Vietnam—a vibrant country of 84 million people—is experiencing rapid economic growth and unprecedented societal change ushered in by globalization. This is posing interesting possibilities and challenges for U.S. assistance and policy. In June 2004, the Bush Administration named Vietnam the fifteenth “focus” country under the President’s Emergency Plan for AIDS Relief (PEPFAR). Vietnam is the sole PEPFAR focus country in Asia, with twelve in Africa and two in Latin America and the Caribbean. The HIV/AIDS epidemic here differs greatly from that of its African counterparts: HIV/AIDS prevalence is quite low and is concentrated among populations which engage in high risk behaviors. The disease has been driven principally by injection drug use, though the rate of infection from sexual transmission is increasing rapidly.

Politically, Vietnam remains a strong Communist state determined to be in charge of its well-developed national HIV/AIDS strategy. Ensuring that donor efforts fall into line with the country’s strategy and priorities is a work in progress for the government. U.S. influence in Hanoi has been limited since relations were normalized a decade ago, yet this is changing where U.S. assistance is involved. Increased donor support for HIV/AIDS—especially from the U.S.—is credited with creating a more visible, vocal and independent non-governmental organization (NGO) sector. Nonetheless, most NGO and donor staff contend that PEPFAR is distorting the HIV/AIDS agenda by focusing so heavily on treatment in a country with relatively low prevalence.

Among the PEPFAR focus countries, Vietnam stands out in one important regard: it has a well-established health care system, capable of reaching down into the provincial and town levels. Two recent health scares in the Asian region—SARS and Avian Flu—did not become major public health crises in Vietnam, partly because the government moved decisively and a vast health infrastructure was in place. A similar political and public health response to HIV/AIDS is only now beginning to mobilize, just as the epidemic is expanding beyond high-risk groups. However, according to one NGO staffer, “There is still a huge amount of work to be done to enable the health system to deal with HIV/AIDS” in the years ahead.

The arrival of PEPFAR happens to coincide with this critical juncture in Vietnam’s epidemic. Yet funding earmarks and policy constraints imposed by Congress and the Office of the Global AIDS Coordinator (OGAC) have emerged as obstacles to crafting a focused and cohesive U.S. strategy in Vietnam. To be sure, Vietnam’s own policy environment—riddled with vague and conflicting approaches to injecting drug use, commercial sex, and HIV/AIDS—has presented challenges for PEPFAR as well as other donor efforts. At publication time, however, recent developments on both fronts demonstrate that the HIV/AIDS environment is extraordinarily dynamic, with policies and programs simultaneously experiencing change.
HIV/AIDS in Vietnam

The first case of HIV in Vietnam was diagnosed in 1990 and since then, prevalence has climbed steadily. The estimated national prevalence rate (the percentage of all adults of reproductive age living with HIV) is 0.51 percent, which is relatively low for the region. Prevalence rates in Vietnam’s large cities, however, are more than double the national level. The commerce capital, Ho Chi Minh City in the south (formerly Saigon), is home to the country’s largest and fastest growing epidemic.

Vietnam’s HIV/AIDS epidemic is a concentrated one, driven by injection drug use and commercial sex work. HIV prevalence among injecting drug users (IDUs) has been the highest of any group since the epidemic began in Vietnam. National prevalence among IDUs is approximately 33 percent. Female sex workers have the next highest prevalence, with an estimated 16 percent of sex workers believed to be HIV positive. For both populations, HIV prevalence is highest in Vietnam’s urban hubs—Ho Chi Minh City in the south, Hanoi and Hai Phong in the north, and elsewhere.

In stark contrast to African epidemics, Vietnam’s epidemic is not as advanced. HIV prevalence is currently far higher among men than women, which is characteristic of the epidemic at its early stages. Eighty-five percent of those people reported to be HIV positive are men; 57 percent are injecting drug users. Vietnamese young adults and adolescents bear the brunt of the disease—70 percent of those living with HIV are under 30 years old and most are sexually active.

Vietnam’s HIV/AIDS epidemic has entered a rapid growth phase with many more people becoming infected than dying each year. The sharing of contaminated needles and other equipment among drug users remains a primary route of HIV transmission. However, sexual transmission of HIV—between drug users and their partners, female sex workers (many of whom also inject drugs) and their clients, clients of sex workers and their wives/partners, and men who have sex with men—accounts for an increasing proportion of HIV infection in Vietnam.

HIV/AIDS is highly stigmatized in Vietnam. For those living with HIV/AIDS, the accompanying stigma and discrimination are formidable barriers to seeking needed care, as well as to receiving quality care. Drug use and commercial sex work are illegal in Vietnam. Together with general crime, they spurred a punitive “anti-social evils” campaign carried out by the government for several years that has since ended. As HIV/AIDS was closely associated with two of the three social evils, the disease fell into the path of this anti-crime crusade, deepening the stigma attached to HIV/AIDS. Consequently, reaching these groups with prevention, testing, and treatment services is extremely difficult and at times risky for NGO staff when dealing with local officials and police.

The government’s principal response to drug use and sex work is rooted in the criminal justice system: compulsory rehabilitation in residential detention centers from two to five years.

“For the next several years, more than 40,000 people a year will contract HIV in the absence of stronger prevention programs.”

—Vietnam Ministry of Health, 2005
years. Officially known as “05/06 centers,” these “re-education” facilities for drug users and sex workers are located throughout the country. A sizeable number of AIDS orphans also reside in the 05/06 centers in the absence of a government strategy and program to provide care and support to these children. Often described as prison-like, the 05/06 centers are widely viewed as the incubators of the epidemic where unprotected sex and drug use are the norm. HIV testing is mandatory, yet test results are not often disclosed to the individual nor treated confidentially. Few centers provide detainees with counseling, treatment, skills training, or social support. As a result of this and the lack of rehabilitation services in the community, recidivism rates are high among drug users and many end up back at the 05/06 centers.

The Vietnamese government is open to international NGOs and donors working within the 05/06 centers to provide staff training, improve health services, and assist drug users and sex workers transition back to their communities. Over the years, however, few donors have taken up the government’s standing invitation to work within the 05/06 centers. Meanwhile, there is widespread awareness that these facilities need to be a priority for HIV/AIDS prevention, care and treatment. In 2006, a large number of rehabilitated IDUs and sex workers—an estimated 15,000-18,000 are scheduled for release in Ho Chi Minh City alone over the next year—will be released. Most are young, sexually active, and a high proportion are HIV-positive, some sick with AIDS. According to most NGOs, not enough has been done to prepare for this imminent migration of 05/06 center residents back into their communities. Had comprehensive drug and HIV/AIDS prevention and treatment services been offered within the 05/06 centers, even in the last few years, the public health ramifications of this move would almost certainly be less worrisome.

The U.S. Enters the Picture

The June 2004 announcement of Vietnam as a PEPFAR focus country was a surprise to many. Virtually overnight, the U.S. became the single largest HIV/AIDS donor in Vietnam, notably in the area of treatment and care. U.S. assistance for voluntary counseling and testing (VCT)—the LifeGap project—has been underway since 2001 through the Centers for Disease Control and Prevention initiative with the Vietnamese Ministry of Health. (Many of the major HIV/AIDS donors and UNAIDS are present in Vietnam—the Global Fund, World Bank, Asia Development Bank, Australian AusAID, British DfID, German KfW and others—funding a vast array of HIV/AIDS activities with the government.) Monetarily speaking, however, U.S. assistance is far above other donors’ annual contributions.

In the summer of 2004, Vietnam received more than $17 million in PEPFAR funds. This was a sizeable sum to dispense within a short timeframe, in a country with few potential local organizations with whom to partner, apart from the government. The PEPFAR designation reportedly was well-received by the government, other donors and the Vietnamese public. Yet PEPFAR’s first year in Vietnam was a difficult one. With limited manpower on the ground and with no clear long-term strategy, PEPFAR was a “chaotic pool of confusion,” according to one seasoned NGO staffer. Poor communications between the U.S. and the Vietnamese government—concerning the flow of PEPFAR dollars primarily to NGOs—also made for a rocky start.

Managing the sheer amount of money—which grew to $27 million in FY05—meant that the small PEPFAR team was hustling to engage as many partners as possible, and quickly,
in order to produce tangible results for the Office of the Global AIDS Coordinator (OGAC). An early casualty, however, was a cohesive strategy that took stock of what other donors and NGOs were doing with regards to HIV/AIDS in order to target PEPFAR funds efficiently. “Truly effective coordination with the government of Vietnam and the country’s own HIV/AIDS strategy” was also sacrificed, senior staff of one NGO remarked.

Two years later, the situation appears to have stabilized somewhat. A stronger PEPFAR team is in place, NGO roles are becoming clearer and a more comprehensive, long-term strategy is taking shape in concert with Vietnam’s national HIV/AIDS strategy. Nonetheless, a senior NGO staffer reported a “general disconnect between reproductive health and HIV prevention,” commenting that PEPFAR-supported prevention efforts aren’t taking advantage of the existing reproductive health network. Multi-year PEPFAR contracts to partners are uncommon, however, which continues to pose planning problems for NGOs when contracts are for one year. “It is difficult for partners to develop a long-term strategy and to scale operations up (or down),” lamented another NGO leader, “We often don’t learn of what other organizations are doing until months into the awarded contract.”

There is widespread consensus that PEPFAR single-handedly jump-started HIV/AIDS care and treatment in Vietnam. Overall, there is optimism about scaling-up anti-retroviral therapy (ART), yet there is much to be done to operationalize treatment for drug users. The mounting pressure to meet OGAC’s treatment targets—22,000 Vietnamese on ART by the end of 2008—is distorting programs and threatens the quality of treatment services. As of mid-2006, only 1,900 Vietnamese receive ART courtesy of PEPFAR.

HIV/AIDS prevention under PEPFAR has not fared as well, due to both financial and policy constraints. Many view the scale-up of treatment as an opportunity to do more and better prevention, citing increased uptake of VCT services as evidence that the availability of treatment bolsters prevention efforts. Others question PEPFAR’s heavy focus on treatment in a country with a relatively low HIV/AIDS prevalence rate. In a setting where the epidemic has been driven by injecting drug use and now increasingly by sex, there is growing concern as to why there has not been an equivalent expansion and strengthening of targeted prevention activities. Otherwise, some warn, Vietnam and its partners—donors and implementing agencies—could face a more costly, generalized epidemic.

U.S. Policies Inhibit Targeted HIV/AIDS Prevention

Reaching high-risk groups is integral to PEPFAR’s mandate and in Vietnam’s case it is paramount. Yet in reality, working with these groups and addressing high-risk behaviors on the ground confront two obstacles: Vietnam’s “anti-social evils” framework and an array of U.S. postures and policies regarding illicit drugs, youth and abstinence, condoms, commercial sex, and homosexuality. All are contentious global and domestic issues that have triggered strong political reactions in the U.S., now manifested as official policies governing American health assistance.

PEPFAR embodies many of the prevailing ideological reactions to these issues, which fall squarely on the prevention side of the HIV/AIDS equation. This has led to some confusion about which prevention activities are permissible; in contrast, NGOs report no such confusion around treatment and care activities carried out under PEPFAR. U.S. prevention policies—especially those concerning drug use, commercial sex, abstinence-until-mar-

“The treatment targets drive most discussions and decisions when it comes to working with the U.S. government. Prevention is all too often ignored even though there are limited funds to support it.”

—Staff, U.S. NGO
riage—coupled with restricted funding for prevention (80% of PEPFAR funds are allocated to treatment and care) and Vietnam’s difficult policy environment, have inhibited a focused, long-term prevention strategy from taking shape.

**Drug Use and Effective Harm Reduction**

Vietnam is the sole PEPFAR focus country where injection drug use is the engine driving HIV/AIDS. In March 2006—nearly two years after PEPFAR landed in Hanoi—the Office of the Global AIDS Coordinator issued guidelines for the field, “HIV Prevention among Drug Users Guidance #1: Injection Heroin Use.”

In the absence of clear guidelines, PEPFAR’s approach to injecting-drug users has been ad-hoc and limited in scope. The long-overdue guidance will do much to assuage PEPFAR grantees’ uncertainty about permissible activities. The guidance makes clear, for example, that substitution therapy (such as methadone treatment) may be provided—subject to OGAC approval—to injecting drug users who test positive for HIV. HIV-negative drug users, however, are not eligible to receive PEPFAR-funded substance abuse therapy. This distinction is dangerously short-sighted and antithetical to sound public health practice.

There is considerable sharing of needles and syringes among drug users in Vietnam, as is the case wherever there is a significant incidence of injection drug use. A fundamental, successful and proven strategy for reducing HIV transmission within this population is the free distribution of clean needles and syringes. Under PEPFAR, however, this evidence-based intervention is already off the table—long-standing U.S. policy prohibits funding for needle-exchange and distribution programs at home. This prohibition pre-dates PEPFAR and now finds itself firmly embedded in U.S. foreign assistance.

In contrast, the Vietnamese government strongly supports needle-exchange programs as do other donors with much smaller HIV/AIDS budgets than PEPFAR. Several provincial governments purchase and distribute needles with their own health budgets. The inability of U.S. assistance to directly support this proven harm reduction approach is a lost opportunity to have a meaningful impact in preventing the spread of HIV.

U.S. concerns about the 05/06 centers led to the decision that no PEPFAR funds could be used within these government re-education facilities. It is widely acknowledged that the 05/06 centers have served as incubators of the epidemic: Nationally, an estimated 40-50 percent of incarcerated drug users and sex workers are living with HIV and many already have AIDS. The level and quality of care provided in these institutions vary, but generally HIV/AIDS services are sparse. “An insidious and absurd revolving door has resulted,” described senior NGO staff, whereby “05/06 center residents suffering from AIDS in need of treatment for their opportunistic infections are released to area hospitals for treatment. Once they regain their strength, often with medicines at the hospital provided by PEPFAR,
they are returned to the 05/06 center to become sick again. And the door revolves: Treatment outside the center, sickness on the inside, and so on.”

Regrettably, this highly vulnerable and accessible population has been off-limits to PEPFAR grantees for the past two years. The inability to provide HIV/AIDS services to residents and conduct trainings of staff within the 05/06 centers using PEPFAR funds represents another missed opportunity to tackle the epidemic head-on, engage a captive audience in need of information, and collaborate with the Vietnamese government to advance the rights of detainees. With up to 18,000 detainees heading back to their families, communities and likely relapse in Ho Chi Min City within the next year alone, PEPFAR grantees have their hands full trying to reach these individuals with prevention information, condoms, social support, and care and treatment.

**Sex, Drugs and Condoms**

A fundamental HIV prevention strategy for high-risk, overlapping groups such as drug users and sex workers is condom promotion and distribution. Reaching these populations is clearly part of PEPFAR’s mandate. Clients of sex workers and men who have sex with men also rank high on the priority list for condom promotion activities. For several years, U.S. HIV/AIDS funds purchased condoms and supported a program of “social marketing” condoms to target groups. During this period, condom availability stabilized and sales of condoms climbed steadily. Once only found in pharmacies and public health clinics, condoms were increasingly bought in less traditional settings, such as karaoke clubs, bars, hotels, cafes, massage parlors and truck stops.

Responsible for much of this success is DKT International, a U.S.-based NGO that has been socially marketing condoms and contraceptives in Vietnam for years. The country’s two most popular condom brands—marketed by DKT—together represent 60-70 percent of the market. These condom brands were first launched in 1998 as part of the “100% Condom Access” HIV prevention project supported by USAID. Under the project, DKT focused its work in six provinces determined to be at highest risk for HIV/AIDS, targeting IDUs and sex workers and their clients in nightclubs, hotels and other venues.

DKT is no longer an implementing partner of U.S. HIV/AIDS assistance as a result of the anti-prostitution pledge requirement attached to PEPFAR. As a condition of receiving U.S. HIV/AIDS assistance, U.S. and local NGOs are required to have a policy explicitly opposing prostitution and sex trafficking. Initially, this policy applied solely to foreign NGOs; in June 2005 the Bush Administration extended its application to U.S. NGOs as well. DKT refused to comply with the requirement when its USAID agreement came up for renewal soon thereafter, maintaining it violated their right to free speech. Becoming the first U.S. NGO to reject the policy, DKT successfully challenged it in federal court back in Washington, DC. The judge ruled the pledge requirement unconstitutional and exempted DKT from the requirement earlier this year. The U.S. Department of Justice has since appealed the ruling.

Initially, the anti-prostitution pledge requirement sparked an atmosphere of uncertainty among PEPFAR’s NGO partners in Vietnam. As of this writing, the primary impact of the anti-prostitution policy was the brief suspension of U.S. condom programming. In refusing the policy, DKT forfeited additional shipments of U.S. condoms. USAID-Vietnam and its NGO partners scrambled to find an interim solution so that the supply of condoms was not disrupted. Meanwhile, DKT reports having enough condoms on hand to last until mid-2007 and has no plans to end its work with the government of Vietnam and other donors throughout the country.
According to USAID-Vietnam, condom promotion aimed at high-risk groups will ramp up once again as a central PEPFAR strategy for 2006 and beyond, albeit with a different NGO partner. It is expected that a new targeted condom social marketing project linking condoms with behavior change activities will be headed up by U.S.-based Population Services International, which is already present in Vietnam implementing a PEPFAR funded communications program supporting VCT, as well as harm reduction activities targeting drug users (funded by the British foreign aid agency, DfID).

Nevertheless, the underlying moralistic tones of PEPFAR are insinuating themselves into the text of condom labels. Under PEPFAR, any communication materials about condoms must include condom failure rates. This has been interpreted to mean that condom packaging must now specify failure rates, possibly casting doubt on the effectiveness of condoms in preventing HIV/AIDS. As one senior NGO staffer noted, “No public health intervention is 100% effective.” To lead with failure rates is “so contrary to public health that it will sabotage any condom promotion.” It is unclear at this point exactly how this will play out in the context of the new condom social marketing project funded by PEPFAR.

**Abstinence-until-marriage Earmark**

PEPFAR’s prevention emphasis of abstinence/be faithful (AB) has been less problematic in Vietnam than in some of the African programs. Based on the epidemiology of HIV/AIDS in Vietnam, the PEPFAR team applied—and successfully made the case—for a waiver from the abstinence earmark for fiscal year 2006. The Office of the Global AIDS Coordinator approved the waiver request while recommending that the Vietnam team allocate one-third of sexual transmission prevention money to AB activities (in lieu of reserving two-thirds of sexual prevention for AB as stipulated in August 2005 guidance—see inset box on the next page). Approximately $1.2 million was allocated for AB programming in Vietnam in FY05, much of it directed towards delaying sex, advocating fewer sexual partners, promoting faithfulness among young men and helping at-risk youth develop healthy living habits and life skills. AB funding is expected to increase to approximately $2 million in FY06.

If the AB spending requirement were to be relaxed for some of the focus countries per OGAC guidelines, there was little doubt that Vietnam stood a very good chance of securing an exemption. Combined with an OGAC-approved, more flexible application of abstinence/be faithful, the modified policy approach is decidedly more in sync with Vietnam’s own HIV/AIDS priorities and strategies, as well as with societal attitudes toward sexual activity among young people. A far more relevant AB activity for Vietnam’s situation is the PEPFAR-supported mass media campaign (“Live Like a Real Man”) targeting men with messages of responsibility and faithfulness.

PEPFAR funding for other prevention activities, such as condom promotion and preventing mother-to-child transmission, is not getting squeezed as is the case in other focus countries. This was recently documented by the Government Accountability Office in its report to Congress. The exemption granted Vietnam does not, however, alter in any way the overall funding allocations for prevention, treatment and care as mandated by PEPFAR.
Looking Ahead…

The PEPFAR situation in Vietnam is incredibly dynamic and fluid at the moment. As of this writing several positive developments are underway. Most recently, a strategic planning process around PEPFAR prevention efforts in Vietnam is happening in-country with everyone at the table. Observers report there is a collective realization among the PEPFAR country team, government agencies and NGO partners that if prevention efforts aren’t deepened and broadened, the care and treatment side of PEPFAR will not succeed. “There is consensus that reaching ART targets hinges on better prevention,” recounted an NGO leader.

In late 2005, a growing sense of urgency among NGOs to work within the 05/06 centers led to a PEPFAR decision to pilot a transitions program offering HIV/AIDS and support services within one 05/06 center in Ho Chi Min City. This case management approach will provide VCT, ART, drug relapse/prevention, peer outreach within the center, community reintegration, and links to employment for some HIV-positive residents returning home. Should this pilot project demonstrate the efficacy of providing HIV/AIDS services—especially treatment—within the 05/06 centers themselves, it may well bring about big changes in PEPFAR-supported activities in Vietnam.

A stronger commitment to prevention of drug use as part of PEPFAR appears to be gaining ground in Vietnam. A senior level drug addiction specialist has joined the PEPFAR team in Hanoi to oversee programming in this area. Another PEPFAR-supported pilot project...
currently underway is a methadone substitution therapy trial in Hai Phong. “There is no drug treatment whatsoever in Vietnam...only cold turkey withdrawal,” one NGO leader remarked. Methadone is illegal in Vietnam but many NGOs and donors expect this to change soon, and give full credit to the U.S. for pushing the Vietnamese government to see the value of substitution therapy. Methadone will “change the scene here when and if it is legalized,” said another NGO staffer, and appears poised to become a major element of PEPFAR prevention programming in Vietnam in the event it wins government approval.

Sexual transmission of HIV/AIDS is clearly on the rise in Vietnam. PEPFAR prevention efforts will need to strengthen behavior change and condom promotion activities among drug users, sex workers and their clients, men who have sex with men, and people living with HIV/AIDS. Condom promotion is a core element of any prevention strategy targeting high-risk groups. (Though coupling abstinence messages with condom promotion to sex workers, as required by OGAC guidelines, is of dubious value.) At this time a re-tooled condom social marketing program in Vietnam has PEPFAR support. The possible inclusion of condom failure rates on condom packaging, however, is highly problematic and is an over-interpretation of the AB guidance. It should be rejected.

“If the government and donors funded and coordinated three activities—clean needles, methadone treatment and drug prevention among Vietnamese youth—it would go a long way toward stabilizing HIV/AIDS in Vietnam.”

—Staff, U.S. NGO

Vietnam’s exemption from the AB earmark is a logical step in the right direction, offering the PEPFAR team more room in which to respond to the local epidemic. Yet, the waiver decision constrains prevention spending in other country programs. As the GAO report found, the waivers granted Vietnam and the other nine countries translates into increased pressure for the non-waived countries to achieve, collectively, the overall AB spending earmark set by OGAC. Consequently, "teams that are not exempted from the requirement must sometimes reduce or cut funding for certain prevention programs," according to the GAO analysis, which found that total prevention funds for “other prevention” declined by $5 million from FY05 to FY06 in the nonexempt countries. The AB earmark must be lifted by Congress so that all countries can tailor prevention activities as Vietnam is doing.

Due in part to U.S. assistance on the policy front, the Vietnamese National Assembly enacted a more progressive, health- and rights-oriented national law regarding HIV/AIDS in mid-2006. Significantly, the new law officially endorses an array of specific HIV prevention activities for groups with high-risk behaviors such as “communication and mobilization, promotion on the use of condom and clean needle and syringes, treatment of opioid addiction by substitution and other harm reduction measures to support safe behaviors to prevent HIV infection and transmission.”

Although many of these activities—along with targets such as 100% condom use among sex workers—were already part of Vietnam’s national HIV/AIDS strategy, no legal framework existed in support of these efforts. Regulations implementing the statute are expected this fall. Ultimately, the policy environment in which donors and NGOs operate appears to be improving dramatically and holds promise for managing the epidemic as long as there is improved coordination among all actors. Visible and sustained political leadership and enforcement of the laws, especially at the provincial and local levels, will be key to overcoming pervasive stigma surrounding HIV/AIDS.

Through PEPFAR, the U.S. is well-positioned to help Vietnam broaden and intensify prevention programming as the epidemic enters a rapid growth phase and sexual transmis-
sion becomes a larger factor. For the past two years, PEPFAR’s ideological policies and the absence of clear guidance from OGAC inhibited decision making on a range of prevention activities. Recent developments in Vietnam suggest that this is changing for the better. Given the early stage of Vietnam’s epidemic and the scale of prevention efforts needed, additional U.S. funds for HIV prevention—accompanied by enhanced flexibility in programming—would greatly aid Vietnam’s chances of curbing the spread of HIV/AIDS, as well as enhance PEPFAR’s chances of success.

Notes


3 Ibid.

4 Ibid.

5 Ibid.

6 MOH statistics, Department of Preventive Medicine and AIDS Control, Nov. 2003.

7 Ibid.


9 No USAID mission existed in Hanoi before PEPFAR. Vietnam has never received U.S. family planning assistance, for example, unlike the 14 other PEPFAR focus countries.

10 See complete text of OGAC guidance at http://www.state.gov/documents/organization/64140.pdf

11 HIV/AIDS Estimates and Projections 2005-2010, MOH

12 See USAID Acquisition and Assistance Policy Directive (AAPD 05-04), June 9, 2005. No U.S. funds may be used “to promote or advocate for the legalization or practice of prostitution or sex trafficking.” No U.S funds may be used “to provide assistance to any group or organization that does not have a policy explicitly opposing prostitution and sex

13 Note: Initially, this requirement applied solely to foreign NGOs. The Bush Administration in June 2005 extended the provision to U.S. NGOs. DKT International successfully brought suit against the U.S. policy in federal court. As a result, DKT International is exempt from the anti-prostitution pledge requirement, as are two other U.S. NGOs—Alliance for Open Society International and Pathfinder International—that challenged the U.S. government in another case and prevailed as well. For copies of the court decision in both cases and other relevant documents, see the website of the Brennan Center for Justice at NYU School of Law at http://www.brennancenter.org/programs/pov/npr_dkt_osi.html


15 Cambodia, India, Malawi, Russia, and Zimbabwe each receive more than $10 million annually in PEPFAR assistance. These five “PEPFAR lite” countries are held to same funding and reporting requirements as the 15 focus countries.

16 The 11 countries exempted from the AB earmark are Cambodia, Cote d’Ivoire, Ethiopia, Guyana, Haiti, India, Mozambique, Russia, Rwanda, Tanzania, and Vietnam.
