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## Scale-up of HIV Treatment Through PEPFAR: A Historic Public Health Achievement

Wafaa M. El-Sadr, MD, MPH, MPA<sup>\*</sup>, Charles B. Holmes, MD, MPH<sup>†</sup>, Peter Mugenyi, MD<sup>‡</sup>, Harsha Thirumurthy, PhD<sup>§</sup>, Tedd Ellerbrock, MD<sup>||</sup>, Robert Ferris, DO, MPH<sup>¶</sup>, Ian Sanne, MD<sup>#</sup>, Anita Asiimwe, MD, MPH<sup>\*\*</sup>, Gottfried Hirnschall, MD, MPH<sup>††</sup>, Rejoice N. Nkambule, MPH<sup>‡‡</sup>, Lara Stabinski, MD, MPH<sup>†</sup>, Megan Affrunti, MSW, MPH<sup>\*</sup>, Chloe Teasdale, MPH<sup>\*</sup>, Isaac Zulu, MD<sup>§§</sup>, and Alan Whiteside, DEcon<sup>||||</sup>

<sup>\*</sup>ICAP, Columbia University, Mailman School of Public Health, New York, NY <sup>†</sup>Office of US Global AIDS Coordinator, Washington, DC <sup>‡</sup>Joint Clinical Research Centre, Kampala, Uganda <sup>§</sup>Department of Health Policy and Management, Gillings School of Global Public Health, University of North Carolina at Chapel Hill, Chapel Hill, NC <sup>||</sup>US Centers for Disease Control and Prevention, Atlanta, GA <sup>¶</sup>US Agency for International Development, Washington, DC <sup>#</sup>University of Witwatersrand, Johannesburg, South Africa <sup>\*\*</sup>Rwanda Biomedical Center, Kigali, Rwanda <sup>††</sup>World Health Organization, Geneva, Switzerland <sup>‡‡</sup>Ministry of Health, Mbabane, Swaziland <sup>§§</sup>Centers for Disease Control and Prevention, Lusaka, Zambia <sup>||||</sup>Health Economics and HIV/AIDS Research Division, University of KwaZulu-Natal, Durban, South Africa

### Abstract

Since its inception in 2003, the US President's Emergency Plan for AIDS Relief (PEPFAR) has been an important driving force behind the global scale-up of HIV care and treatment services, particularly in expansion of access to antiretroviral therapy. Despite initial concerns about cost and feasibility, PEPFAR overcame challenges by leveraging and coordinating with other funders, by working in partnership with the most affected countries, by supporting local ownership, by using a public health approach, by supporting task-shifting strategies, and by paying attention to health systems strengthening. As of September 2011, PEPFAR directly supported initiation of antiretroviral therapy for 3.9 million people and provided care and support for nearly 13 million people. Benefits in terms of prevention of morbidity and mortality have been reaped by those receiving the services, with evidence of societal benefits beyond the anticipated clinical benefits. However, much remains to be accomplished to achieve universal access, to enhance the quality of programs, to ensure retention of patients in care, and to continue to strengthen health systems.

The scale-up of HIV care and treatment services has led to the dramatic expansion of access to antiretroviral therapy (ART) for people living with HIV (PLWH) globally. As of the end of 2010, there were 6.6 million people who initiated ART in low- and middle-income countries (LMICs), compared with only 400,000 in 2003.<sup>1</sup> The number of children receiving ART has risen from 71,500 in 2005 to 456,000 in 2010, with coverage of prevention of mother-to-child transmission (PMTCT) services rising to 48% from only 9% in 2004.<sup>1</sup>

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Correspondence to: Wafaa M. El-Sadr, MD, MPH, ICAP, Columbia University, Mailman School of Public Health, 722 West 168th Street, 13th floor, New York, NY 10032 (wme1@columbia.edu).

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One of the key driving forces behind this success has been the US President's Emergency Plan for AIDS Relief (PEPFAR), which was launched in 2003 by the US government to combat the global HIV/AIDS epidemic. The largest commitment by any nation to address a single disease in history, and the first global initiative to combat a chronic disease, PEPFAR's expansion of treatment access has been unparalleled for a global health and development initiative. As of September 2011, PEPFAR directly supported ART for 3.9 million men, women, and children worldwide and provided care and support to nearly 13 million.<sup>2</sup> The PEPFAR approach is based on the following principles: (1) country ownership of local programs, (2) a result-based accountability approach, (3) engagement of all sectors, and (4) good governance. This article explores PEPFAR's approach to HIV treatment scale-up, key achievements, and opportunities and challenges for the future.

## PEPFAR APPROACH AND POLICY

By reversing a tide of disease, fear, and societal disruption, especially in sub-Saharan Africa, where in some countries the HIV epidemic affected over one-quarter of adults, PEPFAR's treatment programs have had a stabilizing effect on health systems and communities. Despite initial concerns about the cost and feasibility of delivering ART for persons infected with and affected by HIV in challenging global settings with weak health systems, PEPFAR-supported national treatment programs have become a beacon of the global response to HIV for the past 8 years.

These programs have been developed and led by partner governments and supported by academic, nongovernmental, and faith-based organizations, along with US government agencies, including the Centers for Disease Control and Prevention (CDC), the Department of Defense, the Health Resources and Services Agency (HRSA), the Peace Corps, the US Agency for International Development (USAID), and more.<sup>3</sup> They have also been built in a manner that has strengthened underlying health systems, through the renovation of clinical space, support for tiered laboratory networks, cross-training of health care providers, development of multi-commodity supply chain routes, and by encouraging general well-being through income generation activities and explicit support for strong community responses.

Although overall global budgets for HIV have leveled over the past several years, PEPFAR has maintained a strong focus on the expansion of HIV treatment services by leveraging and coordinating with other funders and through strategies to gain efficiency. For instance, in Tanzania, the government has used Global Fund to Fight AIDS, Tuberculosis and Malaria resources to procure first-line antiretroviral treatment, whereas PEPFAR has focused on strengthening regional and district health systems, training health care and public health management personnel, and providing support for innovation and quality improvement.<sup>4</sup> PEPFAR has also pursued an efficiency agenda that has maximized the use of generic antiretroviral drugs (ARVs), supported efforts to enable nurses and other allied health professionals to provide treatment, and expanded use of financial information by program managers to decrease service delivery costs.<sup>5-7</sup>

## PUBLIC HEALTH APPROACH AND TASK SHIFTING

An important factor that enabled the success of the scale-up of HIV treatment was the support by the World Health Organization (WHO) of a standardized and simplified treatment and patient-monitoring approach. Studies have shown that bringing services closer to where people live improves access and utilization and that decentralizing HIV treatment to primary facilities results in better patient retention and treatment adherence, contributes to reducing indirect costs of care for individuals and families, and also supports equity of care.<sup>8-10</sup> However, in the face of the burden of HIV, LMICs face a shortage and

maldistribution of human resources for health, particularly the concentration of health care workers in urban areas, a situation that threatens decentralization and hinders the scale-up of HIV treatment.

In 2008, WHO issued a global recommendation that proposed the adoption of a task-shifting approach to overcome shortages of human resources and rapid increase in access to HIV and other services.<sup>6</sup> Task shifting signifies a rational distribution of tasks among cadres of health workers. Where appropriate, it implies that selected tasks are moved from highly qualified health workers to health workers with shorter training and fewer qualifications. Task shifting potentially saves time for highly specialized health workers to care for more complicated patients, whereas health workers with fewer qualifications provide care for stable patients, and lay workers do patient triage, education, and counselling.<sup>6,11,12</sup>

Several studies demonstrated the relevance of task shifting in different settings. A systematic review of studies in Africa, where HIV disease burden is high, indicated that task shifting is feasible and effective in expanding HIV treatment.<sup>6,13,14</sup> Similar studies also show that task shifting results in comparable patient treatment outcomes and virological suppression.<sup>8,15</sup> For example, in South Africa, based on evidence that nurse-monitored ART was not inferior to physician-monitored treatment, a shift to primary health care-based ART was undertaken.<sup>16</sup> Further implementation research demonstrated that nurse-monitored ART was both cost-effective and led to improved treatment outcomes.<sup>17,18</sup> With PEPFAR support, more than 20,000 nurses have been trained in both HIV and tuberculosis diagnosis and treatment, and nurse-initiated ART has become the norm. Thus, PEPFAR's adoption and support of task-shifting principles has enabled the expansion of HIV treatment in countries with some of the most severe health workforce constraints.<sup>19</sup>

## SUPPLY CHAIN MANAGEMENT AND ARV PROCUREMENT

Improved efficiency in selection and transportation of ARVs, the increasing use of generic drugs and fixed-dose combinations (FDCs), and the transition to preferred ARV regimens has lowered the cost of treatment substantially while improving the overall quality of HIV treatment in PEPFAR-supported focus countries. PEPFAR's per-patient treatment costs, including drugs and service delivery, have declined to \$335 per year, from nearly \$1100 just 7 years ago.<sup>20</sup>

One key improvement adopted by the Supply Chain Management System (SCMS), established and funded by PEPFAR and supported by the USAID, was the transition from air transport to land- or sea-based shipment.<sup>21</sup> It is estimated that using sea freight for major shipments saved up to 85% in transportation costs, and as of December 31, 2010, sea transport had saved PEPFAR \$39.8 million in transportation costs.<sup>21</sup> SCMS also established regional distribution centers in Ghana, Kenya, and South Africa, increasing commodity availability and reducing the lead time needed for delivery.

PEPFAR has also increased its use of generic drugs and FDCs.<sup>7</sup> In 2005, only 16% of PEPFAR-procured drugs were generic. This proportion increased to 97% in 2010, resulting in considerable savings compared with branded drugs (Fig. 1). Between 2008 and 2011 PEPFAR increased purchases of 2- and 3-drug FDCs, as recommended by the WHO (Fig. 2). These regimens are less complex, easier to administer, and may improve patient adherence. Similarly, over the past 4 years since WHO HIV treatment guidelines recommended that countries phase out stavudine in favor of less toxic zidovudine- or tenofovir-based regimens, SCMS orders for stavudine have declined by more than 70%, whereas orders for zidovudine and tenofovir have increased 20-fold (Fig. 3).

## ACHIEVEMENTS

### Scale-up of ART Access

The number of individuals receiving ART is one metric by which PEPFAR's achievement can be summarized. PEP-FAR support increased the number of individuals who initiated ART from 66,700 to 3,905,500 (63% women and girls) from 2004 to 2011 (Fig. 4). During the first phase of PEPFAR, there was a rapid increase in the number of patients receiving ART, doubling each year between 2004 and 2007. In addition, during 2008–2011, PEPFAR increased the number of individuals receiving ART by more than 650,000 patients each year. Importantly, while the growth of PMTCT programs has likely reduced the number of infants newly infected with HIV each year, HIV-infected children comprise about 9% of those supported on treatment by PEPFAR, up from 7% earlier in the response. The treatment program's rapid expansion is also reflected in the increase in the number of health facilities providing ART, growing from 300 sites in 2004 to more than 6400 in 2009 (last year this indicator was reported centrally).

Although the majority of treatment services are concentrated in 8 countries that collectively account for over half of the global HIV/AIDS epidemic, PEPFAR has supported treatment programs in more than 30 countries around the world<sup>26</sup> through contributions to health system's strengthening in the form of policy developments, logistics, protocol or guideline development, advocacy, laboratory support, training, information systems, and capacity building of national HIV/AIDS programs. PEPFAR also has had a strong focus on ensuring quality of services and has used a variety of methods to monitor and ensure the quality of its programs,<sup>27</sup> including sampled national survey studies<sup>28</sup> and other methods, as described in more detail in an article in this journal issue.

### Track 1.0 ART Program

One example that illustrates the rapid scale-up of ART while contributing substantially to health systems strengthening is the Track 1.0 ART Program. In September 2003, CDC and the HRSA published a request for applications (known as the Track 1.0 ART Program) with the goal to fund institutions with extensive HIV expertise to help initiate and support national HIV care and treatment programs in certain PEPFAR focus countries. Four organizations were selected for funding: AIDS Relief, a Catholic Relief Services Consortium, the Elizabeth Glaser Pediatric AIDS Foundation, ICAP at Columbia University, and the Harvard School of Public Health. Over the 8 years of the life of the program, the 4 partners received a total of \$2.2 billion and were instrumental in the initiation of HIV care for 2.5 million and ART for 1.4 million HIV-infected adults and children at more than 1300 health facilities in 14 countries (Fig. 5). As of March 2011, the Track 1.0 ART Program was supporting more than 936,000 persons on ART, which provided for about 1 of 4 patients on ART supported by PEPFAR worldwide and about 1 of 6 persons on ART living in sub-Saharan Africa. Table 1 shows rapid expansion in funding for the program and of the portfolio and achievement of desired targets.

Although initially focused on HIV treatment, over the years, the Track 1.0 ART Program funding has supported other HIV-related services, including PMTCT and integration of tuberculosis and HIV services. The Track 1.0 ART Program was also one of the first programs supported by PEPFAR that focused on strengthening existing health systems and local capacity and has successfully transitioned oversight and management of most programs to the Ministry of Health (MOH) and other indigenous organizations.

The Track 1.0 ART Program partners coordinated their efforts through the MOH; regional, provincial, and district government health offices; and faith-based organizations in each country. At the national level, the partners, working directly with MOH, helped develop and

implement national HIV care and treatment guidelines; establish national laboratory, informatics, and SCMSs; prepare and support clinical and laboratory training courses; and participate in HIV technical workgroups. Support was also provided to regional, provincial, and district government health officers through subagreements to provide technical and infrastructure support. Extensive efforts were also provided at the health facility level, including clinical mentorship, hiring of additional staff, renovation of clinics and laboratories, purchasing of drugs and laboratory equipment and reagents, monitoring and evaluation, and support for community mobilization.

During 2011, CDC transitioned the oversight and management of the Track 1.0 Program from US-based partners to MOH and other indigenous organizations for more than half of 1300 medical facilities in 13 countries that were providing ART for more than 925,000 patients. Over the next 3 years, it is anticipated that the remaining facilities will be transitioned into host country national systems to help assure the sustainability of the programs in the future (Fig. 6).

### **ART Scale-up Saves Lives**

As access to treatment has expanded, the number of AIDS-related deaths has declined substantially. In modeling of the epidemic both with and without ART, the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that ART has averted 2.5 million deaths in LMICs since 1995 with the most deaths averted in sub-Saharan Africa, where approximately 1.8 million lives have been extended as a result of treatment.<sup>1</sup> In sub-Saharan Africa, where AIDS-related deaths peaked in 2005 at 2.2 million, UNAIDS estimates that fewer people (460,000; 30%) died in 2010.

In a recent study that compared mortality in PEPFAR focus countries which were most severely affected with HIV/AIDS and received more PEPFAR resources in Africa versus non-focus countries, persons living in focus countries had 19.8% lower odds of death in the period from 2003 to 2008 when compared with those living in non-focus countries.<sup>29</sup> Another analysis utilizing data from UNAIDS and from demographic health surveys from 2004 to 2007 showed a significant decrease in HIV- and AIDS-related deaths in PEPFAR focus countries after 4 years of implementation as compared with other African countries.<sup>30</sup>

### **ART Scale-up and Social and Economic Outcomes**

The deleterious impacts of HIV infection on individuals in terms of morbidity and mortality have been well documented since the disease first emerged. At the community and national levels, there were dire predictions of social, political, and economic collapse.<sup>41</sup> Although these doomsday scenarios have fortunately been averted,<sup>30,42,43</sup> empirical evidence on the economic impact of the HIV epidemic has also emerged. Significant declines in productivity of HIV-infected workers at tea plantations in Kenya was noted as early as 3 years before death.<sup>44</sup> However, with expanded ART provision, rapid restoration of labor productivity has been noted. Research in rural Kenya demonstrated that employment outcomes improved within 6–12 months.<sup>45,46</sup> More studies have shown similar individual-level economic benefits from ART provision.<sup>47</sup> In South Africa, improvements in treated patients' employment outcomes have been shown to continue through the first 3 years on treatment<sup>48</sup> and similar evidence has been shown in India.<sup>49</sup> Renewed employment of an HIV-infected, working-age adult has had important consequences for household and community welfare as well. In Kenya, children living with adult ART recipients experience an increase in their school attendance and weight-for-height Z-scores, findings that are likely to lead to better economic outcomes for them in adulthood.<sup>50</sup> Although HIV treatment alone is unlikely to transform the local and national economies of HIV-affected regions, wider provision of

ART certainly promises to prevent further economic decline and to potentially restore socioeconomic well-being.

## WAY FORWARD

Access to HIV treatment worldwide has expanded substantially over the past decade with a significant reduction in AIDS-related morbidity and mortality.<sup>1</sup> This achievement is the result of a global commitment and broad partnership between funders, country leadership and institutions, implementing organizations, and communities of people living with and affected by HIV.

Access to treatment has changed HIV disease from a “death sentence” into a manageable chronic condition for millions around the world. Yet, it is acknowledged that only 47% of PLWH in LMICs have access to such lifesaving treatment and, thus, there is great urgency to expand HIV treatment programs. In addition, a number of recent scientific findings have changed the landscape for PEPFAR-supported treatment programs, including the results of the CIPRA Haiti 001 trial, which led WHO to recommend initiation of ART at a higher CD4<sup>+</sup> cell count threshold (<350 cells/mm<sup>3</sup>), and the groundbreaking findings from HPTN 052, which demonstrated the efficacy of ART in reducing HIV transmission by 96% in HIV serodiscordant couples.<sup>51,52</sup> These studies provided compelling scientific rationale for accelerating treatment access at earlier stages of HIV disease, not only for individual health benefits but also to help turn the tide of new infections. Model-based analyses have demonstrated that expanded treatment coverage, as part of a broader combination prevention package, could reduce annual new infections by more than 50% in the next 3 to 4 years.<sup>53</sup>

Key challenges remain to be addressed. Most PLWH are not aware of their HIV status, and in most settings, PLWH access ART at an advanced stage of HIV disease, contributing to mortality and morbidity and missed prevention opportunities.<sup>1,54</sup> Furthermore, linkage from HIV testing to HIV prevention and care programs, retention in HIV care, timely initiation of ART upon eligibility, and achievement of high ART adherence rates remain key challenges in optimizing prevention and treatment outcomes for the individual, their partner, and the community.<sup>54</sup> Continuing to address issues of ARV quality and cost in a proactive manner will also be essential to ensuring that PEPFAR investments result in the greatest possible impact on the HIV epidemic while building efficiencies that will foster greater sustainability and country ownership. This is particularly important in an era of resource constraints, although recent work has shown that in addition to the employment and productivity gains from ART, cost savings are garnered in the form of avoided expenditures on orphan care and delayed end-of-life care costs from AIDS-related morbidity.<sup>55</sup> All in all, these findings suggest that from a societal perspective, the economic benefits are likely to equal or even exceed the costs of treatment provision, thereby indicating a positive economic return to investments in ART.<sup>50</sup> Nevertheless, continuing to build a robust implementation research agenda will be fundamental to furthering the learning from ongoing programming and identifying efficient and effective methods to further expand the work and build on the success of PEPFAR.

In an address coinciding with the 2011 World AIDS Day, the compelling evidence for the remarkable gains achieved by expansion of HIV treatment and its potential impact on stemming the epidemic and enhancing the lives of communities around the world motivated US President Barack Obama to affirm the United States’ leadership role in combating the global epidemic. He pledged to increase by 50% the number of people PEPFAR supports on treatment over the next 2 years. This strong commitment will ensure that PEPFAR continues to lead the world’s response to the global HIV epidemic while serving as the foundation and platform for broader impacts through the US Global Health Initiative.

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**Box 1****Commitment to Local Partnerships**

From its inception, PEPFAR has consistently supported in-country organizations and promoted their ability to expand HIV care and treatment programs. Such local PEPFAR partners understand the specific contexts of their communities, health systems, and HIV epidemic. Their desire to take ownership of a strong local HIV response, coupled with significant PEPFAR support, created some of the premier treatment programs in their countries. Examples include the following:

- Right to Care in South Africa began as a small but innovative local nongovernmental organization in South Africa in 2001 and has rapidly expanded, providing ART services to more than 120,000 individuals through USAID/PEPFAR support.<sup>22</sup> Right to Care, in addition to other partners, is now instrumental in providing expert treatment services and technical assistance to help South Africa achieve the ambitious HIV treatment targets in the National Strategic Plan.
- The AIDS Support Organization (TASO), a Ugandan nongovernmental organization established in 1987, has extended treatment services to more than 23,000 people.<sup>23</sup> CDC/PEPFAR has provided significant scale-up support for The AIDS Support Organization treatment programs.
- The Joint Clinical Research Centre, founded in 1990 in Uganda, initiated more than 20,000 patients on ART as it scaled up HIV treatment at 7 regional centers of excellence, 52 satellite clinics, and 25 primary outreach sites through the “The Regional Antiretroviral Therapy” program funded by USAID/PEPFAR.<sup>24</sup>
- GHESKIO, a CDC/PEPFAR treatment partner in Haiti, continued operations after the January 2010 earthquake, maintaining quality ART access for more than 5000 HIV patients who returned to clinic for follow-up.<sup>25</sup>

**Box 2****HIV Treatment in Times of Crisis**

PEPFAR-supported programs and partners have shown resilience in maintaining delivery of quality HIV treatment services during periods of humanitarian crisis.<sup>9,31</sup> It is recognized that once HIV treatment is initiated, lifelong ART is recommended with few exceptions as treatment interruptions compromise health outcomes.<sup>32,33</sup> Humanitarian crises resulting from civil unrest (eg, armed conflicts, violent protests) or natural hazards (eg, floods, earthquakes) are notable risks for unplanned HIV treatment interruptions. Furthermore, these crises place people at additional risk for other causes of morbidity and mortality. Under such exceptional circumstances, PEPFAR-supported treatment programs strive to minimize the impact of humanitarian crises on PLWH.

Kenya experienced a protracted humanitarian crisis resulting from violence after its 2007 presidential election. At that time, approximately 172,000 people were receiving ART in Kenya.<sup>34</sup> Although this crisis was associated with treatment interruptions for HIV-infected children enrolled in Western Kenya,<sup>35</sup> several factors were reported that may have minimized disruptions in clinical care, including an established network of health facilities, resilient supply chain systems for food and medicines, dedicated community health workers, radio and print communication campaigns, and electronic medical records systems.<sup>36</sup>

Cote d'Ivoire<sup>37</sup> also witnessed an outbreak of violence in December 2010 after a disputed presidential election. At that time, PEPFAR was directly supporting approximately 61,200 HIV-infected individuals on ART in the country.<sup>37</sup> PEPFAR partners worked diligently to support accurate tracking of ARV stocks and HIV commodity pipelines, established drug distribution sites in every health district, and placed additional buffer stocks in these sites.<sup>38</sup>

Following the devastating earthquake in 2010 in Haiti, access to HIV treatment remained largely intact. At one large urban PEPFAR-supported health facility, 85% of the 6000 patients on ART returned to the clinic for follow-up and medication refills.<sup>25</sup> This was accomplished in part because PEPFAR had established partnerships in Haiti since 2004, which allowed partners to mount an immediate and robust response to the earthquake.<sup>39,40</sup> Furthermore, while continuing to provide ARV, PEPFAR supply chain partners also assembled essential medicine kits for health centers and coordinated humanitarian aid donations to assist in the earthquake response, whereas other PEPFAR partners participated in family tracing and reunification to promote child protection in the midst of this tragic crisis.<sup>39</sup>

**Box 3****Achieving High ART Coverage—Rwanda**

Universal access to ART by all PLWH who meet the eligibility criteria is a central priority of the Government of Rwanda (GoR). Since 2004, with funding from PEPFAR, Global Fund to Fight AIDS, Tuberculosis and Malaria, and other sources, ART coverage has increased from only 13% of eligible patients (based on CD4 <200 cells/mm<sup>3</sup>) up to 94% of eligible patients in 2011 (CD4 <350 cells/mm<sup>3</sup>). Key features that enabled this success include the following:

**Integration of HIV programs into health care systems**

People benefit from receiving care services simultaneously when HIV Testing and Counseling (HTC), ART, and PMTCT services are integrated into health services. Currently, of a total of 484 public health facilities, 93% provide HTC services, 85% provide PMTCT, and 81% provide ART.

**Decentralization**

The Rwanda Decentralization Policy allows all Rwandans access to comprehensive health services within a 3.5-km distance of their home, which has enabled HIV patients to receive services closer to where they live and allows for good coverage in service provision.

**Political commitment and leadership**

Rwanda adhered to the “Three Ones” principles: one national coordinating body, one strategic national plan of action, and one national monitoring and evaluation framework with full support from the highest level of leadership.

**Equity**

Access to HIV services is ensured through the community-based insurance scheme called “Mutuelles de Santé.” By supporting Mutuelles membership for marginalized and vulnerable groups and for PLWH, GoR ensures universal coverage to all Rwandans, no matter their socioeconomic status.

**Ownership and accountability**

Rwanda has developed a National HIV/AIDS Strategic Plan 2009–2012 with participation of all stakeholders involved in the fight against HIV/AIDS, including communities, civil society organizations, ministries, and development partners. By participating in its deliberations, all stakeholders were fully committed and accountable to the national priorities.

**Task shifting**

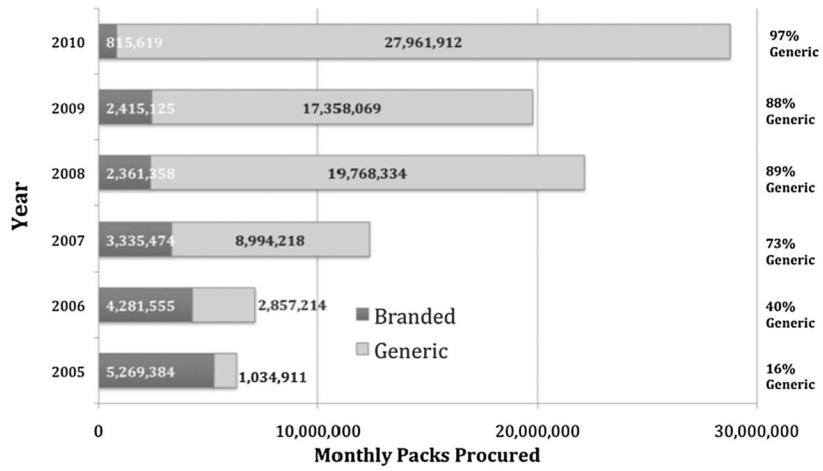
GoR has adopted task shifting in HIV service provision to scale up services and to ensure good coverage of HIV services. Currently, the country has 1 physician per 18,000 inhabitants, whereas there is 1 nurse for every 1476 inhabitants.

**Monitoring and evaluation**

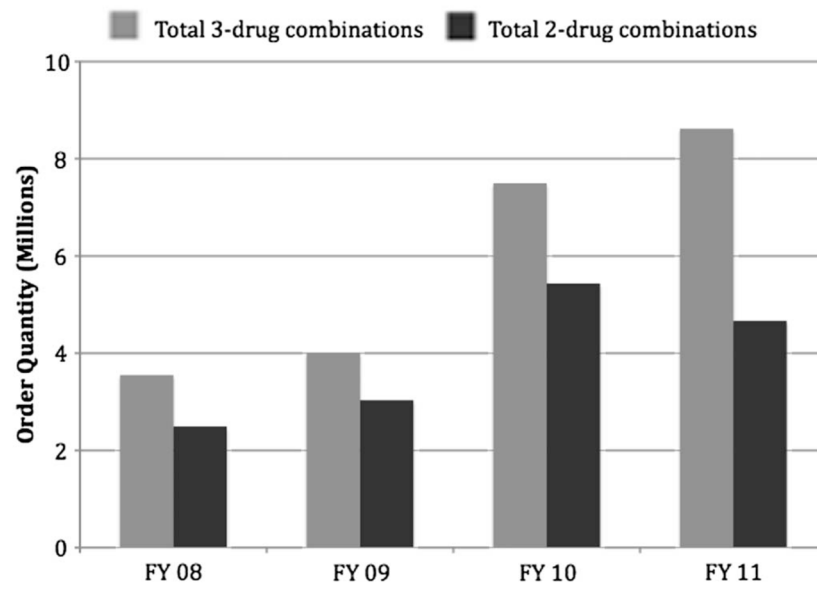
TRACnet, a national electronic cell phone–based and web-based monitoring and evaluation system for both pre-ART HIV care and ART services, has facilitated effective planning and expansion of ART access.

**Common procurement and distribution system**

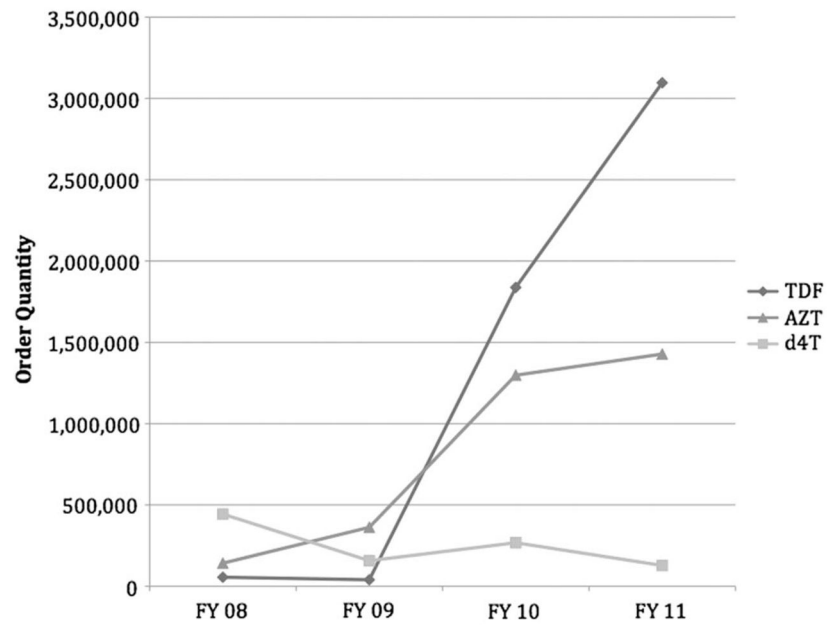
A joint quantification and procurement system for all required commodities for HIV services allows bulk procurement and ensures that patients' support is aligned with national guidelines.



**FIGURE 1.** Number of generic versus branded drugs procured (monthly packs, 2005–2010). PEP-FAR increased its use of generic drugs from 16% in 2005 to 97% in 2010.



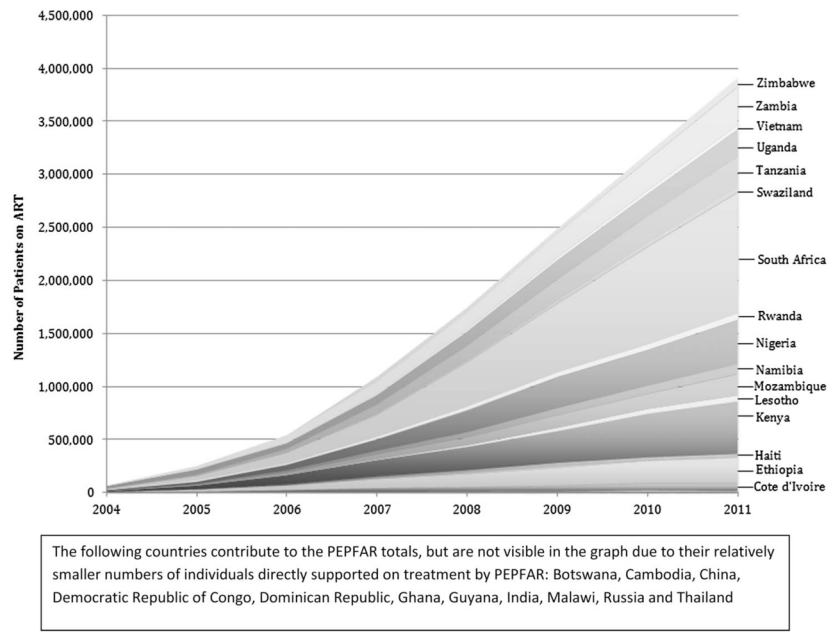
**FIGURE 2.** Total SCMS orders for 2- and 3-drug ARVs. Between 2008 and 2011, PEPFAR increased its purchases of 2- and 3-drug FDCs, as recommended by WHO.



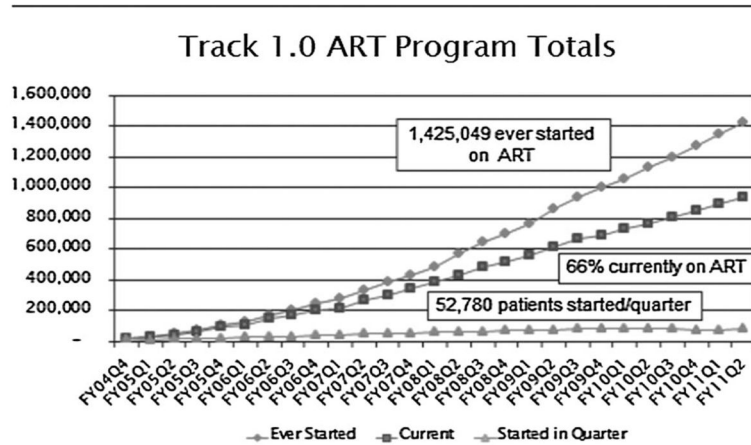
**FIGURE 3.**

SCMS order quantity for zidovudine (AZT), stavudine (d4T), and tenofovir (TDF) in fiscal year (FY) 2008–2011. Since 2008, SCMS orders for stavudine have declined by more than 70%, whereas orders for zidovudine and tenofovir have increased 20-fold.

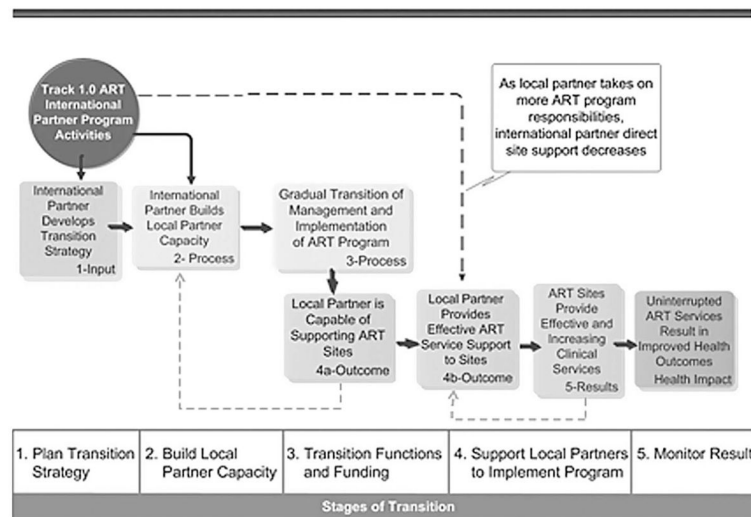




**FIGURE 4.** Number of adults and children with HIV infection receiving ART with direct PEPFAR support in fiscal year 2004–2011. PEPFAR support increased the number of individuals who initiated ART from 66,700 to 3,905,500.



**FIGURE 5.** Track 1.0 ART Program. Over the 8 years of the program, Track 1.0 ART partners were instrumental in initiating ART for 1.4 million HIV-infected adults and children.



**FIGURE 6.** During 2011, CDC transitioned the oversight and management of the Track 1.0 ART Program from US-based partners to MOHs and other indigenous organizations for more than half of 1300 medical facilities in 13 countries that were providing ART for more than 925,000 patients.

**TABLE 1**

## Track 1.0 ART Program Totals, by Program Year

<b>Program Year</b>	<b>Annual Funding (In Million Dollars)</b>	<b>No. Treatment Facilities</b>	<b>No. Patients on ART</b>	<b>No. Patients on HIV Care</b>
2004–2005	92	119	43,564	88,675
2005–2006	172	279	144,203	249,087
2006–2007	206	478	270,688	458,091
2007–2008	320	652	433,280	741,007
2008–2009	443	1030	618,558	979,685
2009–2010	413	1256	771,128	1,129,590
2010–2011	368	1307	936,106	1,344,611
2011–2012	202			

Total funding for 2004–2012 = US \$2.2 billion.