Overview of PEPFAR Prevention

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PEPFAR's Second Phase Prevention Strategy

Four priorities for prevention moving forward:

- Know Your Epidemic, Know Your Response, Adjust Your Portfolio
- Scaling up What Works
- Emphasizing Combination Prevention
- Supporting Evaluation of All Prevention

Outline

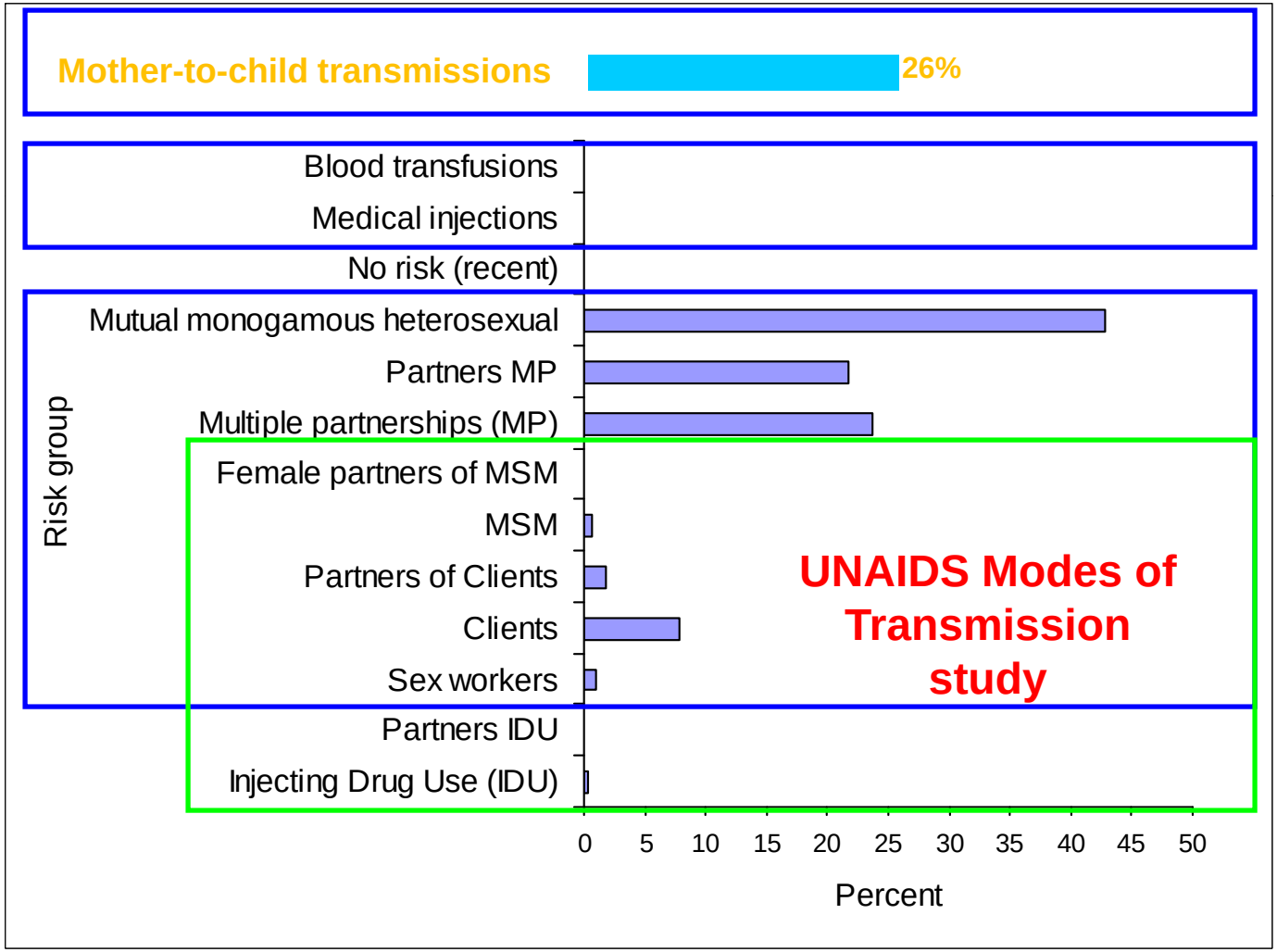
- Know Your Epidemic, Know Your Response, Adjust Your Portfolio
  - Country examples
  - Insights from FY11 COP Budget
- Scaling up What Works
  - New Guidances
  - MC
  - MARPS and concentrates epidemics
  - Examine gaps (condoms and research from behavioral interventions)
  - Initiatives (gender)
- Combination Prevention
  - ARV prevention an essential element
- Supporting Evaluation of All Prevention

Know Your Epidemic, Know Your Response, Adjust Your Portfolio

ALIGNING PORTFOLIOS

Know Your Epidemic - The view from 30,000 feet

- Some occur from mother-to-child (~25%)
- Most infections occur sexually (~75%)
- MARPs: poor data availability, guess work >> poor estimates
- Almost none occur in health care setting (injections, transfusions)



KYR - Countries that have undertaken Prevention Portfolio Reviews

- Botswana 2010
- Guyana: 2010
- South Africa: 2009
- Ethiopia: 2009
- Uganda: 2010
- Mozambique: 2009.
- Tanzania: reviews annually with the GOT
- Kenya: starting in 2008, reviews annually with the GOK

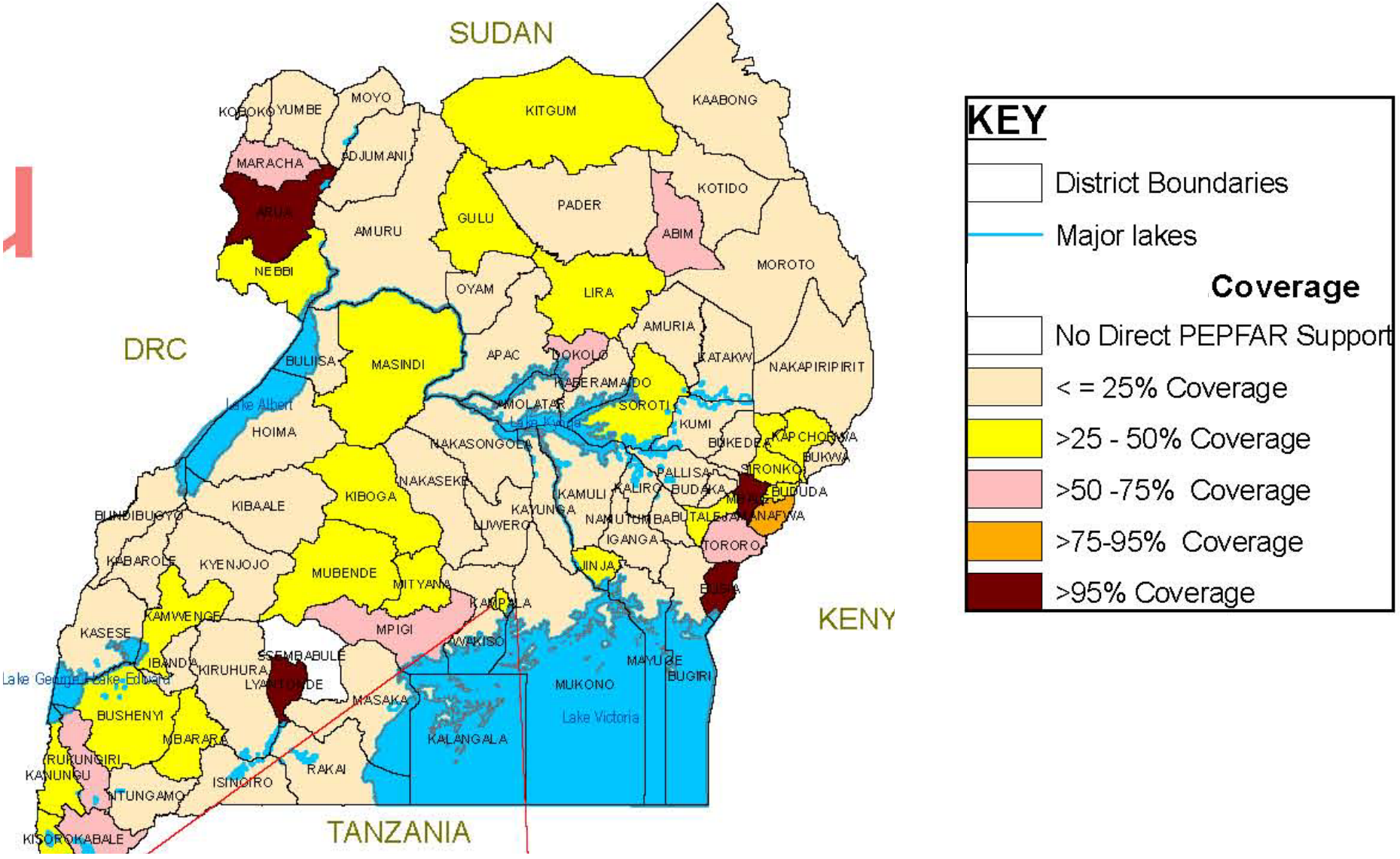
Kenya Portfolio Review – Integrating Cost Effectiveness

Summary Results and Recommendations

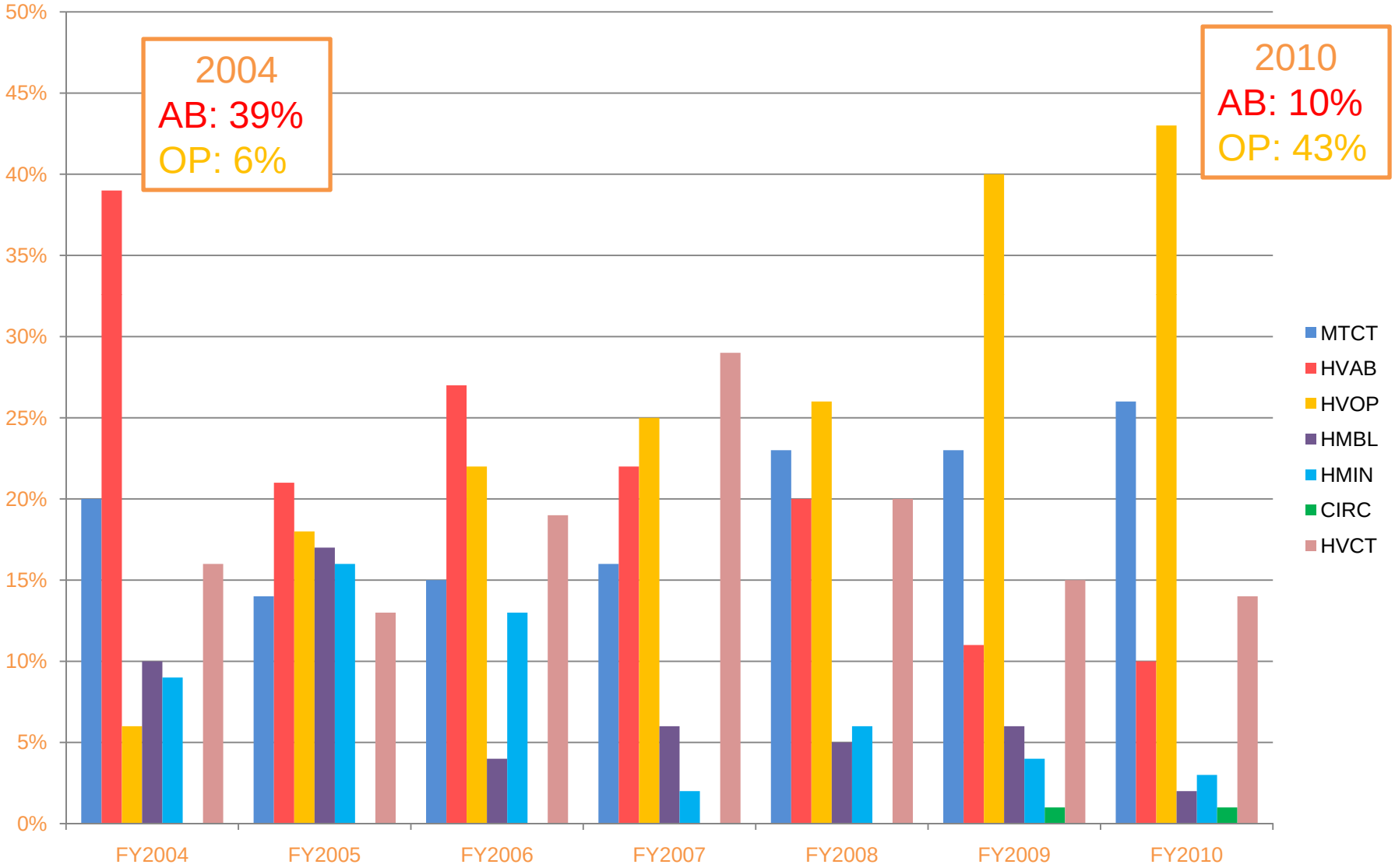
CE Rank	Cost/case averted	Intervention	Population	Epi setting
Most favorable CE	~$2,500	VAMC	Males	Nyanza, Nairobi
		NE; RR counseling	IDUs	Nyanza; Coast
		CSM; CT; STIrx; PwP	Prison	Nairobi; Coast
			SW and partners	Nyanza, Nairobi
			MSM	Nyanza; Coast
Moderate CE	~ $6,000	Standard package	Females	Nairobi - Urban
			Males	Central - Rural
			Males & Females	Coast-Urban
			Females	Nyanza - Rural
			Females	Rift - Rural
			Males & Females	Western - Rural
Least favorable CE	~$14,000 +	Standard package esp. if emphasizes schools-based programs; IEC; female condoms; STI-Rx	General pop. Esp. Youth and those ~45+	Central Eastern North Eastern

Population and epi settings are confined to KAIS and MoT data. Thus, results and recommendations are partial and indicative, not exhaustive.

Uganda Portfolio Review – Integrating Coverage



Ethiopia – Evolution of a Prevention Portfolio



Where are PEPFARs Investments in Prevention? Update on Prevention Spending

Expenditures , etiology and effectiveness

- Budget codes don’t necessarily reflect program
- Doesn’t take into account other in-country expenditures or policy limitations
- Can examine relative expenditures by intervention and country
- Provides starting point to consider optimal allocation of future resources (allocative efficiency)
- Significant challenges exist in considering combinations and synergistic impact that could increase efficiencies and reduce costs

PEPFAR Uganda HIV Prevention budget spending

PMTCT

FY 10: $14,910,546

- 7.1% of Prevention, Treatment, and Care

AB (General Sexual Prevention)

FY 10: $14,962,743

- 7.1% of Prevention, Treatment, and Care

Other Sexual Prevention

FY 10: $13,327,942

- 6.3% of Prevention, Treatment, and Care

Blood Safety

FY 10: $3,000,000

- 1.4% of Prevention, Treatment, and Care

Injection Safety

FY 10: $632,500

- 0.3% of Prevention, Treatment, and Care

Behavioral Interventions: BCC/IEC, mass & print, dialogue

- Youth(in & out of school): promote abstinence, delay of sexual debut
- Targeting HIV infected adolescents and youth
- Decreasing risk behaviors in general population
- Adults: Reducing multiple & concurrent sexual partnerships
- MARPS: Focus on prevention in risk groups incl. FSW, Truck drivers, discordant couples
- Targeted approaches to prevent/reduce sexual risk taking behaviors e.g prevention of alcohol abuse

Biomedical interventions

- Sexually active, MARPS: condom promotion-social mkt & free UHMG e.g Protector, “Condom O ’’
- STI prevention & Rx; BCC to increase care seeking behavior and condom use for prevention –Mulago
- Medical Male Circumcision: Rakai, Lyantonde, Kayunga, STAR, HIPS districts & UPDF
- Integrating prevention into HIV Care & Rx programs(PWP)
- Supporting National Blood Transmission services
- Infection Control and occupational and non-occupational PEP:

Structural interventions

- Male gender norms—underlying youth vulnerabilities e.g transactional sex
- Messages to discourage alcohol abuse (Mbuya, NUMAT, UHMG)
- GBV initiative for rape victims—MJAP,UPDF, NU
- Work place programs- HIV/AIDS work place policy (SPEAR)
- Livelihoods-economic empowerment to address poverty—ROADS, UHMG, Small grants
- Policies—PMTCT, HCT, Condom promotion, Blood safety, STI treatment guidelines, Medical infection control, PEP
- Stigma & discrimination—social mobilization

Scaling up What Works

2010 GUIDANCE DOCUMENTS

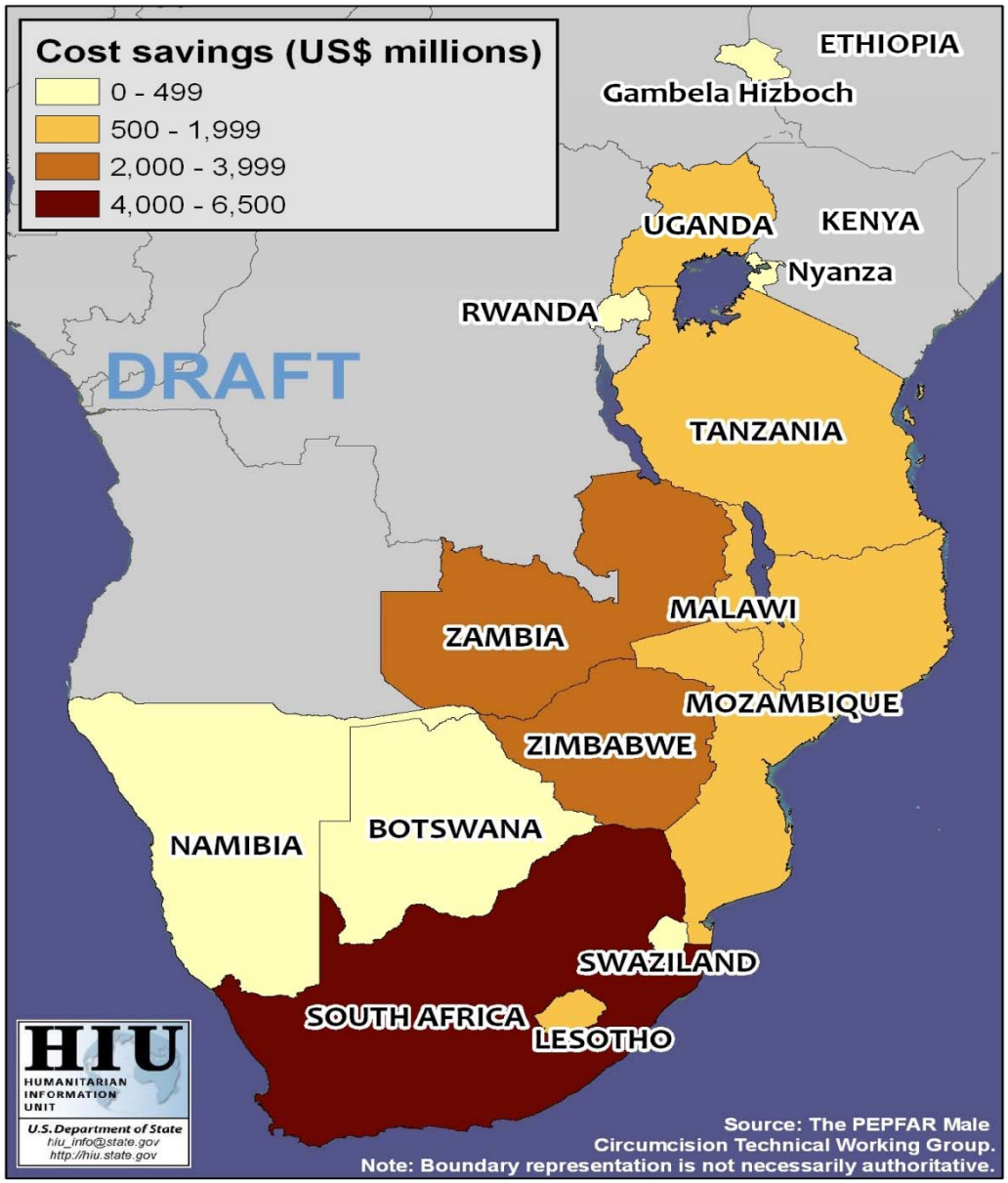
New Guidance Documents

- **IDU Guidance**
  - Released July 2010
- **MSM Guidance**
  - In clearance
- **Integration of PMTCT, Maternal, Neonatal, and Child Health and Pediatric HIV Services**
  - Initiating clearance
- **Prevention Programming Guidance**
  - Consultations Nov. 2010
  - In development
- **Combination Prevention PHEs**
  - Consultation Oct 2010
  - Additional investment

Scaling up What Works

ACCELERATING MALE CIRCUMCISION PROVISION

Cumulative Cost Savings Generated from 2009 to 2025

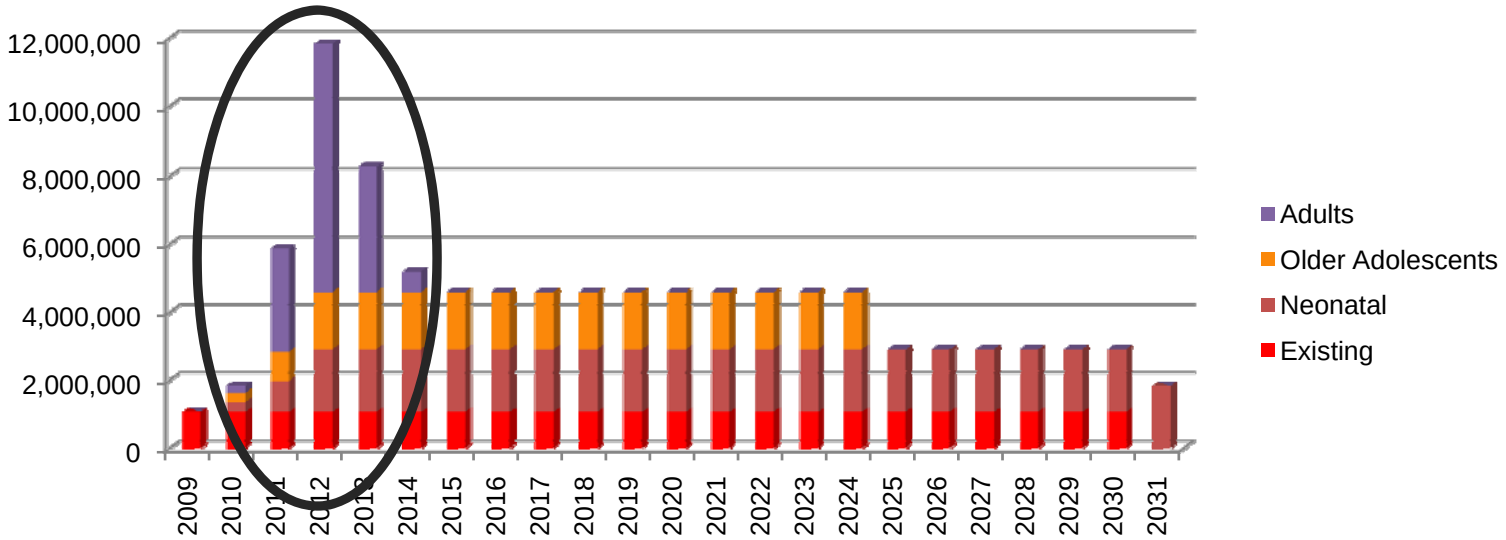


Infections Averted

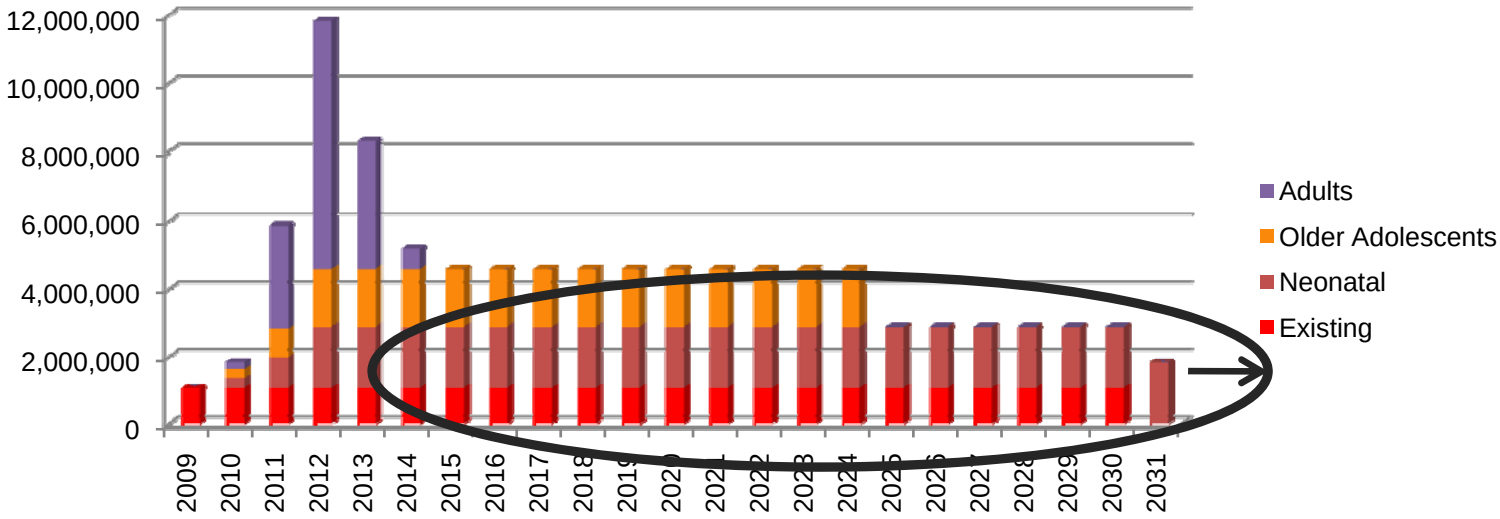
No. MCs to avert 1 HIV infection through 2025 (rounded)	
Botswana	20
Ethiopia (Gambella)	50
Kenya (Nyanza)	40
Lesotho	<10
Malawai	30
Mozambique	30
Namibia	20
Rwanda	90
South Africa	10
Swaziland	<10
Tanzania	70
Uganda	40
Zambia	10
Zimbabwe	<10

Sample data from UNAIDS/USAID's Health Policy Initiative *Decision-Makers' Programme Planning Tool*; generated by Lori Bollinger from Futures Institute. Data are from a model that assumes 80% MC coverage of HIV-negative male neonates and adults (15-49 years of age) by 2015 and MC coverage maintained thereafter.

- Adult MC programs are not sustainable *and they do not need to be*
- Mixed implementation methods—settings & staff—seem to work best for adult programs



- Neonatal MC programs *must be sustainable* and this support is well suited to strengthen health systems and build capacity



What was the Kenyan MC RRI?

- Target of 30,000 MCs in 30 working days across 11 districts of Nyanza Province
- Took advantage of the long school holidays in Nov/Dec 2009
- Led by Ministry of Public Health & Sanitation and Ministry of Medical Services with support from 7 NGO partners
- Used all 3 models of service delivery

Slide courtesy of: Emma Llewellyn, Nyanza Reproductive Health Society

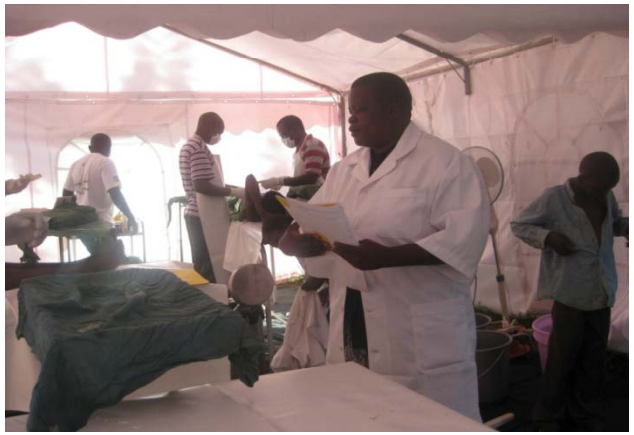
Mobile Services

General SRH session

Group MC education

Individual MC counseling / VCT

Mobile clinic set up



Surgery ongoing

Surgery ongoing

Swaziland Accelerated Saturation Initiative (ASI) for Male Circumcision

Address to the United Nations 65th Session on Millennium Development Goals, His Majesty King Mswati III

"We encourage people to adopt prevention mechanisms since prevention is better than cure. This ***comprehensive integrated HIV prevention package*** ***is to be scaled up and delivered in an accelerated mode in the coming year***."

September 20, 2010, New York

Overview of ASI

- Objective: By December 2011, provide 152,800 adolescents and adult men with medical male circumcision as part of an HIV prevention package (HTC, counseling, etc)
- Target group: 152,800 males ages 15-49 years old
- MC services will be provided at approximately 35 sites (public hospitals, health centers, NGOs, newly erected surgical theatres, and outreach)
- Approximately 35 MOVE teams will be needed at the height of service delivery
- Utilizing lessons learned from rapid scale up campaigns in Kenya, Tanzania and KZN

Projected Benefits of ASI

- Prevent 88,000 new HIV infections
- Reduce HIV incidence by 75%
- Save USD 650 million in HIV care and treatment costs
- Identify 23,000 clients with HIV infection
- Immediately start 4,800 people on ART

- Impact Evaluation at Population level of Combination Prevention

Scaling up What Works

OPPORTUNITIES TO EXPAND EVIDENCE-BASED HIV PREVENTION FOR MARPS

Filling Gaps in Coverage of MARPs with Prevention Services

- Need to ensure that most at risk populations, which have been ignored in some countries, receive adequate funding based on epidemiology
- Guidance documents for MSM and IDU can assist in advocacy for greater and more evidence-based programming for these populations
- Strong evidence base for HIV prevention with MARPs (i.e. minimum package approach)
- Countries should work closely with national governments to advocate for an enabling environment for HIV prevention with MARPs
- Countries should develop goals for high levels of coverage of MARPs with HIV prevention programming

HIV Prevention Programming for MARPs

- Prevention programming in concentrated epidemics should focus on key MARPs relevant to that context
- ‘Scaling up’ HIV prevention programs in concentrated epidemics means reaching 80% coverage of MARPs with a minimum package of services
- Research opportunities for evaluation of programs for drug using populations– through a new collaboration with NIDA

Scaling up What Works

GENDER PROGRAMS

PEPFAR Gender Framework

- Women and girls a priority of GHI and gender figures prominently in PEPFAR Phase 2 strategy

- Approach integrates gender within key programmatic areas and focuses on five crosscutting areas:
  - Increasing gender equity in HIV/AIDS activities and services – including maternal and reproductive health
  - Addressing male norms and behavior
  - Reducing violence and coercion
  - Increasing women's and girls' access to income and productive resources and education
  - Increasing women's and girls' legal rights and protection

New Initiatives

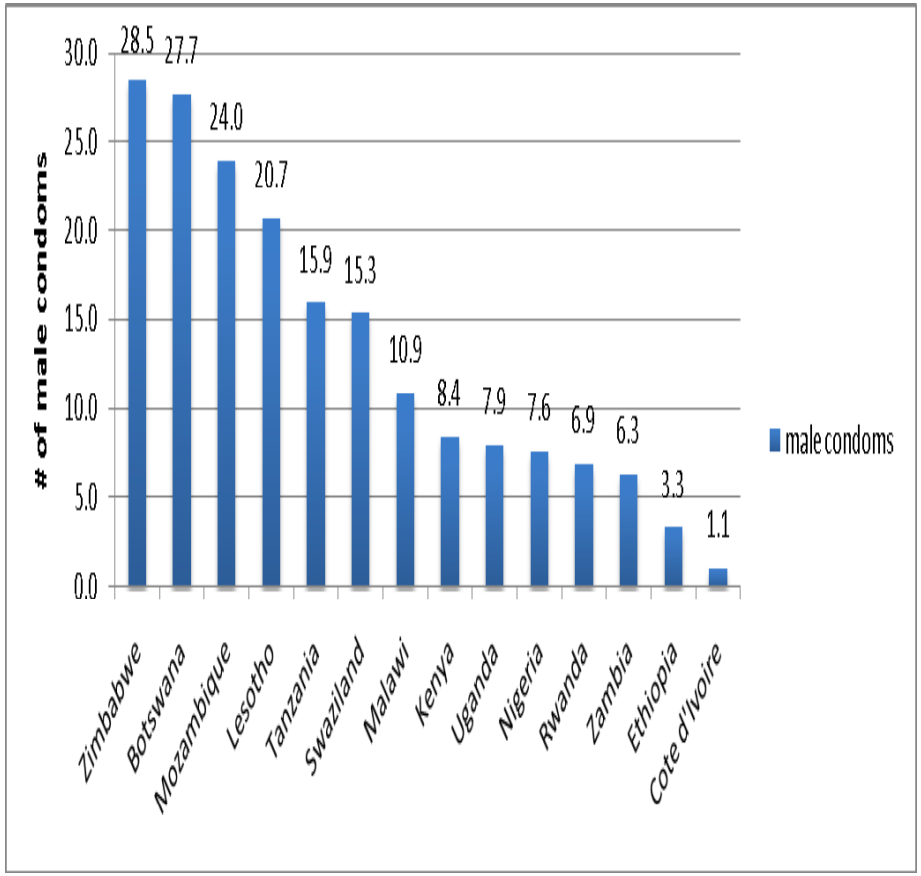
- Scale up comprehensive GBV prevention addressing social norms and post-rape care services building on PEPFAR platforms in Tanzania, Mozambique and DRC. ($19 mil year 1)
- Gender challenge fund; 14 countries match country and central funds to strengthen gender programming ($8.5 mil)
- Together for Girls; Partnership with UN agencies, BD, Nduna Foundation, CDC and PEPFAR - seeks to mobilize stakeholders for a country-wide response using national data on the scale and causes of sexual violence against girls as a foundation for program response
- Key priority is to build the evidence-base; strengthen monitoring and evaluation

Scaling up What Works - GAPS

WHY IS THERE A CONDOM GAP IN 2010?

Male Condom Availability

Number of male condoms shipped by donors per man (aged1564) in 2008



- Large variations
- Median – 9.65 condoms/man/yr
- 9/10 countries experienced public sector stock-outs 2008-2010
- similar issues for female condoms

Barriers to Condom Availability

- At the donor level
  - Insufficient donor support for both condom provision and demand creation
  - Ineffective funding mechanisms
  - Confusion over the USG position on condoms
- At the country level
  - Lack of prioritization of condoms by host governments
  - Weak public sector supply chain systems
  - Unfavorable regulatory policies
    - Import taxes
    - Unnecessary post-shipment testing
- Bottom line:

  Support comprehensive condom programming by increasing funding for multiple program components (beyond condom procurement)

GAPS: Significant gaps in behavioral interventions

- Behavioral Interventions
  - Targeting HIV infected individuals
  - Effective counseling strategies for HIV negatives
  - Interventions designed to reduce concurrent sexual partnerships
  - Interventions among youth that address social norms and wider community influences
  - Approaches to help maintain risk reduction behaviors

Prevention Implementation Gaps

- Gap 1 – prevention efforts do not reach those who most need them
- Gap 2 – structural and human rights factors increase risk and vulnerability
- Gap 3 – fragmented interventions miss opportunities to interrupt transmission
- Gap 4 – prevention efforts lack resources and remain limited in scope

OPPORTUNITIES TO ADVANCE ARV-BASED PREVENTION (ORAL AND VAGINAL) - A CORNERSTONE OF COMBINATION PREVENTION

Lessons learned from preparing for MC for PrEP

1. Engage in the global conversations
2. Establish a PEPFAR interagency task force comprised of HQ and field staff to plan the PEPFAR approach to implementation
3. Fund modeling of cost and benefits at the country level
    1. examine for which populations, in what scenarios, and for what level of effectiveness PrEP would have the greatest impact at the lowest cost
    2. also include variables that address HIV retesting, the development of resistance to TDF and FTC, and determine costs/HIV infection averted for a variety of service delivery strategies, target populations, providers and speed of scale up
4. Fund feasibility and acceptability surveys
5. Develop effective communication strategies
6. Initiate policy dialogue

Treatment as Prevention

"The Four Questions" M. Cohen

1) How effective are ART drugs to prevent HIV transmission ?
   AND HOW WILL WE MAKE THEM MORE EFFECTIVE?

2) What do we tell couples and infected people?
   -THE "SWISS STATEMENT" and its consequences

3) Can we expect reduced population HIV incidence from ART?
   -Can this be measured and monitored?

4) What are barriers to "Treatment as Prevention"?
   -Linkage to care
   -Adherence to ART (…and which ART?)
   -HIV resistance (…reflecting drug selection and adherence)
   -Acute, early infection and/or high viral load

Critical questions for enhancing public health impact of ART for Prevention

- Effective ways to increase HIV testing
- Better linkages to care, including reducing # of steps
  - Potential benefit of point-of-care CD4 testing
- Use of VL for ART initiation for those with higher CD4
- Maintaining adherence over years
- Reducing attrition (priority in resource-poor countries)
- Suite of other interventions necessary to achieve greatest sustainable impact at the population level

Test and Treat Conclusions 2010 – M. Cohen

- **ART has the power to reduce transmission of HIV, but the magnitude is unknown**
- **The population benefit of ART will depend on**
  - **durable transmission suppression**
  - **preventing transmitted resistance**
  - **dealing with acute HIV infection**
- ***We ought to commit resources to the essential research to DEVELOP treatment as prevention, avoiding the pitfalls of hyperbole and wishful thinking***

Combination prevention: How to define the evaluable package

- Evaluation should focus on the *entire* package. Can include:
  - What already exists (e.g.: mass communication and BCC, etc)
  - Newly added components (e.g.: vaginal or oral PrEP, altered eligibility for tx, structural interventions that change economic or legal circumstances, etc)
  - Components that are altered (e.g.: intensifying MC, vouchers for repeat HCT, etc)
- ARV-based prevention will be a critical component

Combination prevention:

Minimal requirements for impact evaluation

- Essentials :
  - Valid counterfactual
  - Direct assessment of impact (infections averted) at the community level
  - Causal attribution of the effect of the entire package takes precedence over attribution of specific components
- Requires continuous feedback on:
  - Process indicators (coverage)
  - Interim outcomes
  - Trends in Impact
- On-going feedback permits course corrections
  - Intervention tweaks
  - Jettisoning or switching components
  - Retargeting

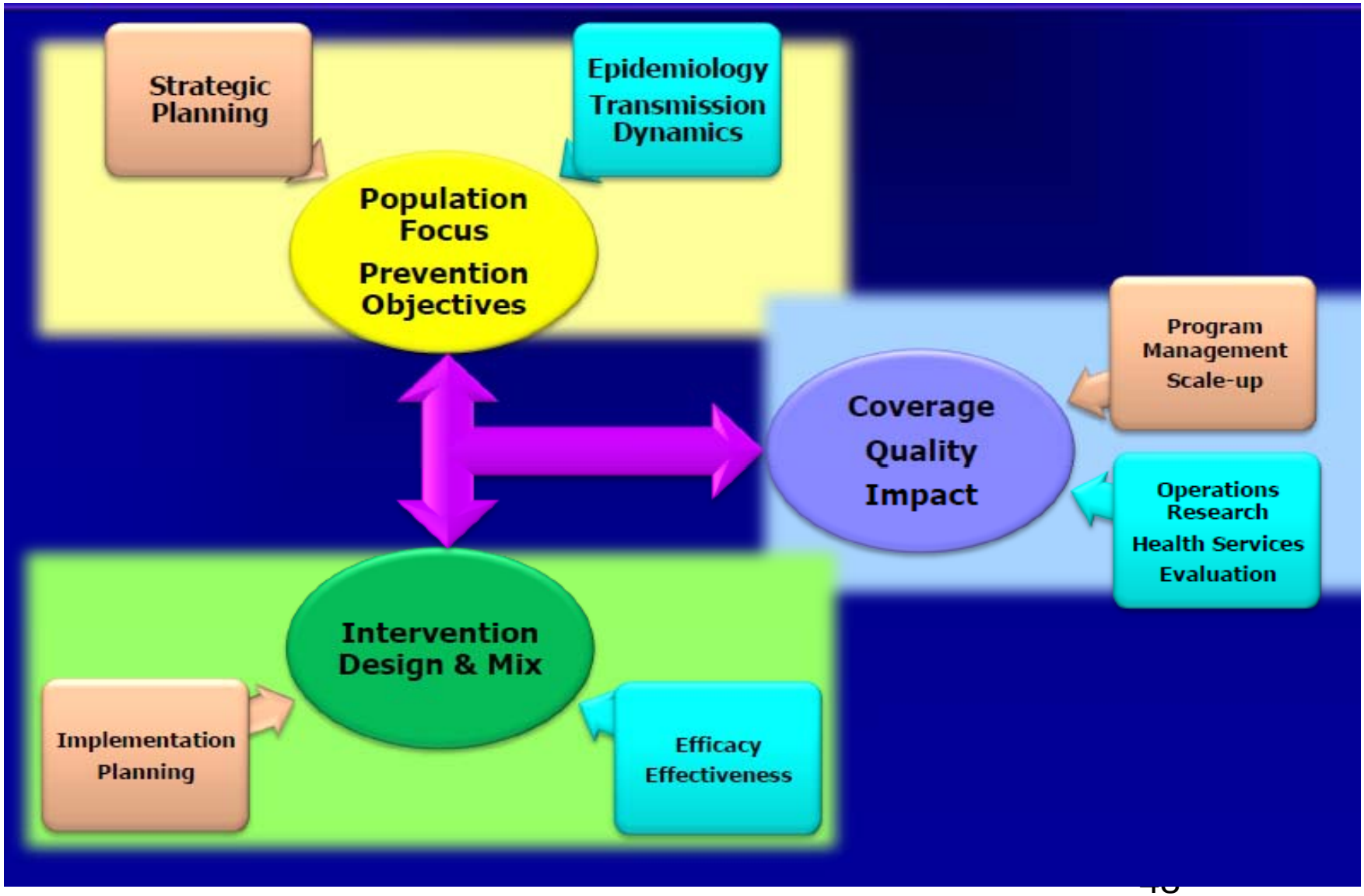
Coordination is essential to move forward

- Need multiple studies on ARV-based and/or combination prevention
- Integration permits
  - Sample sizes sufficient to examine impact at the community level
  - Increased external validity/generalizability to multiple contexts
  - Development of infrastructures capable of rapid scale-up of effective interventions

Requirements for a coordinated effort

- Harmonized definition of key indicators and related data
- Standard protocols for data collection and analyses
- Obligatory semi-annual reporting
- Oversight by a secretariat that will oversee and approve:
  - Evaluation designs
  - Timelines and milestones
  - Common key data elements and objectives
  - Semi-annual reports

Components of Prevention Service Delivery



We also need information that is:

- Population-based
- Produces knowledge about policy and program interventions that have the potential to impact health at the population level
- Includes interventions that operate within and outside the health sector
- Includes interventions that modify social determinants of morbidity
- Includes research into “required and achievable coverage” or reach of interventions
- Includes research into “incremental” or “marginal” benefits of additional interventions
- “Incremental” and “marginal” costs of interventions
- Synergies and antagonisms across interventions
- Differential uptake of interventions
- Issues of adherence to interventions by the population
- Operational research on implementation of interventions
- Sustainability of interventions and their routinization

Prevention - Looking forward

- Need to strike an appropriate, country-specific balance of interventions between those with strong evidence base and where evidence base is emerging

- Move prevention portfolio along continuum to allow for innovation but ensure greater/sufficient proportionality of funding is allocated to areas where evidence is strong

- Evaluate **impact** as we go and shift approaches accordingly

Thank You

- Nancy Padian
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