV from mother to child. Family support groups can provide psychosocial support for HIV-positive pregnant women and their families as part of a comprehensive care package. Through the PEPFAR-supported International Center for AIDS Care and Treatment Program (ICAP) in Tanzania, HIV-positive pregnant and postpartum women, along with their spouses or partners, are recruited to participate in family support group meetings. These bimonthly meetings are held at the reproductive and child health clinic during antenatal care days, and involve health talks and other peer support activities. Family support groups have now been established in 16 health facilities, three regional hospitals, eight district hospitals, four health centers, and one outreach site in regions served by ICAP. These groups empower HIV-positive parents to live positively and improve health outcomes. In the words of a family support group member, "I feel so free, I think my CD4 count is rising with my happiness."

with HIV has dropped slightly, from 460,000 in 2001 to 370,000 in 2007.

PEPFAR supports host nations' efforts to provide PMTCT programs, including HIV counseling and testing for all women who attend ANC, and sharply increased its PMTCT resources in FY2008. PEPFAR has supported PMTCT interventions for women during nearly 16 million pregnancies to date, providing antiretroviral prophylaxis for over 1.2 million HIV-positive pregnancies, and preventing an estimated 237,600 infections of newborns.

Despite significant resources from PEPFAR, levels of PMTCT coverage continue to vary from country to country. While all PEPFAR focus countries have scaled up services significantly in recent years, the results in some countries remain disappointing. A central obstacle in many nations is failure to fully implement policies allowing "opt-out," provider-initiated counseling and testing, under which all women who visit ANCs routinely receive voluntary HIV testing unless they decline. Nations that have adopted and implemented opt-out testing have dramatically increased the rate of uptake among pregnant women, from low levels to around 90 percent at many sites. Under the highly successful national program in Botswana, where approximately 13,000 HIV-infected women give birth annually, the country has increased the proportion of pregnant women being tested for HIV from 49 percent in FY2002 to 86 percent in FY2008. This type of change can be seen in other countries as well. It reflects a combination of political leadership, and implementation of opt-out and HIV rapid testing. Without these changes in policy and their successful implementation, success similar to that achieved by Botswana is unlikely to occur.

Treatment

AIDS is still among the most deadly infectious diseases in the world. In sub-Saharan Africa, the epicenter of the pandemic, it is the leading cause of death. More than 22 million of those infected — more than two thirds of all people living with HIV/AIDS — live in the region, and approximately 1.7 million people die of AIDS there each year, more than three-quarters of the global total.

However, there is new reason for hope. On a global basis, UNAIDS also estimates that the number of people dying of AIDS-related causes has declined in recent years, from 2.2 million in 2005 to 2.1 million in 2007. This is the first time such a decline has occurred, and the change is due largely to the increased availability of ART — though improved prevention and care programs have likely contributed as well. PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) report supporting treatment for a collective total of 2,952,600 persons as of September 2008.

In the focus countries, continued scale-up of ART has led to massive improvements in coverage rates since the beginning of the program (Table 1). In 2003, less than 2 percent of the populations in need of ART received treatment. Just 5 years later, the coverage rate has increased to 38 percent (Range: 27 percent–95 percent). (It is important to note that comparisons cannot be made between treatment coverage estimates published in the 2008 Report to Congress and those published in this 2009 report. The differences are largely the result of refinements in the UNAIDS methodology used to estimate the number of HIV-positive people who are

Table 1: National Treatment Coverage Supported by All Sources

Country	% Coverage 2003[1]	% Coverage 2008[2]	% Change in coverage (2003–2008)
Botswana	15.2%	93%	514%
Cote d'Ivoire	4.1%	27%	548%
Ethiopia	1.0%	39%	3838%
Guyana	12.6%	53%	326%
Haiti	2.9%	49%	1587%
Kenya	1.5%	49%	3057%
Mozambique	1.0%	32%	3246%
Namibia	1.3%	95%	7269%
Nigeria	2.3%	28%	1145%
Rwanda	4.4%	88%	1882%
South Africa	0.2%	32%	16335%
Tanzania	0.1%	33%	25527%
Uganda	6.5%	41%	542%
Vietnam	14.0%	37%	161%
Zambia	0.6%	51%	8005%
Total	**1.9%**	**38%**	**1957%**

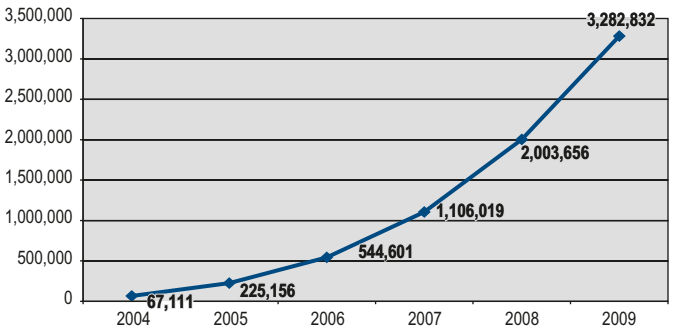
Note:
National treatment coverage includes individuals on treatment as reported by WHO and other multi-lateral agencies and includes all sources of support.

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] Coverage rates were calculated by dividing PEPFAR program (upstream and downstream) results by the estimated number of people eligible for treatment in 2007. The estimated number of people eligible for treatment is taken from "Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Heath Sector, Progress Report, 2008."

Figure 8: Estimated Cumulative Years of Life Gained through FY2009 Due to PEPFAR Support for ART in Focus Countries



Note: Estimates were obtained using final country Spectrum files from UNAIDS and Spectrum version 3.2 , incorporating modeling changes recommended by the UNAIDS/WHO Reference Group on Estimates, Modeling and Projections in 2006 and by new data identified in the 2007 UNAIDS regional workshops on HIV estimates. Total person-years-of life added are based on the actual number of persons on ART as of September 30, 2008 and projected numbers of people to be on treatment for FY2009.

Photo by Arne Clausen

Ambassador Mark Dybul, PEPFAR Coordinator (center), visited the Reach-Out Mbuya Kinawataka Clinic in Uganda on June 4, 2008. Reach Out is a faith-based organization that started in May 2001 with 14 clients, and now cares for more than 3,000 HIV-positive clients and their families. The program provides antiretroviral treatment to more than 1,600 men, women and children. Care and support is mainly provided by community volunteers, 70 percent of whom are also HIV-positive.

eligible for ART, rather than trends in the pandemic itself.[2])

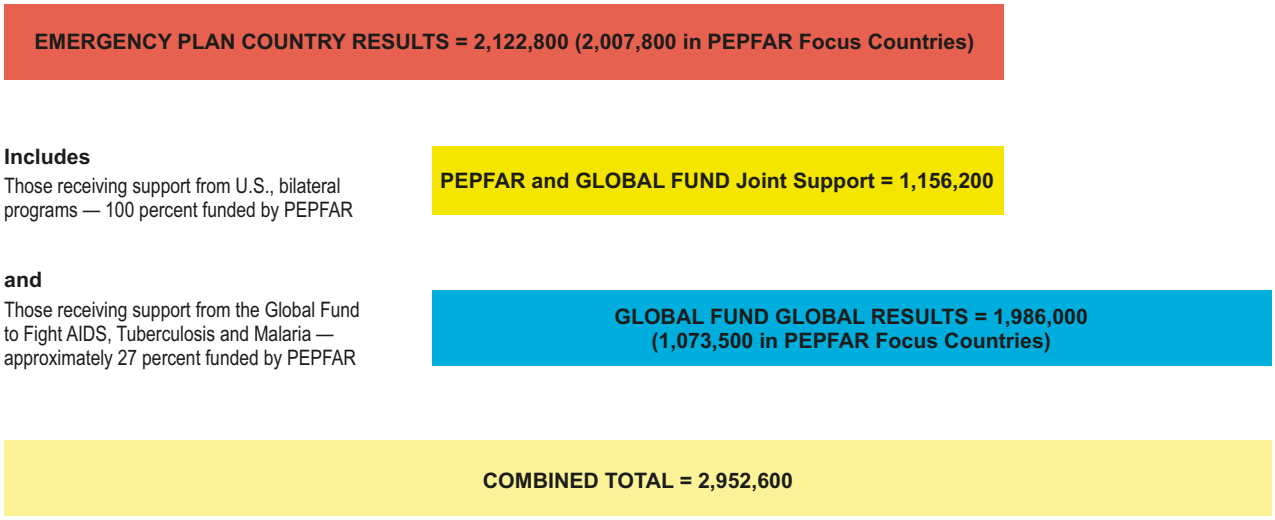
Data on morbidity and mortality naturally lag behind expansions of treatment. However, in Botswana, where former President Festus Mogae provided early leadership for national treatment scale-up beginning in 1999, a treatment-driven decline in adult mortality has already begun to occur.

Lives prolonged through treatment benefit not only those on treatment. The ultimate measure of treatment is the daily impact on individual lives, and therefore on their families, communities and nations. Perhaps the best way to assess the impact of treatment is to estimate its effect on peoples' life spans. Unlike treatment for malaria or TB, treatment for HIV/AIDS cannot cure people, only extend their lives. To reflect this, PEPFAR measures the impact of its treatment programs through "life-years saved" rather than "lives saved" — a small but important distinction. As Figure 8 shows, PEPFAR support for treatment in the focus countries is estimated to save nearly 3.28 million adult years of life through the end of September 2009 (as many as were saved by treatment in the United States from 1989 through 2006). Undoubtedly, this will provide many additional years in which people can play their vital roles for their loved ones.

Along with its bilateral support for treatment programs, PEPFAR is also the largest contributor to the Global Fund, providing approximately 27 percent of all resources to date. The Global Fund has reported support for treatment

[2] As noted in the 2007 AIDS epidemic update published by UNAIDS, "The major elements of methodological improvements in 2007 included greater understanding of HIV epidemiology through population-based surveys, extension of sentinel surveillance to more sites in relevant countries, and adjustments to mathematical models because of better understanding of the natural history of untreated HIV infection in low- and middle- income countries." The report continues: "Because estimates of new HIV infections and HIV-associated deaths are derived through mathematical models applied to HIV prevalence estimates, new estimates of HIV incidence and mortality in 2007 also differ substantially from earlier assessments."

Figure 9: People Receiving ARV Treatment with Support from PEPFAR Globally Through FY2008



Notes: Emergency Plan numbers are rounded off to the nearest hundred. Treatment numbers include upstream and downstream results for the Emergency Plan bilateral programs. Individuals outside of the focus countries receiving treatment as a result of the USG's contribution to systems strengthening beyond those counted as receiving direct USG support are not included in this total. Treatment results for the Global Fund programs are provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria, and are rounded off to the nearest hundred. Overlap estimate based on review of country data with Global Fund and the WHO.

for 1,986,000 million people globally as of the end of 2008, of whom 1,073,000 were reported in PEPFAR focus countries (Figure 9).

Care

As the pendulum on HIV/AIDS interventions swings between prevention and treatment, it is often care that is lost. Yet care is a critical element of a truly comprehensive approach to fighting HIV/AIDS. As defined within PEPFAR, there are three key dimensions to care: care for OVCs; care and support (other than ART) for people infected with or affected by HIV/AIDS; and HIV counseling and testing (which has been counted as Care during the first phase of PEPFAR, but will be counted as part of Prevention for future years). Despite significant progress by PEPFAR in all three areas, much more needs to be done.

Kami, South Africa's popular Takalani Sesame television and radio character, is a 5-year-old orphan who is also the world's first HIV-positive Muppet. Children were delighted when Kami visited the Soweto Hospice and the Mapetla Daycare Centre to inspire them to "live happily ever after."

Orphans and vulnerable children

Even the best OVC program cannot replace parents. Because HIV/AIDS predominantly affects people of childbearing age, its impact on children, extended families, and communities is devastating. If a child's parent dies of AIDS, the child is three times more likely to die, even if he or she is HIV-negative. Besides increased risk of death, children whose parents have died of AIDS face stigmatization and rejection, and often suffer from emotional distress, malnutrition, inadequate health care, poor or no access to education, and a lack of love and care. They may also be at high risk for labor exploitation, sex trafficking, homelessness, and exposure to HIV. Extended families and communities in highly affected areas are often hard-pressed to care for all the children in need.

In families and communities affected by both HIV/AIDS and poverty, there are many children who are not orphans, but who have been made more vulnerable by HIV/AIDS. For example, children whose parents are chronically ill with HIV/AIDS may instead become

caregivers for parents and younger siblings, dropping out of school and assuming the responsibilities of the head of the household. Research indicates that children who care for sick and dying parents are among the most vulnerable.

The best way to support children is to keep parents alive and healthy through effective HIV prevention and treatment. In order to capture the role that treatment programs can play in protecting children from orphanhood, PEPFAR has developed a methodology to estimate the number of orphans averted through treatment programs. Through FY2008, the number is nearly 1.6 million.

Through FY2008, in addition to preventing orphanhood, PEPFAR helped to mitigate the negative social and developmental impact of HIV/AIDS for over 4 million OVCs worldwide up from 630,000 in FY2004. Yet the number reached still falls far short of the need. Although there is uncertainty around OVC estimates in light of UNAIDS' revised HIV prevalence estimates, by 2010, the number of children orphaned by AIDS globally may exceed 20 million, and the number of other children made vulnerable because of HIV/AIDS may be more than double that number.

In addition to scaling up HIV/AIDS programs for OVCs on a larger scale than has been attempted previously, PEPFAR has also sought to strengthen the quality of OVC programs. OVC programs must now report not only on how many of seven key services they provide but also must strive to ensure that these services are making a difference in the lives of children served. Among the areas of support for OVCs in PEPFAR programs are support for food and nutrition and for education. PEPFAR has invested in these areas, and linked to other USG programs addressing these needs.

Care and support for people infected with or affected by HIV/AIDS

The term "care and support" refers to the wide range of services other than ART offered to people living with HIV/AIDS (PLWHA) and other affected persons, such as family members. Care and support comprises five categories of services: clinical (including prevention and treatment of opportunistic infections [OI] and AIDS-related malignancies, and pain and symptom management), psychological, social, spiritual, and preventive services. These services may be provided

In Chimbalanga village in Southern Malawi, the PEPFAR-supported Makhanga home-based care group is making a positive impact in many lives. One of the group's beneficiaries is Gertrude Makasu, a widow with two young children. After receiving voluntary counseling and testing, Gertrude learned that she was co-infected with tuberculosis (TB) and HIV. The home-based care group helped Gertrude register for monthly food rations and have her TB treated. With material and psychosocial support from the group, her health improved. Today, home-based care volunteers continue to visit and counsel Gertrude on living positively with HIV/AIDS.

in facility-, community-, or home-based settings. Care and support is vitally important throughout the lifespan of individuals infected with HIV, starting at the time of diagnosis.

The change in nomenclature from "palliative care" to "care and support" was designed to better describe the broad scope of services provided by PEPFAR, while allowing a more accurate application of "palliative care," as defined by the World Health Organization (WHO). The principles of palliative care remain a priority within PEPFAR; as defined by WHO, palliative care focuses on improving the quality of life for patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering with a focus on assessment and treatment of pain and other symptoms.

An often-overlooked reality of HIV/AIDS care is that many people infected with HIV at a given time do not meet the clinical criteria for ART. Therefore, it is critical to establish programs and services for HIV-positive people that address the needs of those not yet on treatment. A key aspect of caring for PLWHA is the provision of regular clinical and laboratory monitoring to ensure that patients receive treatment promptly once they are eligible. Studies show that patients who start treatment late, often when their immune systems are already severely

compromised and they have serious OIs, do not fare as well as those who start on treatment promptly once they are eligible. Quality care and support services include regular monitoring for treatment eligibility and prompt initiation of treatment when appropriate, which has been shown to reduce HIV-associated illnesses and deaths.

Care and support programs provide a platform for a range of services to allow PLWHA to stay healthy and delay the need for treatment. Services include the five broad categories noted previously; thus care and support may range from supporting income-generating activities to provide economic stability, to providing compassionate end-of-life care. PEPFAR is encouraging countries to work toward providing all HIV-positive individuals with care and support, including provision of a "basic preventive care package" that provides an array of life-saving interventions, such as insecticide-treated bed nets (ITNs), water purification systems and cotrimoxazole prophylaxis. Finally, programs support HIV-positive people — many of whom are in HIV-discordant partnerships — through "prevention with positives" programs which provide them with information and condoms so they can take appropriate steps to avoid infecting others.

PEPFAR has scaled up its support for national efforts to provide high-quality care for OIs related to HIV/AIDS. Co-infection with TB is a leading cause of death among HIV-positive people in the developing world and multi-drug-resistant (MDR) and extensively drug-resistant (XDR) TB are growing threats. PEPFAR increased its funding for HIV/TB more than five-fold, from $26 million to over $140 million, from FY2005 to FY2008.

Counseling and testing

As PEPFAR scales up confidential counseling and testing programs, addressing policy and implementation constraints around testing is essential for success in prevention, treatment, and care. Knowing one's status provides a gateway to critical prevention, treatment, and care services. Since their inception, PEPFAR programs have supported testing for nearly 57 million people, including nearly 16 million pregnant women in PMTCT settings. Impressive as these results are, continued success depends on widespread testing in medical settings, including TB and sexually transmitted infection (STI) clinics, ANCs, and hospitals. People in these settings are far more likely than the general population to be HIV-positive, and to need care, treatment and personalized prevention messages which can be provided in counseling and testing encounters. PEPFAR has worked with host nations to build support for the "opt-out" model of provider-initiated counseling and testing for patients in these settings. With the addition of the use of rapid HIV tests, providers are able to return test results the same day, improving the likelihood that those tested will actually receive their results. As noted previously, during the first phase of PEPFAR, funding for counseling and testing was counted as part of Care; during the second phase, it will be counted as part of Prevention.

Social Impact of HIV/AIDS

HIV/AIDS is more than just a health issue. It is among the most serious economic development and security threats of our time — one reason why the United States and PEPFAR host nations have made addressing this epidemic a priority. As President Bush said at the 2008 White House Summit on International Development, "America is committed — and America must stay committed — to international development for reasons that remain true regardless of the ebb and flow of the markets. We believe that development is in America's security interests. We face an enemy that can't stand freedom. And the only way they can recruit to their hateful ideology is by exploiting despair — and the best way to respond is to spread hope."

Unlike many diseases, HIV/AIDS predominantly affects people between the ages of 15 and 49 years, the most productive and reproductive years. In the hardest-hit countries, the epidemic is taking a heavy toll on parents, teachers, health care workers, bread-winners, and peacekeepers and is rending the social fabric of communities, nations, and a continent. This is a dangerous mix that promotes hopelessness and despair, and is conducive to breeding extremism.

Economic impact

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 due to HIV/AIDS. The International Labor Organization (ILO) has estimated that 41 percent of worldwide 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 pandemic, 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. The pandemic is not only affecting current growth, but it also threatens the future economic prosperity of countries that are particularly hard-hit by the disease because of its devastating impact on teachers. A study in the late 1990s, for example, reported that in Zambia the equivalent of two-thirds of each year's newly trained teachers were being lost to HIV/AIDS.

Impact on peacekeepers

Sergeant First Class Ibo Zeti Jean was diagnosed with HIV in 2001; however, he did not disclose his status out of fear that it would jeopardize his military career. After attending an HIV education session on base, Sergeant Ibo decided to join Espoir FANCI, Côte d'Ivoire's only non-governmental organization for military personnel living with and affected by HIV. With PEPFAR support, Espoir FANCI has helped provide care and support for 632 people living with HIV/AIDS, including 329 women.

Many nations suffer from high HIV prevalence among defense forces, losing their soldiers — including their leadership — to AIDS. Militaries are fundamental to peacekeeping and protecting civilian populations, but 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 7 percent for those deployed for 1 year to 10 percent for those deployed for 2 years and to more than 15 percent for those deployed for more than 3 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 was estimated to account for 70 percent of military deaths, and prevalence in the armed forces has been estimated at between 17 percent 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.

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.

PEPFAR: One Element of a New Era in Development

PEPFAR is the largest international public health initiative aimed at a single disease that any nation has ever undertaken. It represents a bold change from traditional thinking about HIV/AIDS and development, and is part of a new era of partnerships for international development.

Under the leadership of President Bush, and with the bipartisan support of Congress, this new era — with a particular focus on Africa — represents both a massive commitment of treasure and a strengthened sense of compassion for those most in need. The United States is changing the paradigm for development, rejecting the flawed "donor-recipient" mentality and replacing it with an ethic of partnership that emphasizes country ownership, good governance, and accountability.

With support from PEPFAR, a new public health laboratory opened in Guyana in July 2008. The National Public Health Institute is expected to become a national and regional center of excellence for lab standards and research in Guyana.

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."

In addition to PEPFAR, President Bush has presided over a near tripling of support for development worldwide, and a quadrupling of resources for Africa, through the creation of innovative programs like the Millennium Challenge Corporation (MCC), the President's Malaria Initiative (PMI), the Women's Justice and Empowerment Initiative (WJEI) and the African Education Initiative (AEI). The United States has also more than doubled trade with Africa and provided 100 percent debt relief to the poorest countries.

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

While PEPFAR is an important part of connecting the development dots, it does not — and could not — replace the United States Agency for International Development (USAID), MCC, PMI, or any of its sister initiatives or agencies. To respond effectively to the many interrelated causes and effects of the epidemic, PEPFAR must integrate with other development programs as part of a comprehensive approach. Nearly every person affected by HIV/AIDS, and also their families and the broader communities in which they live can benefit from additional food support, greater access to education, economic opportunities and clean water.

Linking PEPFAR with food and nutrition

In FY2008, PEPFAR continued to advance the integration of food and nutrition services, as well as longer-term food security interventions, into its programs. Several countries initiated or made plans to initiate new food and nutrition programs. PEPFAR's 2007 change in policy guidance regarding parameters for food support to HIV-positive adult patients enabled programs to reach increased numbers of HIV-positive individuals with food and nutrition support. In FY2008, having adapted its data system, PEPFAR was better able to report on beneficiaries as well as dollars planned for actual food purchases with PEPFAR resources.

In Mozambique a local organization, assisted by a Peace Corps volunteer, leveraged PEPFAR to assist orphans and vulnerable children (OVCs) affected by HIV/AIDS through agriculture and beekeeping. This project has augmented food consumption for families in need, taught efficient farming techniques, and provided income generation for those selling excess produce. As of September 2008, this program has helped 50 families, including 120 OVCs.

PEPFAR's interagency, multi-sectoral technical working group on food and nutrition actively guides the incorporation of key components of nutrition into HIV programs. In addition to the primary PEPFAR implementing agencies, the group includes other agencies and offices that work directly with issues of food security and nutrition, including USAID's Food for Peace (FFP) program and Bureau for Economic Growth, Agriculture, and Trade, as well as the U.S. Department of Agriculture (USDA). In FY2008, the group provided guidance to PEPFAR country teams on integrating food and nutrition activities into HIV/AIDS programs and developed programmatic guidance on procurement and quality assurance of specialized food products for PEPFAR programs. The group also competitively disbursed $7 million in central funds to 11 countries to jump-start programs specifically targeted at post-natal support and food security/livelihoods, two areas that were identified as programming gaps.

In terms of its own targeted nutritional support to people infected with and affected by HIV/AIDS, PEPFAR guidance designates three priority populations for food support using PEPFAR resources: 1) OVCs born to an HIV-infected parent, regardless of the child's HIV or nutritional status; 2) HIV-positive pregnant and lactating

The PEPFAR-supported Mangulukeni Fish Farming group, made up of the 15 person Oshikuku Support Group and a Peace Corps volunteer, constructed a large pond and protective fence to breed fish in Namibia's northern region. The project was started as a means to generate income for people living with HIV/AIDS. Filled with 3,000 tilapia fingerlings, the pond's first harvest generated more than 165 kilograms of tilapia. Today, the pond is officially a dedicated fish farm.

women, regardless of nutritional status; and 3) HIV-positive adult patients in treatment and care programs who have evidence of malnutrition, which is defined by WHO as a Body Mass Index (BMI) at or below 18.5 (in earlier years, only those adult patients with a BMI under 16 were eligible for nutritional support under PEPFAR). PEPFAR also supports nutrition counseling and multivitamin supplementation as part of a preventive care package for adult PLWHA.

FY2007 marked the first year that PEPFAR requested specific information regarding food and nutrition programming through the country reporting process. That request for information was further refined in FY2008. According to the data received, in FY2008, PEPFAR supported food and nutritional supplementation in the 15 focus countries for approximately:

- 48,000 HIV-positive pregnant or lactating women;
- 814,800 OVCs; and
- 73,000 people receiving ART (with evidence of severe malnutrition as defined by the guidance).

Additional refinements will be undertaken for reporting in FY2009. In addition to the number of people served, the introduction of a new budget code will allow the collection of information on PEPFAR dollars spent and leveraged for food, while next generation indicators will help monitor the impact of food and nutrition support.

The number of examples of integration of food and nutrition into PEPFAR programming continues to increase. In partnership with the World Food Programme (WFP) in Ethiopia, PEPFAR partners ensured that OVCs and PLWHA along the transport corridor received nutritional assistance in addition to home-based care services. Through its partners, USAID/FFP provided 7,220 metric tons of food support to PLWHA and OVCs in 12 food-insecure districts in Rwanda. PEPFAR partners leveraged this support to provide food and nutrition to 8,560 OVCs and 2,332 HIV-positive pregnant or lactating women. This support also improved food security for 65,500 people affected by HIV — of whom 13,100 are PLWHA. In Uganda, a USAID/FFP program is focusing on food security issues in conflict-affected Northern, Central, and Eastern Uganda. This 5-year program is working with PEPFAR partners to link services and increase access for PLWHA. In Kenya, the Emergency Plan supports a "food-by-prescription" approach and is working with the Government, private sector, civil society, WFP and others to ensure that broader communities, as well as individuals who may fall outside of PEPFAR guidelines for support, are reached.

Linking PEPFAR and education

For too many young people, education has been a casualty of the HIV/AIDS pandemic. Partnering with the education sector to ensure that teachers, parents and students have the tools they need to fight the epidemic is a vital component of PEPFAR programming.

In FY2008, PEPFAR made significant strides in partnering with the education sector in HIV/AIDS-affected countries, leveraging USG resources with key international partners and the private sector. Early in 2008, PEPFAR collaborated with other USG actors to develop an action plan for interagency work on education issues. This effort has led to a unified USG strategy in which PEPFAR plays a key role. Together with USAID, PEPFAR formed an Interagency Education Steering Committee charged with developing a strategy for education and HIV/AIDS wraparound programs, to ensure promising practices are shared and utilized to their maximum potential.

PEPFAR works through OVC programs to ensure children's attendance at school. PEPFAR has developed a

particularly strong partnership with the AEI, implemented through USAID, whose goal is to improve educational opportunities for Africa's children so they may lead happier, healthier lives, and become productive members of society. The USG is providing $400 million through AEI to train 500,000 teachers and provide scholarships for 300,000 young people, mostly girls. In Zambia, PEPFAR and AEI fund a scholarship program that helps to keep in school nearly 4,000 OVCs in grades 10 to 12 who have lost one or both parents to AIDS or who are HIV-positive. The scholarship also funds pre-school programs and support for OVCs in primary school. Similar partnerships exist in Uganda, where PEPFAR and AEI are working together to strengthen life skills and prevention curricula in schools. This program targeted 4 million children and 5,000 teachers.

Schools are important venues for teaching age-appropriate HIV prevention strategies as well as identifying and supporting children who have been orphaned or made vulnerable as a result of AIDS. In addition to providing scholarships for school fees, OVC programs provide school materials and supplies, uniforms, meals, mentoring and even child care programs to enable older siblings to attend school. PEPFAR-supported OVCs programs also provide life skills training and HIV prevention messages. At the primary and secondary school levels, OVC programs support vocational training for older students to prepare them to provide economically for their families. This is especially important given the proliferation of child-headed households brought about by the HIV/AIDS epidemic.

In Zambia and Namibia, scholarship programs help girls continue their education beyond primary into secondary school. Also in Zambia, PEPFAR has provided 53 schools with small grants to assist OVCs. In some cases, grants are provided to schools to improve school facilities and materials in exchange for allowing OVCs to attend school for free. In Uganda, through The AIDS Support Organization (TASO), PEPFAR reaches almost 1,000 children with primary and secondary school fees, boarding fees for those in secondary schools, uniforms, and school supplies. Support of in-school feeding programs for OVCs is also a common intervention. In Nigeria, where an estimated one-third of all children do not attend primary school, PEPFAR's support of non-formal schools, focusing on literacy and numeracy for vulnerable children, plays an important role not only in providing basic education but in assisting children to transition to formal schools when ready.

Along with its efforts in primary and secondary school settings, PEPFAR also supports pre-service and in-service training for health care and social workers provided through institutes of higher learning in host countries. Primary and secondary school teacher organizations are also supported as avenues for providing prevention messages and counseling and testing for teachers.

PEPFAR support for education illustrates the fact that support to one sector can leverage support to other sectors to achieve broad benefits. One example is block grants given to schools for specific purposes, such as desks, books, lab equipment or school refurbishment, in exchange for the schools admitting an agreed number of HIV-affected OVCs to attend school without paying fees or with reduced fees for a certain period of time. Such block grants are a way of enabling thousands of HIV-affected OVCs to attend school while benefiting the broader school population.

Other Key Linkages

PEPFAR and PMI have worked together to identify countries with joint opportunities for leveraging. Currently, nine PEPFAR countries with significant programs are also PMI focus countries (Ethiopia, Ghana, Kenya, Malawi, Mozambique, Rwanda, Tanzania,

In Namibia, a five-man a cappella group, Vocal Motion 6, took to the road to bring prevention, stigma reduction, and positive living messages to high school students all over the country. The group was joined by Herlyn Uiras, a HIV-positive woman, who also shared her story of living positively with HIV/AIDS with audiences.

Uganda, and Zambia). PMI and PEPFAR efforts currently overlap in three major areas: ITN distribution and education to pregnant women through ANCs; ITN distribution and education to PLWHA; and coordination of lab services. Together, PMI and PEPFAR are now working with Malaria No More to add a private sector component to this cooperative effort. In Zambia, by using the PEPFAR-supported distribution infrastructure, the RAPIDS consortium led by World Vision, PMI, PEPFAR and the private sector delivered more than 485,000 bed nets before malaria season at a 75 percent savings — and the USG saved half the remaining cost of nets through a public-private partnership led by the Global Business Coalition on HIV/AIDS, TB and Malaria. The two programs are also coordinating on surveys and surveillance to reduce the cost of monitoring program results. Other examples include:

- In Uganda, PEPFAR and PMI are providing joint funding of a nationwide health facility survey. Several PEPFAR partners have gained access to free ITNs through PMI support, and PEPFAR and PMI are providing joint support for ANC interventions for malaria and HIV/AIDS (e.g., distribution of ITNs through ANCs, and integrated training linking PMTCT and malaria prevention to maternal and child health curricula).

- In Kenya, in addition to PEPFAR-PMI support for ANC interventions, PEPFAR is also supporting partners in the distribution of vouchers for ITNs to PLWHA as part of a basic care package in Nyanza Province.

- In Tanzania, PEPFAR and PMI are working together to support the inclusion of a malaria indicator module in the HIV/AIDS indicator survey, and PMI is providing ITNs to PLWHA.

MCC is another key USG partner with which PEPFAR is seeking opportunities for coordinated effort. In Lesotho, PEPFAR has co-located staff with those of MCC to ensure joint support for expansion of health and HIV/AIDS services, with MCC placing a strong focus on infrastructure and PEPFAR on human capacity building.

PEPFAR also supports linkages between HIV/AIDS and voluntary family planning programs, including those supported through USAID's Office of Population and Reproductive Health (PRH). Along with providing linkages to family planning programs for women in HIV/AIDS treatment and care programs, PEPFAR also works to link family planning clients with HIV prevention, particularly in areas with high HIV prevalence and strong voluntary family planning systems. Voluntary family planning programs provide a key avenue to reach women who may be at high risk for HIV infection. PEPFAR supports the provision of confidential HIV counseling and testing within family planning sites, as well as linkages with HIV care and treatment for women who test HIV-positive. Ensuring that family planning clients have an opportunity to learn their HIV status also facilitates early uptake and access to PMTCT services for those women who test HIV-positive. PEPFAR's efforts remain focused on HIV/AIDS prevention, treatment and care, complementing the efforts of USAID/PRH programs and other partners.

Promoting Sustainability and Accountability

Central to 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 developing nations are years from being able to launch comprehensive programs with their own resources. However, it is essential that these countries appropriately prioritize HIV/AIDS and respond to the disease with locally available resources, including financial resources. Many are beginning to make this commitment. Some countries are making progress, 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 ARV drugs, while PEPFAR provides support for other aspects of quality treatment. These developments within hard-hit nations build sustainability in each country's fight against HIV/AIDS.

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. PEPFAR is collaborating with host nations, UNAIDS and the World Bank to estimate the cost of national HIV/AIDS plans, a key step toward accountability. Businesses are increasingly eager to collaborate with PEPFAR, 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 diplomacy in action. While HIV/AIDS is unmistakably the focus of PEPFAR, the initiative's support for technical and organizational capacity-building for local organizations 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. Capacity-building in supply chain management improves procurement for general health commodities. Improving the capacity to report on results fosters quality and systems improvement, and the resulting accountability helps to develop good governance and democracy.

As the name of the Emergency Plan frankly acknowledges, HIV/AIDS is a global emergency, and PEPFAR has rapidly sought to save as many lives as possible. At the same time, it is essential to look to the future with a sustainable, effective response. HIV/AIDS is a chronic disease requiring lifelong prevention, treatment and care and so rather than support one-time interventions, PEPFAR supports enduring contributions that build health systems as part of a broader development approach. PEPFAR is working to ensure a sustainable response by building the capacity of public and private institutions in host nations to respond to HIV/AIDS.

Building health systems

Discussions of global HIV/AIDS efforts have sometimes pitted "vertical" disease-specific programs against "horizontal" programs designed to build health systems. This is a false dichotomy. Disease-specific programs, if appropriately designed, can also strengthen overall health systems. PEPFAR and host nations are demonstrating how HIV/AIDS funding strengthens the ability of nations to improve overall health. Preliminary analysis from Rwanda estimates that 60 percent of PEPFAR resources had an impact beyond HIV/AIDS. According to Dr. Jaime Sepulveda, Chairman of the IOM Committee which in 2007 completed a congressionally mandated study of PEPFAR, "PEPFAR is contributing to make health systems stronger… doing good to the health systems overall." As noted earlier, data from Botswana suggest that HIV/AIDS resources contributed to a decline in infant mortality and increase in life expectancy — significant gains in general health indicators. While much evaluation remains to be done, the only data available clearly indicate that HIV/AIDS resources are having a positive impact on general health care. For this reason, health experts are now talking about "diagonal" programs that have broad effects on the health system even as they focus on a specific disease. PEPFAR is such a program.

Namibia is a large country with much of its population spread out in remote areas. The country faces an acute pharmaceutical personnel shortage, made worse by the increased burden of HIV/AIDS on the health system. More pharmacists and pharmacist's assistants are required to make antiretroviral treatment and other vital services available to the growing number of remote and rural patients. With PEPFAR support, the Namibia Ministry of Health and Social Services is working to improve the National Health Training Center (NHTC), the cornerstone institution for training health care providers throughout Namibia. Over the past year, renovations have transformed two blocks of neglected NHTC buildings from unusable to a state of the art pharmacist's assistant training facility. Renovations created lecture rooms, offices, and space for laboratory demonstrations, as well as updated the simulation laboratory. New computer hardware and software and an updated curriculum and tutors have also been provided. With support from the American people, the Ministry has increased the capacity of the training unit at the Center — more than doubling the intake and tripling the output of pharmacist's assistants.

PEPFAR estimates that approximately $734 million in FY2008 resources were invested in capacity building in the public and private health sectors to support service delivery sites for prevention, treatment and care. A recent study of PEPFAR-supported treatment sites in four countries found that PEPFAR supported a median of 92 percent of the investments in health infrastructure to provide comprehensive HIV treatment and associated care, including building construction and renovation, lab and other equipment, and training (Figure 10). PEPFAR

also supported a median of 57 percent of personnel costs (salaries and retention bonuses) at those sites.

Discussions of health systems often split over the "vertical" versus "horizontal" debate, but also are often grounded in a belief that the public sector is the only valid "horizontal" system. This is not true for two significant reasons: much of the health care in the developing world is not provided through the public sector, and NGO partners can strengthen the public health system. WHO has estimated that FBOs alone provide 30 percent to 70 percent of health care in sub-Saharan Africa. In Kenya, for example, it is estimated that half of health care is provided by FBOs. However, the public sector is an essential component of health care as well, and data show that PEPFAR support as a percentage of total resources was higher in public sector facilities than it was in private sector ones (Figure 10). This reflects PEPFAR's commitment to supporting nations' efforts to expand public sector health infrastructure.

In addition, for a variety of reasons, it is often more cost-effective to use NGO partners to strengthen the public sector. In South Africa, a snapshot of non-governmental PEPFAR partners demonstrated that 19 of 22 were supporting services in the public sector across a range of program areas (Figure 11).

PEPFAR has been instrumental in building laboratory capacity around the world and is partnering with Ministries of Health (MOHs) to support the development of national strategic laboratory plans. Training, logistics and commodities management, facility and equipment maintenance, and quality assurance are cross-cutting aspects of all disease-specific laboratories, and PEPFAR is providing support to address all of these by helping countries develop national strategic laboratory plans. These plans integrate cross-cutting aspects of all disease-specific laboratories. This helps to reduce parallel disease-specific laboratory systems, and thereby build efficiency and augment countries' ability to respond effectively to numerous diseases including HIV, TB, malaria, and avian influenza.

To address the critical need for a well-trained laboratory workforce, PEPFAR partnered with the South African National Health Laboratory Service and National Institute for Communicable Diseases to establish the African Centre for Integrated Laboratory Training (ACILT) in Johannesburg, South Africa. This center is helping

Figure 10: Leveraging HIV Improvements for General Health

In a study of 33 PEPFAR-supported sites providing antiretroviral treatment and associated care in four countries, PEPFAR supported 92 percent of the systems strengthening investments at a typical facility.

Median USG funding for health system investments, by investment type and facility type, for all study sites and time periods (expressed as a percentage of contributions from all sources):

	No. sites	Buildings and renovation	Lab equipment	Other equipment	Training	All investments
		% of All	% of All	% of All	% of All	% of All
Public	28	100.0%	100.0%	100.0%	100.0%	93.3%
Private	5	50.0%	99.8%	86.9%	93.0%	75.1%
All four countries	**33**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**92.3%**

Note: All investment types are not listed individually but are reflected in the total.

Source: Blandford et al, CDC

Figure 11: Examples from South Africa of PEPFAR Partner Support by Sector

Partner	Private-public	Government	Private	NGO
Africa Centre		X		
Africare	X			
American Internal Health Alliance (AIHA)		X		
Absolute Return for Kids (ARK)		X		
Aurum Health Institute	X	X	X	X
BroadReach HealthCare		X	X	X
CAPRISA (University of KwaZulu Natal)		X		
Columbia University		X		X
Catholic Relief Services (CRS)		X		X
Eastern Cape Regional Training Centre (ECRTC)		X		
Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)	X	X		X
Foundation for Professional Development (FPD)		X		
HIVCare	X			
Medical Research Council (MRC)		X		
Phidisa/SA Military Health Services		X		
Perinatal HIV Research Unit (PHRU)		X		
Reproductive Health Research Unit (RHRU)		X		X
Right to Care		X		X
Rational Pharmaceutical Management (RPM Plus)		X		
Solidarity Center				
Quality Assurance Project (QAP)		X		
Integrated Primary Healthcare Project (IPHC)		X		

Source: PEPFAR South Africa

to meet Africa's need for a competent and motivated workforce trained in TB and HIV diagnostics throughout Africa and will also serve as a reference laboratory for TB, HIV, and other diseases.

Impact of HIV/AIDS investment on non-HIV/AIDS health — "diagonal programs"

Perhaps the most striking data on the "vertical/horizontal" debate come from a Family Health International (FHI) study in Rwanda showing that the addition of basic HIV services to primary health centers contributed to an increase in the use of maternal and reproductive health, prenatal, pediatric, and general health care (Figure 12). The study collected data from 30 primary health centers that had at least 6 months of experience providing basic HIV care interventions and controlled for possible influences from other health initiatives. It found statistically significant increases in delivery of 17 non-HIV interventions, including a 24 percent increase in outpatient consultations and a rise in syphilis screenings of pregnant women, from one test in the 6 months prior to the introduction of HIV care to 79 tests after HIV programs began. Large jumps were also seen in non-HIV related laboratory testing and provision of family planning.

Improving the health sector by reducing burdens on it

In the hardest-hit regions, 50 percent or more of hospital admissions are due to HIV/AIDS. As effective HIV programs are implemented, hospital admissions plummet, easing the burden on health care staff throughout the system. In the Rwanda study cited earlier, the average number of new hospitalizations at seven sites that had been offering ART for more than 2 months dropped by 21 percent (Figure 13).

Building human resources for health

Functioning health systems depend on a workforce that can carry out the many tasks and build the systems that are needed. The lack of sufficient health workforce in many of the countries where PEPFAR is working presents a serious challenge not only to HIV/AIDS programs, but to every area of health care. PEPFAR cannot solve the overall health workforce crisis, but it can contribute by making significant investments in capacity building that, while focused on HIV/AIDS, have a broader impact. As Table 2 shows, from FY2004 through FY2008, PEPFAR supported an estimated 3.7 million training and retraining encounters for health care workers. In FY2008, PEPFAR provided an estimated $310 million to support training activities.

Figure 12: Leveraging HIV Improvements for General Health

A study by Family Health International (FHI) at 30 primary health centers in Rwanda examined 22 non-HIV health indicators before and after the introduction of basic HIV care. Only one indicator declined, while 17 showed statistically significant improvement.

Non-HIV health indicators	Before intro of basic HIV care (Average # per site per month)	After intro of basic HIV care (Average # per site per month)	p value	Independent effects
New family planning users	9	13	0.012	HIV exp (p <.001)
Returning family planning users	91	141	0.002	HIV exp (p <.001)
Total family planning users	100	155	0.001	HIV exp (p <.001)
1st trimester ANC visit	5	10	0.001	HIV exp (p=.010)
2nd trimester ANC visit	36	52	<.001	HIV exp (p=.004)
ANC coverage rate (all four visits)	3.00%	4.70%	0.016	HIV exp (p=.020)
Syphilis screening	1	79	<.001	HIV (<.001)

Figure 13: Leveraging HIV Improvements for General Health

In the seven sites included in the FHI Rwanda study that had been offering ART for more than 2 months, the average number of new hospitalizations decreased by 20.9 percent.

ART site	Average monthly # new hospitalizations prior to HIV services	Average monthly # new hospitalizations since HIV services	Percent decrease after introduction of HIV services	# of months experience offering ART
1	53.3	73.2	-37.2%	5
2	63.3	82.3	-30.0%	9
3	231.8	171.5	26.0%	6
4	92.7	79.0	14.8%	15
5	221.3	140.3	36.6%	6
6	90.7	88.2	2.8%	5
7	199.0	118.3	40.5%	7
Mean	**136.0**	**107.5**	**20.9%**	**7.6**

Table 2: Emergency Plan Support for Capacity-Building FY2004–FY2008		
	Number of individuals trained or retrained FY2004–2008[1]	Number of USG-supported service outlets FY2008[2]
Prevention of Sexual Transmission[3]	1,787,900	-
Prevention of Mother-to-Child Transmission	151,126	13,769
Prevention of Medical Transmission[4]	227,190	5,301
Provision of Antiretroviral Treatment	219,700	5,328
Provision of Care for Orphans and Vulnerable Children[3]	702,600	-
Provision of Palliative Care for HIV-positive People	462,500	13,963
Provision of Counseling and Testing	156,800	13,104
Total	**3,707,816**	**-**

Notes:

Among individuals trained, numbers above 100 are rounded to the nearest 100 and then added to get totals. Numbers of sites are not rounded.

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

Footnotes:

[1] Total number for individuals trained or retrained is cumulative from FY2004 through FY2008.

[2] Total number of USG-supported service outlets for all services is not provided, as a service outlet may provide more than one service.

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

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

PEPFAR focuses on areas that most directly impact HIV/AIDS programs: HIV/AIDS training for existing clinical staff such as physicians, nurses, pharmacists, and laboratory technicians; management and leadership development for health care workers; and building new cadres of health workers. This strategy 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 and provides a solid platform on which other health programs can build.

A workforce pyramid

Recognizing the continued importance of human capacity development, for FY2008 PEPFAR country teams supported 1,133,525 training and retraining encounters.

Pre-service training: The expansion of care and treatment requires an expansion in the workforce to provide these services. For FY2008 the amount of funds each PEPFAR country team could use to support long-term pre-service training was increased threefold, to $3 million. Namibia is one country that took advantage of this new allowance. There are no schools of medicine and pharmacy in Namibia. In FY2008, an existing scholarship program for students in these disciplines was expanded to increase the number of students attending training institutions in South Africa, with a requirement to return to Namibia to provide national service. In Kenya, an HIV fellowship program has been developed to train senior HIV program managers. In Vietnam, PEPFAR is working with the Hanoi School of Public Health to increase the number of health professionals receiving advanced degrees in public health and management. There has also been a significant increase in support for expanding HIV curricula in pre-service training programs. These efforts reflect the increase in resources dedicated to training of new doctors, nurses, clinical officers, laboratory technicians, and pharmacists in HIV/AIDS.

To address the critical shortage of health care professionals in Côte d'Ivoire, PEPFAR collaborated with the National Training Institute for Health Care Workers (INFAS) to support the hiring of 35 instructors at three INFAS locations. These skilled instructors have eased the burden on medical personnel and allowed the faculty to introduce best practice methods through regular oversight, assess areas of need for improved student development, and provide a combination of theory and practice for optimal capacity development.

Task-shifting: While building cadres of new highly trained professionals is a long-term objective of PEPFAR and other development initiatives, it can take years to build a sufficient health care workforce. Unfortunately, we do not have years to wait. As experts from PEPFAR and the WHO argued in an article published in the *New England Journal of Medicine*, 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 in resource-limited settings. Changing national and local policies to support task-shifting can

foster dramatic progress in expanding access to HIV prevention, treatment and care, as well as other health programs. PEPFAR supported WHO's efforts to develop the first-ever set of task-shifting guidelines, released in January 2008. This continues and expands PEPFAR's support for the leadership of its host country partners in broadening national policies to allow trained members of the community — including PLWHA — to become part of clinical teams as community health workers.

Support for salaries: Along with support for training, supporting new highly trained health professionals, and task-shifting, PEPFAR supports the growing number of personnel necessary to provide HIV/AIDS services. To capture this support more comprehensively, in the FY2009 Country Operational Plans (COPs), PEPFAR country teams estimated the number of health care workers whose salaries PEPFAR is supporting. They reported support for more than 127,300 workers (Table 3), illustrating PEPFAR's commitment to building health workforces to ensure that lifesaving services are provided to those who need them.

Table 3: Number of Health Care Workers Receiving Support For Salaries Through PEPFAR FY2009 COP[1]

Focus countries	**119,700**
India, Malawi, Cambodia[2]	7,600
Total	**127,300**

Notes:
Individual country numbers are rounded off to the nearest 100 and then added to get the total.

Footnotes:
[1] Health Care Workers include Clinical Staff, Community Services Staff, Managerial Staff with salaries partially- or fully-supported by PEPFAR.
[2] Of the bilateral countries supported by PEPFAR, only Cambodia, India, and Malawi were required to submit full COP including information about salary support for FY2009.

Examples of support for salaries in the focus countries include:

Government sector:

- Namibia: PEPFAR supports the salaries of nearly all clinical staff doing treatment work and counseling and testing in the public sector.

- Kenya: PEPFAR supports the Government's hiring plan to train and deploy retired physicians, nurses, and other health care workers for the public sector; 830 were deployed in 2008.

- Ethiopia: PEPFAR supports the Government's program to train 30,000 health extension workers in order to place two of these community health workers in every rural village; 19,000 have already been trained.

- Cote d'Ivoire: PEPFAR supported the development of the Government's plan to redeploy health workers from the south back to the north and west following the peace agreement.

Non-government sector:

- Uganda: One of the largest HIV/AIDS service providers, TASO, has increased staff from 16 in the early 1980s to several thousands today, and PEPFAR supports salaries for nearly all of them.

PEPFAR seeks to support sustainable national responses to HIV/AIDS, including sustainable local sources of funding for personnel where possible. In Kenya, for example, PEPFAR has reached an agreement under which the MoH will incrementally absorb PEPFAR-supported personnel into the public health system, supporting progress toward long-term sustainability while also allowing for rapid hiring and deployment.

Building supply systems

Procurement capacity is another key element of national health systems. PEPFAR's Supply Chain Management System (SCMS) project strengthens the capacity of local systems to deliver an uninterrupted supply of high-quality, low-cost products that flow through a transparent and accountable system. SCMS activities include supporting the purchase of life-saving ARVs, including low-cost generic ARVs; capacity-building for quantification of needs, safer storage and distribution systems, and effective stock and inventory control systems to avoid "stock outs"; drugs for care for PLWHA, including drugs for OIs such as TB; laboratory materials, such as rapid test kits; and supplies, including gowns, gloves, injection equipment, and cleaning and sterilization items. By pooling procurement across countries, SCMS is able to stabilize supply, plan for capacity expansion, and achieve economies of scale.

In a FY2007 survey, 73 percent of ARVs provided by PEPFAR, and 93 percent delivered through SCMS, were generic formulations (Tables 4 and 5). By using generics, PEPFAR partners were able to save an estimated $64 million — a 46 percent reduction from the cost if they had purchased only innovator drugs. Additionally, by augmenting and improving country supply chains, rather

than replacing functioning systems, SCMS strengthens the capacity of health systems to deal with other health and development issues. These country supply chains are strengthened through the use of regional distribution centers, which distribute commodities in quantities that existing infrastructure can handle reliably and safely. Figure 14 shows the locations of these regional distribution centers in sub-Saharan Africa.

Supporting strategic information for program accountability and improvement

Evidence-based programming depends on strong data. PEPFAR is addressing this need from many directions, and the results will benefit all programs, not just those supported by PEPFAR.

Surveillance and mapping

PEPFAR is building the capacity of resource-constrained nations to strategically collect and use information for program accountability and improvement. Measuring the burden of HIV is essential for developing effective prevention and care interventions. To gain better understanding of the relationships among populations, HIV prevalence, and existing services, PEPFAR is building the capacity of host countries to design, implement, and evaluate HIV/AIDS-related surveillance systems and surveys. PEPFAR also assists and trains countries to analyze, disseminate, and use HIV/AIDS data. These efforts include development of tools, guidelines, recommendations, and policies to translate research for improved planning and program implementation, in addition to supporting evaluation and implementation of novel approaches for conducting surveillance and surveys.

PEPFAR has supported population surveys such as Demographic and Health Surveys (DHS) and AIDS Indicator Surveys (AIS) in 27 countries, including Botswana, Cote d'Ivoire, Ethiopia, and Vietnam. This helps to improve prevalence estimates, among other data, as demonstrated by the recent revision of UNAIDS global estimates. This past year in Kenya, PEPFAR supported the groundbreaking Kenya AIDS Indicator Survey (KAIS) that included measurement of diseases that interact with HIV (i.e., syphilis, Herpes Simplex Virus Type 2 [HSV2], and viral hepatitis), estimation of ART need on the basis of CD4 measurements, and returning HIV test results to participants.

These population surveys are also improving incidence data that help determine where recent transmission has occurred. This information is essential for planning effective prevention programs and also for measuring the success of programs in achieving PEPFAR's prevention goals.

PEPFAR also supports the use of surveys and surveillance within subpopulations to assist in development of more

Table 4: Percentage of Antiretroviral Drugs Delivered by All PEPFAR Partners in 2007 That Were Generic

Quarter Delivered	Branded (# of Packs)	Generic (# of Packs)	Grand Total (# of Packs)	Percentage Generic
1	800,283	1,321,381	2,121,664	62%
2	830,515	2,583,924	3,414,439	76%
3	700,654	2,892,753	3,593,407	81%
4	554,131	1,236,508	1,790,639	69%
Not Specified*	159,933	365,182	525,115	70%
Totals	**3,045,516**	**8,399,748**	**11,445,264**	**73%**

* Not all programs reported delivery dates, meaning that those deliveries could not be designated into a specific quarter

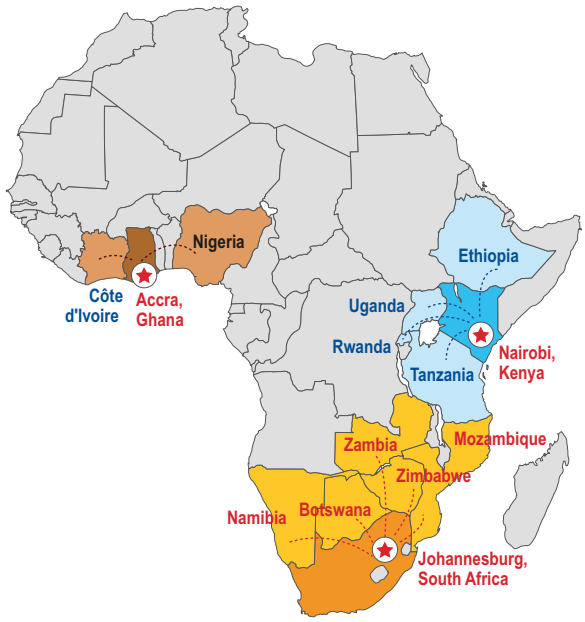
Source: 2007 Annual ARV Procurement Survey

Table 5: Percentage of Antiretroviral Drugs Delivered by SCMS in 2007 That Were Generic

Quarter Delivered	Branded (# of Packs)	Generic (# of Packs)	Grand Total (# of Packs)	Percentage Generic
1	15,961	237,463	253,424	94%
2	51,434	532,142	583,576	91%
3	75,359	1,079,808	1,155,167	93%
4	108,392	1,714,457	1,822,849	94%
Total	**251,146**	**3,563,870**	**3,815,016**	**93%**

Source: 2007 Annual ARV Procurement Survey

Figure 14: SCMS Regional Distribution Centers Help Pool Procurement



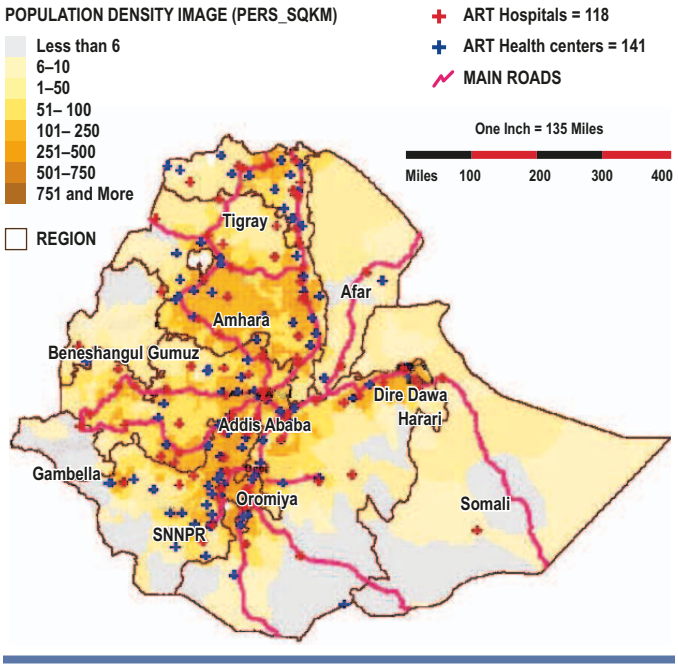
targeted and effective prevention and care interventions. These behavioral or prevalence surveys are employed to characterize specific subpopulations or communities (e.g., pregnant women, youth, migrants, IDUs) which are recognized as primary drivers of local epidemics. These studies provide more detailed information than population surveys and are increasingly being supported even within generalized-epidemic settings. PEPFAR is working with countries to build local capacity to conduct both types of surveys/surveillance, as a combined approach represents the most robust framework against which to develop, monitor, and evaluate interventions.

PEPFAR is also supporting countries to make more effective use of geographic information mapping to assist in data analyses and in program implementation. Increasingly, countries are making use of these technologies to document current efforts and service gaps. For example, Figure 15 shows a sample map that depicts treatment delivery sites in Ethiopia. The technology is also being used to create more dynamic maps tracking the relationships among services and local HIV epidemic patterns.

Next generation of indicators

Constant evaluation to improve programs must characterize all HIV/AIDS efforts, including those of PEPFAR. PEPFAR is thus working with a wide variety of stakeholders to update the performance measures used to evaluate programmatic progress. The new measures will move PEPFAR toward the challenging goal of measuring program outcomes and impacts. The next generation of PEPFAR indicators will be rolled out for use in planning and reporting in FY2010. The continuum of indicators is depicted in Figure 16.

Figure 15: Treatment Delivery Sites in Ethiopia

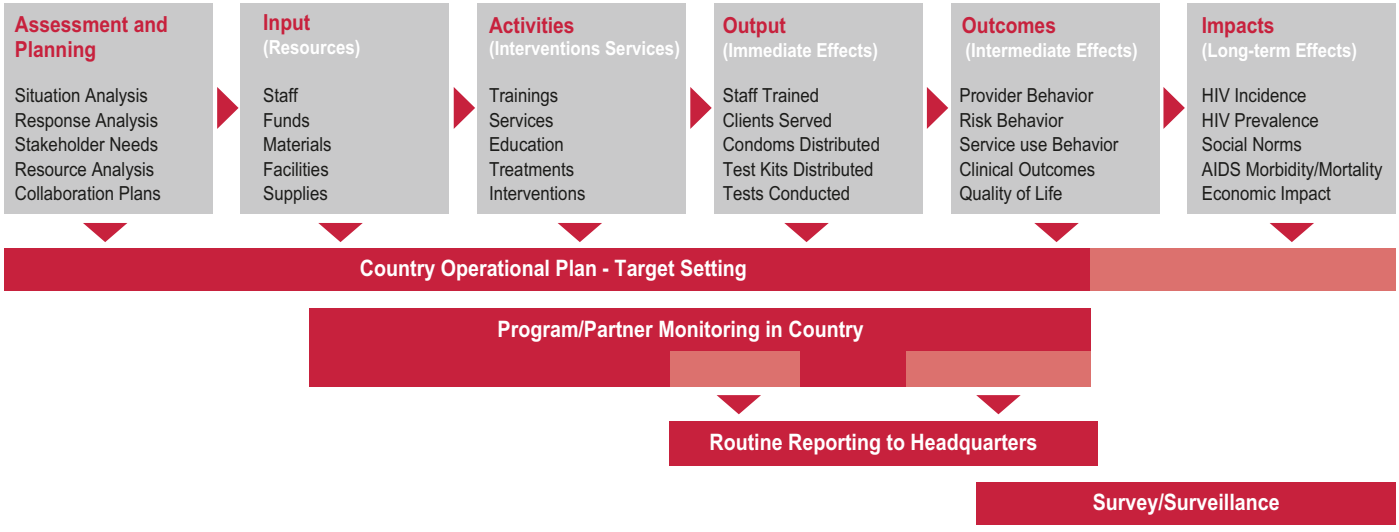


Sharing lessons learned

Public health evaluation

Through Public Health Evaluation (PHE) — also called "implementation research" or "operations research" — PEPFAR supports research on strategic priority questions that can inform and change how PEPFAR and others deliver prevention, treatment and care programs. Because of its size and scope, PEPFAR offers unique opportunities to address and resolve issues related to

Figure 16: Next Generation of PEPFAR Indicators



the implementation of scientifically sound, cost-effective programs. In FY2008, PEPFAR heightened its emphasis on priority research questions that can inform PEPFAR programs globally; respond to identified PEPFAR priorities; reflect the diversity of PEPFAR programs and populations served; and take advantage of coordination and multi-country implementation where appropriate. At the same time, PEPFAR PHE continues to support locally focused research activities that address local implementation challenges.

In FY2008, $40 million was directed toward PHE. These funds were awarded based on competition and PEPFAR programmatic priorities, and further refinement of PHE is anticipated for FY2009. Though PEPFAR is unmistakably focused on implementation, PHE allows PEPFAR to address the important questions that will change how we and others implement programs to save more lives.

International HIV/AIDS Implementers' Meeting

The Emergency Plan seeks to build the capacity of local people and organizations to evaluate their work and present their findings to colleagues from around the world. In June 2008, PEPFAR and its partners convened the HIV/AIDS Implementers' Meeting in Kampala, Uganda. The meeting, which drew more than 1,600 delegates from Uganda and around the world, was hosted by the Government of Uganda and co-sponsored by PEPFAR, the Global Fund, UNAIDS, the United Nations Children's Fund (UNICEF), the World Bank, WHO, and the Global Network of People Living with HIV/AIDS. The vast majority of presenters was from severely affected nations in Africa, Asia, Eastern Europe, and Latin America, and included representatives from governments and NGOs, including FBOs and CBOs, and the private sector.

Photo by Arne Clausen

His Excellency President Yoweri Kaguta Museveni, President of the Republic of Uganda, and Mrs. Janet Museveni, First Lady of the Republic of Uganda, arrive at the opening ceremony of the 2008 HIV/AIDS Implementers' Meeting in Kampala.

Building partnerships

Expanding the circle of local partners

An important part of systems strengthening is PEPFAR's support for local organizations, including host government institutions, groups of PLWHA, FBOs, and CBOs. Annual COP reviews include evaluation of efforts to increase the number of indigenous organizations partnering with PEPFAR. In FY2008, PEPFAR partnered with 2,667 organizations, up from 1,588 in FY2004, of which 86 percent were local. Reliance on local organizations is sometimes challenging but is essential for PEPFAR to fulfill its promise to partner with host nations to develop sustainable responses to HIV/AIDS.

As another step toward sustainability, PEPFAR country programs may devote a maximum of 8 percent of funding to a single partner (with exceptions made for host government partners, commodity procurement, and "umbrella contractors" for smaller organizations). This requirement is helping to expand and diversify PEPFAR's base of partners. New partnerships, particularly with local partners, are vital to sustainability. The exception for umbrella contracts is intended to support large organizations in mentoring smaller local organizations, thus supporting capacity building in challenging areas such as management and reporting. PEPFAR has also worked with its international implementing partners in developing strategies for handing over programs as local organizations increase their capacity to work directly with the USG. PEPFAR's interagency Procurement and Assistance Working Group has also created a new definition of "local partner" that addresses confusion about whether specific organizations qualify for the exemption.

New Partners Initiative

On World AIDS Day 2005, President Bush launched the New Partners Initiative (NPI), part of PEPFAR's broader effort to increase the number of local organizations, including FBOs and CBOs, that work with the Emergency Plan. The first 23 NPI grants were awarded on World AIDS Day 2006, followed by 14 grants on World AIDS Day 2007 and 19 additional grants on World AIDS Day

2008. Altogether, 56 new prime partnerships have been awarded through NPI.

NPI is enhancing the technical and organizational capacity of local partners and is working to ensure sustainable, high-quality HIV/AIDS programs by building community ownership. More than half of NPI grantees have previously received smaller grants from the USG or received PEPFAR funds working as sub-partners to larger organizations. NPI has allowed these organizations to compete among their peers and graduate to "prime partner" status. Each grantee receives comprehensive technical and organizational support through NPI, including support for financial and reporting capacity, enabling them to compete not only for PEPFAR resources but also for grants and contracts from other sources of funding.

Public-private partnerships

Public-private partnerships (PPPs) are collaborative endeavors that combine public and private sector resources to accomplish HIV/AIDS prevention, care and treatment goals. PPPs help ensure sustainability of PEPFAR programs, facilitate scale up of interventions, and leverage private sector resources to multiply impact. In addition to an array of country-level PPPs and workplace programs with local private-sector entities, PEPFAR supported eight large-scale, multi-country PPPs in 2008.

One new initiative was the launch of the Partnership for an HIV-Free Generation, a global PPP to advance youth-focused HIV-prevention. This PPP, initially piloted in Kenya, marries PEPFAR's technical and programmatic capacities with the skills and 21st century tools of numerous private sector entities. For example, a HIV prevention video game was developed in partnership with Warner Bros. Interactive Entertainment.

At the corporate launch of the Partnership for an HIV-Free Generation in Nairobi, Kenya on December 5, 2008, a group of young adults at a youth center play the new video game, "Pamoja Mtaani."

PEPFAR also expanded its PPP with Becton, Dickinson and Company, joining forces with the International Council of Nurses to create a Wellness Center for health workers in Uganda. The Wellness Center will serve 29,000 health workers in Uganda and their families, protecting the people who are the backbone of PEPFAR programming. This type of initiative complements the expansion of existing partnerships, including the Phones for Health PPP for health management and information systems.

Goals for future PPPs include expanding private health insurance options and strengthening health systems, including improving human resource capacity and expanding information communications and technology offerings. PEPFAR also remains dedicated to expanding workplace programs that provide HIV/AIDS prevention, treatment and care.

Working with international partners

The United States is not the only international partner of host nations. Other key international partners include: the Global Fund; the World Bank; United Nations agencies, led by UNAIDS; other national governments; and increasingly the businesses and foundations of the private sector. All of these partners have vital contributions to make to the work of saving lives around the world.

The Global Fund: The USG, through PEPFAR, is the largest contributor to the Global Fund and has given almost $3.3 billion since 2001, or about 27 percent of total contributions. USG representatives chair the Global Fund Board's Finance and Audit Committee, and represent the USG on the Board's Policy and Strategy Committee. Recent Board achievements supported by the USG include the approval of Round 8 grants, which represented the most successful and largest round to date; the adoption of a new and strengthened quality assurance policy for pharmaceutical products; a review of the Global Fund architecture, leading to recommendations for streamlined and strengthened application and implementation processes; the adoption of a gender equality strategy; and the presentation of a report and

Photo by Arne Clausen

From left to right: Dr. Michel Kazatchkine, Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria; Ambassador Mark Dybul, Coordinator of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR); His Excellency President Yoweri Kaguta Museveni, President of the Republic of Uganda; Mrs. Janet Museveni, First Lady of the Republic of Uganda; Dr. Peter Piot, UNAIDS Executive Director; and Dr. Kevin Moody, International Coordinator and CEO of the Global Network of People Living with HIV/AIDS (GNP+).

recommendations on the Partnerships component of the Global Fund Five-Year Evaluation.

The USG also provides direct technical assistance to Global Fund grants that are experiencing implementation bottlenecks, using U.S. legislative authority to withhold up to 5 percent of contributions for this purpose. Such funds are used to improve institutional and program management; strengthen governance and transparency; strengthen procurement and supply-chain management; and improve monitoring and evaluation systems. Because of the close link between TB and HIV/AIDS, the USG also provides technical assistance funding to improve treatment for MDR-TB and to enhance the Advocacy, Communication and Social Mobilization (ACSM) components of country TB programs. The USG also provides funds for Global Fund technical assistance through the Roll Back Malaria international partnership and the three UNAIDS Technical Support Facilities in sub-Saharan Africa.

PEPFAR country teams work closely with the Global Fund grant programs in host nations. USG representatives sit on Global Fund Country Coordinating Mechanisms (CCMs) in 94 percent of PEPFAR countries, the vast majority of which support Global Fund proposal development. PEPFAR country programs have allocated over $10 million annually to technical assistance for Global Fund grants. To promote deeper coordination, the USG has entered into Memoranda of Understanding (MOU) in several countries. These documents bring together Ministries of Health, PEPFAR, and the Global Fund to clarify collaboration and partnership activities, particularly in the area of drug procurement for ART.

UNAIDS: The United States was a driving force behind the creation of UNAIDS' "Three Ones" principles for support of national HIV/AIDS leadership and continues to support UNAIDS' work in a variety of ways. The USG is one of the largest contributors to UNAIDS' all-voluntary budget each year and provided nearly $40 million in FY2008. The United States served as Chair of the UNAIDS Programme Coordinating Board (PCB) in 2008. As PCB Chair, the United States instituted a number of reforms in PCB practice aimed at increasing transparency and effectiveness, particularly in civil society. Other priorities during the U.S. tenure included reforms to maximize UNAIDS' effectiveness at the country level and guidance for leaders as they convened in June 2008 at the U.N. General Assembly for a High-Level Meeting on HIV/AIDS. The gavel was passed to Ethiopia in December at the same time as Michel Sidibe succeeded Dr. Peter Piot as Executive Director.

Among the most important relationships in the multilateral response to HIV/AIDS is that between UNAIDS, which leads a strong in-country United Nations presence, and the Global Fund, which provides funding but no direct technical support to countries. The United States used its term as Chair to promote a stronger Global Fund-UNAIDS relationship, by advocating for adoption of a new MOU between the two and leading discussions on how to cooperate at country level.

WHO: WHO provides evidence-based technical leadership, sound management, and norms and standards to guide the international public health response to HIV/AIDS. As a WHO member state with considerable expertise in HIV/AIDS, the USG has been intimately involved in formulating HIV/AIDS-related policy and guidelines and has partnered with WHO and host countries to roll out, adapt, and implement the policies. Support in FY2008 totaled more than $16 million, with the USG providing technical expertise and financial support to WHO in multiple areas including male circumcision, laboratory capacity, PMTCT, TB/HIV, health systems strengthening, and counseling and testing.

Working with officials overseeing nurse training programs throughout Zimbabwe, a PEPFAR partner designed and implemented an innovative program to ensure that nursing school graduates receive pre-service training in HIV/AIDS adult and pediatric care and treatment. With training from this program, many nurses will work in hard-to-reach or underserved communities where their knowledge and skills are critically needed.

II. Accountability: Report on PEPFAR Partnerships for Prevention, Treatment and Care

Partnerships for Comprehensive Programming

As previously discussed, the vision for PEPFAR was remarkable for both its size and scope — integrating prevention, treatment and care in a comprehensive response. President Bush and a bipartisan Congress got it right. A comprehensive program that includes prevention, treatment and care reflects basic public health realities:

Without treatment, people are not motivated to be tested and learn their HIV status.

Without testing, we cannot identify HIV-positive persons and so we cannot teach them safe behavior, and they cannot protect others.

Without care and treatment programs, we do not have regular access to HIV-positive persons to constantly reinforce safe behaviors — a key component of prevention.

Without testing and treatment, we have no hope of identifying discordant couples, and women have no possibility of getting their partners tested so they can protect themselves.

Without testing and treatment, we cannot "medicalize" the disease, which is essential to reducing stigma and discrimination — which, in turn, is essential for effective prevention and compassionate care for those infected and affected by HIV.

Without care for HIV-positive persons who do not yet require treatment, we cannot follow them to determine when it is optimal to initiate therapy and thereby increase the chance of a successful outcome.

Without compassionate care for children orphaned or made vulnerable by AIDS, the social fabric of entire communities is being torn and we fail in our humanitarian duty.

And, of course, without prevention, we cannot keep up with the ever-growing pool of people who need care and treatment.

As comprehensive programs are scaled up, it is essential to remember that PEPFAR is only one piece — albeit a very large piece — of a complex puzzle of partners engaged in combating HIV/AIDS. The other pieces include: the contributions of countries themselves, including the PLWHA, families, communities, and national leaders

(which can include substantial financial contributions in countries such as South Africa, Botswana, Namibia, and others); the Global Fund (for which the American people, through PEPFAR, provide nearly 30 percent of the budget and which is an important piece of our overall global strategy); other multilateral organizations; other nations' bilateral programs; private foundations; and many others. PEPFAR constantly adapts the shape of our bilateral programming piece to fill its place in this puzzle, and to ensure that at the country level, the needs for prevention, treatment and care are being addressed in a comprehensive way.

Hiwot, an HIV-positive woman, was a guest on Ethiopia's *Betengna*, a popular reality radio program that features people living with HIV/AIDS. The PEPFAR-supported program is designed to encourage behavior change and stigma reduction through dialogue about health, HIV/AIDS, communication, relationships, and lifestyles. *Betengna* has featured the stories of 13 people living with HIV/AIDS on six different Ethiopian stations in three local languages. Since October 2007, *Betengna* received 195,916 web-downloads and 12,565 call-ins, emails and letters.

Partnerships for Prevention

The world cannot defeat this pandemic through treatment and care alone. The UNAIDS *2008 Report on the Global AIDS Epidemic* estimates that there were approximately 2.7 million new HIV infections in 2007. This indicates that new infections still far outpace the world's ability to add people to treatment.

The best approach to the challenges posed by HIV/AIDS is to prevent infection in the first place. Without effective prevention, the growing number of people in need of treatment and care and the growing number of OVCs will overwhelm the world's ability to sustain its response.

Recognizing this, PEPFAR supports the most comprehensive, evidence-based prevention program in the world, targeting interventions based on the epidemiology of HIV infection in each country. In the focus countries in FY2008, PEPFAR provided $712 million to support prevention activities that focus on sexual transmission, mother-to-child transmission, the transmission of HIV through unsafe blood and medical injections, and male circumcision. This investment represented 22 percent of program funding in the focus countries; if counseling and testing is counted as prevention (as most international partners do, and as PEPFAR will beginning in FY2009), this share increases to 29 percent.

PEPFAR also integrates new prevention methods and technologies as evidence is accumulated and normative guidance provided. In recent years the evidence of declining HIV prevalence and incidence as a result of changes in sexual behavior has grown significantly. UNAIDS has stated that, "this reduction in HIV incidence likely reflects natural trends in the epidemic as well as the result of prevention programmes resulting in behavioural change in different contexts." This finding reinforces the importance of comprehensive support for sexual behavior change. However, as demonstrated by the lack of decline in new infections, there is still a tremendous amount of work to be done. In many cases, programs are still using prevention techniques developed 20 years ago. It is important for prevention activities to enter the 21st century and keep pace with evidence-based techniques and modalities that have been developed to change human behavior, especially those developed in the private sector for commercial marketing.

Combination prevention

There is also a clear need for concentrated prevention efforts that mirror progress in treatment. Just as combination therapy revolutionized treatment, combination prevention is needed to revolutionize behavior change programs. Combination prevention includes both biomedical and behavioral interventions, and uses different modalities to affect behavior change depending upon the epidemiological, social, and cultural drivers of transmission in a given geographic region.

Wherever people are, prevention programs must be there to meet and empower them with appropriate knowledge and skills. For example, many youth hear prevention messages in church or in school, but then hear conflicting messages from their peers. Still other youth have no access to either school or church; therefore, in order

Justine Mulenga, one of Zambia's top musicians, realized that his songs contained many messages, but did not address the issue of HIV/AIDS. After he underwent 6 months of training to become an HIV advocate, leader, and peer educator at a PEPFAR-supported leadership training program implemented through the Tourism HIV/AIDS Public-Private Partnership, his approach changed. "I know my HIV status… how cool is that!?" Mulenga remarked. "I went for counseling and testing and now, I know." When Mulenga sings, he touches Zambia's soul, and Zambia rocks with him. Since his training, he has performed and presented his HIV messages to a combined audience of more than 100,000.

to reach all youth, prevention programs must blanket geographic areas with varied prevention modalities to ensure that all youth can hear the messages and change their behavior accordingly.

As part of this effort to implement innovative prevention programs and evaluate their impact, PEPFAR is working to "modularize" successful prevention programs so that the components found to be most effective and easy to transfer to other geographic areas can be rapidly replicated, adapted, and scaled up.

A prime example is the recently launched Partnership for an HIV-Free Generation, a new global PPP. Through the Partnership, leaders from the private sector are joining forces with the public sector and NGOs to revolutionize HIV prevention for youth aged 10–24 years by creating a social movement. The Partnership will pursue combination prevention strategies that surround youth with age-appropriate behavioral, structural, and biomedical interventions under a unifying brand. Combination prevention will parallel the intensity, focus, and success of combination ART — integrating social and behavioral change with proven scientific and medical methods. Nairobi, Kenya, serves as the pilot site to refine the partnership model and

Pamoja Mtaani

Under the Partnership for an HIV-Free Generation, Warner Bros. Interactive Entertainment and PEPFAR have worked to bring cutting-edge technology together with evidence-based prevention through a video game called "Pamoja Mtaani" ("Together in the Hood"). The game, intended to engage youth through fun interaction, is designed to influence HIV risk perceptions, attitudes, and behaviors among young people in sub-Saharan Africa.

"Pamoja Mtaani" is an open world, multi-player PC video game created by Warner Bros. Interactive Entertainment in collaboration with technical experts within PEPFAR. Currently the game can be played at select venues in Nairobi. The game is a pilot that will be evaluated by behavioral change evaluation experts in order to strengthen HIV prevention programming for youth and will then be expanded to other countries as part of the Partnership for an HIV-Free Generation.

Warner Bros. worked closely with youth in Kenya, cultural icons, and regional experts to ensure that the elements were authentic. Top East African hip-hop artists were tapped to provide relevant and inspirational original music for use exclusively in the game.

"Warner Bros. Entertainment is honored to be a partner with the U.S. Government in this worthy and critically important effort to address this global health issue," said Barry Meyer, Chairman and CEO, Warner Bros. Entertainment. "We are proud to contribute our creativity and talent to this effort."

youth-focused HIV prevention strategies. Interventions will then spread to reach youth in other PEPFAR-supported countries.

PEPFAR has also developed the Southern Africa Prevention Initiative (SAPI) to strengthen prevention programming across the region. Southern Africa remains the epicenter of the epidemic, accounting for approximately 35 percent of all PLWHA and almost a third of all new infections and deaths globally. With its nine countries — Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe — consistently reporting adult prevalence rates between 14 percent and 34 percent, it is clear that Southern Africa has a critical need to adopt more strategic HIV prevention approaches to reduce the number of new infections.

Through SAPI, PEPFAR is implementing a comprehensive training package for prevention. The objective is to strengthen the technical expertise to design, implement, monitor, and evaluate prevention programs that are based on the principles of HIV prevention, including: theories of behavior change; updates on recent literature on prevention approaches; the analysis and interpretation of surveys, surveillance, and studies; intervention design and implementation; methods to select and adapt interventions for country use; identifying national prevention priorities; prevention policy and advocacy; and monitoring and evaluation of HIV prevention programs. The trainings include both academic theory and implementation of HIV prevention and incorporate biomedical and community-based interventions.

In addition, PEPFAR is continuing to create effective approaches for older populations, including discordant couples, and is implementing them in the same geographic locales as the youth programs. Effectively reaching these populations demands the use of sexual behavior change messages and biomedical interventions such as male circumcision, as well as work that is outside the traditional realm of public health, such as education and income-generation programs. While programs have made great strides to provide linkages and direct interventions in these areas, combination programs must be evaluated to determine how best to implement them. Programs that might be good for general development but which do not prevent infections in a significant way are the purview of other health and development programs, not those of PEPFAR.

Male circumcision

As another component of combination prevention, PEPFAR is identifying populations for which safe male circumcision is especially promising and, by host country request, prioritizing service delivery to these populations within a comprehensive prevention package. In anticipation of the potential role of safe male circumcision, PEPFAR has been a member of an international male circumcision steering committee led by UNAIDS and WHO. Since 2006 PEPFAR has funded formative and preparatory work within several countries, including assessments of clinical and community preparedness.

With the new WHO/UNAIDS recommendations in place, PEPFAR funds were made available to support the delivery of safe male circumcision services, based on requests from host governments and in keeping with their national policies and guidelines. Male circumcision should be safely provided and integrated into, not substituted for, a comprehensive HIV/AIDS prevention program.

In FY2007, PEPFAR countries were provided an opportunity to request further funding to support male circumcision activities. Nine countries received funding totaling $15 million. Resources were then allocated to support activities consistent with the WHO/UNAIDS recommendations, such as stakeholder meetings, clinic and community assessments, training, and policy work. Countries ready to initiate service delivery were required to submit a letter from the MoH requesting USG assistance for male circumcision services. In FY2008, PEPFAR support grew, as 13 countries submitted requests for male circumcision activities totaling $26 million. Of that total, $11 million supported direct circumcision service delivery. Total investments are expected to rise to at least $30 million in FY2009.

Allocation of funding and support of organizations is competitively determined at the country level and decisions are based on existing agreements, organizational capacity, and technical skills. Many organizations providing male circumcision have past experience with service delivery (some through their own private funding) or have been working in similar areas of intervention. For example, a group that may have worked on health policy may be requested to expand its scope to also address male circumcision.

Scale-up of male circumcision presents significant challenges, including the need for human resources and appropriate counseling to prevent risk compensation (in which men engage in more risky behavior because they believe they are completely protected by circumcision). PEPFAR partners make it clear that male circumcision is not a silver bullet, but only one part of a broad prevention arsenal. ABC behavior change education is incorporated into counseling for men seeking circumcision services. PEPFAR is rolling programs out as rapidly as possible, beginning in areas of high HIV prevalence and among those at greatest risk of infection, such as discordant couples in which the woman is HIV-positive, to maximize the impact of this prevention intervention. There is also a need to develop training and quality-assurance programs to ensure the safety and effectiveness of male circumcision.

As other prevention strategies, such as microbicides or pre-exposure prophylaxis, are identified by normative agencies as effective, PEPFAR will support them as part of a comprehensive prevention strategy. Thanks to PEPFAR's wide network of care and treatment sites, PEPFAR country teams will be able to implement these methods rapidly whenever they become available — demonstrating again the value of integrated programs.

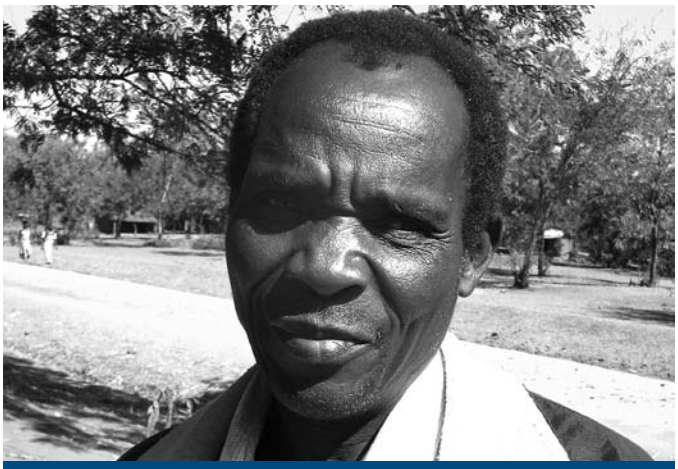
Addressing gender issues

PEPFAR fully integrates gender issues into its prevention, care and treatment programs, recognizing the critical need to address the inequalities between women and men that influence sexual behavior and the norms that put both women and men at higher risk of infection and create barriers to accessing HIV/AIDS services.

PEPFAR supports five key cross-cutting gender strategies that are critical to curbing HIV/AIDS, ensuring access to quality services, and mitigating its consequences. These strategic focus areas are given in Table 6. Activities in support of these focus areas are assessed annually during the COP review process. In FY2008, approximately $1 billion was dedicated to 1,096 activities that included interventions to address one or more gender focus areas.

In 2008, three special gender initiatives continued in nine countries to intensify program efforts in the following focus areas: scaling up evidence-based programs to address male norms and behaviors; strengthening services for victims of sexual violence, including post-exposure prophylaxis (PEP); and addressing the community and structural factors that fuel girls' vulnerability to HIV/AIDS.

Gender issues are central to many HIV prevention programs, including those focused on young men and women since attitudes about sexual relationships and



In the Chikwawa District of Malawi, PEPFAR supported the development of a Bambo Wachitsanzo "Great Guy" Hope Kit, which uses participatory approaches to promote discussion around small actions that men can take to prevent HIV/AIDS. After attending a Bambo Wachitsanzo Open Day focusing on knowing one's status, practicing safe sex, and reducing the number of sexual partners in his village, Lyson Mandere and his wife went for voluntary HIV counseling and testing. In March 2008, Mandere was awarded the "Bambo Wa Chitsanzo Certificate," which is awarded by the community to "Great Guys" who have demonstrated exemplary characteristics. Many people in his community now follow his example and his actions.

Table 6: Number of Activities per Gender Strategic Focus Area in FY2007 and FY2008

Gender strategic focus area	Number of activities that includes this strategic focus area—FY2007	Number of activities that include this strategic focus area—FY2008
Increasing Gender Equity	620	747
Addressing Male Norms and Behaviors	494	712
Reducing Violence and Coercion	325	407
Increasing Women's and Girls' Access to Income and Productive Resources	163	227
Increasing Women's Legal Protection	83	148

Notes:
Each activity may include multiple focus areas.
These totals represent gender activities in the 15 focus countries.

Kenyan journalists Mary Kiio and Jane Mwangi have a difficult time emotionally preparing to interview and write about gender-based violence, including rape. To help them and others better report these important stories to the public, PEPFAR supported a roundtable discussion in March 2008 that brought together a group of Kenyan journalists to focus on the challenges facing writers reporting on gender-based violence and rape. The roundtable is an example of PEPFAR's effort to address gender issues, including the vulnerability of women to HIV infection.

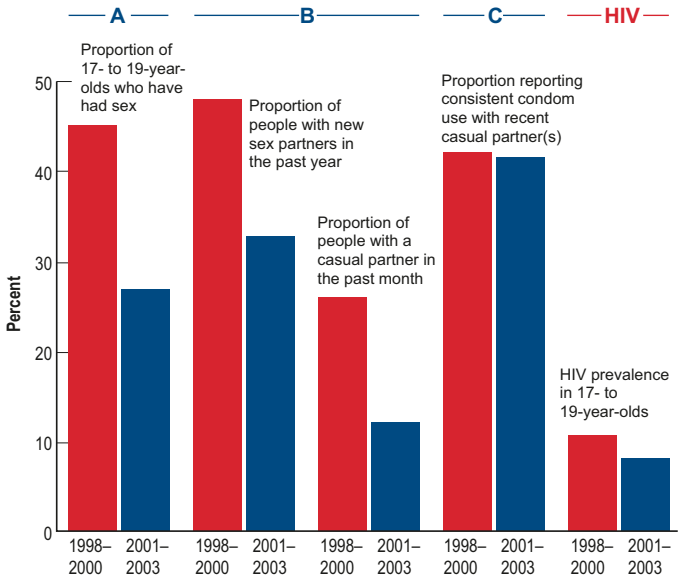
risk-taking behavior are often developed at a young age. Prevention messages about delayed sexual debut, secondary abstinence, fidelity to a single partner, partner reduction, and correct and consistent condom use (included in ABC interventions) can address unhealthy cultural gender norms among boys, girls, men, and women. The messages provide information on the harmful effects of violence against women, cross-generational sex, and transactional sex as part of media and community-based interventions; promote involvement of men in PMTCT and counseling and testing programs; support women in disclosure of their HIV status to their partner and family; and engage communities and policy makers on the importance of inheritance rights and women's access to productive resources to mitigate the impact of HIV/AIDS.

PEPFAR supports the Kenya Federation of Women Lawyers, which provides legal advice to PLWHA concerning rape, sexual assault, and property and inheritance rights. In South Africa and through the Male Norms Initiative in Ethiopia, Namibia and Tanzania, PEPFAR supports the Men as Partners project, which tailors behavior change interventions to redefine masculinity and strength in terms of men taking responsible actions to prevent HIV infection and gender-based violence. In Namibia, PEPFAR supports the Village Health Fund Project, a microenterprise program that provides vulnerable populations, such as widows and grandmothers who care for orphaned grandchildren, with start-up capital for income-generating projects.

Prevention of Sexual Transmission

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. Data that pre-date PEPFAR scale up link adoption of all three of the ABC behaviors to reductions in prevalence. To illustrate an example, Figure 17 shows changes in HIV prevalence and sexual risk behavior in Zimbabwe during the late 1990s and earlier part of this decade. Learning from the evidence, PEPFAR will continue to support all three elements of the evidence-based ABC strategy in ways appropriate to the epidemiology, social and cultural context, and national strategy of each host nation.

Figure 17: Behavior Change Among Males in Manicaland, Zimbabwe



Source: Gregson et al, *Science*; 311:2006

Funding in FY2008 for sexual transmission prevention in the focus countries totaled $408.2 million, or 12.6 percent of all program funding. Table 7 shows that an estimated 58,344,900 people were reached by community outreach programs promoting ABC and related prevention strategies. Along with its programs that teach correct and consistent condom use for those who are sexually active, the USG seeks to ensure an adequate supply of condoms. Table 8 shows the USG has supplied more than 2.2 billion condoms worldwide from 2004 through December 2008,

Table 7: Prevention: FY2008 Prevention of Sexual Transmission Results						
Country	**Number of individuals reached with community outreach HIV/AIDS prevention activities that promote abstinence and/or being faithful[1]**	**Number of individuals reached with community outreach HIV/AIDS prevention activities that promote correct and consistent use of condoms and related interventions[2]**	**FY2008 total**	**Cumulative number of behavior change community outreach encounters, FY2004–FY2008**	**Planned funding FY2008[3, 4]** in USD millions	**Planned funding FY2004–FY2008[3, 4]** in USD millions
Botswana[5]	212,900	38,100	251,000	1,281,400	$16.4	$47.8
Cote d'Ivoire	633,100	671,600	1,304,700	2,997,600	$12.2	$33.4
Ethiopia[6]	6,970,900	5,416,500	12,387,400	46,008,500	$35.9	$93.3
Guyana[7]	61,700	39,600	101,300	726,400	$3.8	$15.1
Haiti	585,200	899,400	1,484,600	4,815,600	$8.4	$31.8
Kenya	4,574,300	5,941,000	10,515,300	33,150,400	$66.8	$162.2
Mozambique	2,389,700	2,019,800	4,409,500	11,867,900	$23.8	$69.3
Namibia	321,200	400,400	721,600	2,049,700	$15.8	$44.9
Nigeria	4,670,700	1,506,600	6,177,300	23,163,200	$41.9	$96.7
Rwanda	717,200	776,900	1,494,100	3,861,100	$12.1	$37.6
South Africa	1,178,700	3,030,500	4,209,200	31,384,400	$61.0	$151.0
Tanzania	2,814,600	2,692,200	5,506,800	35,089,200	$29.8	$87.9
Uganda[8]	4,519,800	1,737,000	6,256,800	47,628,900	$30.6	$103.7
Vietnam	375,200	480,600	855,800	2,642,700	$16.6	$43.5
Zambia	1,487,400	1,182,100	2,669,500	9,457,300	$33.0	$99.3
Totals	**31,512,600**	**26,832,300**	**58,344,900**	**256,124,200**	$408.2	$1,117.3
		Total funding including additional attributions			**$538.2**	**$1,469.1**

Notes:

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

Numbers above 100 are rounded to nearest 100.

Footnotes:

[1] AB programs promote as their primary behavioral objectives that: (1) unmarried individuals abstain from sexual activity as the best and only certain way to protect themselves from exposure to HIV and other sexually transmitted infections, and (2) individuals practice fidelity in marriage and other sexual relationships as a critical way to reduce risk of exposure to HIV. Programs may focus on individual behavior change or may address relevant social and community norms. Abstinence programs promote as their primary behavioral objective that unmarried individuals abstain from sexual activity as the best and only certain way to protect themselves from exposure to HIV and other sexually transmitted infections. Programs may focus on individual behavior change or may address relevant social and community norms. Abstinence programs are counted as a subset of AB programs.

[2] Correct and consistent use of condoms and related HIV/AIDS prevention includes behavior change activities, outside of those promoting abstinence and being faithful, that are aimed at preventing HIV transmission. Examples include community outreach programs to promote avoidance or reduction of HIV risk behavior, and the social marketing or promotion of condoms, including work with high-risk groups such as injecting drug users, men who have sex with men, people in prostitution and their clients, and people living with HIV/AIDS. FY2004 and FY2005 results include activities with mass media and community mobilization for HIV testing. Indicators were refined in FY2006, resulting in small changes in the numbers reached.

[3] All funding figures are in millions of U.S. dollars and reflect regularly-updated planned program funding.

[4] Some or all of the individuals reached by PEPFAR may also be supported by other funding sources such as host governments and other donors. This amount varies by country.

[5] Botswana results are attributed to the National HIV Program. Beginning FY2005, 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.

[6] Ethiopia reported fewer people receiving AB messages in FY2008 compared to FY2007. This drop was due to a change in methodology. In FY2008 the estimated number of people present at large public rallies was not included in the total as it was in FY2007. This modification is consistent with the standardized indicator definition.

[7] Guyana reported fewer people receiving prevention messages in FY2008 compared to FY2007. This drop was due to data quality support to partners over the course of the fiscal year that reduced the risk of double-counting of individuals served.

[8] Uganda reported fewer people receiving AB messages in FY2008 compared to FY2007. The reduction is attributable to data quality issues associated with a major contributor to this program area. The data reported here represent 6 months of programming and are likely an underestimate.

lending support to comprehensive ABC approaches based on the epidemiology of each country.

It is important to note that prevention of sexual transmission is chronic disease management — as is treatment and care. An individual must be reached at an early age to have maximum impact on lifelong behavior, and prevention messages must change in an age-appropriate way to address changes in risk behavior. Prevention programs span from about 10 years of age until the time at which a person is presumed to be beyond risk — i.e., when he or she is no longer sexually active. Efforts must continue unabated across the lifespan to reinforce and maintain safe and personally responsible behavior. For this reason, data on the reach of behavior change messages and condom supply are provided both for FY2008 and cumulatively from FY2004 through FY2008.

Elements of ABC interventions

ABC programs are more complex than the simple acronym suggests, because changing human behavior is a uniquely difficult undertaking. Achieving ABC requires significant cultural changes. Children must be reached

Table 8: USG Total Condoms Shipped, Calendar Year 2008[1] and Calendar Years 2004–2008[1]		
Country	**CY2008 shipped[1]**	**CY2004–CY2008 shipped[1]**
Botswana	6,000,000	17,367,000
Cote d'Ivoire	3,288,000	8,136,000
Ethiopia	21,579,000	165,978,000
Guyana	2,001,000	2,991,000
Haiti	10,005,000	51,382,000
Kenya	0	40,002,000
Mozambique	41,202,000	125,922,000
Namibia[2]	0	0
Nigeria	5,001,000	9,705,000
Rwanda	10,968,000	50,724,000
South Africa	3,000,000	3,330,000
Tanzania	15,222,000	72,559,000
Uganda	18,495,000	133,911,000
Vietnam	11,925,000	34,998,000
Zambia	9,999,000	69,707,000
Total focus	**158,685,000**	**786,712,000**
Total global	**375,900,000**	**2,233,414,000**

Notes:

[1] Condom numbers as of December 20, 2008.

[2] The Government of Namibia procures its own condoms, receives donations from other development partners, and also supports a condom social marketing program. The exception to this practice was in FY2003 and FY2004, where at the special request of the Government of Namibia, the USG provided 10 million condoms to the Namibian Government for distribution to NGO and regional entities.

at an early age to encourage delay of sexual debut and to minimize their number of partners. It is essential to rapidly expand life skills programs for youth because of the generational impact. Influencing a 10-year-old's future behavior is far easier than changing a 25-year-old's settled behavior. Behavioral impact from programs for children may not immediately be apparent. We must be patient and persistent. These programs influence future behavior and we are only 5 years into PEPFAR's partnerships for a generational approach to prevention.

ABC also includes changing gender norms. Partnering with children's parents and caregivers to support their efforts to teach children to respect themselves and others is the best way to promote gender equality. For the ABC approach to be effective it must address the gender dynamics that affect sexual decision-making and strive to reduce sexual coercion, violence, and rape. Through support for delayed sexual debut, secondary abstinence, fidelity to a single partner, partner reduction, and correct and consistent condom use, ABC contributes to changing unhealthy cultural gender norms.

It is also essential to reduce stigma against PLWHA and also against those who choose healthy lifestyles. On the other hand, cross-generational sex, including the phenomenon of older men preying on young girls, and

Tayoa, a PEPFAR-supported Tanzanian youth organization, is dedicated to running the national AIDS helpline services, providing online HIV counseling, and supporting youth prevention networks at the community level. In an effort to reach youth with information about healthy decision-making, Tayoa members use popular forms of communication and self-expression, including art, comics, digital story telling, traditional dances and art exhibitions, to spread information about behavior change and HIV risk reduction. In addition, Tayoa supports youth leaders ("youth balozi") to play an active role in helping their peers with problem-solving, making informed decisions, and building self-esteem. To launch this program, Tayoa organized a contest where 813 youth aged 14–24 created art, music, traditional dances, and skits for the Tayoa youth balozi art center. The art center has become increasingly popular among Tanzanian youth. The products developed at the center have been used for public service announcements and other educational purposes to help young people examine and subsequently change risky behaviors.

sexual violence, should be identified and even vilified. We must also intensify efforts to reduce stigma against women and girls who are victims of sexual violence; strengthen services for them; and ensure that HIV PEP, related medical care, and psycho-social support are accessible to all survivors.

Recent PEPFAR-supported efforts include a growing number of interventions with PLWHA. The adoption of healthy living and reduction in risk behaviors among HIV-positive people leads to a substantial improvement in quality of life and a reduction in HIV transmission rates. These prevention efforts aim to mitigate the spread of HIV to sex partners, IDU partners, and infants born to HIV-infected mothers, and to protect the health of infected individuals. For example, in Uganda, a collaborative provider training initiative involving NGOs, community groups, and the Uganda MoH was developed to build capacity of service providers to deliver effective HIV counseling for PLWHA. Organizations and networks of PLWHA worked together to create prevention

messages on a variety of topics, including: partner testing; status disclosure; socio-cultural barriers to prevention; HIV discordance; condom use; and managing the "new lease on life" challenges after ART, including dating, marriage and child-bearing.

Knowing your epidemic

ABC programs must be comprehensive to be effective. They also must be tailored to the contours of each country's epidemic. ABC behavior change should be at the core of prevention programs, but one size does *not* fit all. PEPFAR takes different approaches, depending on whether a country has a generalized or a concentrated epidemic. In countries with concentrated epidemics where, for example, 90 percent of infections are among persons in prostitution and their clients, the epidemiology dictates a response more heavily focused on B and C interventions.

The 2008 bill reauthorizing PEPFAR supports this focus on the epidemiology of each country. The law changed the statutory approach to prevention of sexual transmission of HIV. The original 2003 PEPFAR authorization required the program to ensure that at least 33 percent of all prevention funding was committed to "abstinence-until-marriage" programs. In computing this, PEPFAR counted funding for both the A and B interventions of the ABC approach.

Namibia's senior political and health leaders participated in the First National Conference for Men on HIV and AIDS in Namibia on February 20, 2008. The theme of the conference was, "Namibian Men: Our Time to Act." Chaired by the President of Namibia, His Excellency Hifikepunye Pohamba, more than 200 male leaders from Namibian society, including the Prime Minister, Parliamentarians, and government Ministers, as well as military, business, and religious leaders, attended the conference. These national leaders raised the level of awareness about the relationship between men's behavior and the spread of HIV, discussed ways for men to respond to the epidemic, and encouraged men to make a strong commitment to prevent the spread of HIV.

Section 503 of the 2008 Reauthorization Act requires the Global AIDS Coordinator to "provide balanced funding for sexual transmission prevention activities for sexual transmission of HIV/AIDS," and to "ensure that activities promoting abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction are implemented and funded in a meaningful and equitable way in the strategy for each host country based on objective epidemiological evidence as to the source of infections and in consultation with the government of each host country involved in HIV/AIDS prevention activities."

The Coordinator is to establish a sexual transmission prevention strategy in each country with a generalized epidemic. If the strategy provides less than 50 percent of funds for activities promoting abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction, the Coordinator is required, not later than 30 days after the issuance of this strategy, to report to Congress on the justification for this decision.

Programs or activities that implement new prevention technologies or modalities are not included in this requirement. For example, among the interventions not subject to determining compliance with this requirement are medical male circumcision, blood safety, promotion of universal precautions, investigation of suspected nosocomial infections, microbicides, pre-exposure pharmaceutical prophylaxis to prevent transmission of HIV, and programs and activities that provide counseling and testing or PMTCT interventions

Addressing multiple concurrent partnerships and discordant couples

For older adolescents and adults who are sexually active, ABC includes reducing casual and multiple and concurrent partnerships, which can rapidly spread HIV infection through broad networks of people. Multiple and concurrent partnerships are common in many countries hardest-hit by HIV, and PEPFAR supports programs that emphasize partner reduction toward the goal of faithfulness to a single HIV-negative partner.

In October 2008, PEPFAR hosted a technical consultation on "Addressing Multiple and Concurrent Sexual Partnerships in Generalized HIV Epidemics." The meeting brought together colleagues from the

Like many students at the Hong Cam Mining Vocational College in Vietnam, 22-year-old Pham Van Duy leads a busy academic and social life. In addition to his coursework and extracurricular activities, Duy is an active Peer Educator trained by Project N.A.M, a PEPFAR-supported project that provides a comprehensive HIV prevention program for at-risk young men in vocational schools and out-of-school settings. In 2008, 700 peer educators and club members like Duy reached more than 45,000 at-risk young men.

field, implementing partners, headquarters staff, and prevention experts to deepen understanding of the role of multiple and concurrent sexual partners in the spread of HIV; share emerging programmatic approaches; and build consensus on promising programmatic strategies to address and mitigate multiple and concurrent partnerships.

The limitations of current quantitative methods for measuring multiple and concurrent partners was identified as a key issue in this area. For example, DHS data show a strong correlation between multiple partners and sero-prevalence by country, but do not show a similar strong correlation for concurrent partnerships. Statistical modeling, on the other hand, shows that very small increases in the mean number of concurrent partners very significantly increases the connectivity of sexual networks and HIV prevalence. The corollary is that a relatively small number of people who change their behavior could potentially have significant population-level impact. A less obvious but important point is the difference between individual-level and population-level risk. Having concurrent partners increases one's risk of infecting others more than one's own risk of infection.

Several attendees from across sub-Saharan Africa shared their experiences with implementing programs focused on reducing multiple and concurrent partnerships. While significant challenges were noted, including low risk perception related to concurrent partnerships, the presentations demonstrated that multiple and concurrent partnerships *can* be addressed effectively through multi-sectoral, culturally sensitive programs.

The meeting identified challenges and areas for more expansive research including the need to collect more rigorous impact and process data. Findings from the meeting have been shared with field staff, and PEPFAR will continue to build on the continued evidence that the role of multiple and concurrent partnerships is a key component of HIV prevention interventions.

Discordant couples, in which one partner is living with HIV and the other is not, are another important focus for intensive HIV prevention interventions. Given the large number of infections occurring through these discordant partnerships, PEPFAR supports efforts to reach discordant couples through a range of different interventions that include: couples HIV testing; behavior change counseling, including on the importance of being faithful and using condoms correctly and consistently; and ensuring that the HIV-infected partner is linked to appropriate care and treatment services, which can lower the likelihood of transmission.

Injecting Drug Users (IDUs)

Substance use, including injection drugs, is a major means of spreading HIV in many parts of the world. According to UNAIDS, outside of sub-Saharan Africa injecting drug use comprises just under one-third of global HIV transmission. IDUs everywhere are at great risk for infection with HIV, through contaminated needles and syringes, risky sexual practices, and higher rates of STI.

With the exception of Vietnam, the PEPFAR focus countries have generalized epidemics driven by sexual behavior, and substance use plays a much smaller role in HIV transmission. PEPFAR therefore invests the most resources in prevention of sexual and mother-to-child transmission, which are the primary drivers of the epidemic globally.

PEPFAR has supported national efforts to establish the political support, policy frameworks, and programmatic experience to scale up HIV/AIDS prevention, treatment and care for IDUs. In Vietnam, PEPFAR invested approximately $89 million in FY2008 for programs focused primarily on injecting drug use. Cambodia, China, India, Kenya, Russia, Tanzania, Thailand, Ukraine,

and Vietnam plan to carry out activities to target drug users, both injecting and non-injecting, in FY2009.

PEPFAR supports three primary approaches to HIV prevention among IDUs: 1) tailoring HIV prevention programs to substance abusers; 2) supporting substance abuse therapy programs for HIV-positive individuals, and in certain cases in pilots for HIV-negative individuals, as an HIV prevention measure; and 3) offering HIV-positive drug users a comprehensive HIV/AIDS treatment program to reduce the risk of transmission.

An important emerging strategy that PEPFAR supports for HIV prevention is medication-assisted therapy (MAT), also known as opioid substitution therapy, for IDUs. PEPFAR supports the use of MAT for HIV-positive and HIV-negative IDUs, focusing on HIV-positive IDUs because they represent an especially high-risk population. HIV-positive IDUs pose a risk for transmission of HIV to HIV-negative individuals — including other IDUs — and for fostering drug resistance if they are not adherent to their ART. Regardless of their serostatus, capacity for MAT interventions for IDUs is extremely limited in PEPFAR countries, so prioritizing interventions for HIV-positive individuals is critical. However, where capacity allows it, PEPFAR has begun to pilot HIV prevention programs that include preventing and treating injection drug use in HIV-negative individuals.

PEPFAR has supported MAT globally by working first with governments to develop the political acceptance and national policies to permit MAT interventions. However, because the IDU population is heavily stigmatized, MAT interventions are controversial, and not all countries have passed enabling legislation. A significant breakthrough occurred in 2006 when with strong PEPFAR support Vietnam changed its 5-year national HIV/AIDS strategy and passed HIV legislation to legalize MAT for IDUs. In FY2008 PEPFAR launched pilot MAT centers in Vietnam to serve HIV-positive and -negative clients. PEPFAR also launched pilot MAT centers in Ukraine to deliver this therapy to HIV-positive drug users.

Prevention of Mother-to-Child Transmission

UNAIDS estimates that 370,000 children under the age of 15 became infected with HIV/AIDS in 2007, down from 460,000 in 2001. Approximately 90 percent of these infections were due to mother-to-child transmission. PMTCT is a key element of the prevention strategies of host nations, and PEPFAR has provided support for

In November 2007, Veronica learned that she was HIV-positive during her first antenatal visit to Tanzania's Njombe Health Center, a PEPFAR-supported clinic that trains health professionals on prevention of mother-to-child HIV transmission. Worried that she would pass HIV to her unborn child, Veronica began attending HIV/AIDS counseling at the Center and received Nevirapine during child birth. Thanks to the work of Njombe, Veronica gave birth to an HIV-negative baby girl.

host nations' PMTCT interventions for women during approximately 16 million pregnancies. Of these, more than 1.2 million women were determined to be HIV-positive and received preventive ARVs, preventing an estimated 237,600 infections of newborns. Table 9 shows that PEPFAR provided $211.2 million in support of PMTCT programs in FY2008, or 6.5 percent of the total program funding in the focus countries.

Table 10 shows that access to vital ANC interventions varies across the focus countries. PEPFAR supports host governments' and other partners' efforts to provide PMTCT interventions, including HIV counseling and testing, for all women who attend ANCs. PEPFAR is working to address obstacles to successful scale-up of PMTCT programs including: 1) failure to adopt and fully implement "opt-out" provider-initiated counseling and testing; 2) lack of integration as a basic part of maternal and child health care; 3) difficulties extending coverage to peripheral and rural sites; and 4) challenges in developing effective linkages with HIV care and treatment services.

PEPFAR support has allowed many nations to make significant progress in reaching pregnant women with PMTCT interventions in recent years, often building on programs that pre-dated PEPFAR (Table 10). In other countries, progress has been slower, and

Table 9: Prevention: FY2008 Prevention of Mother-to-Child Transmission Program[1] Results									
Country	Pregnant women receiving HIV counseling and testing services[2]			Number of HIV+ pregnant women receiving ARV prophylaxis			Total estimated infant infections averted[5]	Planned funding FY2008[6, 7] in USD millions	Planned funding FY2004–FY2008[6, 7] in USD millions
	Number receiving upstream system strengthening support[3]	Number receiving downstream site-specific support[4]	Total	Number receiving upstream system strengthening support[3]	Number receiving downstream site-specific support[4]	Total			
Botswana[8]	38,800	0	38,800	10,900	0	10,900	2,100	$3.9	$17.0
Cote d'Ivoire	43,700	110,600	154,300	1,200	4,600	5,800	1,100	$5.3	$14.5
Ethiopia	0	214,200	214,200	0	5,300	5,300	1,000	$17.8	$38.2
Guyana	0	12,000	12,000	0	200	200	38	$0.5	$5.9
Haiti	0	138,900	138,900	0	1,400	1,400	300	$4.5	$13.5
Kenya	0	988,800	988,800	0	61,100	61,100	11,600	$29.2	$83.5
Mozambique	105,600	348,300	453,900	8,700	31,200	39,900	7,600	$19.4	$51.1
Namibia	0	37,000	37,000	0	6,500	6,500	1,200	$5.3	$14.8
Nigeria	81,000	556,300	637,300	2,900	26,900	29,800	5,700	$23.4	$58.6
Rwanda	119,300	120,300	239,600	4,700	5,100	9,800	1,900	$6.4	$20.7
South Africa	426,700	407,700	834,400	23,500	106,100	129,600	24,600	$35.4	$77.1
Tanzania	52,800	694,200	747,000	2,700	34,400	37,100	7,000	$22.4	$50.8
Uganda	235,700	594,300	830,000	6,900	34,700	41,600	7,900	$16.2	$46.3
Vietnam	4,800	242,400	247,200	0	900	900	200	$3.7	$7.2
Zambia	0	276,700	276,700	0	42,900	42,900	8,200	$17.8	$51.1
Totals	**1,108,400**	**4,741,700**	**5,850,100**	**61,500**	**361,300**	**422,800**	**80,400**	$211.2	$550.5
				Total funding including additional attributions[9]				**$266.1**	**$721.5**

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.

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, counseling and support for safe infant feeding practices, and voluntary family planning counseling referrals.

[2] The number of pregnant women receiving PMTCT services includes only women who have been counseled and tested, and received their test results.

[3] 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, or protocol and curriculum development.

[4] Number of individuals reached through downstream, site-specific support includes those receiving services at USG-funded service delivery sites.

[5] The number of infant infections averted was calculated by multiplying the total number of HIV+ pregnant women who received ARV prophylaxis (upstream and downstream) by 19 percent, reflecting a consensus estimate that current interventions (which vary by country and site) are reducing transmission, on average, from a background of 35 percent to 16 percent. Countries with more effective interventions (eg. Botswana) are likely averting more infant infections than shown here.

[6] All funding figures are in millions of U.S. dollars and reflect regularly-updated planned program funding.

[7] Some or all of the individuals reached by PEPFAR may also be supported by other funding sources such as host governments and other international partners. This amount varies by country.

[8] Botswana results are attributed to the National HIV Program. Beginning FY2005, 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.

[9] Total funding for each prevention, treatment and care programmatic area includes attribution of field and central dollars from the following categories: central procurements, supply chain, technical leadership and support, New Partners Initiative, strategic information, management and staffing, policy analysis, and systems strengthening activities. These attributions are made at the aggregate level and then added to the programmatic funding levels to get the total amount of support for each programmatic area.

the Emergency Plan is supporting these nations in redoubling efforts to close the gap. When comparing results from the first year of PEPFAR in FY2004 to FY2008, all countries have scaled up, and most have dramatically improved availability of PMTCT interventions to pregnant women.

Nations have sought to ensure that all women receive the option of an HIV test through pre-test counseling during pregnancy (or at or after delivery, if they do not seek care before delivery). By promoting the routine offer of voluntary HIV testing to ensure that women receive testing unless they opt out, host nations have increased the rate of uptake among pregnant women from low levels to around 90 percent at many sites. Adoption and effective implementation of opt-out testing, rapid testing, and other essential policy changes, is essential for success. For further information on policies relating to HIV testing, please see the section on Counseling and Testing.

Prevention of Medical Transmission

Ensuring an adequate supply of safe blood is a critical prevention priority. A key part of PEPFAR's health systems strengthening activities has been 5 years of support to improve national blood transfusion services. In FY2008, PEPFAR provided approximately $92.4 million for medical transmission prevention activities in the focus countries, or 2.9 percent of program funds. This included direct support for 5,287 blood-safety service outlets or programs, as well as broader efforts

Table 10: Prevention: Prevention of Mother-to-Child Transmission Program[1] with USG Support in FY2004 and FY2008		
Country	Estimated coverage of pregnant women receiving HIV counseling and testing Percent coverage	
	FY2004	FY2008
Botswana[2]	58%	86%
Cote d'Ivoire	3%	23%
Ethiopia	0.2%	6%
Guyana	32%	87%
Haiti	8%	53%
Kenya	19%	69%
Mozambique	4%	56%
Namibia	12%	76%
Nigeria	0.4%	12%
Rwanda	11%	59%
South Africa	46%	85%
Tanzania	2%	53%
Uganda	8%	55%
Vietnam[3]	0.1%	17%
Zambia[3]	11%	59%
Totals	**6%**	**32%**

Notes:

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

This indicator was revised beginning in FY2005. FY2004 results include an adjustment accounting for pregnant women who were counseled, tested, and received their test results.

Coverage rates were calculated by dividing PEPFAR program (upstream and downstream) results by the estimated population eligible for the service. Eligible populations were based on the estimated number of births for each year provided by the International Database of the U.S. Census Bureau. Coverage estimates for FY2004 were revised from estimates provided in the PEPFAR Third Annual Report to Congress, using eligible populations from the U.S. Census Bureau. This methodology provides a standardized comparison across all countries and the reported rates may differ from those reported by countries.

Footnotes:

[1] PMTCT includes activities aimed at providing the minimum package of services for preventing mother-to-child transmission. This indicator is based on pregnant women who received HIV counseling and testing and received their test results.

[2] Botswana results are attributed to the National HIV Program. Beginning FY2005, 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.

[3] An error occurred in reporting coverage rates in the PEPFAR Third Annual Report to Congress. FY2004 results for Vietnam and Zambia were reversed. The correct estimates are now reported in this table.

to strengthen blood service management, commodity procurement, infrastructure, and national policies.

Over the past 5 years, the 14 countries that received PEPFAR support for prevention of medical transmission have substantially increased total blood collections from low-risk, voluntary, non-remunerated donors and seen a decrease in the prevalence of HIV-infected units. In addition, laboratory capacity in these countries has been strengthened to ensure that all collected units are screened for HIV and other transfusion-transmissible infections.

With PEPFAR support, total blood collections have increased in all 14 countries since the start of the program. Further, in 11 of 14 countries collections per 1,000 population per year have also increased since 2003, indicating that countries are moving progressively closer to meeting their annual demand for safe blood.

In order to build capacity for a sustainable response into the future, PEPFAR also supported blood safety training or retraining for 9,838 people in FY2008.

Ensuring that medical injections are safe for patients, health workers, and communities is also a vital HIV prevention intervention. PEPFAR has supported medical injection safety programs in 16 countries, reaching more than 150,000 healthcare workers since 2004, and is providing essential commodities for safe medical injections.

Partnerships for Treatment

Photo by Ndlovu Medical Trust

Thanks to antiretroviral treatment from the PEPFAR-supported Ndlovu Medical Centre in South Africa, Lettie is an active member of her community.

It was just a few years ago that many doubted that large-scale ART programs could work in the world's poorest nations. Millions of people are living proof that they can.

Over 2.1 million people, including more than 2 million in the 15 focus countries, received treatment with support from rapidly scaled-up bilateral PEPFAR partnerships with host nations. In FY2008, PEPFAR provided nearly $1.6 billion in support of treatment programs, including treatment for pediatric patients, or 48.4 percent of program funding in the focus countries. The striking growth of PEPFAR support for treatment in the focus countries is shown in Figure 18, Table 11, and Table 12.

By September 2008 in the focus countries, approximately 54,100 individuals were being added to the number

Figure 18: Treatment: Number of Individuals Receiving Antiretroviral Treatment in the 15 Focus Countries (Total of both upstream and downstream USG-supported interventions)

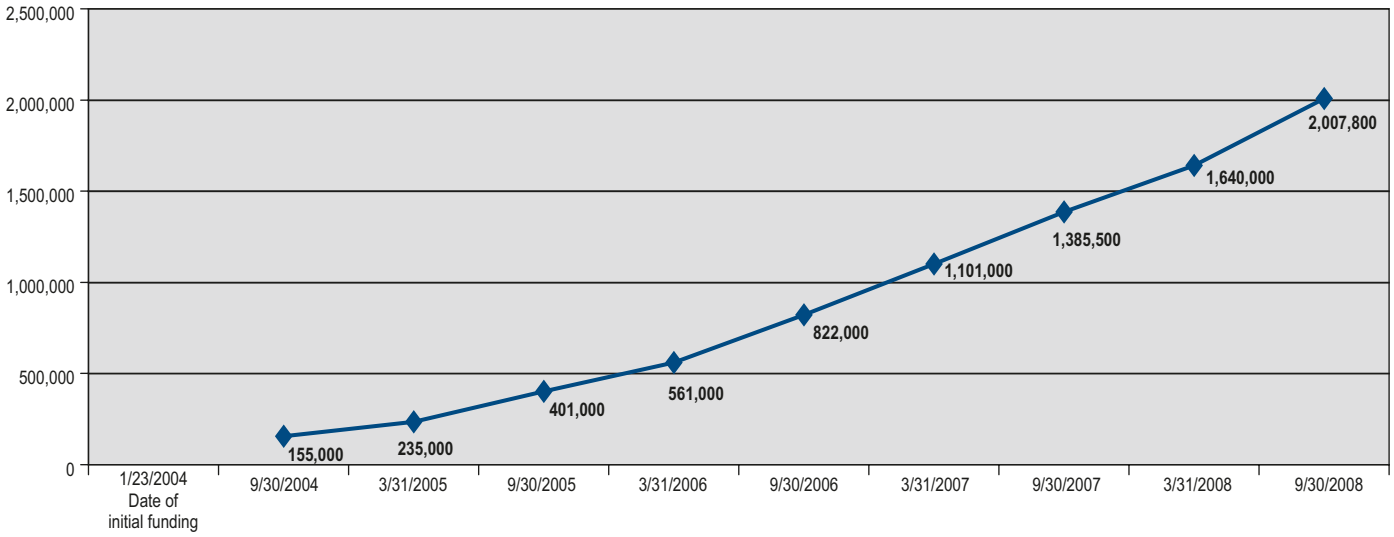


Table 11: Treatment[1]: FY2008 Overall Results

Country	Number of individuals receiving upstream system strengthening support for treatment[2]	Number of individuals receiving downstream system site-specific support for treatment[3]	Total number of individuals reached	Planned funding FY2008[4, 5] in USD millions	Planned funding FY2004–08[4, 5] in USD millions
Botswana[6]	111,700	0	111,700	$25.9	$88.2
Cote d'Ivoire	11,200	39,300	50,500	$53.5	$135.7
Ethiopia	0	119,600	119,600	$167.5	$393.7
Guyana	29	2,300	2,300	$7.0	$32.3
Haiti	0	17,700	17,700	$40.3	$128.0
Kenya	10,000	219,700	229,700	$242.0	$605.2
Mozambique	47,300	70,700	118,000	$95.0	$219.6
Namibia	0	56,100	56,100	$31.7	$96.3
Nigeria	13,400	198,100	211,500	$220.7	$541.9
Rwanda	23,000	36,900	59,900	$45.4	$149.5
South Africa	133,700	416,000	549,700	$258.2	$643.9
Tanzania	5,500	138,600	144,100	$142.0	$373.3
Uganda	14,200	130,800	145,000	$106.9	$349.0
Vietnam	9,200	15,300	24,500	$25.8	$67.7
Zambia	0	167,500	167,500	$102.0	$346.1
All focus countries	**379,229**	**1,628,600**	**2,007,800**	**$1,563.9**	**$4,170.5**
		Total funding including additional attributions[7]		**$1,884.5**	**$5,067.9**
Other countries	**115,000**	**0**	**115,000**		
All countries	**1,743,600**	**379,229**	**2,122,800**		

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.

Footnotes:

[1] Treatment includes the provision of antiretroviral drugs and clinical monitoring of antiretroviral treatment among those with advanced HIV infection.

[2] 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, protocol and curriculum development.

[3] Number of individuals reached through downstream, site-specific support includes those receiving services at USG-funded service delivery sites.

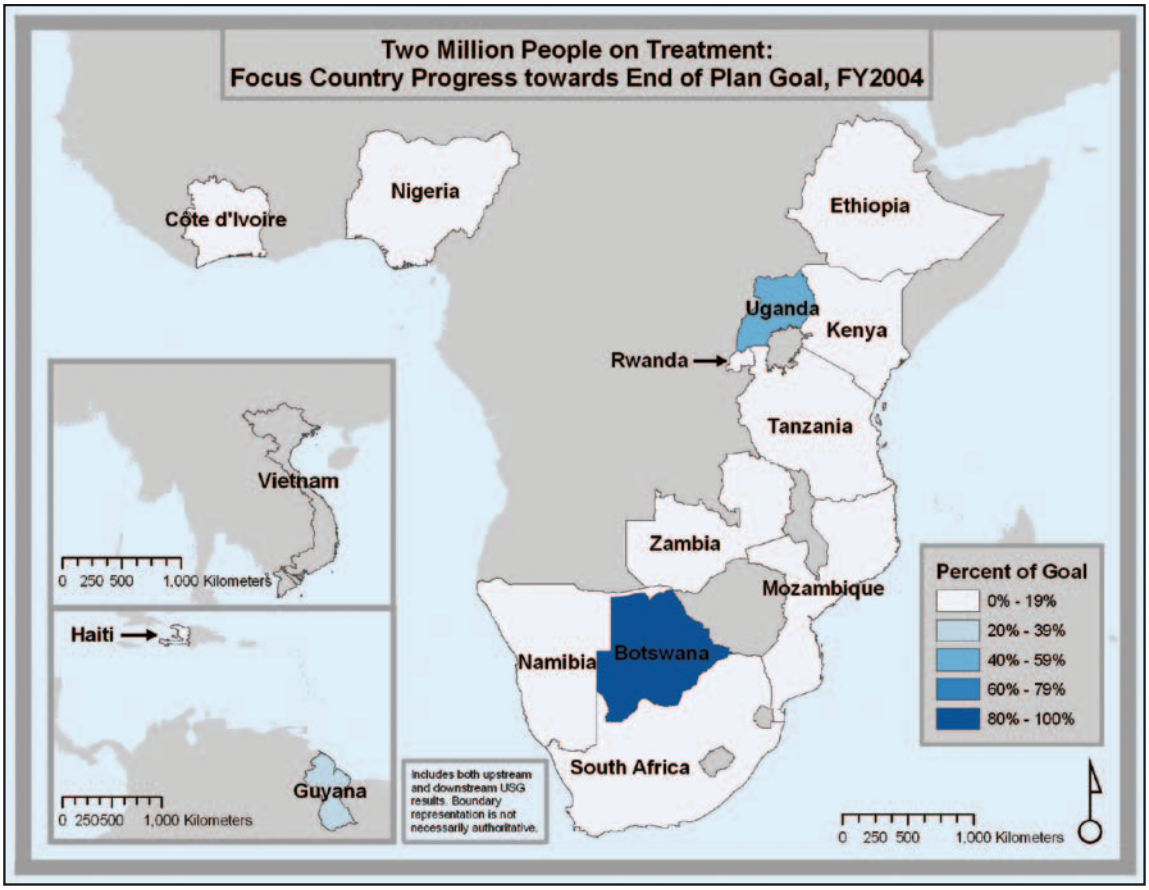
[4] All funding figures are in millions of U.S. dollars and reflect regularly-updated planned program funding.

[5] Some or all of the individuals reached by PEPFAR may also be supported by other funding sources such as host governments and other international partners. This amount varies by country.

[6] Botswana results are attributed to the National HIV Program. Beginning FY2005, 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. This decision mostly affected reporting in the areas of care and treatment.

[7] Total funding for each prevention, treatment and care programmatic area includes attribution of field and central dollars from the following categories: central procurements, supply chain, technical leadership and support, New Partners Initiative, strategic information, management and staffing, policy analysis, and systems strengthening activities. These attributions are made at the aggregate level and then added to the programmatic funding levels to get the total amount of support for each programmatic area.

Figure 19: PEPFAR Treatment Programs Supported



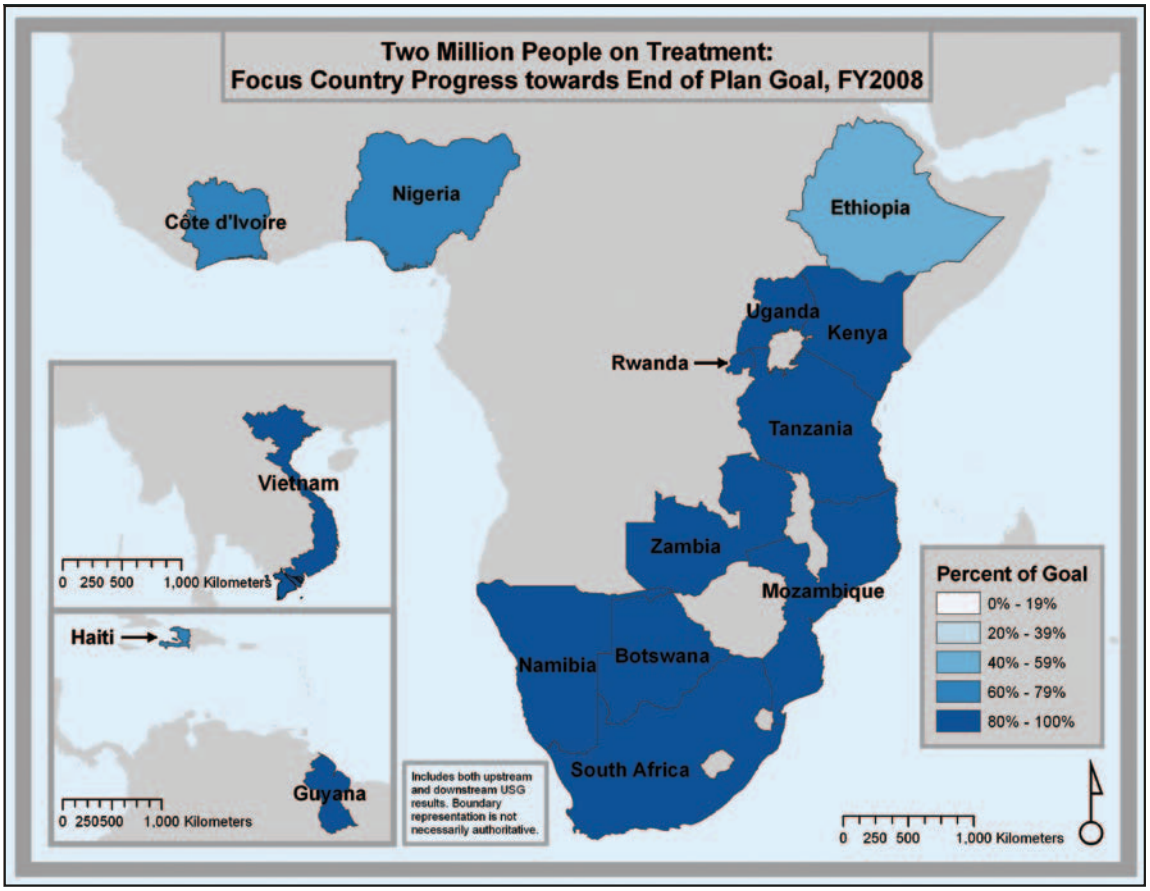


Table 12: Treatment[1]: FY2008 Progress Toward Target of 2 Million Individuals on Treatment in Focus Countries			
Country	**Emergency Plan 5-year target**	**Total number of individuals reached**	**Percentage of 5-year target met**
Botswana[2]	33,000	111,700	338%
Cote d'Ivoire	77,000	50,500	66%
Ethiopia	210,000	119,600	57%
Guyana	2,000	2,300	115%
Haiti	25,000	17,700	71%
Kenya	250,000	229,700	92%
Mozambique	110,000	118,000	107%
Namibia	23,000	56,100	244%
Nigeria	350,000	211,500	60%
Rwanda	50,000	59,900	120%
South Africa	500,000	549,700	110%
Tanzania	150,000	144,100	96%
Uganda	60,000	145,000	242%
Vietnam	22,000	24,500	111%
Zambia	120,000	167,500	140%
All countries	**2,000,000**	**2,007,800**	**100%**

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.

Total includes 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, or protocol and curriculum development, as well as those receiving services at USG-funded service delivery sites.

Footnotes:

[1] Treatment includes the provision of antiretroviral drugs and clinical monitoring of antiretroviral treatment among those with advanced HIV infection.

[2] Botswana results are attributed to the National HIV Program. Beginning FY2005, 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. This decision mostly affected reporting in the areas of care and treatment.

of people benefiting from PEPFAR support for life-extending treatment every month. The number of sites providing treatment increased 80 percent from FY2007 to FY2008, and each month approximately 197 new treatment sites came on line.

Progress in national scale-up

The maps in Figure 19 depict the increase in PEPFAR support for treatment coverage as programs scaled up toward the 5-year target of treatment support for 2 million people.

Beyond the focus countries, other bilateral PEPFAR treatment programs supported an additional 115,000 people (including only those reached with downstream PEPFAR support), for a total of over 2.1 million receiving treatment with PEPFAR support worldwide.

Reaching women and children

As part of its commitment to ensure treatment availability for children and women, PEPFAR bilateral programs have led international partners in supporting host nations in tracking clients by age and gender. Table 13 shows that of those for whom PEPFAR provided downstream support for treatment in the focus countries, approximately 63 percent were women, which is higher than the estimated percentage of women living with HIV in sub-Saharan Africa.

Table 13: Number of Children and Women Among Those Receiving Treatment with Downstream Emergency Plan Support in Focus Countries				
	FY2007		**FY2008**	
	Children (ages 0–14)	Women (all ages)	Children (ages 0–14)	Women (all ages)
Total	**85,900**	**575,300**	**130,100**	**968,100**

Notes:

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

Numbers above 100 are rounded to the nearest 100 and added to get totals.

Numbers shown reflect only those receiving downstream support. Results for those who benefit from upstream support cannot be disaggregated by age or sex. In FY2008, Botswana and Namibia did not provide disaggregated results and are not included in the totals.

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

PEPFAR has also expanded access to treatment for children, with the number of children receiving ART through downstream PEPFAR support increasing 51 percent from FY2007 levels. PEPFAR dedicated approximately $140 million to pediatric treatment in FY2008, reaching approximately 130,100 children with downstream support in FY2008, compared with only 4,800 in FY2004.

Pediatric treatment has made steady progress, increasing the share of those receiving PEPFAR-supported treatment who are children from 3 percent in FY2004 to 8 percent in FY2008. This percentage is above UNAIDS' estimate of the global share of HIV-positive people who are children (7.5 percent). For FY2008, PEPFAR directed all focus

Kiziba refugee camp, located in the Western Province of Rwanda, is home to nearly 18,000 Congolese refugees who have fled violence from the rebel and militia fighting in Democratic Republic of Congo. With PEPFAR support and site accreditation by the Rwandan Ministry of Health, the United Nations High Commission for Refugees initiated a treatment program at Kiziba camp. ART is integrated in the full health service package that is offered to refugees, as well as the surrounding local community.

countries to increase their level of support for pediatric treatment, moving toward having children represent 10 percent to 15 percent of all individuals on treatment.

Improving infant diagnosis

Increasing the availability of pediatric treatment is pressing because 50 percent of HIV-positive children will die by age 2 if they are not treated. However, effectively addressing the issue of pediatric treatment requires more than increased resources. Standard HIV tests, which test for HIV antibodies, cannot reliably identify children as being HIV-infected until after 18 months of age due to the presence of maternal antibodies. Thus, it is difficult to determine which infants and children are infected and need treatment. To accurately diagnose HIV infection in infants and children so they can access treatment, PEPFAR supports nations in expanding polymerase chain reaction (PCR) testing to identify the presence of HIV. To expand access to accurate diagnosis, PEPFAR-supported programs are testing infants and children using dried blood spots on filter paper, which require less blood per test than older methods and can be easily transported to central laboratories for testing.

PEPFAR has supported country-level policy change to allow PCR-based dried blood spot testing in order to reduce the cost and burden of infant diagnosis. Most PEPFAR countries have now adopted such policies, making accurate diagnosis and management of pediatric treatment a growing reality.

Addressing ongoing barriers to pediatric treatment

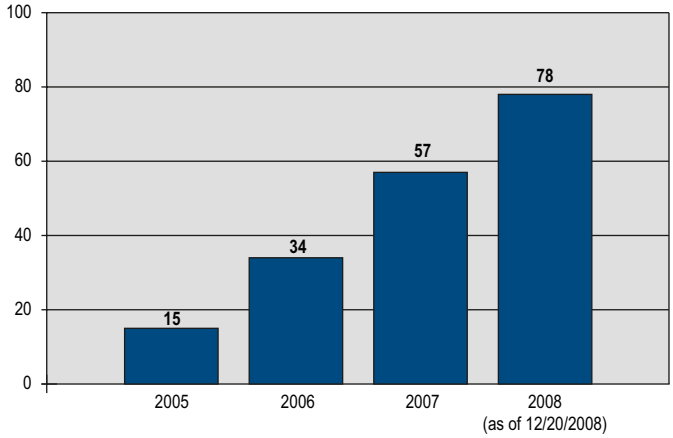
Other barriers currently limiting the scale-up of pediatric treatment and care services include a lack of providers equipped with the necessary skills to address the special needs of HIV-positive children, the relatively high cost of pediatric ARV formulations, regulatory barriers to registering pediatric ARV formulations, weak linkages between PMTCT and treatment services, and limited information about pediatric doses of medicines at different ages and weights. To address these barriers, PEPFAR supports training programs to teach health care workers how to treat pediatric patients, and has supported the development of dosing guides for children of various ages and sizes. PEPFAR also continues to work with pharmaceutical companies, implementing organizations, and multinational organizations such as UNICEF and WHO through a PPP (announced by Laura Bush in 2006) to address these barriers.

Increasing the availability of safe, effective, low-cost generic medications

PEPFAR's impact on treatment access extends beyond PEPFAR-supported programs to increased availability of safe, effective, low-cost, generic 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 to allow ARVs from anywhere in the world, produced by any manufacturer, to be rapidly reviewed to assess quality standards and subsequently cleared for purchase under PEPFAR. As of December 20, 2008, 78 generic ARV formulations had been approved or tentatively approved by HHS/FDA under the expedited review, including 16 fixed-dose combination products that contain two drugs in the same tablet or capsule, and seven fixed-dose combination products that contain three drugs in the same tablet or capsule. Twenty of the newly approved ARVs are intended primarily for pediatric use. Figure 20 shows the steady increase in approvals. The process has also expedited the availability in the United States of seven generic versions of ARVs whose U.S. patent protection has expired.

The safety, reliability, and efficacy of drugs procured with PEPFAR funding is of the utmost importance. Any

Figure 20: Treatment: Cumulative HHS/FDA Approvals/ Tentative Approvals of Generic ARVs, Calendar Years 2005, 2006, 2007 and 2008



known or suspected failure of a PEPFAR-procured ARVs to meet its required specifications in quality-assurance testing, or to perform as expected when used properly, results in immediate action to inform USG staff and partners in the field. Where necessary, the product is recalled and necessary substitutions in patient regimens are made along with efforts to locate a manufacturer with a more reliable product.

Table 14 is drawn from the work of SCMS in 2007 and shows that SCMS has been able to achieve the lowest price on nearly 70 percent of antiretroviral regimens for which internationally published prices were available (17 of 20 first-line regimens and three of nine second-line regimens).

Table 14: SCMS Prices Compared to Prices Reported by Other International Programs

ARV	SCMS discount relative to next lowest price (parentheses indicate ARV for which another purchaser obtains lower price)
Abacavir (as sulphate) 20mg/ml, oral solution, bottle of 240ml	5.82%
Abacavir (as sulphate) 300mg, tablets, 60 tablets	0.43%
Didanosine 100mg, tablets, 60 tablets	0.64%
Didanosine 25mg [Videx], tablets, 60 tablets	(0.57%)
Didanosine 50mg [Videx], tablets, 60 tablets	(0.21%)
Efavirenz 30mg/ml [Stocrin/Sustiva], oral solution, bottle of 180ml	(0.26%)
Efavirenz 50mg, capsule, 30 capsules	10.04%
Efavirenz 600mg, tablets, 30 tablets	5.42%
Indinavir 400mg [Crixivan], capsules, 180 capsules	(1.22%)
Lamivudine 10mg/ml, oral solution, bottle of 240 ml	1.04%
Lamivudine 150mg, tablets, 60 tablets	1.73%
Lamivudine/Stavudine 150mg/30mg, tablets, 30 tablets	21.61%
Lamivudine/Stavudine/Nevirapine 150mg/30mg/200mg, tablets, 60 tablets	5.81%
Lamivudine/Zidovudine 150mg/300mg, tablets, 60 tablets	2.66%
Lamivudine/Zidovudine/Abacavir 150mg/300mg/300mg [Trizivir], tablets, 60 tablets	0.03%
Lamivudine/Zidovudine/Nevirapine 150/300/200mg, tablets, 60 tablets	5.54%
Lopinavir/Ritonavir 200mg/50mg [Aluvia], tablets, 120 tablets	(8.37%)
Nevirapine 10mg/ml, oral suspension, bottle of 240 ml	0.00%
Nevirapine 200mg [Viramune], tablets, 60 tablets	0.00%
Nevirapine 200mg, tablets, 60 tablets	3.58%
Ritonavir 100mg [Norvir], capsules, 4x84 capsules (cool)	(0.15%)
Saquinavir 200mg [Invirase], capsules, 270 capsules	(22.73%)
Stavudine 1mg/ml, powder for oral solution, bottle of 200 ml	0.00%
Stavudine 20mg [Zerit], capsules, 60 capsules	(5.62%)
Stavudine 20mg, capsules, 60 capsules	2.78%
Stavudine 30mg, capsules, 60 capsules	27.59%
Tenofovir disoproxil fumarate/Emtricitabine 300mg/200mg [Truvada], tablets, 30 tablets	5.00%
Zidovudine 10mg/ml, oral solution, bottle of 240 ml	2.78%
Zidovudine 300mg, tablets, 60 tablets	(2.41%)

Note:
*Displayed discount represents the discount achieved by SCMS as compared to the nearest internationally published price.
For this analysis, SCMS weighted average prices were calculated using purchase history from July 1 – September 30, 2007. The calculated unit price was then compared to published prices from the WHO Global Price Reporting Mechanism (purchases from July 1 - September 30, 2007), Medecins Sans Frontieres (July 2007 report), and the Clinton HIV/AIDS initiative (May 2007 Price List).

While this level of savings is a considerable achievement, the use of generics within and between countries varies, and significant challenges remain including:

- Prices for pediatric ARV formulations and second-line ARVs remain higher than first-line regimens.
- In countries where approval and registration of generic ARVs is slow, partners may still have to use innovator drugs.
- Some buyers continue to purchase branded ARVs, due to unfounded concerns that even HHS/FDA-approved generics are not as effective.

In addition, the increasing cost of raw materials for ARVs could slow or stop the decline of ARV prices, and fluctuations in the value of the U.S. dollar against other currencies can also have an impact.

Partnerships for Care

PEPFAR supports host nations' wide-ranging programs to meet the care needs of OVCs affected by the pandemic, as well as people living with or affected by HIV/AIDS. PEPFAR now supports care for over 10 million worldwide as of September 2008, including over 4 million OVCs. Figure 21 and Table 15 show that nearly 9.7 million people were supported in the 15 focus countries through September 2008, including nearly 4 million OVCs. In FY2008, PEPFAR provided 29.5 percent of focus country program resources, or $953 million, in support of care (including $216 million for counseling and testing programs).

Orphans and Vulnerable Children (OVCs)

Along with the tragedies individual children can experience, the increasing needs of millions of OVCs are severely straining the economic and social resources of families, communities, and entire societies. Inadequate care and protection of children can 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 victims of child labor or human trafficking.

Children whose parents are sick or have died from AIDS are often also left without an education or needed

Table 15: Care[1]: FY2008 Progress Toward Emergency Plan Target of 10 Million Individuals Receiving Care in Focus Countries

Country	Emergency Plan 5-year target	Total number receiving care services	Percentage of 5-year target met
Botswana[2]	165,000	247,100	150%
Cote d'Ivoire	385,000	180,100	47%
Ethiopia	1,050,000	892,700	85%
Guyana	9,000	5,500	61%
Haiti	125,000	154,000	123%
Kenya	1,250,000	1,074,000	86%
Mozambique	550,000	773,900	141%
Namibia	115,000	187,300	163%
Nigeria	1,750,000	837,800	48%
Rwanda	250,000	153,000	61%
South Africa	2,500,000	2,380,800	95%
Tanzania	750,000	892,800	119%
Uganda	300,000	1,146,100	382%
Vietnam	110,000	61,800	56%
Zambia	600,000	706,900	118%
All countries	**10,000,000**	**9,693,800**	**97%**

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.

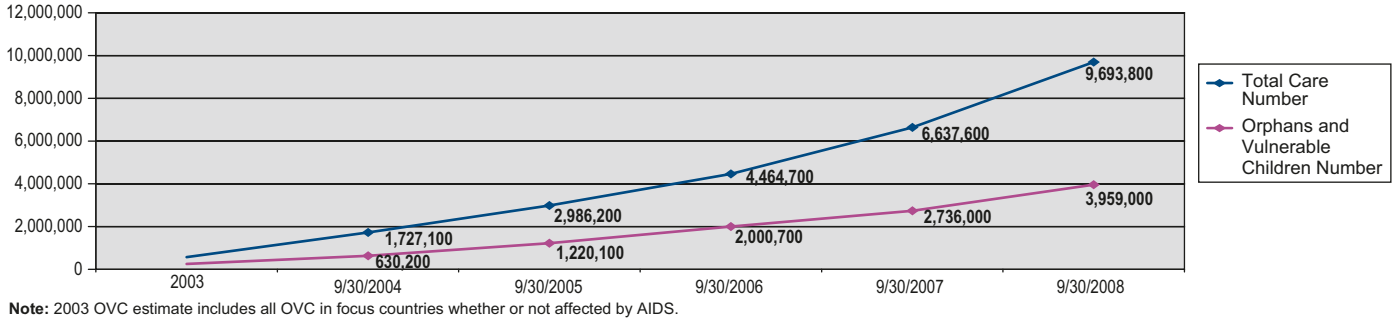
Total number receiving care includes individuals reached through upstream contributions to national, regional and local activities such as training, laboratory support, monitoring and evaluation, logistics and distribution systems, or protocol and curriculum development, as well as those receiving services at USG-funded service delivery sites.

Footnotes:

[1] Care includes the areas of Orphans and Vulnerable Children and Care and Support (including TB/HIV).

[2] Botswana results are attributed to the National HIV Program. Beginning FY2005, 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. This decision mostly affected reporting in the areas of care and treatment.

Figure 21: Care: Number of Individuals Receiving Care in the 15 Focus Countries (Orphans and Vulnerable Children + Care for People Living with HIV/AIDS)



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

vocational training. Thus, the skills young people need for economic independence can be lost, potentially condemning them — and ultimately their whole society — to continued poverty. One World Bank simulation of the economy of South Africa — a nation with a relatively well-developed economy — found that, without effective intervention to meet the needs of OVCs, by 2020 the average household income will be less than it was in 1960, and will continue to decline thereafter. OVCs themselves face elevated risk of HIV infection, and PEPFAR supports efforts to expand prevention and HIV counseling and testing, which are entry points to care and treatment. In addition, meeting the needs of children with HIV also can serve as a way to build relationships with their caregivers, who may themselves need care. Female OVCs face a disproportionate risk for exploitation, abuse, and HIV infection. This is especially true for pre-adolescent and adolescent girls who have become heads of households. In economically hard-pressed families, girls are often first to leave school to provide child care, assume extra domestic chores, take on the difficult care of ill parents or relatives, and enter the informal work sector to contribute to family income.

Table 16 shows that PEPFAR provided $312 million in funding for OVC activities in the focus countries in FY2008. This represented 9.7 percent of program funding.

The best way to care for children in countries with a high HIV burden is to provide prevention and treatment to their parents to keep them alive. Even the best OVC program can never substitute for a parent. Recognizing the central importance of preserving families, PEPFAR

Table 16: Care: FY2008 Orphans and Vulnerable Children[1] Results

Country	Number of OVCs receiving upstream system-strengthening support[2]	Number of OVCs receiving downstream site-specific support[3]	Total	Planned Funding FY 2008[4, 5] in USD millions	Planned Funding FY2004–FY2008[4, 5] in USD millions
Botswana[6]	101,000	0	101,000	$7.8	$22.7
Cote d'Ivoire	8,800	68,100	76,900	$10.1	$23.1
Ethiopia	0	456,200	456,200	$30.6	$72.3
Guyana	0	1,200	1,200	$0.9	$3.5
Haiti	5,000	53,900	58,900	$8.6	$22.7
Kenya	0	533,700	533,700	$46.0	$105.5
Mozambique	0	242,800	242,800	$19.6	$54.2
Namibia	26,600	52,100	78,700	$8.9	$25.3
Nigeria	3,100	91,100	94,200	$40.0	$70.5
Rwanda	0	63,300	63,300	$13.0	$35.8
South Africa	154,100	374,000	528,100	$52.4	$121.0
Tanzania	250,800	290,300	541,100	$25.3	$57.1
Uganda	548,300	205,700	754,000	$26.2	$74.9
Vietnam	0	6,800	6,800	$2.7	$5.9
Zambia	0	422,100	422,100	$20.0	$63.2
Totals	**1,097,700**	**2,861,300**	**3,959,000**	**$312.0**	**$757.5**
	Total funding including additional attributions[7]			**$398.3**	**$958.7**
Other countries	**0**	**87,000**			
All countries	**1,097,700**	**2,948,300**	**4,046,000**		

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.

Footnotes:

[1] Orphans and vulnerable children activities are aimed at improving the lives of children and families directly affected by AIDS-related morbidity and/or mortality.

[2] 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, protocol and curriculum development.

[3] Number of individuals reached through downstream site-specific support includes those receiving services at USG-funded service delivery sites.

[4] Total number for each prevention, treatment and care programmatic area includes attribution and central dollars from the following categories: central procurements, supply chain, technical leadership and support, New Partners Initiative, strategic information, management and staffing, policy analysis, and systems strengthening activities.

[5] Some or all of the individuals reached by PEPFAR may also be supported by other funding sources such as host governments and other international partners. This amount varies by country.

[6] Botswana results are attributed to the National HIV Program. Beginning FY2005, 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. This decision mostly affected reporting in the areas of care and treatment.

[7] Total funding for each prevention, treatment and care programmatic area includes attribution of field and central dollars from the following categories: central procurements, supply chain, technical leadership and support, New Partners Initiative, strategic information, management and staffing, policy analysis, and systems strengthening activities. These attributions are made at the aggregate level and then added to the programmatic funding levels to get the total amount of support for each programmatic area.

Through theater, six young boys, ages eight through 14, are encouraging abstinence, behavior change, and healthy lifestyles in an effort to prevent the spread of HIV/AIDS in Angonia, Mozambique. Drawn to the stage after seeing a group of the district's senior boys perform an interactive PEPFAR-supported production about HIV/AIDS prevention, these young boys formed the "Junior Theatre Group of Angonia." So far this youth theatre group, supported by PEPFAR through a faith-based organization, has hosted performances about HIV/AIDS and its effects on issues including gender, children's rights, family relationships, and friendship.

focuses on strengthening the capacity of families to protect and care for OVCs by prolonging the lives of parents and caregivers.

PEPFAR supports efforts — many by CBOs and FBOs — to provide both immediate and long-term therapeutic and socio-economic assistance to vulnerable households. Children are often deeply affected by their HIV-infected parents and community members through loss of care, income, nutritional food, and schooling. For those who are orphaned or made vulnerable, care activities emphasize strengthening communities to meet the needs of OVCs, supporting community and family-based responses, helping children and adolescents meet their own needs, and creating a supportive social environment to ensure a sustainable response. PEPFAR recognizes the urgency of addressing these needs by supporting the growth and development of children and adolescents to ensure that they become healthy, stable, and productive members of society. Community and faith-based peer support can be crucial for children and adolescents who are faced with both the normal challenges of growing up and heavy economic, psychosocial, and stigma burdens.

PEPFAR supported training or retraining for approximately 247,000 individuals in caring for OVCs. Training includes promoting the use of time and labor saving technologies, supporting income-generating activities, and connecting children and families to essential health care and other basic social services, where available.

PEPFAR has partnered with host countries to scale up programs for children affected by HIV/AIDS more significantly than has ever been attempted previously, yet ensuring the quality of these rapidly growing programs is also essential. PEPFAR requires partners to track and report on how many of seven key interventions they provide; of those OVCs receiving direct support, nearly half received three or more of the following services:

1. Food and Nutritional Support: In addition to direct provision of food and nutrition, programs leverage support from other international or host country partners and work for more sustainable solutions, such as improved gardening.

2. Shelter and Care: The HIV/AIDS epidemic overloads impoverished communities to the point where many children are left without suitable shelter or care. Children who find themselves without a caregiver become highly vulnerable to abuse and stunted development. Given the number of OVCs, particularly in sub-Saharan Africa, and their complex needs, the most effective responses place families, households, and communities at the center of interventions.

3. Protection: Programs confront the reality of stigma and social neglect faced by OVCs as well as abuse and exploitation, including trafficking, the taking of inherited property, and land tenure, and helping children obtain birth certificates to legalize their status.

4. Health Care: There are three areas related to health that are addressed by OVC programs: meeting general health needs of OVCs by providing access to primary health care; linking HIV-positive children with appropriate health care; and guidance for the prevention of HIV.

5. Psychosocial Support: Children affected by HIV/AIDS generally suffer anxiety and fear during the years of parental illness, then grief and trauma with the death of a parent. Cultural taboos surrounding the discussion of HIV/AIDS and death often compound these problems. Programs provide children with support that is appropriate for their age and situation and recognize that children and adults often respond differently to trauma and loss.

6. Education and Vocational Training: Research demonstrates that education can leverage significant improvements in the lives of OVCs. In addition to learning, schools can provide children with a safe, structured environment; the emotional support and supervision of adults; and the opportunity to learn how to interact with other children and develop social networks. Education and vocational training are keys to employability and can also foster a child's sense of competence.

7. Economic Opportunity/Strengthening: OVCs and caregivers often experience diminished productive capacity and cash resources necessary for household purchases. Economic strengthening is often needed for the family/caregivers to meet expanding responsibilities for ill family members or to welcome OVCs into the household.

PEPFAR has worked with its partners to develop a Child Status Index to help the programs ensure that these services result in the improved well-being of the children served.

PEPFAR activities seek to provide OVCs access to core interventions by reaching out to partners, beyond traditional health agencies and networks, to ensure a coordinated, multi-sectoral approach. Because of the complex array 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. For this reason, PEPFAR augments its own OVC programs by "wrapping around" those of others that address critical vulnerabilities in the areas of food and nutrition and education. For information on PEPFAR's activities in the areas of education and nutrition for OVCs, please see the previous sections on *Linking PEPFAR and education* and *Linking PEPFAR and food and nutrition*.

Care and Support for People Infected with or Affected by HIV/AIDS

In FY2008 PEPFAR committed nearly $425 million for care and support for people infected with or affected by HIV/AIDS in the focus countries. These resources represented 8.8 percent of program funding, supporting care for over 5.7 million people.

Mestawot Wase, an Ethiopian mother of three, learned that she and her eldest son were HIV-positive shortly after her estranged husband died of AIDS. Stigmatized and traumatized, she began to attend support meetings through a PEPFAR-supported faith-based organization. Mestawot used the training she received during the support meetings to become an outspoken community leader. She then decided to enter a line of work where she could earn a living and raise HIV/AIDS awareness. With the 500 Birr (US $50) she was lent by the support group, Mestawot opened a barbershop. Her barbershop is now thriving and she has touched many customers with her story of resilience.

Care programs often serve as a critical link between HIV counseling and testing and ARV treatment programs. Care programs include a wide range of providers and delivery sites within a network model of care. Within the network model of care, PEPFAR supports a variety of interventions at different levels (including home-based care programs, as well as health care sites that deliver services). In addition, support is provided to fill specific gaps in national training, laboratory systems, strategic information systems, and health systems strengthening (e.g., monitoring and evaluation, logistics, and distribution systems) that are essential to the effective roll-out and sustained delivery of quality care.

Care and support for PLWHA includes regular clinical and laboratory monitoring to ensure that they receive ART promptly once they are eligible. Care programs also provide a platform for "prevention with positives," providing PLWHA with information, condoms and other needed support for prevention. Finally, care helps keep PLWHA healthy and free of OIs, delaying the need for ART. Care can include pain and symptom management; prevention and treatment of TB and other OIs; social, spiritual and psychological support; and compassionate end-of-life care.

In addition, PEPFAR supports the development and dissemination of "preventive care packages," adapted to local circumstances, for children and adults living with HIV. These packages may include a number of interventions, such as cotrimoxazole prophylaxis, water purification systems, and insecticide-treated nets, to keep HIV-positive persons healthy and delay the need for treatment. Like many best practices developed by PEPFAR, these advances in the area of care for PLWHA have the potential to have a wide impact beyond PEPFAR-supported programs, and PEPFAR is working to disseminate them broadly.

In March 2008, a technical consultation was convened to assess whether PEPFAR should support cervical cancer screening in HIV-positive women. HIV-positive women are known to have an increased risk of pre-cancer and cancer of the cervix, compared to women without HIV; thus cervical cancer can be considered an opportunistic process. Based on this consultation and further review by the PEPFAR Scientific Steering Committee, PEPFAR will now support, as part of a comprehensive approach to OIs, pilot programs which provide screening and treatment to prevent cervical cancer in HIV-positive women, using as a model the "see and treat" approach.

Tuberculosis and other opportunistic infections

PEPFAR has scaled up its support for national efforts to provide high-quality care for OIs related to HIV/AIDS. Especially important in this area is care for HIV/TB co-infection, the leading cause of death among HIV-positive people in the developing world. Table 17 shows

Table 17: Care: FY2008 Care and Support[1] Results

Country	Number of HIV-infected individuals who received care and support (including TB/HIV)			Number of HIV-infected clients receiving HIV care and support services that are receiving treatment for TB disease (subset of all care and support)			Planned funding FY2008[4, 5] in USD millions	Planned funding FY2004–FY2008[4, 5] in USD millions
	Number receiving upstream system strengthening support[2]	Number receiving downstream site-specific support[3]	Total	Number receiving upstream system strengthening support[2]	Number receiving downstream site-specific support[3]	Total		
Botswana[6]	146,100	0	146,100	2,900	0	2,900	$10.3	25.4
Cote d'Ivoire	18,900	84,300	103,200	0	3,900	3,900	$9.9	23.6
Ethiopia	0	436,500	436,500		26,900	26,900	$30.8	74.4
Guyana	0	4,300	4,300	0	200	200	$2.4	7.7
Haiti	0	95,100	95,100		1,600	1,600	$14.2	42.2
Kenya	30,000	510,300	540,300	0	40,000	40,000	$60.0	142.4
Mozambique	183,000	348,100	531,100	0	7,000	7,000	$21.7	57.1
Namibia	0	108,600	108,600	0	7,600	7,600	$13.7	34.2
Nigeria	49,300	694,300	743,600	1,400	32,200	33,600	$49.7	118.2
Rwanda	1,500	88,200	89,700	1,500	1,400	2,900	$17.0	45.0
South Africa	318,300	1,534,400	1,852,700	131,100	81,200	212,300	$83.8	186.8
Tanzania	0	351,700	351,700	0	15,400	15,400	$28.5	72.4
Uganda	51,600	340,500	392,100	1,600	12,800	14,400	$37.1	130.2
Vietnam	0	55,000	55,000	0	4,200	4,200	$18.0	45.1
Zambia	0	284,800	284,800	0	22,500	22,500	$27.9	78.6
Totals	**798,700**	**4,936,100**	**5,734,800**	**138,500**	**256,900**	**395,400**	$425.0	$1,083.4
				Total funding including additional attributions[7]			**$532.3**	**$1,398.3**

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.

Footnotes:

[1] Care and support includes all clinic-based and home/community-based activities aimed at optimizing quality of life of HIV-infected (diagnosed or presumed) clients and their families throughout the continuum of illness by means of symptom diagnosis and relief; psychological and spiritual support; clinical monitoring and management of opportunistic infections including TB and malaria and other HIV/AIDS-related complications; culturally-appropriate end-of-life care; social and material support such as nutrition support, legal aid, and housing; and training and support for caregivers.

[2] 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, protocol and curriculum development.

[3] Number of individuals reached through downstream site-specific support includes those receiving services at USG-funded service delivery sites.

[4] All funding figures are in millions of U.S. dollars and reflect regularly-updated planned program funding.

[5] Some or all of the individuals reached by PEPFAR may also be supported by other funding sources such as host governments and other international partners. This amount varies by country.

[6] Botswana results are attributed to the National HIV Program. Beginning FY2005, 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. This decision mostly affected reporting in the areas of care and treatment. Botswana experienced expansion of services to the community through strengthening of civil society participation leading to increased coverage and linkages to the National TB program, resulting in significant increases over last year.

[7] Total funding for each prevention, treatment and care programmatic area includes attribution of field and central dollars from the following categories: central procurements, supply chain, technical leadership and support, New Partners Initiative, strategic information, management and staffing, policy analysis, and systems strengthening activities. These attributions are made at the aggregate level and then added to the programmatic funding levels to get the total amount of support for each programmatic area.

the results from FY2008. From FY2005 to FY2008, PEPFAR increased bilateral funding for HIV/TB from $26 million to $140 million, supporting TB treatment for over 395,400 HIV-infected patients through September 2008. Through the end of FY2008, the Global Fund reported providing an estimated $2.25 billion in additional funding for TB programs around the world.

PEPFAR-supported HIV care and treatment programs are a platform to further HIV/TB collaborative activities. Important interventions supported by PEPFAR include screening for TB among clients in care and treatment, TB infection control and promoting a safe environment in which services are delivered, access to ART for co-infected clients, and monitoring and evaluation. PEPFAR supports a variety of efforts to co-locate TB and HIV services as an important strategy to increase access to services for co-infected persons.

In collaboration with WHO, PEPFAR supported a program in Rwanda through which more than 88 percent of TB patients are now tested for HIV, 61 percent of co-infected patients receive cotrimoxazole preventive therapy, and 36 percent of TB/HIV patients have accessed ART. In Kenya, approximately 30,000 TB patients benefited from joint PEPFAR-WHO support, HIV testing increased from 41 percent to 84 percent, uptake of cotrimoxazole increased from 39 percent to 90 percent, and ART uptake increased from 19 percent to 28 percent.

PEPFAR supports governments and NGOs, including CBOs and FBOs, to conduct intensified TB case-finding among PLWHA at each encounter to ensure early diagnosis and treatment of TB. PEPFAR also supports host country governments to strengthen their TB laboratory capacity by implementing an external quality assurance system for sputum smear microscopy and establishing liquid-culture capacity to promote rapid diagnosis of TB, including smear-negative disease among HIV-infected patients.

Since 2007, PEPFAR has accelerated programming to combat the emerging threat of XDR-TB. Activities include systems strengthening; improving laboratory infrastructure for culture and drug susceptibility testing; TB infection control; and, perhaps most importantly, ongoing efforts to strengthen national TB programs' capacity to carry out basic DOTS programs to reduce the spread of new drug-resistant TB.

Linkages with care programs

PEPFAR also supports a variety of economic-strengthening programs to address the prevention, treatment and care needs of PLWHA and OVCs. These programs enable people infected and affected by HIV/AIDS to provide for themselves and their families with dignity; strengthen the ability of communities and families to look after OVCs; give adolescent OVCs the opportunity to support themselves and, in many cases, their younger siblings; and empower women and girls to avoid risky behavior that can lead to HIV infection.

Counseling and Testing

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. As noted previously, PEPFAR programs have worked to ensure that counseling and testing is targeted to those at increased risk of HIV infection such as TB patients and women seeking PMTCT services. Table 18 shows achievements in FY2008. PEPFAR invested approximately $216 million in counseling and testing in settings other than PMTCT

Bahati Mwitula received HIV counseling training by a PEPFAR-supported mobile HIV/AIDS counseling and testing program that serves the remote areas of Tanzania. Now a certified trainer, Mwitula travels to Tanzania's rural areas to spread HIV/AIDS awareness. On one of his recent visits, Bahati and his team of trainers identified a 16-year-old female as HIV-positive. The girl explained that she had never engaged in high-risk behavior and questioned if she should inform her mother about her status. With Mwitula's encouragement, she disclosed her status to her mother and learned that she had contracted HIV at birth. Bahati was able to refer the mother and daughter to the nearest care and treatment center for additional services. By bringing mobile counseling and testing services to remote villages, counselors are able to encourage behavior change and risk reduction in rural settings.

Table 18: Care: FY2008 Counseling & Testing Services Results[1] (in settings other than PMTCT)					
Country	**Number of individuals receiving upstream system-strengthening support[3]**	**Number of individuals receiving downstream site-specific support[3]**	**Total number of individuals receiving counseling and testing**	**Planned funding FY2008[4, 5]** in USD millions	**Planned funding FY2004–FY2008[4, 5]** in USD millions
Botswana[6]	201,400	0	201,400	$8.9	$32.9
Cote d'Ivoire	78,900	206,100	285,000	$4.1	$15.2
Ethiopia	0	3,504,800	3,504,800	$15.8	$43.6
Guyana	17,100	33,200	50,300	$1.3	$6.6
Haiti		475,600	475,600	$5.1	$15.7
Kenya	0	1,722,400	1,722,400	$31.5	$77.7
Mozambique	0	402,200	402,200	$10.9	$29.0
Namibia	0	175,700	175,700	$8.7	$30.5
Nigeria	197,400	1,429,000	1,626,400	$19.4	$54.2
Rwanda	311,300	556,800	868,100	$4.4	$20.7
South Africa	1,093,300	1,286,100	2,379,400	$42.4	$106.2
Tanzania	691,300	2,650,600	3,341,900	$18.1	$47.4
Uganda	429,700	1,613,700	2,043,400	$18.7	$70.9
Vietnam	77,500	106,900	184,400	$5.8	$14.9
Zambia	0	640,400	640,400	$21.2	$69.3
All countries	**3,097,900**	**14,803,500**	**17,901,400**	$216.2	$634.8
		Total funding including additional attributions[7]		**$272.4**	**$833.0**

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.

Footnotes:

[1] Counseling and testing results include only those individuals who received their test results.

[2] 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, or protocol and curriculum development.

[3] Number of individuals reached through downstream site-specific support includes those receiving services at USG-funded service delivery sites.

[4] All funding figures are in millions of U.S. dollars and reflect regularly-updated planned program funding.

[5] Some or all of the individuals reached by PEPFAR may also be supported by other funding sources such as host governments and other international partners. This amount varies by country.

[6] Botswana results are attributed to the National HIV Program. Beginning FY2005, 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. This decision mostly affected reporting in the areas of care and treatment.

[7] Total funding for each prevention, treatment and care programmatic area includes attribution of field and central dollars from the following categories: central procurements, supply chain, technical leadership and support, New Partners Initiative, strategic information, management and staffing, policy analysis, and systems strengthening activities. These attributions are made at the aggregate level and then added to the programmatic funding levels to get the total amount of support for each programmatic area.

Table 19: Care: Cumulative Counseling and Testing Results, FY2004–FY2008						
	FY2004	**FY2005**	**FY2006**	**FY2007**	**FY2008**	**Cumulative counseling and testing to date**
Number of women receiving counseling and testing through PMTCT[1]	1,017,000	1,957,900	2,809,500	4,011,600	5,850,100	15,646,100
Number of individuals receiving counseling and testing in other settings	1,791,900	4,653,200	6,426,500	10,580,800	17,901,400	41,353,800
Total	**2,808,900**	**6,611,100**	**9,236,000**	**14,592,400**	**23,751,500**	**56,999,900**

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 as well as those receiving services at USG-funded service delivery. sites.

The same individual may receive counseling and testing on multiple occasions, and the same individual may receive PMTCT services for multiple pregnancies.

Footnotes:

[1] This indicator was revised beginning in FY2005. FY2004 results include an adjustment accounting for pregnant women who were counseled, tested, and received their test results.

in FY2008, or about 6.7 percent of program funding in the focus countries.

Table 19 shows the cumulative progress achieved by PEPFAR-supported programs. These programs have far exceeded the target of 30 million, supporting nearly 57 million counseling and testing encounters through FY2008. Among these, nearly 16 million encounters were with women seeking PMTCT interventions, a key target population.

A key barrier to the universal knowledge of serostatus is the lack of routine testing in medical settings, including TB and STI clinics, ANCs, and hospitals. In many coun-

tries, studies have found that 50 percent 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. Most PEPFAR focus countries have now adopted opt-out testing policies, but without successful implementation of opt-out testing, it will be impossible to achieve success in prevention, treatment and care. PEPFAR has also contributed to WHO's development of guidelines for counseling and testing in health care settings.

Another key policy trend in many nations that PEPFAR has supported is the use of rapid HIV tests which improve the likelihood that those who are tested will actually receive their results. All of the focus countries now have policies supporting the use of rapid tests, though opportunities for improvement in implementation of these policies remain.

White House photo by Joyce N. Boghosian

HIV/AIDS activist Mohamed Kalyesubula of Uganda waves to acknowledge the applause of guests, joined by fellow HIV/AIDS activist nurse Agnes Nyamayarwo of Uganda, left, at the signing ceremony of P.L. 110-293, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008.

The Future of Partnerships

Partnership Compacts

To build on the success the American people's partnerships have achieved to date and reflect the paradigm shift to an ethic of mutual partnership, the USG is working with host countries to develop Partnership Compacts: agreements that engage governments, civil society, and the private sector to address the issues of HIV/AIDS. The goal of Compacts is to advance the progress and leadership of host nations in the fight against HIV/AIDS, with a view toward enhancing country ownership of their programs.

Country ownership is the heartbeat of effective development, and Partnership Compacts will be tailored to local circumstances and will foster accountability. In addition to outlining responsibilities and commitments made by both partners, they will set forth an expected progression over time of USG support and host country investment and policy change.

Above all, Partnership Compacts will place a premium on measurable and sustainable results. They will promote deeper integration of HIV/AIDS prevention, care and treatment into health care and public health networks, and seek to promote sustainability by ensuring that HIV/AIDS programs build capacity and benefit health care overall. Through Compacts, PEPFAR will strengthen its support for a comprehensive approach to the epidemic that engages multiple sectors — not just government to government, but people to people, including NGOs, FBOs and CBOs, and the private sector.

Thus PEPFAR will continue to be part of this new era of development that champions friendship and respect, mutual understanding and accountability — and trusts in the people on the ground to do the work.

The people of severely affected nations have accomplished much in their fight against HIV/AIDS, and the American people are extraordinarily privileged to partner with them in this work. As President Bush remarked of Africa in a comment equally applicable to other regions, "Africa's most valuable resource is not its soil or its diamonds, but…the talent and the creativity of its people." PEPFAR partnerships are compelled by this creativity. They are based on a profound belief in the dignity and worth of every human life — and the logical corollary that everyone deserves a chance; that seemingly ordinary people will do extraordinary things with a little support.

The world now knows, from 5 years of partnership, that communities can take ownership of their futures by combating HIV/AIDS one person at a time. We know that PLWHA have much to contribute by standing up

to be counted with courage and strength. We know that all people, regardless of economic means, care about and rightly have pride in themselves, their families, their communities, and their nations. And we know their deep commitment because we have seen, as one community health worker put it, that they "do it out of love."

America will continue to support their work — and to join them in celebrating life.


UNITED STATES PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF