

SUMMARY OF RECOMMENDATIONS FOR REAUTHORIZING THE PRESIDENT'S EMERGENCY PLAN ON AIDS RELIEF (PEPFAR)

July, 2007

The following is a summary of recommendations put forth by the U.S. global AIDS community in the interest of furthering the work of PEPFAR as it is reauthorized and enters a second phase. The recommendations emanate from the work of the Global AIDS Roundtable's (GAR) working groups on PEPFAR reauthorization.

The Global AIDS Roundtable (GAR) is an independent U.S. based advocacy working group that works towards robust resources for and effective U.S. global HIV/AIDS programs and policies. This group meets monthly and is convened by the Global Health Council, the largest membership alliance dedicated to saving lives by improving health throughout the world.

The GAR established four working groups to specifically focus on the reauthorization process. These are prevention, gender, treatment, and structural. In addition, the Health Workforce Working Group, Nutrition and HIV Working Group, the NGO Harm Reduction Working Group, and the Orphans and Vulnerable Children working group have also been focusing on reauthorization.

These working groups, together, have produced a PEPFAR reauthorization paper that includes detailed recommendations, covering policy and legislation in cover policy and legislation in most of the ongoing key areas, such as prevention and treatment. They also include a section on gender which requires greatly increased attention and sections on healthcare workforce, linkages to other health issues and services as well as specific attention to monitoring and evaluation and developing indicators that reflect deeper and more relevant realities.

The recommendations are organized as follows:
Linkages to broader health and development services
Prevention
Treatment
Gender
Monitoring and Evaluation
Health Systems and Health Workforce Capacity
Country Operational Plans

Following are the names of the working group chairs:
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SUMMARY OF RECOMMENDATIONS FOR PEPFAR REAUTHORIZATION

July, 2007

I. Strengthen systemic resource and programmatic coordination between PEPFAR-supported HIV prevention, treatment and care (PTC) services with other basic health and development services

In order to more effectively address poor health and development conditions of an HIV affected community, PEPFAR supported programming must be better linked and coordinated with basic health and development services. This includes de-emphasizing single disease, vertical interventions and rather, wherever possible, implementing a comprehensive global health and development program. For example, HIV PTC services must include:

- Nutrition/food to an entire community affected by HIV;
- Ante-natal care and basic child health services in a mother to child prevention program;
- Access to basic education in an orphans and vulnerable children (OVC) program;
- Water and sanitation in a treatment program;
- Strengthening multi-modal health systems;
- Linkage to efforts to address the socio-economic and legal issues affecting vulnerable populations at risk of HIV infection, especially women

II. Strengthen flexibility in policies and programming at the country level

A. Modify current targets

1. Remove general one size fits all budget allocation and provide more flexibility in implementing PTC programs at a country level with targets tailored to national priorities and epidemiological data.
3. Provide direct financing and support for treating at least 33 percent of the people in clinical need worldwide, while supporting universal access in current and future focus countries. Provide a U.S. one-third fair share contribution to funding for prevention programming.
4. Set specific national pediatric treatment targets for each focus country.
5. Under prevention, set specific targets for reaching vulnerable and marginalized populations per national epidemiological data.

B. Increase greater flexibility in use of PEPFAR funding to:

- Provide related services such as providing water and nutrition to a heavily, HIV-affected community or providing education to OVCs;
- Build infrastructure to provide HIV and other basic health services or educational services such as building a clinic or a school

C. Increase country level ownership in policies, programming and implementation

U.S. global health initiatives should be designed and implemented in a manner consistent with the “three ones” principles., consolidating planning, supply chains system support, and monitoring and evaluation with national governments, other development partners, and public and private actors at the country level, including consultation and improved collaboration with the Global Fund to fight AIDS, TB and Malaria’s CCM infrastructure and processes over time.

III. Require greater civil society consultation in planning, policies and implementation including reviewing final country operational plan

- A. Encourage wide variety of civic participation including people living with HIV/AIDS, and other vulnerable populations such as injecting drug users and commercial sex workers, local village health activists, community based workers, local community civil society organizations including faith-based organizations, labor unions and other stakeholders.
- B. Promote greater participation of women and girls in national AIDS policy and implementing structures:
 - a. Invest in women’s organizations and networks to strengthen their institutional capacity and build a critical mass of skilled women leaders, especially women living with HIV/AIDS
 - b. Improve coordination with other multilateral planning mechanisms and support women NGOs’ capacity to participate in those processes as well.
 - c. Create concrete and transparent mechanisms through which civil society can review, comment on and influence OGAC country operational plans.

IV. Establish guidance on country selection

A. Focus Countries

1. Select additional focus and mini-focus target countries based on epidemiology that includes prevalence rates and rate of acceleration.

2. Exit or graduating plan at the time should be considered and determined at the time of country selection with waiver allowance to provide for unforeseen circumstances. "Graduations" of focus countries and/or shifts of bilateral funding to the Global Fund should not reduce overall US contributions or obligations to combating the global spread of HIV/AIDS.

B. Increase emphasis on non-focus countries

Increase attention and resources in countries with high HIV prevalence and concentrated populations of people living with HIV in order to effectively combat the global spread of HIV/AIDS.

VI. Authorize specific funding targets for:

- Non-focus countries;
- Health workforce (need: \$650 m additional in the first year);
- OVCs (need: minimum 10% of total PEPFAR funds);
- Nutrition and HIV (need: \$200 m out of PEPFAR funds);
- Pediatric Treatment;
- Addressing TB/HIV co-infection (need: minimum 10% of total PEPFAR funds);
- Gender-based violence;
- The Global Fund to Fight AIDS, TB, and Malaria

Currently, the Global Fund is projected to grow in size to \$6 billion annually in 2010, and with increased demand, this level could reach \$8 billion. As a result, for the U.S. to maintain its one-third share of total contributions, reauthorization should include at least \$2 billion per year for the Global Fund.

- Operations Research

VII. Monitoring and Evaluation

A. Develop a more robust and useful set of program indicators for all areas including OVCs, pediatric treatment, impact of programs on women and girls, and human resource capacity.

B. Establish Independent audits.

OGAC should be audited independently on a regular basis. Hard targets should be set, but measuring progress towards benchmarks must become more transparent. For instance, if PEPFAR covers 50% of the cost of treatment for 1000 people, this should be reported as treatment for 500 "full treatment equivalents" rather than the 1000 currently counted.

C. Assess health systems obstacles.

- OGAC focus countries should assess the health system obstacles to scaling up HIV, TB, and malaria services and, in coordination with the national health plan, as well as other partners and U.S. health programs, invest in overcoming these obstacles in a system-wide manner;
- OGAC should prepare annual progress reports towards meeting minimum target densities of health professionals and community health workers as well as progress towards fully compensating a country for the impact of U.S. health initiatives on local health systems.

VIII. Operations Research

Create a separate title or section to authorize appropriations within USAID or PEPFAR for operations or evaluation research to improve program quality and performance, including establishing: "best practice" models; the cost-effectiveness of various strategies and models; the qualitative basis for the design and re-design of projects; and evidence-bases for models that address the needs of vulnerable populations.

IX. Prevention

A. Strike the abstinence-until-marriage earmark

B. Strike the prostitution pledge

C. Support and implement a comprehensive prevention approach that:

- Draws on all components of abstinence, be faithful, and condoms (ABC);
- Targets specific populations with appropriate evidence-based interventions;
- Engages broader determinants of vulnerability, including the legal, economic and cultural status of women; the individual and community-level effects of extreme poverty, deprivation and conflict; and lack of access to basic services, including, but not limited to, health care infrastructure and systems;
- Builds and strengthens linkages to related interventions in sexual and reproductive health and family planning, clinical and public health services, development assistance and

humanitarian relief as appropriate in assisting individuals and communities reduce their risk of infection or adverse outcome;

- Reaches out to all vulnerable populations, particularly in concentrated epidemics;
- Reduces transmission of HIV in health care setting, through unsafe injections and other medical procedures

D. Remove inflexible and arbitrary funding restrictions

E. Increase efforts to prevent HIV transmission among injection drug users (IDUs)

1. Aim to reach at least 60% of (IDUs) through both primary and secondary prevention interventions.
2. Support 4 key strategies as called for by the Institute of Medicine (IOM) which includes treating drug dependence; increasing outreach and education and mandating that the US government provide information about the efficacy of HIV prevention methods for IDUs

E. Expand prevention of mother to child transmission (PMTCT) programs

1. Increase access of pregnant women to mother to child transmission services
2. Expand PMTCT programs to include counseling on HIV prevention for all women who test negative.
3. Ensure lifelong treatment for the entire immediate family of anyone living with HIV detected through PMTCT programs

F. Address HIV transmission in health-care settings such as unsafe medical injections and other medical procedures

X. Gender

A. Prioritize women and girls in U.S. law and OGAC operational policy by:

1. Explicitly recognizing gender inequality as a key driver of the AIDS epidemic, and adopting a strict requirement for gender integration across all HIV/AIDS prevention, treatment and care programs;
2. Adopting clear goals related to gender and issuing operational guidance, and provide technical assistance on how to address gender at the design, implementation, monitoring and evaluation of all programs.

B. Strengthen linkages between sexual and reproductive health services and HIV/AIDS prevention, treatment and care programs by.

1. Providing family planning and SRH service providers with information about HIV/AIDS, expanded access to male and female condoms, and STI screening and treatment.
2. Providing sexual and reproductive health care education and services simultaneously with HIV testing, treatment, and PMTCT services, including supporting the fertility decisions of HIV-positive women and girls.

C. Intensify priority to and resources for reducing violence against women and girls, sexual coercion, stigma and discrimination as barriers to prevention, testing and treatment of HIV/AIDS by:

1. Integrating screening and response for violence and sexual coercion into all HIV prevention and treatment programs
2. Strengthening linkages with and direct support for stand-alone local and national efforts to reduce violence against women, particularly those targeted at men and boys;
3. Adopting school-based education and referral programs and shelter, medical, legal services for victims of violence;
4. Working with governments to establish initiatives to strengthen the enactment and enforcement of laws prohibiting violence against women

D. Develop a specific strategy to address vulnerabilities of adolescent girls and young women, including:

1. youth initiatives that provide education, support, and services to girls both in and out of school;
2. efforts to discourage the practice of early marriage and cross-generational and transactional sex;
3. increased educational and economic opportunities for girls and young women

E. Improve overall social, economic, education and legal status of women and girls by strengthening linkages and providing direct funding for other bilateral and multilateral efforts to strengthen gender laws, policies and programs.

XI. Treatment

A. Legislation should continue and strengthen the practice of the original legislation and establish a commitment to support treatment for one-third of those in immediate clinical need worldwide, while implementing U.S. pledges to support universal access to treatment. Specifically, US should:

1. Directly provide financing and support for at least 33% of the people in clinical need worldwide
2. Work with current and future focus country governments and public and private actors as well as other development partners to ensure universal access in these select nations.

B. Support ARV Therapy for all vulnerable populations

In particular, for injecting drug users, the USG should support comprehensive approaches that integrate substance abuse services such as methadone and buprenorphine therapy, along with outreach, counseling, adherence support, and prevention and treatment of co-morbidities including tuberculosis and viral hepatitis

C. Increase access to pediatric treatment

1. OGAC should prioritize reaching children with HIV in its treatment programs through a mapping of children in a community who are in need of treatment.
2. Investments must also be made in child friendly pediatric formulas.
3. Training and retaining health care workers specialized in pediatrics.

C. FDA Approval Process

1. Set aside the FDA approval process which has presented a costly barrier to utilization of cost-effective medicines. Promote an alternate requirement that all medicines be approved at a country's request either by the internationally accepted WHO Drug Prequalification program, or through other recognized drug regulatory authority with suitably stringent quality standards.
2. PEPFAR commodities should be purchased at the lowest available prices available through transparent competitive bids for medicines that are at least WHO quality assured. Such competitive tenders should also give preference to fixed dose combination medicines when possible to support increased adherence and efficacy.
3. Increase focus on non-palliative care including training health professionals to identify and treat opportunistic infections.
4. Adopt a proportional treatment measurement system that reports more accurately the level or percentage of support received by a country or a specific program. If PEPFAR covers 50% of the cost of treatment for 1000 people, this should be reported as treatment for 500 "Full Treatment Equivalents."

XII. Addressing Health Systems Capacity and Health Workforce

A. OGAC should work with Focus Country governments to achieve new minimum health workforce density targets, recommended by WHO to be at least 2.3 doctors and nurses per thousand residents.

1. Country Operational Plans should include forecasting health workforce gaps including logistical and infrastructure needs, and implement plans to fully address these gaps working with governments, public and private health actors and other development partners.

B. OGAC should cover the impact of its own programs: Fill gaps caused by U.S. programs that hire scarce health professionals away from struggling public health systems by launching training and retention initiatives for at least as many *new* health workers as are needed by U.S.-supported programs.

C. Community Health Workers (CHWs): Utilize the power of numerous informal care providers already working at the community level by training and supporting deployment of 250,000¹ CHWs to provide primary care services, including voluntary counseling and testing, prevention education and related services, treatment literacy, adherence counseling and symptoms monitoring and reporting.

1. PEPFAR should achieve minimum recognized densities of one CHW-per-thousand residents in all Focus Countries²;
2. CHWs should be integrated into overall public primary care systems, and must be supported by sufficient numbers of new health professionals in numbers sufficient to provide supervision and care for CHW referrals³;
3. Certified CHWs must be paid living wages; provided ongoing training and opportunities for promotion.

D. Supply Chain Management Capacity Building:

¹ 250,000 is one third of the minimum CHWs needed in sub-Saharan Africa at the recommended minimum 1-per-1000 resident densities.

² Many countries and programs have established a ratio of 1 (or more) CHW per 1,000 population. These include 1:780 in the Mosvold Health District, South Africa; 1-plus:1,000 in Malawi; 1:90-125 households according to the South African Department of Health's Community Health Worker Policy Framework. With 750 million residents in sub-Saharan Africa, the U.S. share—1/3rd of the total need—is roughly 250,000 CHWs.

³ Recommended professional-to-lay health workers ratios are estimated at 1 health professional for every 7 CHWs. At 250,000 new CHWs, roughly an additional 45,000 new doctors, nurses and non-physician clinicians would be necessary for oversight and to care for CHW referrals.

1. PEPFAR's procurement and supply chain management efforts should increase the proportion of funding for developing country capacity and strengthening country systems. PEPFAR should prioritize building, operating, and over time transferring systems to national governments, with ongoing technical assistance and sustained support to ensure the function of these systems.
2. OGAC or an independent auditor should produce an annual report on how SCMS is building toward national-self sufficiency in each country it operates, including progress towards specific benchmarks, and the expected amount of time necessary before focus countries can fully sustain their own supply and distribution systems at a scale necessary for national primary health needs.