Phase I of the Strategy Development Process for the Children Affected By HIV/AIDS (CABA) Priority Area

Key Activities

• Conducted research on the landscape of needs, funding flows, and current efforts of key players attempting to address this population

• Conducted interviews with 30+ experts in funding, service provision, and policy

• Completed additional research identifying preliminary opportunities for intervention

• Vetted preliminary findings with Children Affected by HIV/AIDS stakeholders at a convening held at UNICEF headquarters in New York
The AIDS Pandemic Remains a Massive Global Health Problem Despite Almost Three Decades of Sustained Effort to Address the Disease

- **33.3 million** people were estimated to be **living with HIV** at the end of 2009 and this number continues to grow.
- **2.6 million** people were estimated to be **newly infected** by HIV in 2009.
- **Almost two-thirds** of those with HIV/AIDS in low and middle income countries are **not receiving the treatment they need**.

Source: UNAIDS 2010 Global Report
Ongoing Efforts Targeting HIV/AIDS and Child and Maternal Health Are Aligned with the Millennium Development Goals

In 2000, the largest gathering of world leaders at the United Nations Headquarters in New York adopted the United Nations Millennium Declaration. The Declaration, endorsed by 189 countries, committed nations to a new global partnership to reduce extreme poverty and set out a series of targets to be reached by 2015. These have become known as the Millennium Development Goals (MDGs).

<table>
<thead>
<tr>
<th>Millennium Development Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eradicate extreme poverty and hunger</td>
</tr>
<tr>
<td>2. Achieve universal primary education</td>
</tr>
<tr>
<td>3. Promote gender equality and empower women</td>
</tr>
<tr>
<td>4. Reduce child mortality</td>
</tr>
<tr>
<td>5. Improve maternal health</td>
</tr>
<tr>
<td>6. Combat HIV/AIDS, malaria, and other diseases</td>
</tr>
<tr>
<td>7. Ensure environmental sustainability</td>
</tr>
<tr>
<td>8. Develop a global partnership for development</td>
</tr>
</tbody>
</table>

MDG 6 aims to have halted HIV/AIDS’ growth by 2015 and begin its reverse while achieving universal access to treatment by 2010. While the growth of HIV has stabilized in many countries, the rate of infection continues to surpass the amount of treatment resources available.

MDG’s 4 and 5 are also closely tied to work in the area of children affected by HIV/AIDS.

Children and communities affected by HIV/AIDS require more than just health interventions; poverty relief, education, and support for gender equality are needed for long-term impact.
AIDS Continues to Be a Massive Global Health Issue, with Southern and Eastern Africa Bearing a Disproportionate Share of the Burden of the Disease

The majority of new HIV infections and AIDS-related deaths are also concentrated in sub-Saharan Africa*

* 1.8M of 2.6M new infections worldwide and 1.3M of 1.8M AIDS-related deaths occurred in sub-Saharan Africa in 2009. Source: UNAIDS 2010 Global Report
Research suggests that there are approximately 30 million total children affected by HIV/AIDS in Sub-Saharan Africa*

Sub-Saharan Africa represents only 13% of the world’s population...

6.9 billion
87%
13%
All other regions

World’s Population

...yet this region bears a disproportionate share of the HIV/AIDS burden

33 million
4% 5% 12%
68%
4%

Total Population Living with HIV

2.5 million
6% 4%
92%

Total Children Living with HIV

* Based on 2004 World Bank report. Includes children orphaned by AIDS, separated from parents, living with dysfunctional caretakers, or with needs beyond parental care. 2009 UNICEF data on vulnerable children suggests there are over 70 million vulnerable children (due to factors including but not limited to AIDS) within Sub-Saharan Africa. Sources: UNAIDS 2010 Global Report. Population Reference Bureau, 2010 World Data Sheet; 2004 World Bank report entitled Orphans and Vulnerable Children (OVC); number of vulnerable children is a directional figure calculated by multiplying UNICEF’s child population statistics (414 million in 2009) by the average of regional percentages of children in African countries that are vulnerable (19.05%) compiled in UNICEF’s 2009 Progress Report.
The Number of Orphans Due to AIDS Also Continues to Grow, with Sub-Saharan Africa Again Shouldering the Majority of the Burden

Estimated Orphans Due to AIDS, 2001 and 2009 (in millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Sub-Saharan Africa</th>
<th>Other Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>8.9</td>
<td>1.1</td>
</tr>
<tr>
<td>2009</td>
<td>14.8</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Source: UNAIDS 2010 Global Report
Children Are Affected by HIV/AIDS in a Variety of Ways – Those Who Are the Most Vulnerable Are Often Those Who Are Not Orphans

Children Affected by HIV/AIDS in sub-Saharan Africa (~30M Total)

- Orphans
- Community impoverished by AIDS
- Infected by AIDS
- Family member infected
- Family supports others affected by AIDS

In order to truly address the most vulnerable and destitute children, it is critical to serve all children affected by HIV/AIDS

Targeting orphans may discriminate against other vulnerable children, lead to stigmatization of orphans, and may result in children being called orphans to access services

When a Family Member Is Infected with HIV, It Triggers a Range of Interrelated Problems for CABA

Problems Among Children and Families Affected by HIV/AIDS

Sources: Lippincott Williams & Wilkins, 2000, as referenced in Richter, Manegold and Pather. (2006), *Family and Community Interventions for Children Affected By AIDS*, funded by the WK Kellogg Foundation.
The Problems Impacting Children Affected By HIV/AIDS Are Wide-Reaching and Mutually-Reinforcing

- Persistent, Severe Poverty
- Potential for Exploitation
- Devastating Health Outcomes
- Social Stigma, Isolation, or Depression
- Significant Barriers to Education
Each of These Areas Adds to the Challenges that CABA Face

### Persistent, Severe Poverty
- Reduced family income affects the ability to provide for children's basic needs
- Surviving family members can be forced to sell their assets
- For orphans, deeper slides into poverty due to weakened family structure
- Lower future income potential stemming from barriers to education

### Devastating Health Outcomes
- Higher risk of Mother-to-Child Transmission
- Poor nutrition, due to reduced family income or increased family expenditures
- Less likely to be immunized, and to get adequate care for childhood illness
- Less likely to receive HIV treatment, lack of access to Antiretroviral Therapy
- Loss of access to services after loss of chief advocate
- Inadequate coverage/quality of early childhood development programs
- Low levels of school readiness due to lack of formative learning opportunities
- Children are withdrawn from school to become caregivers or laborers
- Cost of care for family makes school (uniforms, transport) unaffordable
- Stigma prevents children from going to school

### Significant Barriers to Education
- Subject to stigma/discrimination due to association with infected individual
- Feelings of depression or isolation, particularly after losing family members
- Psychological distress due to their role as a caregiver or head of household or due to economic strains
- Children affected by HIV/AIDS often face sexual exploitation or violence, or exploitative labor, particularly in domestic settings
- Discrimination may stem from community members or caregivers (e.g., less food, lack of support for school, increased domestic chores)

### Social Stigma, Isolation or Depression

See appendix for key sources
One Can Evaluate a Child’s Overall Level of Vulnerability Based on Several Different Criteria

**Age**
Research and interviews suggest that early childhood years (0-5) and adolescence (12+) are the ages when CABA are most vulnerable.

**Family Structure**
Children are less likely to be vulnerable to the extent that they have at least one adult in their lives who provides consistent care, attention, and support and who ensures they are safe from abuse, neglect, or exploitation.

**Economic Circumstances**
Socioeconomic status has a significant bearing on outcomes for children affected by HIV/AIDS. Poverty is an issue that pervades all efforts in this space.

**Health Status**
Children who are infected with HIV/AIDS or at risk of being infected by a parent are made physically vulnerable by the (threat of the) disease.

Sources: FSG interviews, literature review and analysis; Child Status Index, accessed at www.ovcsupport.net.
The Prenatal-to-Five Age Range Is Widely Regarded as the Time During Which CABA Are Most Vulnerable

- Children affected by HIV/AIDS are physically, emotionally, and developmentally most vulnerable before the age of five (e.g., high rates of mortality, illness, and malnutrition, urgent needs for love)
- This population is especially underserved by providers and funders
- Interventions targeted at this age range are more effective and efficient than those targeted at other ages

- CABA age 6-12 also face difficulties (e.g., low levels of school readiness, can be withdrawn from school)
- However, this age group receives the vast majority of available services
- It is also most effective to preempt issues above by working with children at a younger age

- CABA, like other vulnerable children age 13-18, begin to face more adult issues (e.g., can be required to make a livelihood, can face sexual advances or exploitation)
- However, it is extremely difficult to remediate for these issues by the time the child reaches adolescence and beyond and, therefore, more effective to prevent these issues earlier in life
- CABA at this age are also slightly more equipped than those at younger ages to manage their own needs
While Improving Outcomes for CABA Requires the Efforts of All Players in the Surrounding Ecosystem, Families and Communities Are the First, Crucial Line of Response

- ~95% of all CABA, including those who have lost parents, continue to live with their extended family
- Community-based initiatives for CABA have unparalleled reach in sub-Saharan Africa, and enjoy high levels of approval and trust among the people they serve
- Community and family networks are under increasing strain in many settings, as the pressures of HIV/AIDS, poverty, and food insecurity intensify. However, they remain vital for CABA
- External efforts reach only a fraction of the most vulnerable children, suggesting that interventions will only have significant, sustainable impact to the extent they strengthen the capacities of families and communities to protect and care for vulnerable children

Building family and community capacities is not sufficient, but it must be the foundation for addressing the impacts of HIV/AIDS on children

There Are Four Main Sources for HIV/AIDS Funding Globally

**Domestic**
- Domestic expenditures in affected countries
  - Spending by governments within their own country, and out-of-pocket spending by individuals and affected families
  - In low- and middle-income countries, domestic resources account for over half of all AIDS-related investments. (In low-income countries, 88% of spending on AIDS comes from international funding)

**International**
- Bilateral aid*
  - Contributions made directly from one country to another
  - The majority of international funding for AIDS comes from bilateral donors
  - The U.S. is the largest international donor, providing 58% of all bilateral aid in 2009
- Multilateral aid*
  - Contributions by governments through an international intermediary
  - The Global Fund is the largest multilateral agency, accounting for 72% of disbursements from multilateral sources
- Private Philanthropy
  - Funds provided by corporate and philanthropic donors (e.g., Gates Foundation, Abbott Fund, etc.)

Overall, the U.S. provides the largest proportion of global funding (through bilateral and multilateral channels, as well as philanthropically)

* Taken together, bilateral and multilateral aid are often referred to as Official Development Assistance (ODA). Source: Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from the G8, European Commission, and Other Donor Governments in 2009 [http://www.kff.org/hivaids/upload/7347-06.pdf], UNAIDS Global Report 2010

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Public Funding for HIV/AIDS Efforts Dwarfs the Funding Made Available by Private Philanthropy

Total Funds Made Available for HIV/AIDS in Developing Countries, 2005-2008

<table>
<thead>
<tr>
<th>Year</th>
<th>Public Funding</th>
<th>Private Philanthropy</th>
<th>Multilateral Aid</th>
<th>Bilateral Aid</th>
<th>Domestic Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>$7.9B</td>
<td>$1B</td>
<td>$3.1B</td>
<td>$2.8B</td>
<td>$1.0B</td>
</tr>
<tr>
<td>2006</td>
<td>$8.8B</td>
<td>$1.2B</td>
<td>$3.3B</td>
<td>$2.5B</td>
<td>$1.0B</td>
</tr>
<tr>
<td>2007</td>
<td>$11.4B</td>
<td>$1.5B</td>
<td>$3.6B</td>
<td>$2.2B</td>
<td>$1.0B</td>
</tr>
<tr>
<td>2008</td>
<td>$15.6B</td>
<td>$1.8B</td>
<td>$3.9B</td>
<td>$1.8B</td>
<td>$1.0B</td>
</tr>
</tbody>
</table>

*Private funders must leverage their investments in order to make an impact, given the relatively small proportion of dollars they contribute.*

*The Gates Foundation provides a significant portion of all private philanthropic funding (e.g., its 2008 disbursements totaled ~$380M out of ~$780M in total private funding).*

**This data represents average sources of funds in low- and middle-income countries. Low-income countries receive only 12% of funding from domestic sources.**

The U.S. Government Spent $23.4B in 2008 on HIV/AIDS with the Majority of Funding Allocated to Domestic Care and Treatment

The 2010 U.S. Federal Budget for HIV/AIDS Totaled $25.9 Billion

Federal Funding for HIV/AIDS Focuses Primarily on Care and Treatment (in billions)

<table>
<thead>
<tr>
<th>Category</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care/Treatment</td>
<td>$10.3</td>
<td>$11.0</td>
<td>$11.7</td>
<td>$12.5</td>
<td>$13.2</td>
</tr>
<tr>
<td>Cash/Housing Assistance</td>
<td>$2.1</td>
<td>$2.2</td>
<td>$2.3</td>
<td>$2.4</td>
<td>$2.5</td>
</tr>
<tr>
<td>Prevention</td>
<td>$0.9</td>
<td>$0.9</td>
<td>$0.9</td>
<td>$0.9</td>
<td>$1.0</td>
</tr>
<tr>
<td>Research</td>
<td>$2.6</td>
<td>$2.7</td>
<td>$2.7</td>
<td>$2.8</td>
<td>$2.8</td>
</tr>
<tr>
<td>Global</td>
<td>$3.2</td>
<td>$4.4</td>
<td>$5.8</td>
<td>$6.3</td>
<td>$6.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$19.2</strong></td>
<td><strong>$21.2</strong></td>
<td><strong>$23.4</strong></td>
<td><strong>$24.8</strong></td>
<td><strong>$25.9</strong></td>
</tr>
</tbody>
</table>

- Mandatory budget includes domestic entitlements, such as Medicare, Medicaid, SSI
- Global and Domestic are annual discretionary funding
- PEPFAR is included in Global budget line
- Research includes CDC and NIH

### PEPFAR, the Global Fund, and the World Bank’s Multi-Country HIV/AIDS Programs Are the Three Most Significant Channels for Bilateral and Multilateral HIV/AIDS Funding

<table>
<thead>
<tr>
<th>Sources of Funds</th>
<th>Details</th>
</tr>
</thead>
</table>
| **PEPFAR**  
(President’s Emergency Plan for AIDS Relief) | - Contributed $39.1 billion to HIV/AIDS efforts from 2003 to 2011  
- Distributes bilateral HIV/AIDS-related funding and contributes to Global Fund  
- 10% of funds are authorized for OVC-focused programs  
- Targets 15 focus countries (Kenya, South Africa, and Nigeria received the most in 2009) |
| **Global Fund to Fight AIDS, Tuberculosis and Malaria** | - Provides funding to fight all three diseases  
- In the most recent round of funding, 61% of funds went toward HIV/AIDS  
- In total, from 2002-2010, the Fund distributed $11 billion focused on HIV/AIDS  
- Has funded provision of support for 4.9 million orphans, distribution of 2.3 billion condoms, and ART treatment of 2.8 million people with HIV |
| **World Bank’s Multi-Country AIDS Programs** | - Provided $1.98 billion in loans from 2001-2011  
- Supports HIV/AIDS prevention, care, support and treatment, and emphasizes need for evidence-based programs, building capacity, and scaling interventions  
- Requires existence of an HIV/AIDS coordinating body and government agreement to implement quickly and use multiple implementation groups |

Source: AVERT website([http://www.avert.org/aids-funding.htm](http://www.avert.org/aids-funding.htm)), World Bank Multi-Country AIDS Program website
10% of the PEPFAR Funding Goes to OVC Efforts, Mainly in Sub-Saharan Africa

In 2008, PEPFAR was reauthorized for an additional 5-year period and up to $48 billion to combat HIV, TB, and malaria

Source: KFF Global Health Facts PEPFAR funding website; USAID, “President’s Emergency Plan for AIDS Relief Funding and the Global Economic Crisis” December 15, 2008; Celebrating Life: PEPFAR 2009 Annual Report to Congress
Philanthropic Funding for HIV/AIDS Is Highly Concentrated; the Ten Largest Donors Worldwide Account for 83% of Private HIV/AIDS Funding

Contributions of the Top Five European Private Funders of International HIV/AIDS Efforts, 2009

Contributions of the Top Five U.S. Private Funders of International HIV/AIDS Efforts, 2009

Private Spending Focuses Primarily on Medical Areas (Research, Prevention, and Treatment)


A large portion of this research funding comes from the Gates Fdn. ($143M out of $186M in 2009), which is primarily focused on medical research such as new vaccines or improved treatment modules.

Meanwhile, OVC-related efforts receive a very small proportion of private HIV/AIDS funding

Note: This data excludes contributions from a few funders that did not meet the timeline required; data comes from combining findings from FCAA’s U.S. Philanthropic Support to Address HIV/AIDS in 2009 report and EFG’s European Philanthropic Support to Address HIV/AIDS in 2009 report; European data for international-specific HIV/AIDS efforts was not available in the report, and was estimated by multiplying total funding distribution by the portion not spent in Western and Central Europe.
Medical Interventions – Including Treatment, Care, and Prevention – Receive By Far the Largest Amount of Overall Funding for HIV/AIDS

HIV/AIDS Spending by Programmatic Area in 43 Low- and Middle-Income Countries, 2006-2008 (in $ millions)

Meanwhile, direct funding for children affected by HIV/AIDS (listed as “Orphans and Vulnerable Children”) represents only ~6% of overall funding for HIV/AIDS

Source: UNAIDS. Enabling Environment = advocacy efforts to reduce stigma and promote prevention, human rights programs that aim to protect the human and legal rights of those affected by HIV/AIDS, efforts to strengthen local organizations involved in this type of work, and programs meant to support AIDS-affected women and reduce gender violence. Incentives for human resources = training, recruitment, retention, deployment, and rewarding of quality performance by health care workers and managers in the HIV field. Some direct human resources costs are included in other categories; this category focuses on additional incentives that aim to ensure availability of health services.
The Vast Majority of Funding for HIV/AIDS Is Spent to Address Health Outcomes, While Other Issues Receive Very Few Resources

* Health outcomes includes funding for “care and treatment,” and for “prevention.” Other includes “Program Management and Administration Strengthening,” “Incentives for human resources,” “Enabling environment,” and “Research.” Source: UNAIDS
While the Number of Children Living with HIV Is Growing, this Population Is Less Likely than Adults to Receive Treatment

Antiretroviral therapy coverage is increasing but needs to be more equitable:

- **37%** of adults eligible for treatment in sub-Saharan Africa were able to access life-saving medicines in 2009.
- **26%** of children under the age of 15 in sub-Saharan Africa received treatment in 2009.

Criteria to Assess 42 Sub-Saharan African Countries and Determine a Preliminary Set of Geographies for Further Research

42 Countries

- **Enabling Environment**
  - A country has to be relatively stable

- **Adult Burden of Disease**
  - The adult burden of disease should be high, representing overall high need and high opportunity for impact

- **Child Burden of Disease**
  - Countries where there are large numbers of children affected by HIV/AIDS to address

- **Current Programmatic Outcomes**
  - Countries that are not currently seeing significant outcomes on CABA programs

Rationale
Filter Criteria Pointed to 16 Potential Priority Countries that Were Grouped into Three Clusters (According to Geographic, Cultural, and Political Similarities)

See appendix for further information on geographic criteria.
Sources: UNICEF, USAIDS, The Economist, United Nations Development Project
A Preliminary Set of Countries with a High Disease Burden, Enabling Environments in Which to Work, and Poor Outcomes

<table>
<thead>
<tr>
<th>Country</th>
<th>Children with HIV</th>
<th>Adult HIV prevalence</th>
<th>Political stability**</th>
<th>Domestic Investment Priority Index***</th>
<th>Development outcomes****</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eastern Africa</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tanzania</td>
<td>160,000</td>
<td>5.6%</td>
<td>High</td>
<td>-</td>
<td>Low</td>
</tr>
<tr>
<td>Uganda</td>
<td>150,000</td>
<td>6.5%</td>
<td>Medium</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>-</td>
<td>2.1%</td>
<td>High</td>
<td>-</td>
<td>Low</td>
</tr>
<tr>
<td>Kenya</td>
<td>180,000</td>
<td>6.3%</td>
<td>Medium/Low</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td><strong>Central Africa</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mozambique</td>
<td>130,000</td>
<td>11.5%</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Burundi</td>
<td>28,000</td>
<td>3.3%</td>
<td>Medium</td>
<td>-</td>
<td>Low</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>150,000</td>
<td>14.3%</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Zambia</td>
<td>120,000</td>
<td>13.5%</td>
<td>Medium/Low</td>
<td>-</td>
<td>Low</td>
</tr>
<tr>
<td>Malawi</td>
<td>120,000</td>
<td>11.0%</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Rwanda</td>
<td>22,000</td>
<td>2.9%</td>
<td>High</td>
<td>-</td>
<td>Low</td>
</tr>
<tr>
<td>DRC</td>
<td>7,900*</td>
<td>-</td>
<td>Low</td>
<td>Medium</td>
<td>Low</td>
</tr>
<tr>
<td><strong>Southern Africa</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swaziland</td>
<td>14,000</td>
<td>25.9%</td>
<td>High</td>
<td>-</td>
<td>Medium</td>
</tr>
<tr>
<td>Lesotho</td>
<td>28,000</td>
<td>23.6%</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
</tr>
<tr>
<td>South Africa</td>
<td>330,000</td>
<td>17.8%</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
</tr>
</tbody>
</table>

Note: *While there is limited available HIV/AIDS data on DRC, it is included for now based on qualitative factors and will be researched further in Phase II. **The political instability index published by the Economist was used to measure political stability, countries that have higher political stability were preferred over lower ***The DIPI is a measure of the extent of investment priority governments give to the AIDS response, higher was preferred over lower ****The Human Development Index was used to measure development outcomes and lower was preferred over high scores. Sources: UNICEF, USAIDS, The Economist, United Nations Development Project
High Child, Infant, and Neonatal Mortality Rates Afflict These Geographies

Child and Infant Mortality Rates (deaths per 1,000 live births)

<table>
<thead>
<tr>
<th>Country</th>
<th>Child (under-five) mortality rate</th>
<th>Infant mortality rate</th>
<th>Neonatal mortality rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eastern Africa</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tanzania</td>
<td>103</td>
<td>67</td>
<td>32 (2004)</td>
</tr>
<tr>
<td>Uganda</td>
<td>135</td>
<td>84</td>
<td>29 (2006)</td>
</tr>
<tr>
<td><strong>Central Africa</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mozambique</td>
<td>130</td>
<td>90</td>
<td>37 (2004)</td>
</tr>
<tr>
<td>Burundi</td>
<td>168</td>
<td>102</td>
<td>35 (1987)</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>96</td>
<td>62</td>
<td>24 (2006)</td>
</tr>
<tr>
<td>Zambia</td>
<td>148</td>
<td>92</td>
<td>34 (2007)</td>
</tr>
<tr>
<td>Malawi</td>
<td>100</td>
<td>65</td>
<td>27 (2004)</td>
</tr>
<tr>
<td>Rwanda</td>
<td>112</td>
<td>72</td>
<td>28 (2008)</td>
</tr>
<tr>
<td>DRC</td>
<td>199</td>
<td>126</td>
<td>42 (2007)</td>
</tr>
<tr>
<td><strong>Southern Africa</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swaziland</td>
<td>83</td>
<td>59</td>
<td>22 (2007)</td>
</tr>
<tr>
<td>Lesotho</td>
<td>79</td>
<td>63</td>
<td>46 (2004)</td>
</tr>
</tbody>
</table>

For comparison, the child (under-five) mortality rate in the U.S. was 8 deaths per 1,000 live births in 2008, while the infant mortality rate was 7 deaths per 1,000 live births.

*Note: Neonatal mortality data is compiled from latest reported data in WHO Country Profiles, which span a broad range of years; thus, the year of collection has been included. Sources: World Health Organization Global Health Observatory Database, WHO Country Profiles; all child and infant mortality data is from 2008 or 2009, except for the DRC’s statistics which are from 2005.
Key Principles to Guide Strategic Decision-Making Going Forward

Priorities for Developing Strategic Recommendations

• Large number of CABA
• Most vulnerable CABA
• Greatest possible impact relative to dollars spent
• Evidence-based interventions
• Build upon existing Conrad N. Hilton Foundation experience
• Partnership opportunities with other key players
• Ability to leverage public and private funds

Sources: FSG interviews, literature review, and analysis
Next Steps to Guide Phase II of Children Affected by HIV/AIDS Strategy

**Phase II**

- Identify **strategic options** to address all CABA and to effectively serve the prenatal to age 5 age range
- Conduct **additional geographic research** to examine country-specific needs and current efforts
- Identify **potential partners** to make a leveraged impact
- Host a **funders convening** and a **site visit to Africa** to deepen understanding of potential options for impact

- **All children affected by HIV/AIDS, including orphans**
- **Prenatal to age 5**
- **Eastern, Central, or Southern Africa**
Appendix
Glossary

• **AIDS**: Acquired immunodeficiency syndrome
• **ART**: Antiretroviral therapy
• **ARV**: Antiretroviral
• **CABA**: Children affected by HIV/AIDS
• **CBO**: Community-based organization
• **FBO**: Faith-based organization
• **GFATM**: Global Fund for AIDS, TB and Malaria
• **HIV**: Human immunodeficiency virus
• **Incidence**: The number of new infections
• **MTCT**: Mother to child transmission
• **NGO**: Non-governmental organization
• **Orphan**: Child who has lost one or both parents
• **OVC**: Orphans and vulnerable children
• **PEPFAR**: U.S. President’s Emergency Plan for AIDS Relief
• **PMTCT**: Prevention of mother to child transmission
• **PrEP**: Pre-exposure prophylaxis
• **Prevalence**: The number of people living with disease
• **SSA**: Sub-Saharan Africa
• **STI**: Sexually transmitted infections
• **TB**: Tuberculosis
• **UNAIDS**: The Joint United Nations Programme on HIV/AIDS
• **WHO**: World Health Organization
Organizations That Participated in the Landscape Research

**Service Providers**
- CARE
- Child Fund
- Firelight Foundation
- FXB International
- Save the Children

**Funders**
- Bernard van Leer Foundation
- Children’s Investment Fund Foundation
- ELMA Foundation
- Global Fund for Children
- Hewlett Foundation
- PEPFAR
- USAID

**Multilateral Organizations**
- UNAIDS
- UNICEF
- WHO
- World Bank

**Others**
- Cal Poly State University, San Luis Obispo
- Coalition on Children Affected by AIDS
- The Consultative Group on Early Care and Childhood Development
Key Sources for Phase I Landscape Research Findings