



The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)

November 2011

Although the U.S. has been involved in efforts to address the global AIDS crisis since the mid 1980s, the creation of the President's Emergency Plan for AIDS Relief (PEPFAR) in 2003 marked a significant increase in funding and attention to the epidemic.^{1,2} First proposed by President George W. Bush in January 2003, PEPFAR was authorized by the *United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003* (P.L. 108-25),³ a 5-year, \$15 billion initiative to combat global HIV/AIDS, TB, and malaria primarily for 15 hard hit "focus countries," and multilateral contributions to the Global Fund to Fight AIDS, Tuberculosis, and Malaria (The Global Fund)⁴ as well as UNAIDS; appropriations from Congress over this period were higher, totaling \$18.8 billion.^{1,5}

In 2008, PEPFAR was reauthorized by the *Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008* (P.L. 110-293 or "Lantos-Hyde"),⁶ for an additional 5 years (FY 2009–FY 2013) at up to \$48 billion, including \$39 billion for HIV and the Global Fund, \$4 billion for TB, and \$5 billion for malaria. Reauthorization also relaxed prior spending directives, emphasized country partnerships and health systems strengthening (HSS), mandated 5-year strategic plans for HIV, TB, and malaria, and ended the statutory ban on HIV-positive visitors and immigrants wishing to come to the United States. In 2009, President Obama introduced a 6-year Global Health Initiative (GHI) calling for a broader, global health agenda and coordination across the U.S. government's global health portfolio, and citing PEPFAR as a central component.^{7,8,9}

under PEPFAR's authorizing legislation for TB and malaria, PEPFAR remains an AIDS-specific program, with most TB and malaria efforts carried out separately (unless linked with HIV).

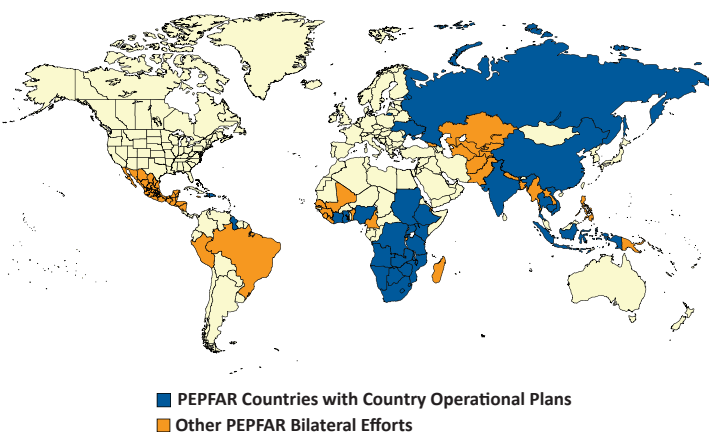
- **The U.S. Global AIDS Coordinator & OGAC.** PEPFAR's original authorization created the position of "U.S. Global AIDS Coordinator," a Presidential appointee, requiring Senate confirmation and holding the rank of Ambassador who reports directly to the Secretary of State.³ The law also established the Office of the Global AIDS Coordinator (OGAC) at the State Department.¹⁴ (Lantos-Hyde also codified the position of a U.S. Malaria Coordinator; there is no coordinator for TB).⁶
- **Implementing Agencies.**² In addition to State, other implementing departments and agencies for HIV activities include: USAID; the Department of Health and Human Services, primarily through the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), and National Institutes of Health (NIH); the Departments of Labor, Commerce, and Defense (DoD); and the Peace Corps.

P.L. 108-25 (FY 2004–2008)	Lantos-Hyde (Through FY 2013)	PEPFAR Strategy/GHI (Through FY 2014)
Support: <ul style="list-style-type: none"> • Treatment of 2 million • Prevention of 7 million new infections • Provision of care to 10 million, including OVCs 	Support: <ul style="list-style-type: none"> • Treatment of at least 3 million¹⁰ • Prevention of 12 million new infections • Provision of care to 12 million, including 5 million OVCs • Training & retention of 140,000 new health care workers 	Support: <ul style="list-style-type: none"> • Treatment of more than 4 million • Prevention of more than 12 million new infections • Provision of care to more than 12 million, including 5 million OVCs • Training & retention of more than 140,000 new health care workers

Targets & Results. Several broad goals or targets, often referred to as the "2-7-10" goals, guided the first 5 years of PEPFAR: support the treatment of 2 million, prevention of 7 million new infections, and the provision of care to 10 million.³ These targets were updated by Lantos-Hyde and, more recently, by PEPFAR's 5-year strategy, also incorporated into the GHI.^{6,8,9} As of September 2010, PEPFAR reports that it has supported antiretroviral treatment for more than 3.2 million, care for 11 million, including 3.8 million orphans and vulnerable children (OVC), and in FY 2010, by providing antiretroviral prophylaxis to HIV positive pregnant women, enabled 114,000 babies to be born HIV-free.^{11,12}

Key Structures & Mechanisms. PEPFAR's original authorization established new structures and authorities, consolidating all U.S. bilateral and multilateral activities and funding for global HIV/AIDS. Several U.S. agencies, host country governments, and other organizations are involved in implementation.^{2,13} Although funding is also authorized

Figure 2: PEPFAR Countries, FY 2010⁵



- **Countries.** PEPFAR bilateral activities are carried out in more than 60 countries in Africa, the Middle-East, Asia, Europe, the Americas, and the Caribbean (in FY 2010).⁵ Most FY 2010 funding is concentrated in 31 countries, including 15 "focus countries" targeted in PEPFAR's first phase (Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Viet Nam, and Zambia).¹ More countries are reached through U.S. contributions to the Global Fund.
- **Operational Plans.** These 31 countries and the Central Asian, Caribbean, and Central American regions are required to develop "Country Operational Plans" (COPs) to document annual investments and anticipated results.¹⁵ In addition, in FY 2012, two additional countries (Burundi and Cameroon) will be required to develop COPs. OGAC reviews all COPs and when approved, they are incorporated into an annual PEPFAR "Operational Plan."¹⁶

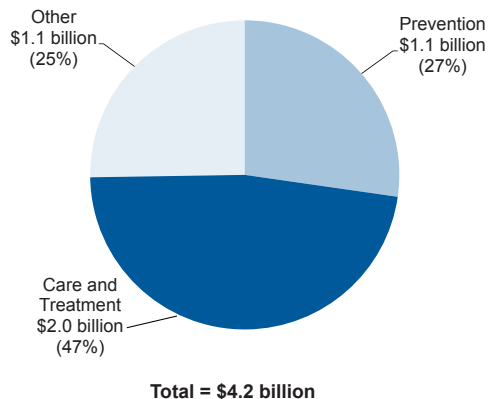
- **Partnership Frameworks.**¹⁷ Lantos-Hyde included a new emphasis on country ownership to help foster sustainability and accountability by authorizing “Partnership Frameworks” with recipient countries, 5-year joint strategies for cooperation between the USG, the partner (“host”) government, and other partners that outline the responsibilities of each party in achieving a country’s national HIV/AIDS strategy. Countries must be invited to develop Partnership Frameworks and, as of April 2011, 19 countries and 2 regions have signed Partnership Frameworks.¹⁸ For countries and regions with signed Frameworks, COPs serve as a yearly plan outlining USG responsibilities to the Partnership.¹⁵

Funding. Total PEPFAR funding includes all bilateral funding for HIV as well as U.S. contributions to the Global Fund and UNAIDS (bilateral funding for TB is also counted in PEPFAR’s totals). Congressional appropriations for PEPFAR have increased over time, rising from \$2.3 billion in FY 2004 to \$6.8 billion in FY 2011. The President’s FY 2012 budget requests nearly \$7.2 billion.⁵ PEPFAR represents the vast majority of GHI funding (73% of the FY 2012 request), and the Administration has indicated that PEPFAR will account for more than 70% of cumulative GHI funding over the Initiative’s 6-year period.⁷

Of the \$6.8 billion appropriated for PEPFAR in FY 2011:

- \$5.5 billion (81%) is for HIV, \$238 million (3%) for TB, and \$1.046 billion (15%) for the Global Fund.^{5,19}
- The majority of PEPFAR funding is channeled by Congress to State (\$4.6 billion in FY 2011 – most of which is then transferred to other agencies), followed by NIH (\$783 million in FY 2011), USAID (\$588 million in FY 2011), CDC (\$119 million in FY 2011), and a small amount to DoD (\$10 million in FY 2011). These amounts include the \$1.046 billion contribution to the Global Fund, provided through State (\$749 million) and NIH (\$297 million).⁵
- The largest share of approved bilateral program funding in PEPFAR countries is for care and treatment (47% in FY 2010), followed by prevention (27%). Funding for OVCs is part of care funding, and totaled 8% of approved funding in FY 2010.¹⁶

Figure 3: Distribution of Approved PEPFAR Funding in Countries that Prepared COPs by Activity, FY 2010¹⁶

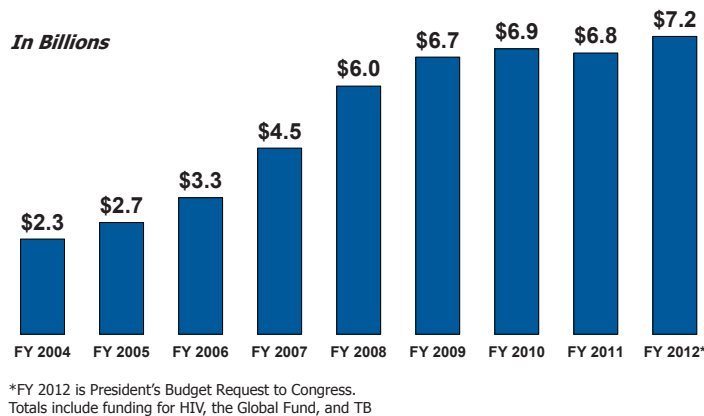


Spending Directives/Earmarks. In PEPFAR’s original authorization, Congress recommended that 55% of funds be spent on treatment, 15% on palliative care, 20% on prevention, of which at least 33% be spent on abstinence-until-marriage programs, and 10% on OVCs.³ For FY 2006–2008, Congress required 55% to be spent on treatment, 10% on OVCs, and 33% of prevention funding on abstinence-until-marriage. Lantos-Hyde relaxed some of these directives: while requiring that 10% of funds be spent on programs targeting OVCs and at least half on treatment and care, the 33% abstinence-until-marriage directive was removed and replaced by a requirement of “balanced funding” for prevention to be accompanied by a report to Congress if less than half of prevention funds were spent on abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction activities in any host country with a generalized (high prevalence) epidemic.⁶

PEPFAR & The Global Fund. The U.S. is the single largest donor to the Global Fund. Congressional appropriations to the Fund totaled \$6.7 billion through FY 2011.⁵ In 2010, President Obama pledged a 3-year, \$4

billion (FY 2011–FY 2013) contribution to the Global Fund.²⁰ Assuming the FY 2012 request (\$1.3 billion) were to be approved by Congress, cumulative contributions for the first two years of this pledge period (FY 2011–FY 2012) would be \$2.35 billion.⁵ The Global Fund provides another mechanism for U.S. support by funding programs developed by recipient countries, reaching a broader range of countries, and supporting TB, malaria, and HSS programs in addition to (and beyond their linkage with) HIV. To date, over 140 countries have received Global Fund grants; 53% of Global Fund support has been committed to HIV programs, 29% to malaria, 17% to TB, 1% to HIV/TB, and 1% to HSS.²¹ The initial authorization of PEPFAR included a cap on cumulative U.S. contributions at 33% of the Global Fund’s total contributions, a provision retained in the 2008 reauthorization.^{3,6}

Figure 4: Total PEPFAR Funding, FY 2004–2012⁵



Looking Ahead. Since PEPFAR’s launch in 2003, many successes have been achieved and lessons learned and PEPFAR is viewed by the new Administration and others as one of the most significant of our global health initiatives and central to the GHI. Still, there are several key issues going forward. These include:

- Shifting from an “emergency” response to a sustained, country-led model, including the need to engage host governments in new ways and integrate a growing focus on HSS;¹³
- Moving toward a more outcomes-based system to assess impact, including the challenge of attributing results in the field directly to PEPFAR support;
- Integrating and coordinating PEPFAR with the GHI and applying lessons learned from PEPFAR more broadly;
- Striking the appropriate balance in funding between HIV treatment, prevention, and care; between bilateral HIV programs and the Global Fund; and between HIV and other parts of the global health portfolio;¹³ and
- Determining the extent to which the U.S will support policies that include a more comprehensive approach to reducing sexual transmission of HIV and support harm reduction among injection drug users as part of its HIV prevention policy.

¹ PEPFAR. *2009 Annual Report to Congress*; January 2009.
² KFF. *The U.S. Government’s Global Health Policy Architecture: Structure, Programs, and Funding*; April 2009.
³ U.S. Congress. Public Law No. 108-25; May 27, 2003.
⁴ The Global Fund is an independent, multilateral institution, providing grants to combat HIV/AIDS, TB, and malaria.
⁵ KFF analysis, of data from: FY 2012 Budget of the United States; Federal Agency Budget and Congressional Justification documents; ForeignAssistance.gov; Office of Management and Budget, personal communication.
⁶ U.S. Congress. Public Law No. 110-293; July 30, 2008.
⁷ White House. *Statement by the President on Global Health Initiative*; May 5, 2009.
⁸ PEPFAR. *Five-Year Strategy*; December 2009: <http://www.pepfar.gov/strategy/index.htm>.
⁹ GHI. *The Global Health Initiative: Strategy Document*; March 2011: <http://www.pepfar.gov/documents/organization/136504.pdf>.
¹⁰ Treatment target based on personal communication with OGAC. Lantos-Hyde specified the target as follows: increase the number treated by at least the percent increase in amount appropriated compared to FY08; by an additional percent increase equal to the percent decrease in the average cost of treatment per patient compared to FY08; and based on other factors including the share of treatment needs met by other donors.
¹¹ PEPFAR. *World AIDS Day: Latest Results, December 2010*: <http://www.state.gov/ir/pa/prs/ps/2010/12/152194.htm>.
¹² PEPFAR. *Seventh Annual Report to Congress on PEPFAR*; June 2011.
¹³ CRS. *PEPFAR Reauthorization: Key Policy Debates and Changes to U.S. International HIV/AIDS, Tuberculosis, Malaria and Programs and Funding*; January 2009.
¹⁴ PEPFAR. *About OGAC*: <http://www.pepfar.gov/c22835.htm>.
¹⁵ PEPFAR. *Fiscal Year 2012 Country Operational Plan (COP) Guidance*; August 2011.
¹⁶ PEPFAR. *Fiscal Year 2010: PEPFAR Operational Plan*; April 2011.
¹⁷ PEPFAR. *Partnership Frameworks*: <http://www.pepfar.gov/frameworks/index.htm>.
¹⁸ PEPFAR. *Partnering in the Fight against HIV/AIDS*; April 2011: <http://www.pepfar.gov/press/121652.htm>.
¹⁹ PEPFAR. *Making a Difference: Funding*; February 2011: <http://www.pepfar.gov/press/80064.htm>.
²⁰ Department of State. *Obama Administration’s Pledge to Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis*; October 5, 2010. Available at: <http://www.state.gov/ir/pa/prs/ps/2010/10/148642.htm>.
²¹ The Global Fund. *Grant Portfolio*; accessed November 2011: www.theglobalfund.org/programs/search/?lang=en. Numbers may not equal 100% due to rounding.