PEPFAR

2016 Annual Report to Congress

Front cover photos
LEFT:
Photo: Girls at HIV prevention program in Kenya
Photo Credit: Rose Mutisya/USAID Kenya

RIGHT:
Photo: PMTCT mother and baby at Iganga Hospital in Central Uganda
Photo Credit: Karin Schermbrucker, courtesy of mothers2mothers

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Young women in Kenya. Photo Credit: Irene Angwenyi/USAID Kenya

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White House

“When we help African countries feed their people and care for the sick it’s the right thing to do, and it prevents the next pandemic from reaching our shores. Right now, we’re on track to end the scourge of HIV/AIDS. That’s within our grasp.”

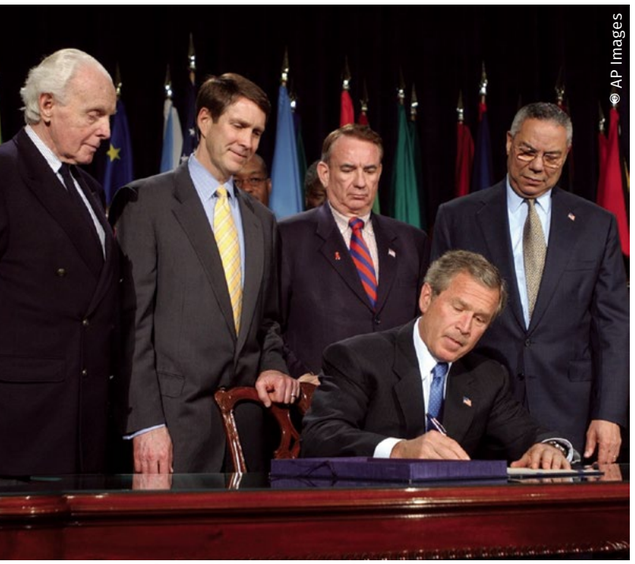
– President Barack Obama,
State of the Union Address, January 12, 2016

Executive Summary

The bold and visionary leadership by President George W. Bush and the United States (U.S.) Congress that created the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR)—a legacy that President Barack Obama has embraced and on which he has significantly expanded—has fundamentally transformed the global HIV/AIDS response. Since 2003, with Congress’s extraordinary investment, PEPFAR has helped to halt the relentless escalation of new HIV infections and mortality rates across the globe. PEPFAR has saved millions of lives and prevented millions more HIV infections by providing core HIV prevention and treatment services, changing the very course of the HIV pandemic. Our investments have resulted in more than 1.5 million babies who would have otherwise been infected being born HIV-free, and have provided compassionate care and support for millions of AIDS orphans and vulnerable children (OVC).

PEPFAR has built and strengthened the capacity of country-specific and country-led responses in both government and civil society, and brought key partners to the table. We have fostered collaboration among the U.S. government, partner governments, and global partners around the world, including multilateral institutions, civil society, including faith-based organizations (FBOs), the private sector, foundations, and people living with HIV.

Our engagement on the ground has provided invaluable lessons and experience that will continue to inform and improve the U.S. government’s responses to unforeseen health crises in the future. The U.S. government, through PEPFAR, has accelerated the progress toward a world safer and more secure from infectious disease threats by strengthening the global capacity to prevent, detect, and respond to health threats. PEPFAR’s substantial health system strengthening investments in countries with a sizable HIV/AIDS burden have paid large dividends in these countries’ ability to swiftly detect and respond to Ebola, avian flu, cholera, and other outbreaks.



On May 27, 2003, President George W. Bush signed P.L. 108-25, the United States Leadership Against Global HIV/AIDS, Tuberculosis, and Malaria Act of 2003.

"HIV/AIDS is one of the greatest medical challenges of our time...Across Africa, this disease is filling graveyards and creating orphans and leaving millions in a desperate fight for their own lives. They will not fight alone... The legislation I sign today launches an emergency effort that will provide $15 billion over the next five years to fight AIDS abroad. This is the largest single up-front commitment in history for an international public health initiative involving a specific disease... In the face of preventable death and suffering, we have a moral duty to act, and we are acting."

-President George W. Bush, PEPFAR Bill Signing, May 27, 2003

PEPFAR's impact extends well beyond the health sector, also strengthening economic development, stability and communities. PEPFAR has powerfully and unequivocally proven that investing in health is not only the right thing to do, but also the smart thing to do.

Our nation has demonstrated that we can work together, save lives, and ensure global health security while doing good around the world. **As President Bush said when proposing PEPFAR, "seldom has history offered a greater opportunity to do so much for so many,"** a philosophy that guides our work. Across all of sub-Saharan Africa, fewer than 50,000 people were on treatment in 2002. To save lives and decrease transmission of HIV, as of September 30, 2015, PEPFAR has supported lifesaving antiretroviral treatment (ART) for 9.5 million men, women, and children—a more than four-fold increase since the beginning of President Obama's administration. To prevent infection in young men, PEPFAR has supported more than 8.9 million voluntary medical male circumcisions (VMMCs) in eastern and southern Africa. In fiscal year 2015 alone, to prevent infection in babies, PEPFAR supported HIV testing services (HTS) for more than 14.7 million pregnant women. This enabled 831,500 of the women who tested positive to get antiretroviral medications (ARVs) for their own health and to ensure their babies are born HIV-free. PEPFAR is on track to achieve the bold HIV prevention and treatment targets announced by President Obama in September 2015. But these results are more than numbers; each individual reached through PEPFAR contributes to the health of his or her family, community, and country. This is our ultimate measure of success.

At its core, PEPFAR is a reflection of the compassion of the American people. It has become an iconic brand of U.S. government engagement in health, development, and diplomacy and has proven that by setting and being held accountable to clear metrics, it is possible to demonstrate clear outcomes and impact. And this work is far from done.

Achieving an AIDS-Free Generation Is Possible, but the Time to Act Is Now

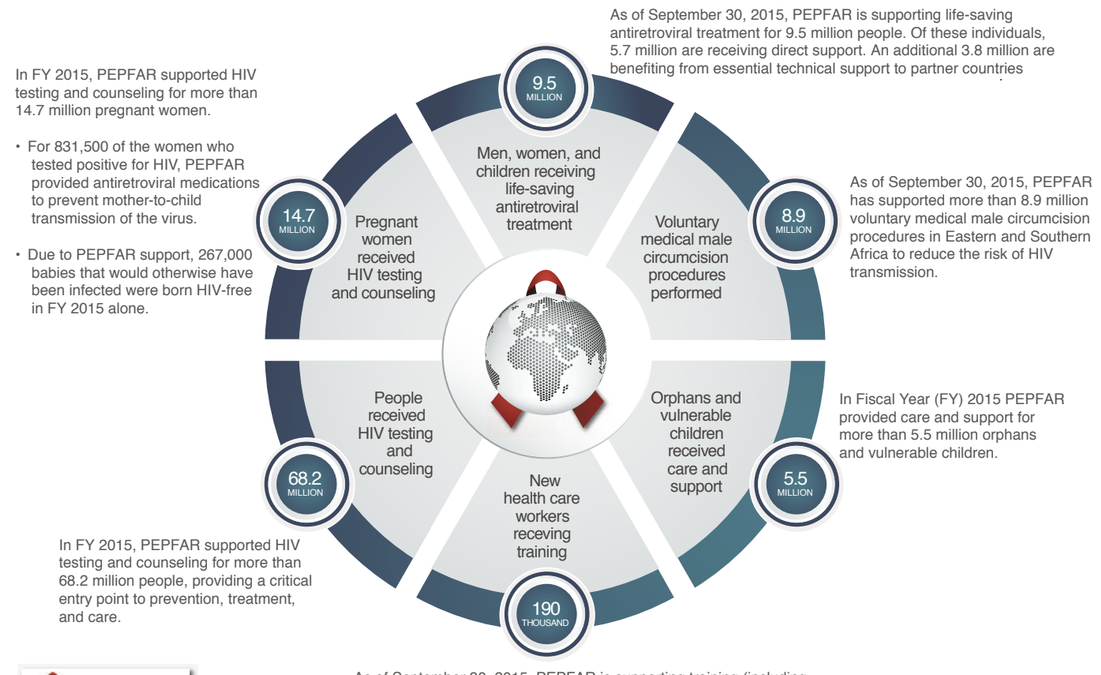
Today, thanks to our efforts and those of PEPFAR's many partners, we have everything we need—the tools, science, shared vision—to decrease the number of new HIV infections by 90 percent. We envision the creation of an AIDS-free generation where no one is left behind, when every person diagnosed with HIV will be prioritized for treatment immediately, and when HIV is no longer a public health threat. That future is possible, but the time to act is now.

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), nearly 37 million people are living with HIV/AIDS globally. Although the current estimate of individuals on treatment for HIV (15.8 million) has doubled within the last five years—an amazing accomplishment—there is still more to do. With "business as usual," we risk a cumulative 100 million HIV infections by 2030, which is far beyond the global community's ability to respond.

Every week, nearly 35,000 people are infected with HIV globally. While HIV incidence has declined by 50 percent since its peak in sub-Saharan Africa, the population in the region has increased by 340 million during the same period. Due to the resulting "youth bulge" in sub-Saharan Africa, millions of young people are entering a time in life when they are most susceptible to HIV infection. In fact, Africa has the youngest population in the world, with 200 million people between 15 and 24 years of age. Given these demographic trends, we have to work hard just to keep up with, and

2015 PEPFAR LATEST RESULTS

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) represents America's commitment to saving lives and the shared responsibility of all global partners toward achieving an AIDS-free generation.



First Ladies Michelle Obama and Laura Bush at the African Leadership Summit

even harder to keep ahead of, the epidemic. It is clear that if we begin to drift, lessen our aspirations, or fail to follow the science, we will have squandered our cumulative investments and allowed the accomplishments of the last decade to unravel.

We must seize this opportunity. We have a five-year window to fast-track our efforts and thereby change the trajectory of the HIV/AIDS epidemic and create a better future. In September 2015, when the world adopted the 2030 Agenda for Sustainable Development and the Sustainable Development Goals, the global community collectively committed to a goal of ending the AIDS epidemic by 2030. President Obama made clear that the United States will lead the way by announcing bold new HIV treatment and prevention targets for PEPFAR. By the end of 2017, PEPFAR will:

- Support 12.9 million men, women, and children with lifesaving treatment.
- Provide 13 million VMMCs.
- Reduce HIV incidence by 40 percent among adolescent girls and young women within the highest-burden geographic areas of 10 sub-Saharan African countries.

New game changing guidelines from the World Health Organization (WHO) in fall 2015 provide tremendous opportunities to prevent and treat HIV/AIDS immediately. WHO released guidance that recommends ART for all persons living with HIV irrespective of clinical or immunologic status through a “Test and Start” treatment model (see box on page 11). This will increase the number of persons eligible for treatment, but will also provide an individual as well as population-level benefit, as persons who start ART early remain healthier and greatly reduce their risk of transmitting the virus to others.

WHO also released new service delivery guidelines that recognize the evolution in the HIV/AIDS response. Stable patients who are identified while already healthy will require fewer clinical interventions. A large number of patients who are stable on ART can be cared for with less frequent clinical visits (every six months) and less frequent medication refills (every six months). Such patients can safely receive care in their communities by lay providers, improving adherence and decongesting clinics so they may focus on the smaller group of sicker patients who need clinical care. Rapid adoption of this streamlined approach has great potential to free up resources to treat more patients in need (see box on page 11).

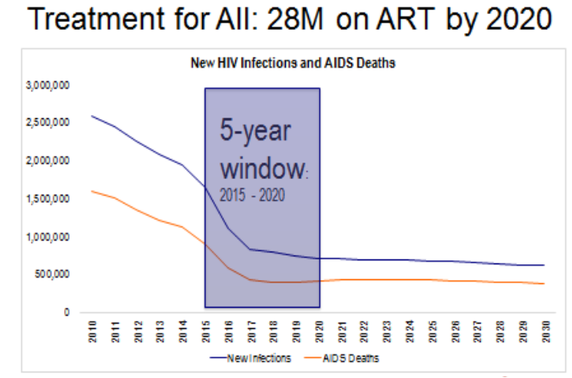
Finally, WHO also released new guidance related to pre-exposure prophylaxis (PrEP) recommending that oral PrEP containing tenofovir should be offered as an additional prevention choice for people at substantial risk of HIV infection. This recommendation enables key at-risk populations to benefit from this additional prevention option.

We need to seize these opportunities working in close coordination with our partner countries and multilateral organizations to explore the implementation of these recommendations. As has been documented from the Fast-Track strategies of UNAIDS and others, the speed at which countries adopt these new policies is key to reducing new HIV infections and reducing future treatment costs. Expanding treatment eligibility to all persons living with HIV and the adoption of key service delivery recommendations in the next few months will have the greatest impact in achieving the 2020 and 2030 global goals. We can make our limited resources twice as effective with respect to lives saved and infections averted if these changes are appropriately and aggressively implemented. If implemented, we can control and ultimately reduce the out-year costs of addressing the HIV/AIDS pandemic.

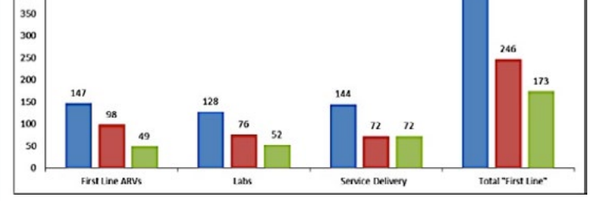
Cost Savings: We Can Support 2 ART Clients for the Price of 1

Models show that if partner countries rapidly adopt the 2015 WHO guidelines for Test and START and new differentiated models of care, 28 million people can access antiretroviral treatment by 2020 (up from 15.8 million in June 2015). By pursuing Treatment for All, we can reduce new HIV infections and AIDS-related deaths by more than 50 percent by 2020. Best of all, through these strategic policy changes, this can be accomplished in a nearly revenue-neutral manner.

We have a five-year window to put countries on the path to controlling their HIV/AIDS epidemics and, ultimately, achieving an AIDS-free generation. This requires all partners to pull in the same direction.



Source: John Stover, 2015



Source: John Stover, 2015

The World Before PEPFAR

Just 15 years ago, an AIDS-free generation was unimaginable. The reports from the front lines were fraught with despair. At that time, an HIV diagnosis was a virtual death sentence in many countries. Families and communities were being devastated around the globe, with disastrous social and economic consequences. Gains in global health and development were being lost: in the hardest-hit regions of sub-Saharan Africa, infant mortality had doubled, child mortality had tripled, and life expectancy had dropped by 20 years or more. At that time, the rate of new HIV infections in the hardest-hit regions was exploding, and people were getting sick and dying during the most productive years of their lives.

Despite early efforts to provide HIV prevention, care, and treatment services, the epidemic continued to rage unabated, as lifesaving medications that might have turned the tide were inaccessible and unaffordable to those most in need. Further, many experts assumed that people living with HIV/AIDS in many parts of the world would be unable to sustain the complicated dosing regimens required.

"As our nation moves troops and builds alliances to make our world safer, we must always remember our calling, as a blessed country is to make the world better...We have confronted, and will continue to confront HIV/AIDS in our own country. And to meet a severe and urgent crisis abroad, tonight I propose the Emergency Plan for AIDS Relief, a work of mercy beyond all current international efforts."

–President George W. Bush, State of the Union Address, January 28, 2003

Following President Bush's call to action in his 2003 State of the Union Address, the U.S. Congress passed PEPFAR with strong bipartisan support just four months after it was announced. At that point, the tide began to turn.

Turning the Tide

At the time of its launch, PEPFAR was well named: the global HIV/AIDS epidemic was an emergency. By 2003, more than 20 million men, women, and children had died in sub-Saharan Africa alone. They were mothers, fathers, teachers, doctors, and nurses, and in the wake of their untimely deaths, 14 million orphaned children were left behind.

While Phase I of PEPFAR focused on the emergency response, Phase II, which commenced in 2008, emphasized enhanced country engagement and sustainability. During this period, PEPFAR established Partnership Frameworks (PFs)—joint strategic roadmaps on HIV/AIDS, agreed to and signed by the United States and partner governments, promoting mutual accountability and sustainability of the HIV/AIDS response. PEPFAR signed 22 PFs from 2009 to 2012, launching a new era of collaborative planning with our partner governments.

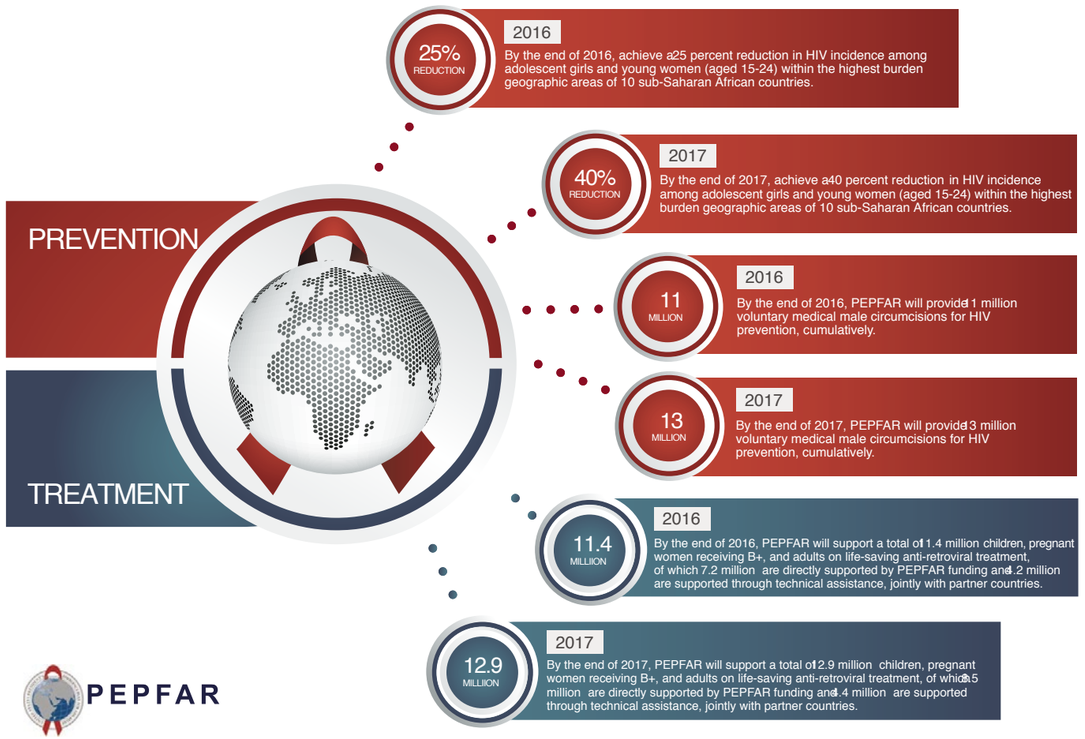
Evidence-based interventions driven by sound public health science were brought to scale: ART, prevention of mother-to-child transmission (PMTCT), VMMC, and comprehensive prevention programs that included the use of condoms were implemented with PEPFAR support in countries around the world.

The Vision for Getting It Done

To control the epidemic and, ultimately, achieve an AIDS-free generation, we must sustain and expand our collective gains. Led by our strategic vision, PEPFAR 3.0—Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation—we are using data to do the right things, in the right places, right now, and in the right way. PEPFAR 3.0 outlines our strategic focus for Phase III of the program: sustainable control of the HIV/AIDS epidemic through five action agendas.

- **Impact Action Agenda—**focusing resources and leveraging finances to address the most vulnerable populations and to control the epidemic.
- **Efficiency Action Agenda—**increasing transparency, oversight, and accountability across PEPFAR and its interagency partners to ensure every taxpayer dollar is optimally invested and tracked.
- **Sustainability Action Agenda—**ensuring that when the United States and partner countries have scaled up interventions and reached epidemic control, the services, systems, financing, and policies required to maintain that control are readily available to PEPFAR beneficiaries.
- **Partnership Action Agenda—**strengthening partnerships to achieve sustainability and ultimately create an AIDS-free generation.

PEPFAR HIV PREVENTION AND TREATMENT TARGETS



Spotlight: Public-Private Partnerships for Impact

PEPFAR has changed how we engage in public-private partnerships, maximizing impact by aligning our core programs with private sector partners.

Investing in Adolescent Girls and Young Women

- DREAMS is an ambitious $385 million partnership to support adolescent girls in becoming Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe women. The partnership brings together PEPFAR, the Bill & Melinda Gates Foundation, Girl Effect, Johnson & Johnson, Gilead, and ViiV Healthcare to reduce new HIV infections among adolescent girls and young women within the highest-burden areas of 10 sub-Saharan African countries.

Delivering on Our Commitment to Children

- Accelerating Children's HIV/AIDS Treatment (ACT): PEPFAR and the Children's Investment Fund Foundation (CIFF) are jointly investing $200 million to accelerate children's access to HIV/AIDS treatment. ACT is a two-year effort to double the number of children receiving lifesaving antiretroviral treatment (ART) in nine high-priority countries in sub-Saharan Africa. As of September 30, 2015, PEPFAR is supporting 498,000 children (0–19 years of age) with ART, putting ACT on track to achieving the fiscal year 2017 target of 600,000 children on lifesaving treatment.

- **Human Rights Action Agenda—**securing and protecting human rights and addressing the human rights challenges of those affected by the disease.

UNAIDS's Fast-Track strategy, which has now been adopted by many countries as their own, sets out 90-90-90 targets: 90 percent of people living with HIV know their HIV status, 90 percent of people who know their HIV status are accessing treatment, and 90 percent of people on treatment have suppressed viral loads. Together, in 2015, PEPFAR and our intergovernmental partners have made significant strides toward achieving these goals.

Delivering Results, Improving Efficiencies

We have learned many lessons since 2003, and we never forget that we are accountable to the U.S. Congress and the American people. They put their trust in PEPFAR to save lives and to adapt and evolve in order to deliver the greatest possible return on their investment.

From its inception, PEPFAR has thrived due to the exceptional contributions from within the U.S. government. The leadership at the U.S. Department of State's Office of the Global AIDS Coordinator and Health Diplomacy; United States Agency for International Development; the U.S. Department of Health and Human Services and its agencies, including the Centers for Disease Control and Prevention, Health Resources and Services Administration, and the National Institutes of Health; the Department of Defense; the Peace Corps; and the Department of Labor, as well as our new partnership with the U.S. Treasury, has been instrumental and has demonstrated the true strength of interagency collaboration. The dedicated career staff working internationally under the leadership of the chiefs of mission at our embassies have been equally important to bilateral engagement and ensuring successful implementation of the program.

We have been steadfast in the adoption of a data-driven, targeted approach to address one of the most complex global health crises in modern history. By taking evidence-based, community-focused HIV prevention, treatment, and care programs to scale in under-resourced settings, the United States has challenged the conventional wisdom that nothing could be done to turn the tide of new HIV infections and disease progression among those infected.

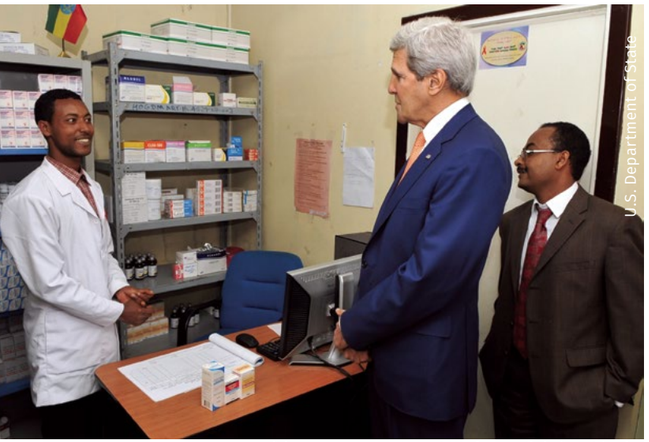
PEPFAR has become even more efficient and effective, driving down costs to save dollars and save lives. However, we know that it will take all partners, working in a focused, coordinated, data-driven manner, to succeed. PEPFAR works with the Global Fund to Fight AIDS, Tuberculosis (TB) and Malaria (the Global Fund), of which we are the largest donor, to maximize our joint investments. Increased partnership between PEPFAR and the Global Fund serves to improve the impact of our investments through more strategic use of resources to support efficient and evidence-based programs that are truly collaborative and sustainable.

Since its founding, PEPFAR has worked to build health infrastructure and strengthen capacity through an emphasis on sustainability. These efforts have not only supported patients living with HIV/AIDS, but also are leveraged for maternal and child health, malaria, immunizations, and emergency disease outbreak response. We have invested in strong laboratories and well-trained laboratory specialists critical to well-functioning health systems, enabling clinicians and health workers to diagnose and treat a range of diseases and conditions. To date, PEPFAR has trained more than 190,000 health care workers to deliver HIV care and other health services. These efforts not only improve HIV care, but also enable countries to improve the overall health of their

Rick Warren, Senior Pastor of Saddleback Church, Sir Elton John, Amb. Mark Dybul, Executive Director of the Global Fund, and Amb. Deborah Birx, U.S. Global AIDS Coordinator & Special Representative for Global Health Diplomacy testifying before the Senate Appropriations Committee on May 6, 2015.

Examples of PEPFAR and Global Fund Engagement

Level	Description
Policy & Governance	• Senior U.S. government officials participate in Global Fund board meetings twice each year. • Senior U.S. government officials serve in leadership positions on the Global Fund board committees on strategy, finance, and governance. The designated PEPFAR official on each committee participates in committee meetings throughout the year. • Every month, PEPFAR participates in the Global Fund's Grant Approvals Committee (the governance body that recommends funding decisions for new and existing Global Fund grants).
Program	• At the headquarters level, PEPFAR: communicates daily with Global Fund staff, seconds personnel to Global Fund headquarters, hosts headquarters-to-headquarters meetings to assess key implementation challenges in core joint-investment countries, and hosts annual coordination meetings with the Global Fund on implementation topics, such as procurement and supply chain. • At the country level, PEPFAR teams: deploy "Global Fund Liaisons" to coordinate implementation and share information about the Global Fund with PEPFAR teams (and vice versa), share implementation data with Global Fund counterparts quarterly, and are actively involved in country-level Global Fund governance bodies that oversee grant implementation. • In 2015, PEPFAR invited Global Fund Portfolio Managers to participate in PEPFAR's Country Operational Plan process and invited the Global Fund to provide input on the FY 2016 Country Operational Plan Guidance.
Technical Assistance	• PEPFAR is the largest donor in technical assistance to support the activities of the Global Fund. • Global Fund Technical Assistance activities include supporting development of national strategic plans and grant proposals, building the capacity of governments to manage their grants, supporting countries to mobilize increased domestic resources for HIV/AIDS, and strengthening national supply chains to deliver lifesaving commodities. • PEPFAR is an active partner in the Global Fund's Implementation Through Partnership (ITP) project, launched in 2015, to drive programmatic success in 20 high-priority countries. These 20 countries represent 54 percent of all Global Fund money and 67 percent of expected scale-up activities. • PEPFAR's investments in technical assistance for the Global Fund will be aligned to support the actions identified in the ITP project.



Secretary Kerry visits PEPFAR-supported HIV/AIDS clinic in Ethiopia.

citizens by creating a lasting infrastructure that positions partner countries to respond to a range of health challenges and threats.

There are indirect economic benefits for treating people living with HIV before they develop AIDS. Healthy HIV-infected individuals on treatment are able to work and support their families. Keeping parents healthy also lessens other social costs, such as caring for orphans whose parents die of AIDS-related illnesses. Robust statistical models have shown that the economic benefits of treatment will likely exceed program costs within just 10 years of investment. In other words, treating people will not only save lives, but will also generate considerable economic returns.

The Work Ahead

PEPFAR continues to make great strides, focusing on reaching and serving key affected populations (including adolescent girls and young women), strengthening community engagement, addressing stigma and discrimination, and making program decisions supported by clearer and more granular data.

Despite these successes, considerable work remains and critical gaps need to be addressed, as Secretary of State John Kerry stated on World AIDS Day 2015.

PEPFAR is now well into the implementation

> **"Even as we mark the progress we've made, we recognize that the months and years ahead will be critical. There are still over 20 million people worldwide living with HIV/AIDS, without any treatment at all. Experts tell us that we have a five-year window to fundamentally change the trajectory of the HIV/AIDS epidemic—to accelerate the progress we've made and stop HIV/AIDS in its tracks."**
>
> ***-Secretary of State John Kerry on World AIDS Day 2015***

of its third phase—PEPFAR 3.0—in which the earlier successes are being leveraged aggressively to focus on the sustainable control of the epidemic. PEPFAR is partnering with the international community to drive toward the UNAIDS 90-90-90 global goals, and in order to do so, PEPFAR has shifted its manner of doing business. This pivot, based on what has been learned in the previous 10 years and where the future epidemic trend is leading, is toward a data-driven approach that strategically targets geographic areas and populations where the greatest impact can be achieved.

We are **determined** to dramatically reduce new HIV infections among adolescent girls and young women by implementing a comprehensive, targeted strategy to protect their health, secure economic opportunity for them, and enable them to pursue their dreams. Every year, 380,000 adolescent girls and young women are infected with HIV—more than 1,000 every day. Globally, adolescent girls and young women face more than 1,000 new HIV infections every day, and in sub-Saharan Africa, they account for 71 percent of new HIV infections among adolescents. Since gender-based violence (GBV) and HIV are intricately linked, girls who experience violence are three times more likely than girls who do not experience violence to have an unwanted pregnancy, and up to three times more likely to have HIV or other sexually transmitted infections.

That is why PEPFAR, the Bill & Melinda Gates Foundation, and Girls Effect were founding members of the DREAMS partnership, now $385 million (subject to approval by the U.S. Congress). DREAMS is supporting adolescent girls and young women to be Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe, and it aims to achieve a 40 percent reduction in new HIV infections among adolescent girls and young women within the hardest-hit areas of 10 sub-Saharan Africa countries by the end of 2017.

On World AIDS Day 2015, PEPFAR and several private sector partners announced new investments in DREAMS, including the new DREAMS Innovation Challenge. PEPFAR committed an additional $80 million from within its existing FY 2015 budget for this Challenge, and Johnson &

Young women at DREAMS workshop in Tanzania

Engaging and Investing in Civil Society

Involving Civil Society Early and Often in PEPFAR Planning Process

- To ensure increased participation and integration of civil society in HIV/AIDS planning and implementation, all PEPFAR countries were directed to actively engage civil society throughout the development of their annual Country/Regional Operational Plans (COP/ROP). During the 2015 COP in-person reviews, each country was empowered to invite members of civil society, partner country governments, multilaterals, and other stakeholders to participate in discussions directly with Ambassador Birx around the annual PEPFAR planning process.
- In November 2015, PEPFAR posted its draft 2016 Country/Regional Operational Plan (COP/ROP) Guidance online to collect feedback from all stakeholders, including civil society organizations. The comments directly informed the final guidance, posted online on December 1, 2015.

Investing in Civil Society Leadership and Capacity

In 2015, PEPFAR announced several investments to strengthen the leadership and capacity of civil society organizations, including:

- $80 million for the DREAMS Innovation Challenge;
- $10 million for PEPFAR's partnership with the Elton John AIDS Foundation to provide grants to organizations working to meet the HIV-related needs of LGBT people;
- a $10 million contribution to the Robert Carr Civil Society Networks Fund (RCNF) over the next three years to support and build the capacity of global and regional civil society networks; and
- a joint $4 million contribution to the PEPFAR-UNAIDS Faith Initiative.

Johnson, Gilead Sciences, and ViiV Healthcare joined our call to action by committing $25 million to support both the DREAMS partnership and the Innovation Challenge. This partnership model reflects a shift toward aligning our core programs with private sector partners to maximize our investment and our collective impact.

We are **committed** to saving children's lives through an aggressive plan to provide comprehensive treatment, care, and support to those infected with HIV. In 2014, 2.6 million children under the age of 15 were living with HIV/AIDS globally. Of these children, nearly 90 percent live in sub-Saharan Africa, and only 32 percent were receiving ART in 2014. Without ART, half of the children infected with HIV at birth or in infancy will die before their second birthday, and 80 percent will die before their fifth birthday. PEPFAR has taken action to change this, including through the Accelerating Children's HIV/AIDS Treatment (ACT) Initiative—a two-year, $200 million partnership between PEPFAR and the Children's Investment Fund Foundation to double the total number of children receiving lifesaving treatment in nine high-priority countries by the end of 2017. As of September 30, 2015, in just one year, we have more than doubled the number of children tested for HIV and have achieved a 55 percent increase in the rate of new children on ART. PEPFAR is supporting 498,000 children ages 0–19 with lifesaving ART, putting ACT on track to achieve the FY 2017 target of 600,000 children living with HIV/AIDS on ART with PEPFAR support. We are ensuring that our OVC programs—which play a valuable role for both children and their caregivers, including socioeconomic support—provide key linkages to other services such as HIV treatment and prevention.

We are **enhancing** our efforts through PMTCT to reach the day when no child is born HIV-positive and to ensure that mothers remain healthy through expansion of Option B+ programming, or lifelong ART, for pregnant women. Since 2009, there has been a 48 percent reduction in new HIV infections among children in the 21 priority countries of the Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive, which PEPFAR has co-chaired with UNAIDS.

Driven by the President's targets, we are **scaling up** targeted prevention investments in VMMC, which is a core prevention intervention. Circumcision reduces the risk of heterosexually-acquired HIV infection in men by approximately 60 percent. PEPFAR has supported more than 8.9 million VMMC procedures in eastern and southern Africa to reduce the risk of HIV transmission, and will have supported 13 million circumcisions by FY 2017.

Preventing New HIV Infections Through Voluntary Medical Male Circumcisions

As a result of one PEPFAR-funded organization in South Africa, 100,000 men have reduced the risk of contracting HIV by 60 percent. It is estimated that five circumcisions result in one averted HIV infection. So far, the voluntary medical male circumcision (VMMC) program has averted 20,000 new HIV infections.

Clinical research has shown medical circumcisions reduce the risk of acquiring HIV by 60 percent. Men who have had this procedure find it easier to maintain personal hygiene while protecting their female partners from a number of other sexually transmitted infections. Circumcision also reduces a woman's risk of cervical cancer.

Since commencing in 2010, the program has made a considerable impact in the Gauteng, KwaZulu-Natal, Mpumalanga, and Free State communities.

At the organization's Pietermaritzburg site alone, it has performed some 4,277 VMMCs annually since the program started. This site, which operates from a temporary mobile location, is responsible for 21 percent of the nationwide achievement of 100,000 VMMCs.

Xolani Zwane, a 38-year-old, became the organization's 100,000th VMMC client. Prior to his visit to the clinic, he had no knowledge of this service. Susan Molutsoane, the clinic's site manager, told him about the procedure and its medical benefits.

"The final decision to get circumcised came from me, there was no reason for me not to do it and I feel great," Xolani said two days after his circumcision.

The father of three is so pleased with the procedure's outcome that he plans for his four-year-old son to get circumcised as soon as medically possible.

Andrew Medichini/AP Photo

Pope Francis blesses a young woman living with HIV in Uganda.

We are **collecting, using, and sharing data** like never before through a program-wide imperative to have the greatest possible impact with each dollar entrusted to us by the Congress and the American people. This allows PEPFAR to strategically target populations at greatest risk in geographic areas with the highest HIV/AIDS burden—reaching more individuals, families, and communities with lifesaving HIV prevention, treatment, and care services.

We are **steadfast in** our conviction that the protection of human rights must remain at the core of our work, including for key affected populations. When human rights are valued, promoted, and preserved, people have the ability to access HIV/AIDS or other health services without facing stigma or discrimination. Conversely, when any member of a community is stigmatized or discriminated against, the health and human dignity of everyone in that community is at risk.

Taking Care of Herself for the Sake of Her Child

When Nteboheleng discovered she was pregnant with her second child, she waited nearly five months—much longer than recommended—to have her first prenatal visit. Nteboheleng knew with this visit, she would also learn her HIV status, something she had delayed for years.

"I was suffering to go, but afraid of the psychological stress of learning my [HIV] status," she explains. But, with a new baby on the way, she knew she needed to take care of herself for the sake of her child. When Nteboheleng finally visited a maternal and child health clinic in Lesotho, she learned she was HIV-positive and immediately started antiretroviral treatment (ART) to protect her unborn child from becoming infected with HIV.

Nteboheleng's immediate enrollment on treatment is a result of the World Health Organization's guidelines for treatment of pregnant women living with HIV. The Lesotho Ministry of Health and its partners have adopted these recommendations, often referred to as "Option B+." Nteboheleng is now on lifelong HIV treatment, meaning ART will protect the life of her child through pregnancy, childbirth, and breastfeeding—as well as her own health throughout the course of her life.

"I am now OK with my status," says Nteboheleng. "I thought when I learned I was HIV-positive I was going to get sick. But I am now stronger than before. Getting into treatment before I got sick … I really appreciate that."

Heather Mason/EGPAF

Nteboheleng


Gurinder Osan/AP Photo

Girls in New Delhi, India participate in a walk commemorating World AIDS Day.

To achieve an AIDS-free generation, we must ensure that every person can access the HIV/AIDS prevention and treatment services they need. No one should be left behind. Reaching this goal not only requires robust clinical interventions, but also addressing social, cultural, economic, and legal barriers that inhibit equal access to health services. We must build the capacity of civil society organizations, engage partner governments, and work in concert with our multilateral and bilateral partners. We are committed to ensure that partners receiving PEPFAR funds implement their programs in a way that supports the protection of and respect for human rights.

We are **ensuring** that our efforts are informed by and engaged with a variety of voices from all sectors and disciplines. Since the earliest days of the HIV/AIDS epidemic, civil society has been at the forefront of the response—demanding accountability, delivering lifesaving services, and driving transformational change. Without civil society, we would never be where we are today, and its role now is as vital as ever. PEPFAR is committed to engaging, empowering, and supporting civil society at every step of the planning process.

PEPFAR **prioritizes** daily our key collaborations with multilateral organizations, including UNAIDS and the Global Fund. PEPFAR works closely with UNAIDS, drawing on the UNAIDS and partner country epidemiological technical resources and capacity. This collaboration provides critical support to countries in overcoming key policy, programming, and implementation challenges. As discussed above, PEPFAR works with the Global Fund to maximize our joint investments.

We are **collaborating with and gaining critical knowledge from** our many private sector partners, leveraging not only their financial resources but also their business acumen and insights, which bring innovation and new thinking to address difficult problems. The progress we are making through our ACT and DREAMS initiatives, as well as the recently launched "Treatment For All" campaign, can be attributed to the shared engagement of and the novel contributions of these partners.

We are **benefitting** from the expertise and experience of leading scientists, academics, and practitioners, including new and diverse members of PEPFAR's Scientific Advisory Board named in 2015.

We are **working** hand-in-hand with our Chiefs of Mission, who have the unique diplomatic access and assets to strengthen our partnership with host countries, promote key policy changes, and advance critical dialogue around sustainability.

We are **engaging and coordinating** in unprecedented ways with all our partners, since we know our best chance of success is to have all of our partner countries fully involved in a transparent process of program development and implementation to help drive our decision making. Underlying all of our programming must be a dedication to ensuring information and program data are understandable, digestible,

Transparency in Action

PEPFAR has opened its data, leading by example to drive greater transparency, impact, and accountability. Data are only as useful as they are accessible, usable, and actionable:

- In the past two years, PEPFAR's score on the Aid Transparency Index has risen by more than 40 points (16.1 to 56.5).
- Building on the new data available on the PEPFAR Dashboards, in 2016 PEPFAR plans to release even more data, including around the impact of our work at the subnational level.
- PEPFAR also has joined a wide range of partners through the Global Partnership for Sustainable Development Data to fill critical data gaps and to invest in capacity building so that data can be analyzed and used by the people that need it most.

+40 *PEPFAR's score improvement on the Aid Transparency Index*


Jane Justing Mirembe

Robinah Babirye

Becoming a Proud Peer Educator

Robinah Babirye, a Ugandan, remembers her mother giving her pills from the time she was very young, but she didn't know why and couldn't explain it to her questioning classmates.

It wasn't until age 9 that she and her twin sister discovered they were born HIV-positive. Their mother told them she had contracted HIV during a blood transfusion in 1994 and didn't have access to measures for preventing transmission to her children.

To avoid fellow students' questions, Robinah tried taking her pills without anyone noticing, or not taking them at all. "Growing up with HIV was hard," Robinah says. "I had to take lots of medicines daily, yet I was told the disease I had was incurable. This was demoralizing, and I could not tell people about it."

As a result of poor adherence to her medication, Robinah developed resistance to antiretroviral therapy.

With her life in danger, Robinah was put on second-line treatment. Her mother paid for her to attend weekly counseling sessions, and Robinah developed a strategy to take her medications in her school clinic. When she forgot to take her pills, the school nurse reminded her.

Once she finished her secondary studies, Robinah decided to make a change. She posted a picture of herself on Facebook wearing a shirt with the words "I AM HIV POSITIVE." That night, she connected with many people who applauded her courage. She was suddenly in the public eye and began appearing on TV and radio shows. Since then, Robinah has started university and founded an organization to help young HIV-positive people with adherence and psychological challenges.

"Being HIV-positive is not the end of life," Robinah says. "Whoever reads my story will be empowered and encouraged to fight stigma in society. I am grateful to the American people for giving us support."

and actionable. We need to be more nimble and act more rapidly in making program improvements for impact based on the latest data. We are committed to using data to focus our investments on the geographic areas and populations that face the greatest HIV/AIDS burden. Our collective ability to achieve an AIDS-free generation requires the ongoing translation of what we know into programs that have impact.

Conclusion

The road ahead will be challenging and will test our resolve, but we will reach our destination. The ways in which we are focusing and strengthening PEPFAR's efforts and partnerships will hasten our arrival. Over the last 13 years, PEPFAR has adapted, responding to changing needs on the ground among the people we serve. We have taken lessons learned to heart, and our stewardship over PEPFAR has been informed by our clear responsibility to spend each dollar appropriated to us by the U.S. Congress and the American people in the most wise and purposeful way. We can't afford not to.

Our work is guided each day by the memory of the more than 40 million people who have died since the HIV/AIDS epidemic was first recognized, including the estimated 1.6 million lives lost in the past year. We are inspired by the millions of people who are living today with HIV/AIDS to work harder, faster, and smarter with our partners across the globe to create an AIDS-free generation. And it is possible if we remain focused, steadfast, and keep pushing together. The time to act is now.


James Pursey/EGPAF

A mother and her children in Malawi

Appendices


Vasco Possley

A nun holds a baby boy in Zambia.

A woman visits an HIV testing and counseling clinic in Vietnam.

APPENDIX A: How PEPFAR Uses Data for Maximum Impact to Get to Epidemic Control

PEPFAR is now 14 months into the implementation of its third phase—**PEPFAR 3.0**[1]—in which earlier successes are being leveraged aggressively to focus on the sustainable control of the epidemic. PEPFAR is intensely focused on increasing the impact of every dollar invested. We are partnering with the international community to drive toward an AIDS-free generation through the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 global goals,[2] while at the same time expanding the critical prevention intervention of VMMC and of the DREAMS partnership to reduce the number of new HIV infections in adolescent girls and young women.

Since 2014, PEPFAR has shifted its manner of doing business. This pivot, based on what has been learned in the previous 10 years and on where the future epidemic trend is leading, is toward a data-driven approach that strategically targets geographic areas and populations where the greatest impact can be achieved.

1 PEPFAR. (2012). *PEPFAR 3.0 – Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation*. Available at http://www.pepfar.gov/documents/organization/234744.pdf

2 90 percent of people living with HIV know their HIV status, 90 percent of people who know their HIV status are accessing treatment, and 90 percent of people on treatment have suppressed viral loads.

The encompassing PEPFAR 3.0 agendas are built upon multiple strategies to address the HIV/AIDS epidemic through improvements in impact, efficiency, sustainability, partnerships, and human rights. In particular, the Impact Action Agenda is grounded in the need to do the right things in the right places right now.

Right Things

Science has demonstrated what tools are most effective in reducing new HIV infections and AIDS-related mortality globally. PEPFAR has realigned its programming to ensure an even greater focus on evidence-based core activities that will accelerate progress toward achieving sustainable control of the epidemic. Combination prevention—ART, PMTCT, VMMC, condoms, and DREAMS interventions focused on geographic areas and populations with higher disease burden—forms the backbone of PEPFAR's approach. In addition, PEPFAR's support to orphans and vulnerable children (OVC) and their families, and to specific elements of health systems strengthening, remains key to reaching this goal.

Right Places

Global and national patterns in HIV burden have guided intervention responses for years. But as data systems evolve (both surveillance and program), more precise data from local units, including counties and districts, demonstrate considerable variation in the HIV epidemic within every country context. PEPFAR has driven the more granular analysis as well as the utilization of the data to target the geographic areas and populations in greatest need of effective responses. PEPFAR continues to develop new analytic tools, in conjunction with site-specific service delivery and quality data, to drive the allocation of resources and program responses in order to strengthen epidemic control strategies.

Right Now

Evidence demonstrates that earlier treatment for adults (including key populations, people co-infected with TB/HIV, and sero-discordant couples) leads to improved outcomes and will have a dramatic impact on controlling the epidemic.[3] Preventing new infections among young women and girls is also vital to controlling the epidemic. Earlier HIV testing for exposed infants and children, tied to immediate linkage to care and treatment services, will address another significant component of the epidemic, providing quality services for adolescents through OVC and ART services and strengthening the suppression of new infections in the future. We know that with the youth bulge in sub-Saharan Africa, there are 40 percent more young people at risk. This rapid demographic shift has the ability to reverse all our collective gains if new interventions are not scaled immediately. Accelerating scale-up of all core interventions in geographic areas with the highest disease burden is essential to achieving sustainable epidemic control as quickly as possible.

Changing the Annual Country Operational Plan (COP): Focus on Data for Program Improvement

PEPFAR is utilizing a variety of tools and data sources to accelerate progress toward epidemic control and has integrated new analytic methodology into the very fabric of our planning cycle.

Table 1. Data Sources by Level of Disaggregation

Level of Disaggregation	Data Source
National	Survey, surveillance, mathematical modeling, budget
Local (Subnational e.g., region, district)	Expenditure analysis, survey, surveillance
Site	Targets, results, SIMS, sentinel surveillance

3 WHO. (2013). *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*. Available at http://www.who.int/hiv/pub/guidelines/arv2013/en/

Table 1 illustrates the different types of data used for COP planning and program monitoring. Different survey and surveillance data reveal variation in the risk of HIV infection and burden of disease at a subnational level both geographically and by subpopulations.[4] The locations and subpopulations with greatest disease burden and highest rates of HIV transmission demand more focused attention from program interventions to control epidemic growth and achieve positive program outcomes. Program performance data (i.e., results) are tied to individual service delivery sites and individuals. These data are being leveraged in many ways and include:

(1) Use of PMTCT results at the site level, providing the granular information that may be available from survey data, allowing for further targeting of investments;

(2) Identification of sites that have not been productive in the past year, allowing for the redirection of resources to sites that are diagnosing and treating more individuals living with HIV/AIDS; and

(3) Mapping sites and service uptake with disease burden to optimize allocative efficiency.

Analyses of expenditure data also reveal expenditure trends by subnational unit and by implementing partners. Integrating these three data sources—survey and surveillance, program performance, and expenditure—offers an evidence-based alignment of resources and programs to most effectively strengthen the response to the epidemic. Success in these applications leads to successful epidemic control.

Finally, the analytic framework moves analysis down to the most granular level (at site level) to ensure every site is performing optimally. This methodology identifies both high-performing sites, which can be evaluated for determination of success, and poor performers.

4 Anderson, S-J., Cherutich, P., Kilonzo, N., et al. (2014). Maximising the effect of combination HIV prevention through prioritisation of the people and places in greatest need: a modelling study. *The Lancet*, 384, 249–256.

Young girls living in small village in Malawi

The information can then be used to improve overall program performance through detailed site improvement plans and may be used to shift partners as needed.

The initial use of the full complement of these data sources was in the COP submissions for U.S. Government Fiscal Year 2015. In the year prior to the COP 2015 submission, headquarter and U.S. government country teams sharpened their understanding of the heterogeneity of the epidemic within their countries and the optimal programmatic response. This resulted in a more targeted alignment of program interventions to address the most critical drivers of the epidemic.

The PEPFAR Country/Regional Operational Plan 2015 Guidance[5] detailed how this approach was to be applied in order to advance progress toward achieving an AIDS-free generation and toward the UNAIDS 90-90-90 goals,[6] which aim to ensure 81 percent of people living with HIV are on ART and 73 percent of people living with HIV are virally suppressed. As these goals also are beyond what PEPFAR alone can achieve in any given country, PEPFAR country teams were instructed to identify the geographic areas in which new infections were likely to be the greatest and where interventions were well coordinated with other relevant stakeholders. PEPFAR country teams designed portfolios that, at a minimum, will assist partner country governments in reaching 80 percent coverage of people living with HIV on ART by the end of FY 2017 in select high-burden subnational units and/or populations, optimizing program impact through geographic focusing and targeted, effective interventions.[7]

Developing a portfolio to achieve these goals requires a sharper focus on geographic locations and populations with the greatest HIV/AIDS burden. This alignment requires a targeted inquiry of demographic, epidemiologic, and programmatic data to the lowest possible subnational level, in addition to understanding how the current response is funded and implemented by all relevant partners. PEPFAR country teams were instructed to review the alignment of the current PEPFAR portfolio with the epidemic profile, and to account for identified gaps, bottlenecks, and structural or cultural barriers that might impede progress toward epidemic control.[8] Once priority, high-burden geographic areas were identified, PEPFAR country teams adjusted their portfolios accordingly and set targets to reach 80 percent coverage of those in need of combination prevention strategies in these areas.

Site Improvement Monitoring System (SIMS): Data for Quality Assurance and Quality Improvement

In 2014, PEPFAR initiated an ambitious effort to improve site-level quality, referred to as the Site Improvement through Monitoring System (SIMS). SIMS is PEPFAR's primary, standards-based quality assurance system designed to improve and increase the impact of HIV programs toward achieving 90-90-90 global goals. PEPFAR country and regional staff have been visiting sites for program monitoring purposes utilizing different frameworks since the inception of PEPFAR. However, SIMS systemizes and broadens site monitoring and improves documentation of oversight by using standard tools to assess adherence to standards of quality service delivery. Under SIMS, program quality is assessed and monitored at both the point of service delivery—in health facilities and surrounding communities—and at the "above-site" level through assessment of the quality of technical support provided to institutions that guide and support service delivery. SIMS results are used to ensure compliance of PEPFAR-supported services with global and national service delivery standards, as well as to serve as a basis for monitoring program improvement.

Launched within all of PEPFAR's 36 Operating Units at the beginning of FY 2015, there has been a clear demonstration of scale-up by PEPFAR teams, as well as use of SIMS data, within PEPFAR at all levels for program improvement. During FY 2015, more than 4,000 SIMS visits took place across all of PEPFAR's implementing agencies. Three-quarters of those visits took place within health facilities, with the remainder occurring in communities that link beneficiaries to facility-based services and above-site institutions that support delivery of HIV services. SIMS data are being analyzed by all programmatic areas within PEPFAR. SIMS data are serving as the basis for PEPFAR teams to initiate program improvement within their countries, for headquarters agency staff to understand cross-country challenges to delivery of HIV services, and for all PEPFAR stakeholders to identify areas of needed intensified technical assistance to improve program quality. Significant scaling up of coverage of SIMS visits will begin in FY 2016, directly supporting PEPFAR teams' programmatic pivots to the high-volume health facilities and priority geographic areas that are the critical gateways to achieving 90-90-90 global goals.

All PEPFAR country teams submitting annual operational plans implemented PEPFAR's new approach in 2015, and after extensive effort to compile, analyze, and review the data, all PEPFAR country teams have made adjustments to their program portfolios. To illustrate how this new approach to data is leveraging more effective programming and leading to increasing impact, Uganda is presented here as a case study for this critical realignment.

Uganda Case Study: Why We Know PEPFAR's Focused Approach Will Work

Unlike most other countries in sub-Saharan Africa, Uganda experienced a resurgence in new HIV infections between 1998 and 2011, countering the tremendous gains that had been made toward achieving epidemic control in the previous decade (Figure 1). PEPFAR responded to this trend while planning for COP FY 2012, resulting in a more targeted approach

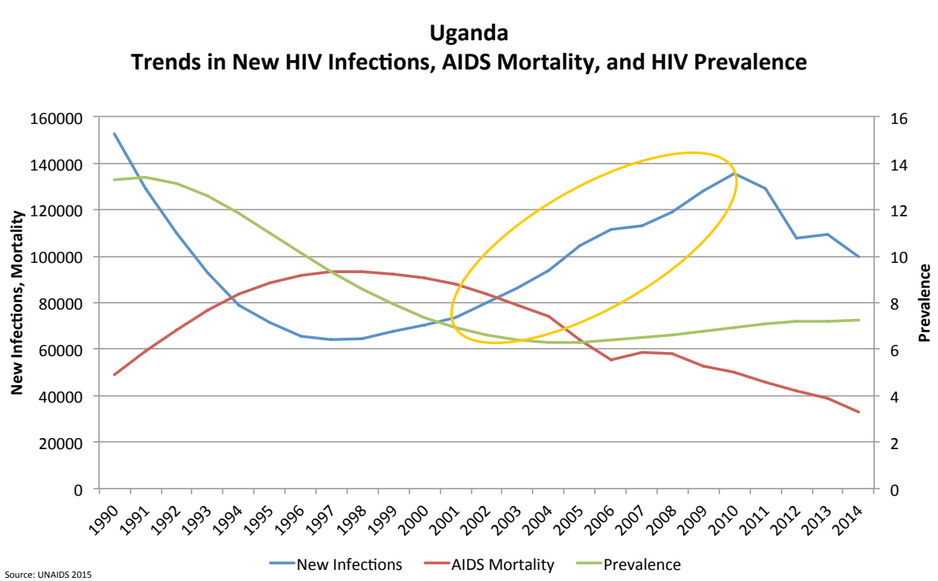
5 PEPFAR. (2015). PEPFAR Country/Regional Operational Plan (COP/ROP) 2015 Guidance. Available at http://www.pepfar.gov/documents/organization/237669.pdf

6 UNAIDS. (2014). 90-90-90: An ambitious treatment target to help end the AIDS epidemic. Available at http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf

7 PEPFAR. (2015). PEPFAR Country/Regional Operational Plan (COP/ROP) 2015 Guidance. Available at http://www.pepfar.gov/documents/organization/237669.pdf

8 PEPFAR. (2015). *Country/Regional Operational Plan (COP/ROP) 2015 Guidance.* Available at http://www.pepfar.gov/documents/organization/237669.pdf

Figure 1. Trends in New HIV Infections, AIDS Mortality, and HIV Prevalence, Uganda



to service delivery to more directly address the key drivers of the epidemic. The program results are reflected in ART (Figure 2), PMTCT (Figure 3), and VMMC (Figure 4), and associated impacts can be observed in the larger trends in new infections (Figure 1). The data underlying this programmatic realignment were much more limited than what are currently available, but the principles are the same. The objective was to focus resources and provide high-quality, effective programs in the geographic areas and populations with the greatest HIV/AIDS burden to prevent the growth of new infections and AIDS-related mortality. Critically, the program realignment resulted in a substantial increase in results in a budget-neutral environment. But more importantly, the acceleration in performance has been maintained over the past 3 years. The impact on the epidemic is clearly seen in Figure 5.

Local school children learn more about HIV/AIDS at a U.S. Embassy Uganda event.

Figure 2. PEPFAR-Supported ART Trends Relative to Overall Budget Demonstrates Dramatic Increase in Results with Realignment in 2011, Uganda

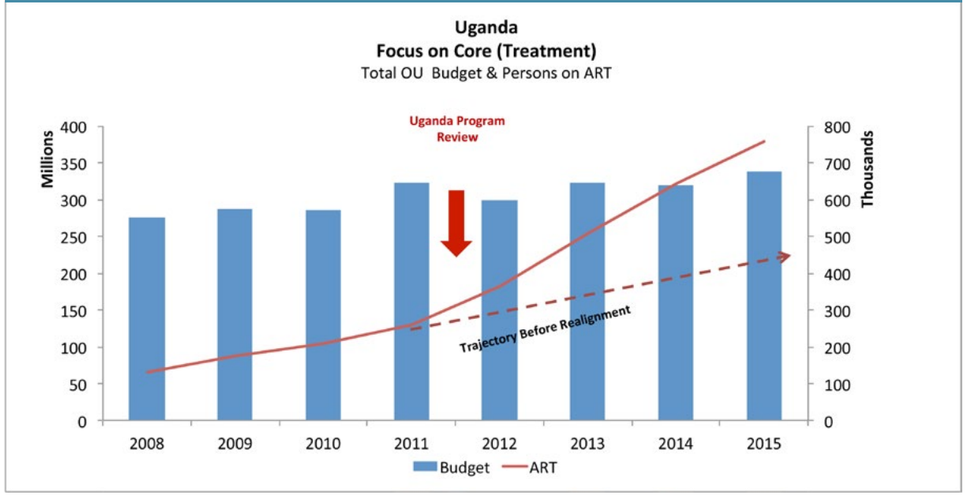


Figure 3. PEPFAR-Supported PMTCT Trends After Program Realignment, Uganda

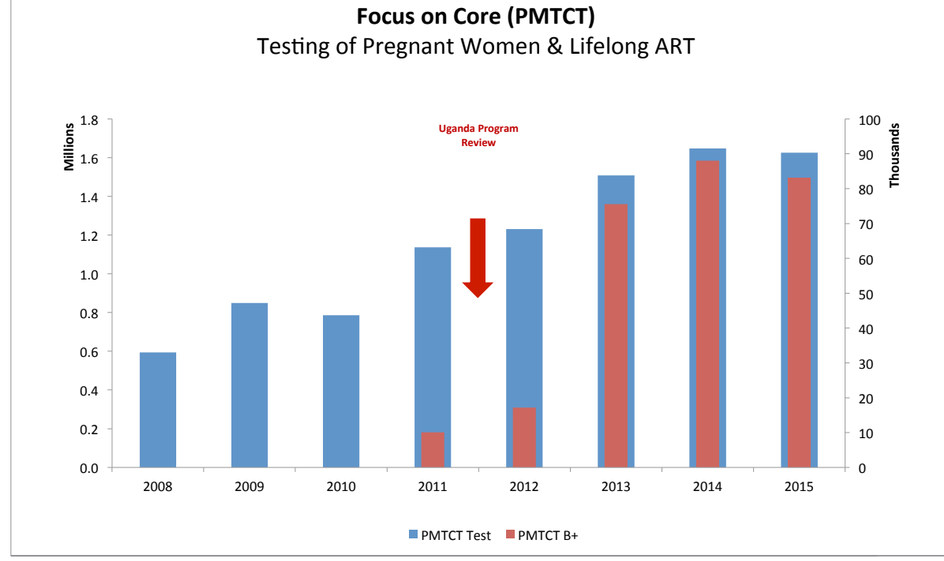


Figure 4. PEPFAR-Supported VMMC Trends After Program Realignment, Uganda

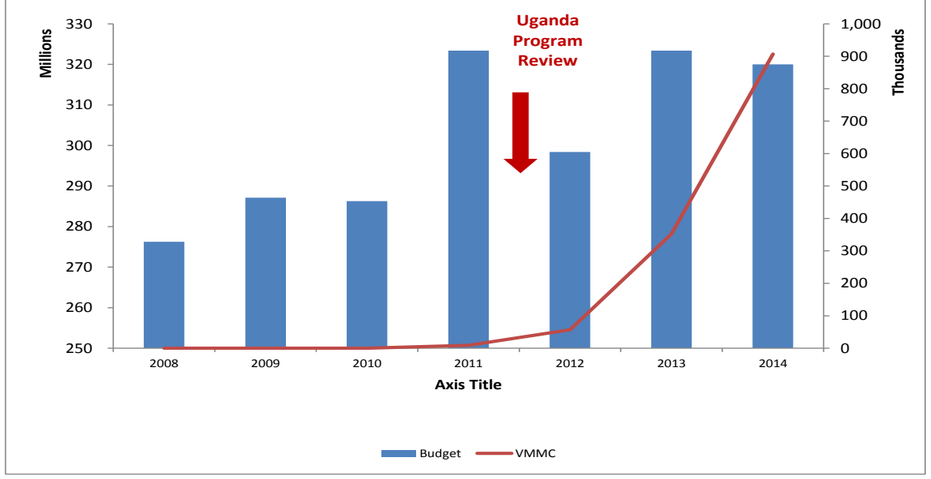
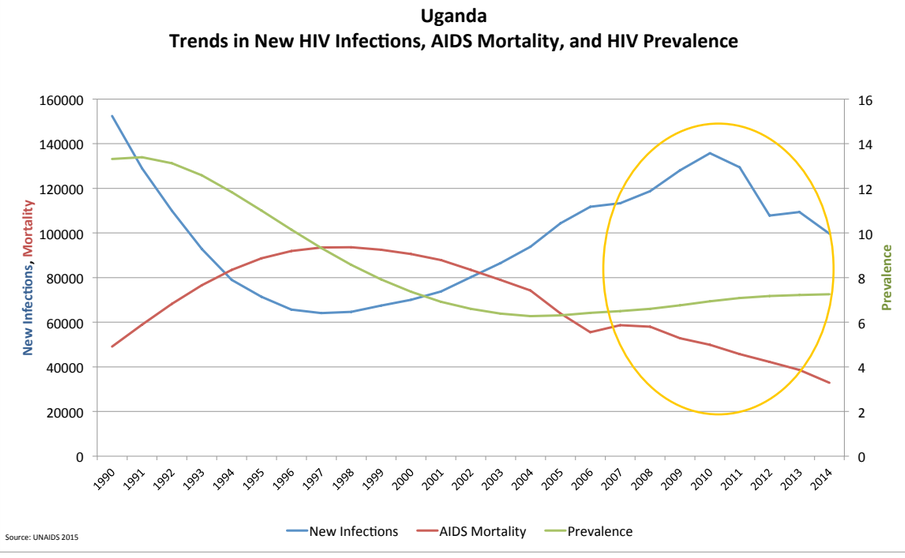


Figure 5. Trends in New HIV Infections, AIDS



Source: UNAIDS 2015

Geospatial Mapping to Ensure Program Impact

PEPFAR placed an even greater emphasis on the use of data for decision making in preparation for COP FY 2015 and developed new visualization tools to facilitate data analysis for action. The fundamental parameters for this approach are established according to the distribution of the estimated number of people living with HIV and HIV prevalence rates in Uganda. These can vary considerably among subnational (district) units (Figures 6 and 7), leading to significant differentiation in the burden of disease across geographic areas. Disseminating limited HIV/AIDS care and treatment services equally across all of these areas led to geographic areas with large numbers of people living with HIV being underserved and those with few people living with HIV being overserved. Conversely, current distribution patterns for ART services (Figure 8), PMTCT (Figure 9), and OVC and VMMC (Figure 10) reflect an equity-driven approach to service delivery across Uganda, whereby availability of services is increasingly being aligned with identified burden and need.

The Uganda PEPFAR team ranked districts according to the number of people living with HIV and found that 82 percent of people living with HIV reside in 61 of 111 total districts. This means that 45 percent of the districts serve less than 18 percent of the burden. The 61

Figure 6. Distribution of People Living with HIV by District Demonstrating Burden of Disease, Uganda

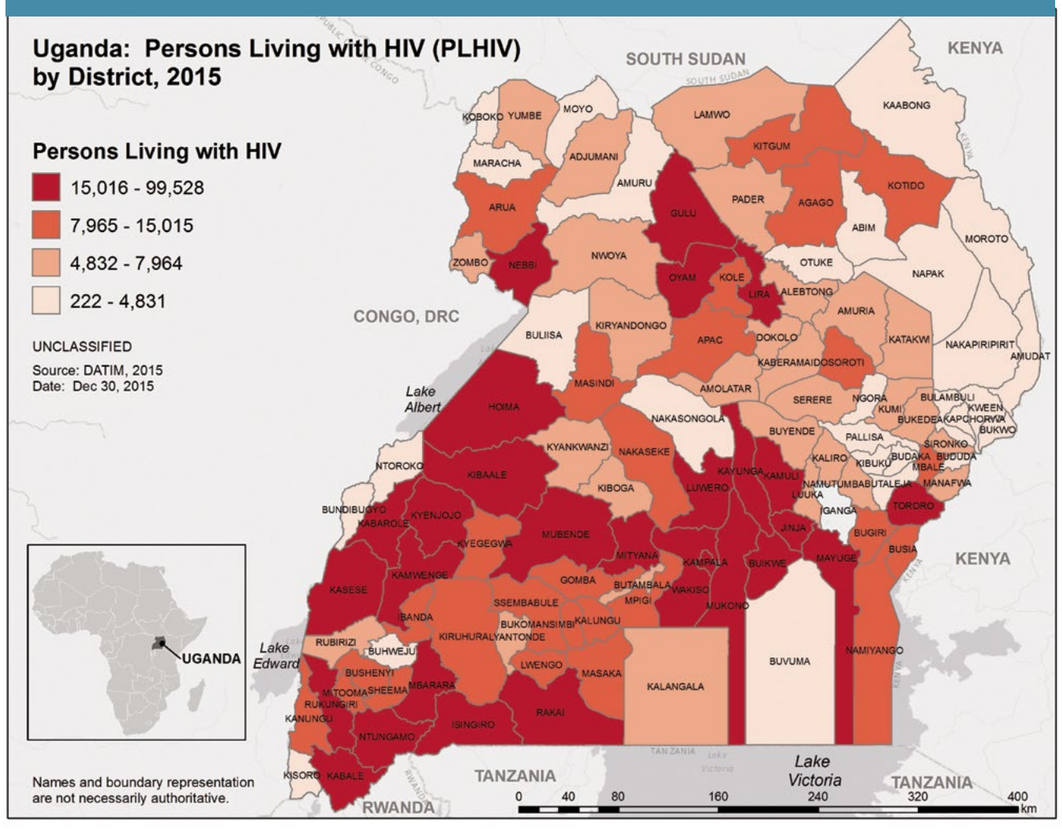
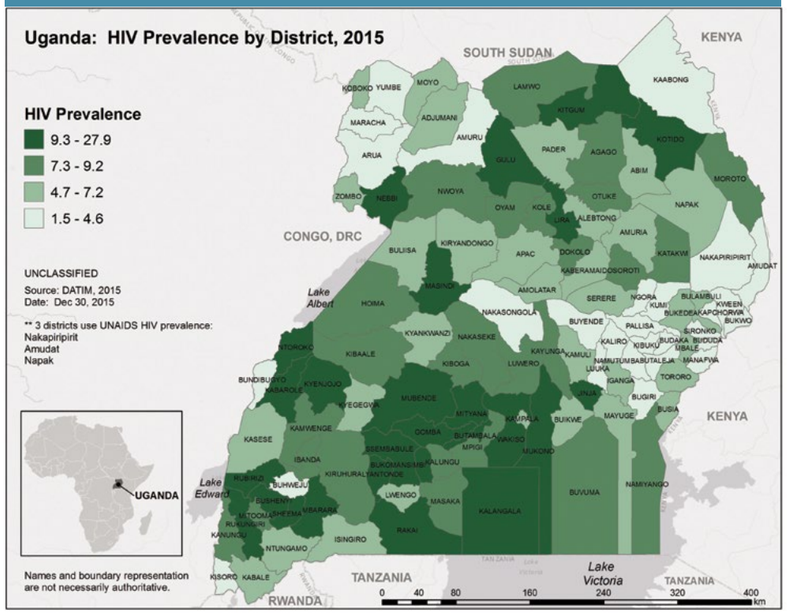


Figure 7. Distribution of HIV Prevalence by District, Demonstrating Areas of More Intense HIV Transmission, Uganda



districts where 82 percent of the people living with HIV reside were designated as priorities for scaling up core interventions in COP 2015.

Using Program Data to Drive Program Efficiency

The next step in this process was to conduct efficiency analysis of HIV diagnosis at HIV testing and PMTCT sites. The analysis prepared for COP 2015 found that 45 percent of the HIV testing sites (1,029 sites) diagnosed 90 percent of the people identified as living with HIV (Figure 11) in Uganda. Through this analysis PEPFAR learned that 135 of these sites had zero HIV-positive patients identified. The trend was similar for diagnosing pregnant women, with 36.5 percent of the PMTCT sites (2,138) diagnosing 80 percent of the women. These analyses informed the relocation of resources to sites that were effectively diagnosing, linking, and treating more individuals.

Using epidemiologic data and site-level performance, resources were expanded to scale up


CDC

CDC Officer interviews a nurse at a health center in Namibia.

efforts in high disease burden areas, with the goal of reaching 80 percent of people living with HIV with lifesaving treatment, including support for adherence and retention, by FY 2017.

Figure 12 provides an overview of the distribution of ART service sites after this transition. This realignment consolidates resources in these high-burden areas to expand testing,

Figure 8. Distribution of ART Clients Age 15+ by District, Ensuring Services Are Aligned with Need to Increase

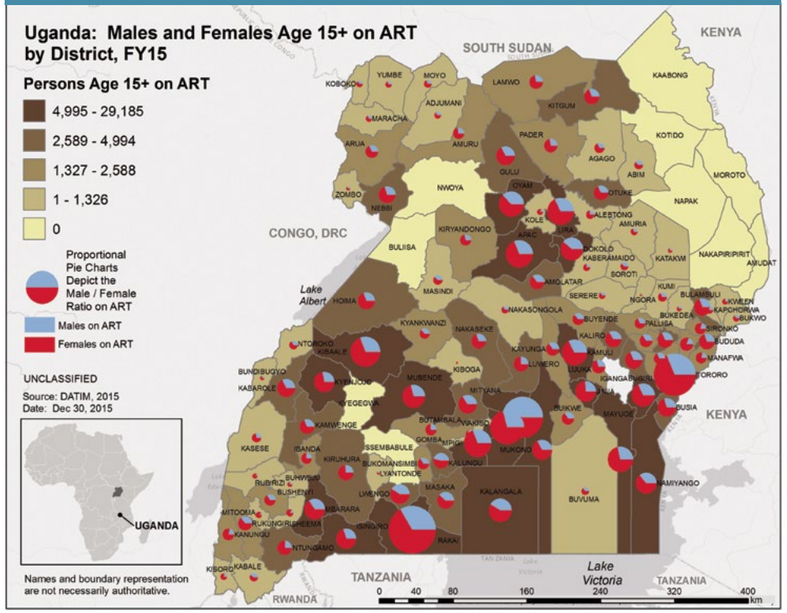


Figure 9. Distribution of Pregnant Women on ARVs by District, Ensuring All HIV-Positive Women Have Access to Services, Uganda

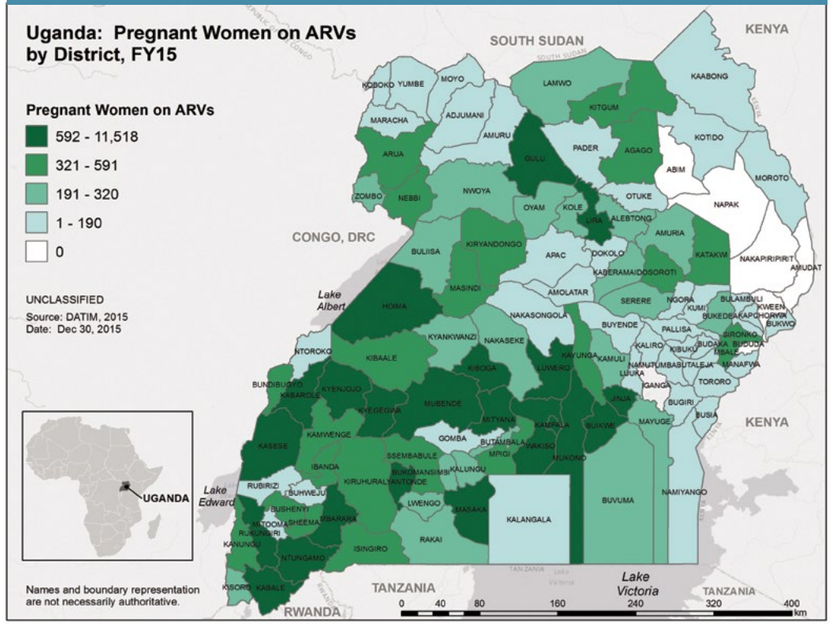


Figure 10. Distribution of OVC and VMMC Services by District: Improving Core Prevention Interventions with Areas of Transmission to Maximize Impact and Value Per Dollar Invested, Uganda

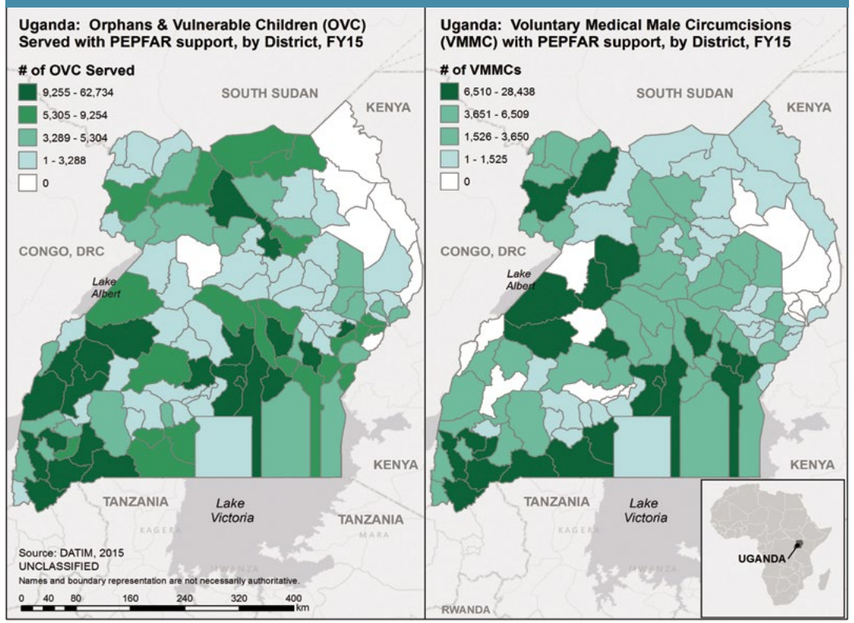


Figure 11. Efficiency Analysis: HIV Testing Yield by Site

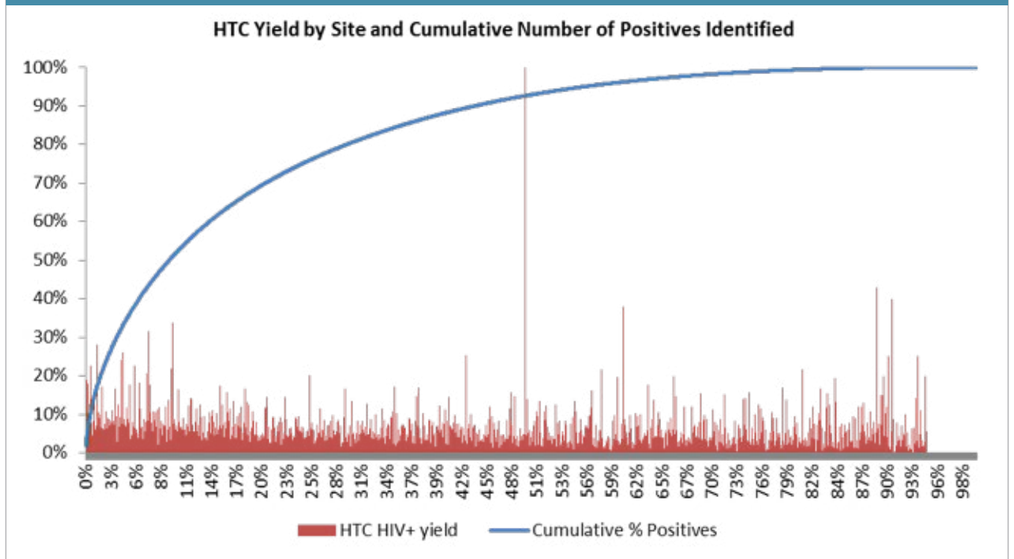
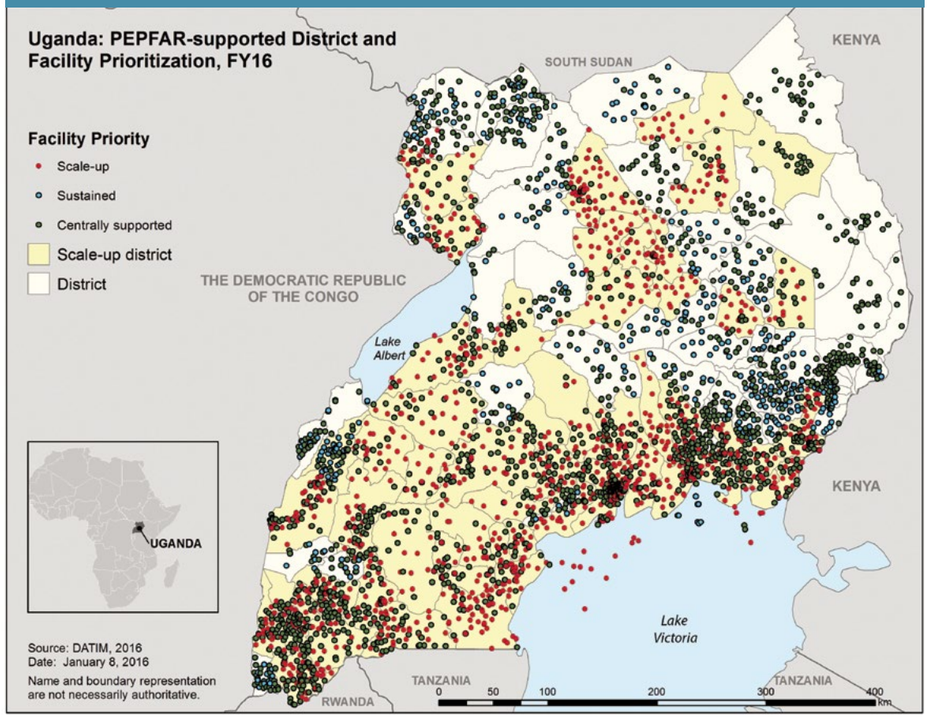


Figure 12. Distribution of PEPFAR-Supported Sites According to Priority Category and District, Uganda



PMTCT, and ARV provision rapidly and increase the overall impact of these investments in terms of both treatment and prevention, driving down mortality rates and new infections—the two critical measures of epidemic control.

In the last decade, there has been tremendous progress in addressing some of the most pressing global health challenges. The U.S. government, including PEPFAR, has been a major force behind this progress, both in terms of funding and the use of data-driven innovation. This last decade has provided an unprecedented opportunity to learn from experience and leverage these lessons to improve implementation and increase impact.

One of the most valuable lessons from the last decade of the global HIV/AIDS response is the recognition that national-level data are no longer sufficient. To better tailor our response to the complexity of the epidemic and maximize our impact, we need more detailed, higher-quality data, as well as more sophisticated analytics. Achieving epidemic control demands new approaches and new thinking, all based on more complete and better information.

Summary

The programmatic transformation in Uganda illustrates the profound impact of applying a data-driven approach to preventing more new HIV infections and saving more lives. This is the methodology we are translating to every PEPFAR country, increasing our effectiveness site by site, district by district, and country

A young girl celebrates World AIDS Day after visiting a health care center in Cambodia.

by country. Effectively employing this new methodological approach demanded substantial effort in the assembly, organization, and analysis of data. The results of this work have critical implications for the local HIV/AIDS portfolios—as illustrated in the evolution of the ART service delivery strategy—and have increased the impact of the overall response. In coming years, this approach will continue to be refined by expanding sources of information and increasing analytics and visualization techniques.

In order to expand our technical skills across all agencies to the use of data for decision making, in FY 2015 the Office of the U.S. Global AIDS Coordinator and Health Diplomacy (OGAC) at the State Department established the Interagency Collaborative for Program Improvement (ICPI). ICPI brings together subject matter experts in HIV/AIDS technical areas, data, and analytics from PEPFAR's six interagency partners to serve as a catalyst for data-driven, objective, and transparent interagency decision making. Through the ICPI, there will be an increased emphasis on more validated decision making and more effective progress toward epidemic control. Through these efforts, PEPFAR endeavors to dramatically reduce new HIV infections and HIV/AIDS-related mortality and help put partner countries on an accelerated path to achieving epidemic control.

Early Measures of PEPFAR 3.0

The initial measure of progress in implementation of PEPFAR 3.0 is how effectively the program has realigned its programs and investments to those facilities and communities that bear a greater proportion of the HIV/AIDS burden. This realignment, in turn, will be reflected in more targeted transitions of activities from lower-yield to higher-yield sites, from what have been prioritized as "centrally supported" and "sustained" sites to "scale-up" sites. PEPFAR is monitoring these pivots with new quarterly reviews of all PEPFAR countries.

Long-Term Strategy Countries

Long-Term Strategy (LTS) countries are countries in need of external support for HIV/AIDS programs and are generally characterized by high HIV prevalence, significant unmet service needs, substantial gaps in capacity, and insufficient domestic financial resources. LTS countries are low or low-middle income countries.

Among LTS countries, one can observe greater alignment between disease burden and service delivery by reviewing FY 2015 results and FY 2016 targets (Figure 13). Across the 18 LTS countries, persons currently on ART are linked to 74 percent of scale-up sites in FY 2015, and this proportion increases to 82 percent in FY 2016. This signals an important improvement among treatment programs to provide ARVs to a greater proportion of people living with HIV for more effective epidemic control.

Similarly, a dramatic shift can be seen in the delivery of PMTCT testing services between FY 2015 results and FY 2016 targets. Results contributed from scale-up sites in FY 2015 represent 27 percent of the total; in FY 2016, this proportion will increase to 65 percent. This change is indicative of a shift in focus and resources to PMTCT sites where the number of HIV-positive pregnant women is higher and more services are needed. The final category of

Figure 13. Distribution of Indicator Results and Targets by Site Prioritization, Long-Term Strategy Countries (LTS)

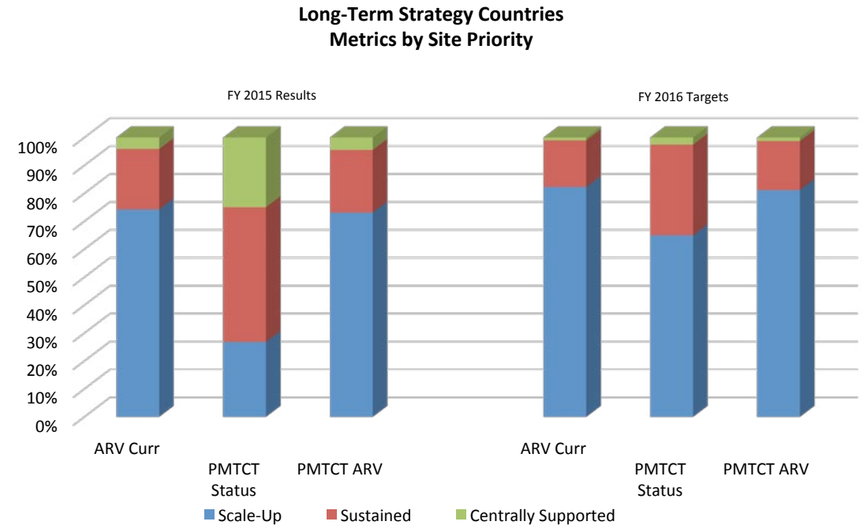
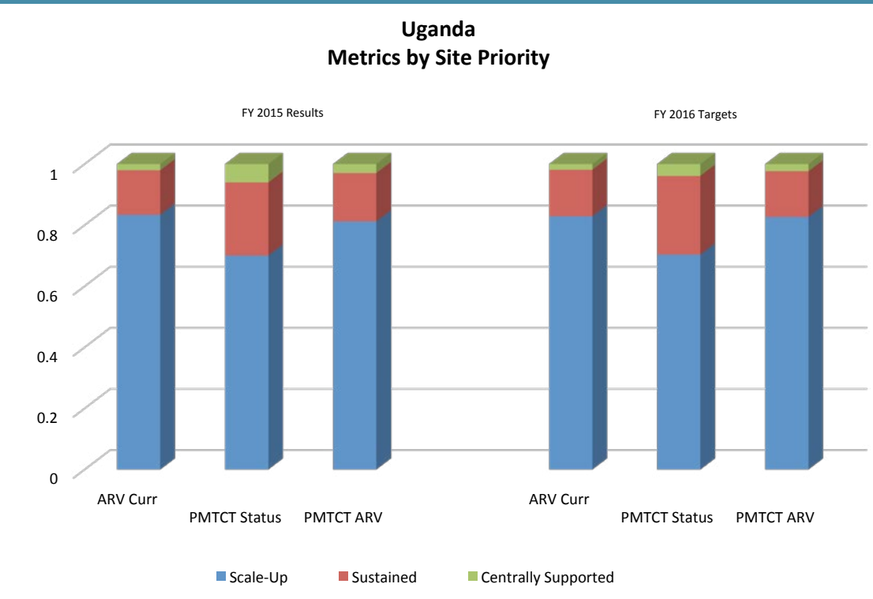


Figure 14. Distribution of Indicator Results and Targets by Site Prioritization, Uganda



Kerika Orlius/USAID

A community health worker sits with her patients after making a home health care visit in Haiti.

sites presented in Figure 13, PMTCT ARVs, shows that PEPFAR is ensuring that PMTCT testing sites that serve high volumes of HIV-positive women also provide ARVs to women, which greatly increases the linkages of HIV-positive pregnant women to services that can save their lives and ensure their babies are born HIV-negative. Consistent with the encompassing framework of PEPFAR 3.0, these improvements from FY 2015 to FY 2016 underlie the greater efficiencies to be achieved in PEPFAR programs, which will help reach an AIDS-free generation.

The Uganda realignment offers important lessons for how this approach can be broadly applied. As demonstrated by the proportional transitions of ARV and PMTCT service sites between FY 2015 results and FY 2016 targets (Figure 14), Uganda profiles between these two time points are nearly identical. As noted above, Uganda undertook a similar approach to target high-yield service delivery sites in preparation for COP FY 2012. The site priority categorization for FY 2015 results and FY 2016 targets illustrate that the initial FY 2012 approach yielded similar results to those achieved within the framework of PEPFAR 3.0. This is why we know this approach will be effective and why we have moved aggressively to align all PEPFAR countries. Uganda has modeled the PEPFAR 3.0 evolution, and while supporting the resurgence of epidemic control strategies in the country, realignment of programs across all LTS offers the greatest opportunity to reach the Sustainable Development Goal target of ending the AIDS epidemic by 2030.

APPENDIX B: How PEPFAR Documents Results

As discussed in Appendix A, one of the ways that PEPFAR ensures impact is by thorough monitoring of all data from the global HIV/AIDS response—tracking both national and PEPFAR results. A critical part of strengthening the PEPFAR 3.0 results reporting is using specific progress indicators and outcome measurements, as well as expanding to impact indicators.

PEPFAR support definitions were revised in FY 2014 to accommodate a greater cognizance of the scope of the program in accordance with the statutory requirements of the ***PEPFAR Stewardship and Oversight Act of 2013 (Public Law 113-56)*** and the related Senate Foreign Relations Committee's Report on those requirements ***(S. Rept. 113-112)***. In the context of increased country capacity to plan, deliver, manage, and directly fund HIV prevention, care, and treatment programs, PEPFAR program support has evolved. PEPFAR's revised approach to program monitoring, evaluation, and reporting is focused on specifically, accurately, and effectively capturing the range and evolution of PEPFAR efforts to support host country governments' HIV responses. In addition to clarifying PEPFAR support and capturing results, we are also measuring the quality of the program providing the results, the cost of generating those results, and the impact of the collective results on the HIV/AIDS epidemic country by country, province by province, district by district, and site by site. Through this methodology, PEPFAR will be able to define those programs and sites with the most effective programming to evaluate those effective sites and ensure all sites receive the same rapid feedback for continual improvement toward the most effective programs.

Table 2. Two Types of PEPFAR Support, Applied to Individual and Site-Based Indicators

Technical Assistance for Service Delivery Improvement (TA-SDI)[Otherwise Supported]
Individuals (individual-based indicators) and sites (site-based indicators) will be counted when PEPFAR support is used for
• Frequent, at least quarterly, support to improve quality of services
Direct Service Delivery (DSD)
Individuals (individual-based indicators) and sites (site-based indicators) will be counted when PEPFAR support is used for
• Provision of key staff or commodities • Frequent, at least quarterly, support to improve quality of services

The new approach will allow PEPFAR to differentiate the type of support provided to beneficiaries, recognizing the greater share of investment made by countries able to make significant financial contributions to their HIV/AIDS response, such as South Africa, Namibia, Botswana, and Vietnam. There are two primary types of PEPFAR support:

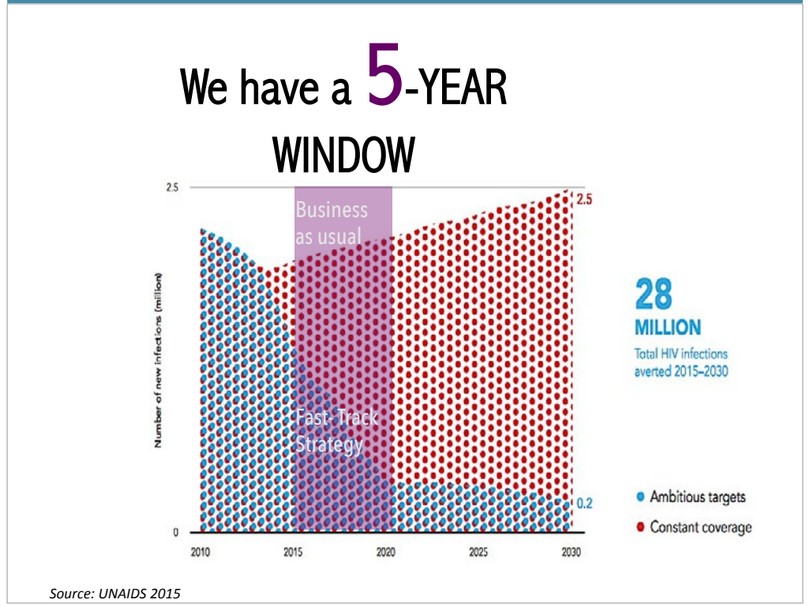
- Technical Assistance for Service Delivery Improvement (TA-SDI) support—referred to as "otherwise supported activities" in P.L. 113–56—is defined by the provision of essential technical support to the site, which takes place on at least a quarterly basis. This technical support may take the form of clinical mentorship, supportive supervision, site-level quality improvement, or quality assurance support, as well as routine support of monitoring, evaluation, and reporting activities. This type of assistance, described below in Table 2, was included in our FY 2014 results and is highlighted in Appendix W: Tables (available at www.pepfar.gov), and shows this transition from U.S. government direct support to technical assistance support. This evolution recognizes the leadership and financial investment by those countries.
- Direct Service Delivery (DSD) support requires direct financial investment from PEPFAR toward critical inputs to support those in need, including health care worker salaries and commodities at the site level. In addition to these inputs, quarterly visits at the point of service delivery are essential to ensure quality services are being provided (Table 2). In the aggregate, this approach will allow the U.S. government to describe our efforts as a contribution to national and global efforts alongside all partners.

Subsequent tables address these different types of support in terms of portfolio balance and program impact (Appendix W: Tables).

Overall, PEPFAR's revised approach to monitoring, evaluation, and reporting provides increased accountability of U.S. government investments, and more accurately and effectively captures the range of PEPFAR efforts to support countries' HIV responses. PEPFAR can now differentiate the type of support provided to beneficiaries, recognizing the greater share of investment made by financial collaboration countries. OGAC is working with each U.S. implementing agency to ensure validation of results at the site level. During FY 2016, PEPFAR will specifically validate reported data from sites by making site visits.

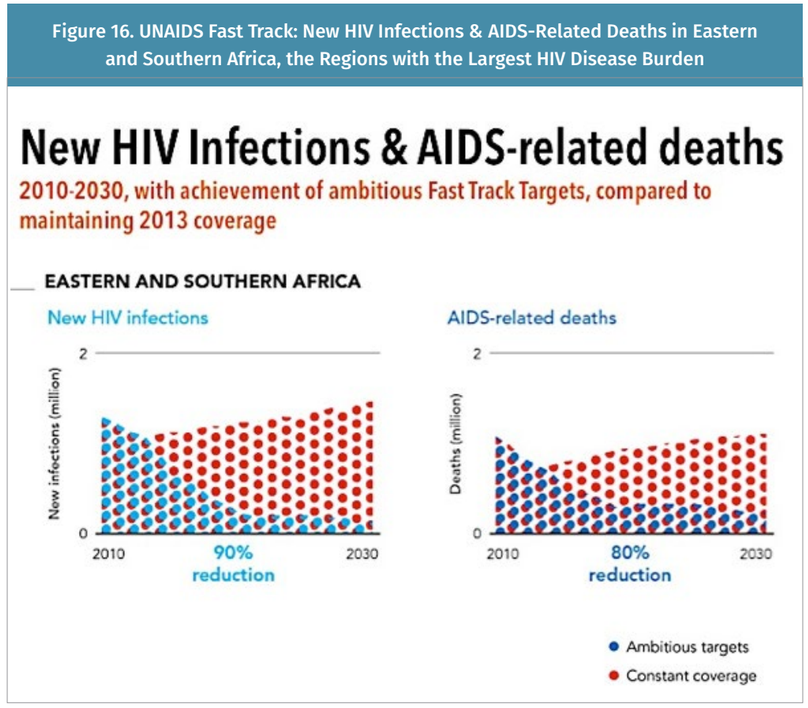
In addition, PEPFAR is equally committed to improving how we document results, and during FY 2015 we began a process to explore options to achieve this objective. The principles underlying this effort are to ensure our alignment with 90-90-90 goals and epidemic control, to simplify data collection and reduce data points required, to align gender and age disaggregates with global practices, to strengthen our alignment of indicators with our multilateral partners, and to increase reporting frequency to align with and support national and multilateral procedures. Results from these deliberations and formal changes to PEPFAR practices will be announced in early 2016.

Figure 15. UNAIDS Fast Track: New HIV Infections in LMIC Will Rise Due to the Expanding Population Between 15-24 If We Do Not Change How We Work



Source: UNAIDS 2015

Figure 16. UNAIDS Fast Track: New HIV Infections & AIDS-Related Deaths in Eastern and Southern Africa, the Regions with the Largest HIV Disease Burden



PEPFAR is specifically focused on the sustainable control of the epidemic. An ever-expanding epidemic—and the associated expanding need for services—is not financially sustainable, even with the collective effort of all partners. Ensuring a focus on impact, changing the course of the epidemic through specific and focused intervention where the epidemic is expanding rather than contracting will define the overall success of the PEPFAR investment. UNAIDS, in its December 2014 ***Fast-Track*** document, clearly projects the course of the epidemic over the next 15 years. There are two pathways: one distinguished by expanded burden of disease that outdistances our collective ability to afford the response and puts our multibillion dollar investment at risk, and one characterized by a new and focused effort that brings epidemic control while decreasing or stabilizing the need for long-term investment (Figure 15).[9] This pathway is illustrated by the data on new HIV infections and AIDS-related deaths in eastern and southern Africa (Figure 16).

APPENDIX C: Global Trends in New HIV Infections

PEPFAR will ensure that core HIV prevention and treatment interventions (Figure 17) are strategically scaled up to reduce the number of new HIV infections below the number of all-cause mortality among persons infected with HIV—an essential metric in demonstrating epidemic control (Figure 18). When the number of new infections is less than the mortality of all HIV-positive individuals, the total burden of disease and the financial cost of the epidemic will decline globally. The number of annual new infections across all PEPFAR-supported countries was 2,585,400 in 2003; 1,638,000 in 2013; and 1,372,600 in 2014. Accelerating this downward trend is key to achieving an AIDS-free generation (Appendix W: Table 1).[10] PEPFAR

9 UNAIDS. (2014). Fast-Track – Ending the AIDS epidemic by 2030. Geneva.

10 In the 2012 PEPFAR Blueprint: Creating an AIDS-free Generation, Secretary Clinton defined an AIDS-free generation as one where "virtually no children are born with the virus. As these children become teenagers and adults, they are at far lower risk of becoming infected than they would be today thanks to a wide range of prevention tools, and if they do acquire HIV, they have access to treatment that helps prevent them from developing AIDS and passing the virus on to others."

Two health extension workers prepare for site visits in Ethiopia.

is focused on continuing to reduce new infections by working to saturate high-burden areas at the subnational level (county, district, and subdistrict) with prevention and treatment services, including targeted HIV testing and counseling. By strategically refocusing, PEPFAR programs will be able to identify and treat as many HIV-infected persons as possible, reducing new infections by lowering the community viral load (the amount of HIV particles in a sample of blood) in high transmission areas. Ensuring saturation with prevention services in the same high transmission zones will result in the greatest impact on the epidemic. These efforts will focus on increasing coverage of combination prevention interventions among priority populations: serodiscordant couples, key populations, people co-infected with TB/HIV, children, and young women and girls.

Overall, there has been a significant decrease in rate (incidence) of new HIV infections over the last 15 years, and the percent change in new infections varies by country (Figures 19, 20, and 21). These declines have been driven in large part by effective PMTCT programming and decreasing the number of pediatric infections.

Unfortunately, progress in decreasing new infections in adults has been substantially less,

Figure 17. The Right Things: Core, Near-Core, and Non-Core Activities

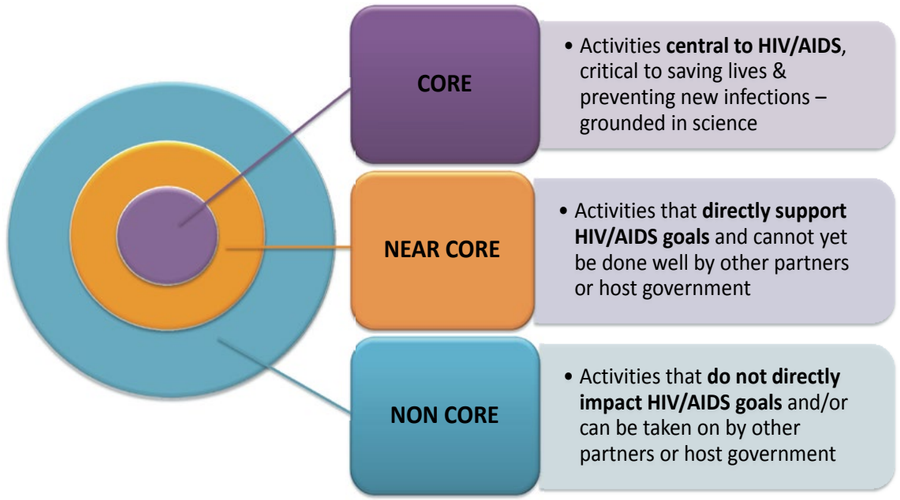
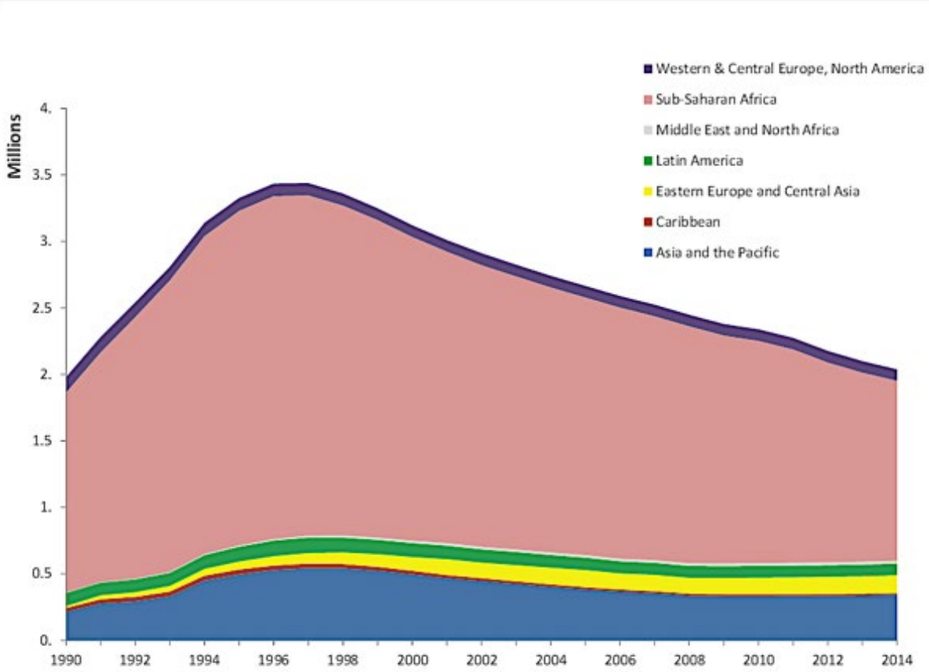
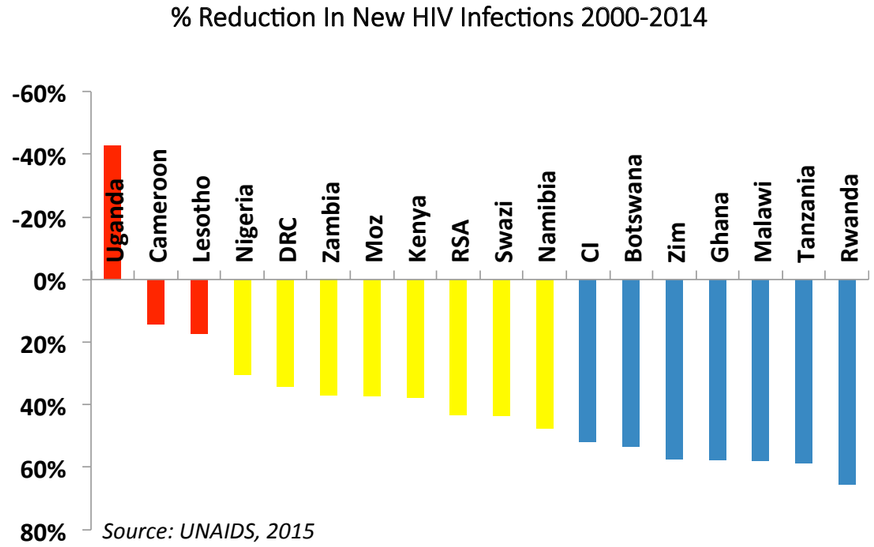


Figure 18. Global Trends in New HIV infections, 1990-2014



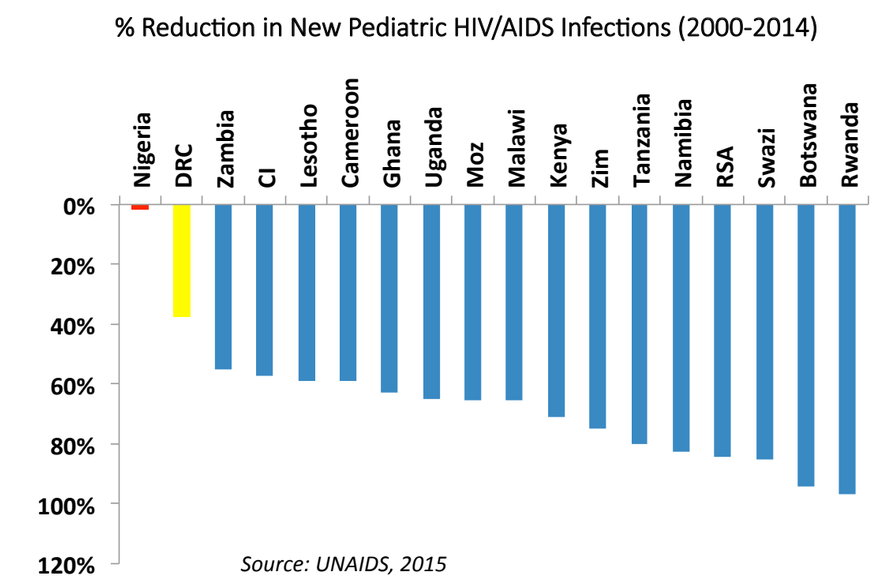
Source: UNAIDS 2015

Figure 19. Percent Change in New HIV Infections, Select Countries, 2004-2014



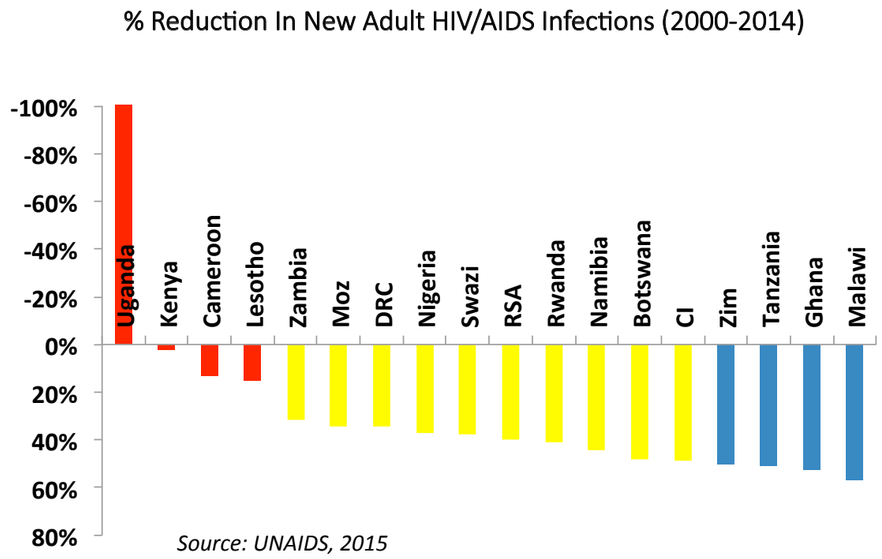
Source: UNAIDS, 2015

Figure 20. Percent Change in New Pediatric HIV Infections, Select Countries, 2000-2014, Substantial Progress in Preventing New Pediatric Infections



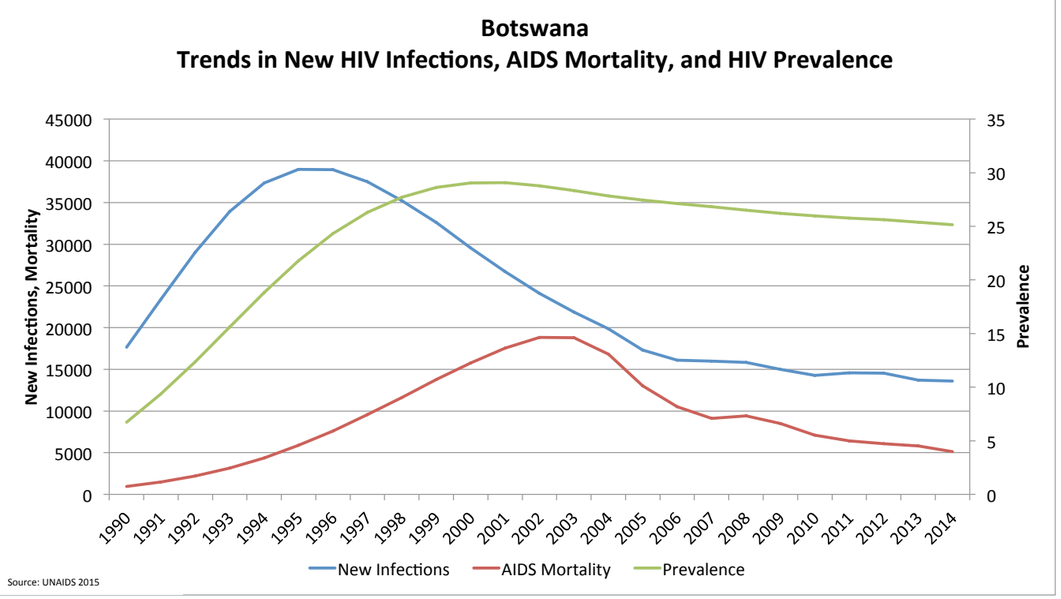
Source: UNAIDS, 2015

Figure 21. Percent Change in New Adult HIV Infections, Select Countries, 2000-2014, Less Progress in Adult New Infections Than Pediatric New Infections



Source: UNAIDS, 2015

Figure 22. Trends in New HIV Infections, AIDS Mortality, and HIV Prevalence, Botswana



and uneven. This is why PEPFAR has increased funding to focus on preventing infections in young women through DREAMS (COP 2015) and expanding VMMC (COP 2015) to prevent infections in young men. A critical missing element has been the testing and treating of HIV-positive men to improve their health and decrease transmission. This is a key focus of COP 2016.

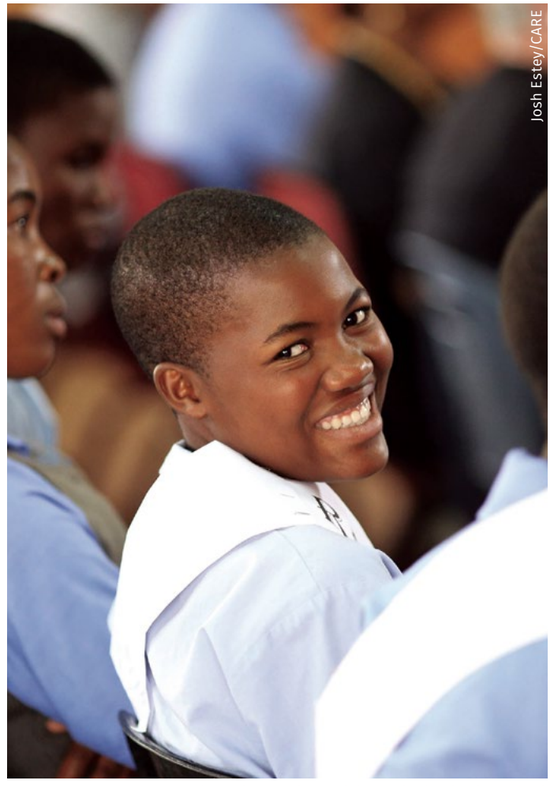
Globally, the shift is the greatest in sub-Saharan Africa, where the epidemic has been the most costly and deadly, but results vary due to the natural history of the epidemic and coverage of specific interventions. Effective interventions have not advanced at the same rate and in the same manner, and so changes in new infections and AIDS-related mortality differ (Appendix W: Table 1). In countries with effective scale-up of combination prevention services; for example, Botswana (Figure 22) and Tanzania (Figure 23), new infection and mortality rates drop markedly, while those countries with more moderate scale-up, such as Kenya (Figure 24), follow a similar but less dramatic pattern of reductions. Countries with slow or stalled scale-up, like Uganda (Figure 25), have more complex incidence and mortality trends associated with an earlier loss of momentum and a subsequent resurgent response to control the epidemic in recent years.

The focus on decreasing the absolute number of new infections—not just incidence—is essential for both epidemic control and fiscal sustainability because it drives the burden of disease and cost for caring for HIV-infected individuals. While the incidence rate has declined in most PEPFAR countries, the populations most at risk for HIV infection, especially young women, have substantially expanded in the last 20 years due to overall population growth, particularly in sub-Saharan Africa due to high fertility rates and improving child survival (Figure 26). With the significant increases in the total population of sub-Saharan Africa and specifically the increase in young people, we have reached a critical juncture.

Each year, the population at risk for HIV infection is increasing, and each year our programs must be that much more effective in order to maintain the status quo.

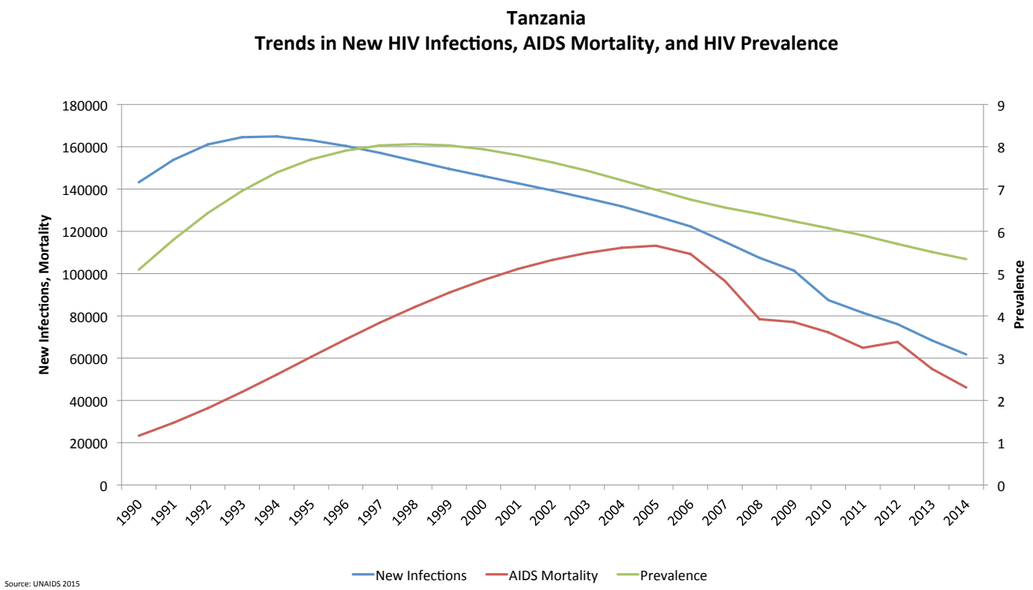
If we do not increase program effectiveness either through more effective interventions or enhanced geographic focusing, the actual burden of HIV in sub-Saharan Africa increases by 25–26 million more new infections by 2030,[11] nearly doubling the current cost globally to provide needed services. The escalating cost of treatment to save lives cannot be sustained by any combination of financing from a host country, the Global Fund, or PEPFAR. We are at a moment in time when we have the tools to change the course of the epidemic, but we must laser focus every dollar in a new way or face an epidemic that could spiral out of control.

11 UNAIDS. (2014). Fast-Track – Ending the AIDS epidemic by 2030. Geneva.



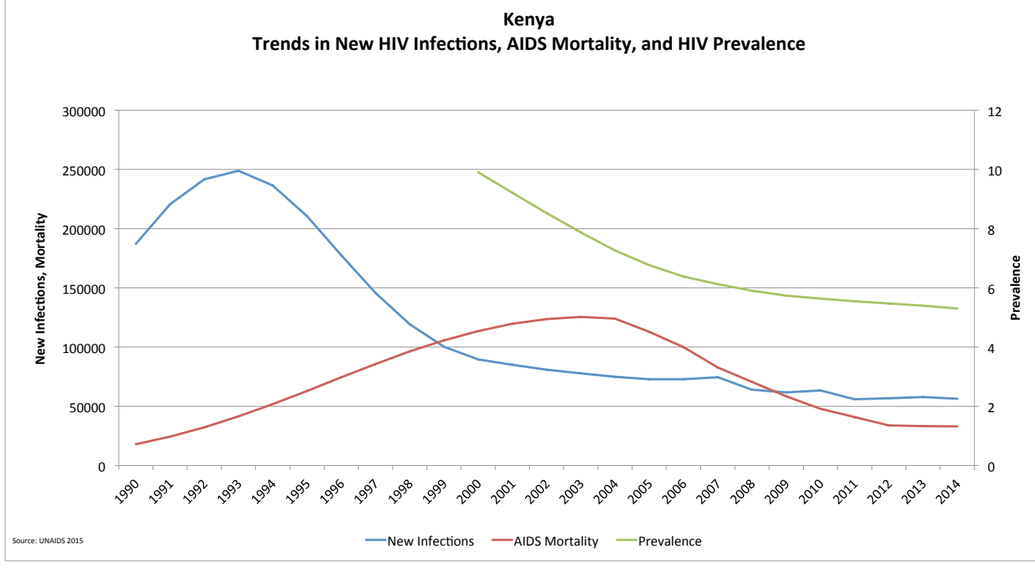
A young girl smiles during a visit by dignitaries in Malawi.

Figure 23. Trends in New HIV Infections, AIDS Mortality, and HIV Prevalence, Tanzania



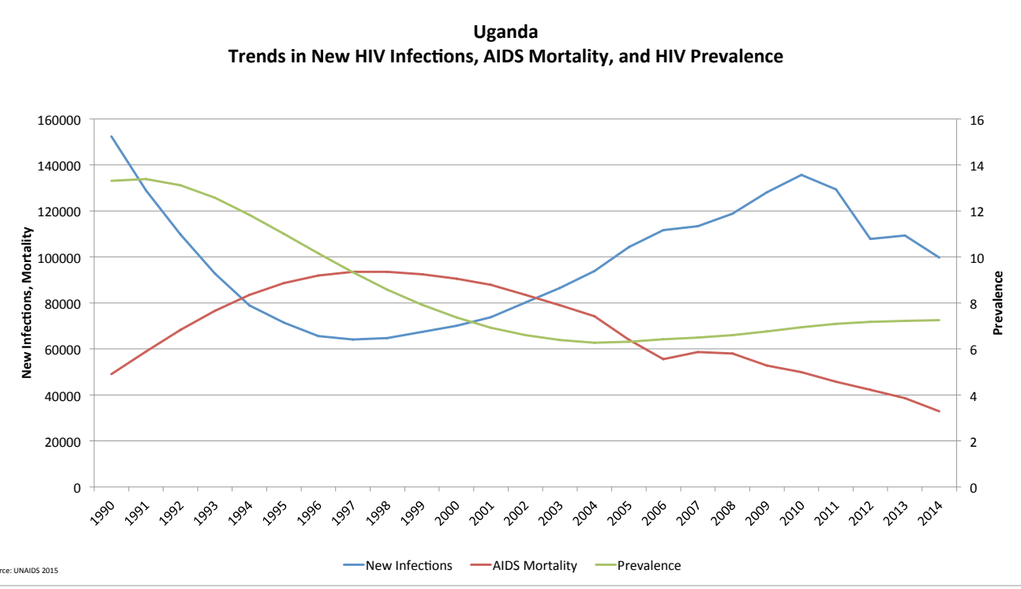
Source: UNAIDS 2015

Figure 24. Trends in New HIV Infections, AIDS Mortality, and HIV Prevalence, Kenya



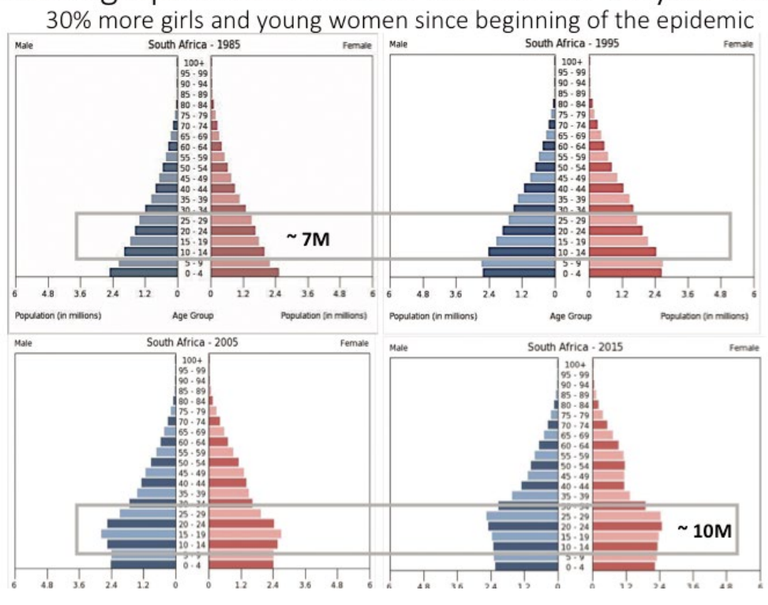
Source: UNAIDS 2015

Figure 25. Trends in New HIV Infections, AIDS Mortality, and HIV Prevalence, Uganda



Source: UNAIDS 2015

Figure 26. Demographic Shift in Sub-Saharan Africa

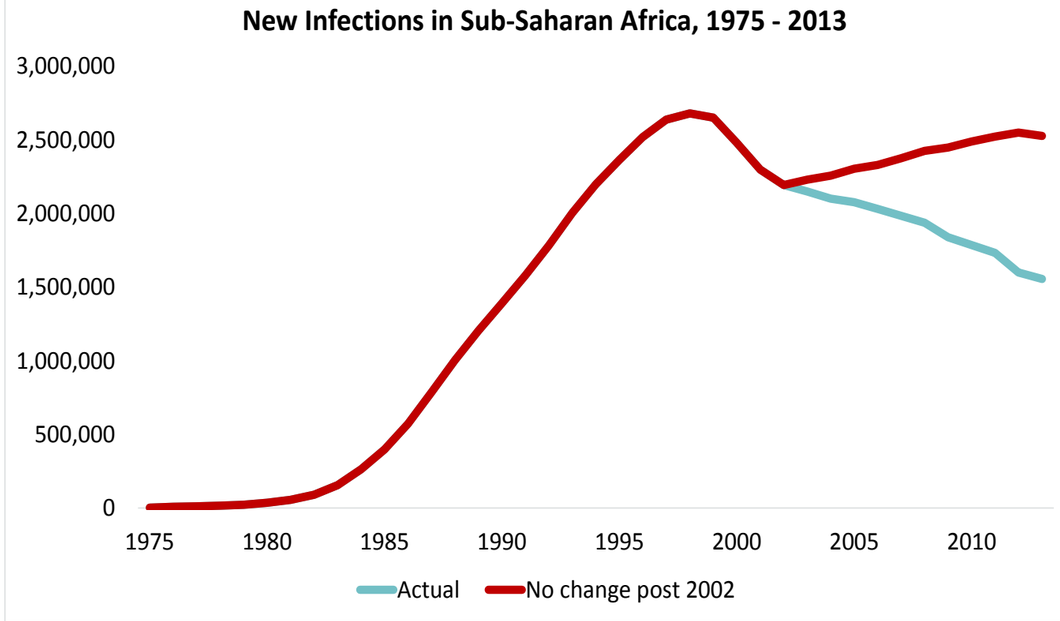


APPENDIX D: Infections Averted

Currently, the documentation of infections averted is primarily dependent on mathematical modeling, but it is increasingly also measured directly and estimated more precisely through impact assessments. PEPFAR is modeling partner country results with the most recent national data available from UNAIDS using the Goals model, which UNAIDS developed for costing and resource allocation during the development of national HIV/AIDS strategic plans and investment framework.[12] Preliminary work has been conducted for a global illustration with 2013 results (Figure 27). Figure 27 illustrates where the epidemic was headed without intervention, depicting the trend line of new HIV infections without more than a decade of investments in treatment and prevention from PEPFAR, the Global Fund, and the countries themselves. There is a second trend line, estimating the impact of the interventions implemented since 2002. The cumulative result of these differences indicates infections averted, totaling approximately three million. Validation of this model is proceeding in two ways: First, three combination prevention studies in five countries (Botswana, Kenya, South Africa, Uganda, and Zambia) will measure HIV incidence directly; second, large surveys called Population HIV Impact Assessments (PHIA) will estimate HIV incidence, prevalence, and viral load suppression among adults and children. We have launched PHIAs in three countries in 2015, and several more countries will be initiated in 2016, with incidence data to be available by World AIDS Day 2016.

12 UNAIDS. (2014). Fast-Track – Ending the AIDS epidemic by 2030. Geneva.

Figure 27. Modeling New Infection Trends, Continuing Intervention Scale-Up vs. Stable Programming from 2002



APPENDIX E: Global Prevalence—Refining PEPFAR's Impact and Progress Toward Epidemic Control

According to the ***UNAIDS World AIDS Day 2015 Fact Sheet***, sub-Saharan African countries account for 70 percent of the yearly two million new HIV infections that occurred in 2014.[13] The report notes that focusing on populations that are underserved and at higher risk of HIV is essential to ending the AIDS epidemic. This principle underpins the PEPFAR 3.0 strategy: doing the right things, in the right places, at the right time to achieve maximum impact.

On a country-by-country basis, there are four general patterns of prevalence (Appendix W: Table 21):

- The first category includes prevalence curves that exhibit a generally flat profile (e.g., Kenya [Figure 24], Lesotho, Mozambique, Namibia, South Africa, and Swaziland) based on a rate of new infections that is consistently greater than mortality. This link suggests that the new infections "replace" those persons lost due to AIDS-related mortality, resulting in a flat trajectory. The total burden of disease remains constant, and thus costs are either constant or increasing as coverage of services improves and countries adopt new eligibility criteria that all persons living with HIV now benefit from HIV treatment (the "Treatment for All" recommendation from the WHO, also referred to by PEPFAR as "Test and START").
- The second category includes those countries in which new infection rates are slightly lower than or nearly equal to mortality rates (e.g., Tanzania [Figure 23], Ethiopia, Ghana, Haiti, Malawi, and

13 UNAIDS. (2015). World AIDS Day 2015 Fact Sheet. Geneva, 13.

Men at an advocacy training organized in Kenya

Zimbabwe). Prevalence rates exhibit a downward trend, and there is a sustained decline in new infections. In these countries, the disease burden is decreasing, and cost increases are primarily driven by expanding service delivery coverage of combination prevention in high transmission areas to ensure the rates of new infections remain in check. Overall, out-year costs will begin to decline as the cohort ages. In high transmission areas, it is important to ensure that patients adhere to and are retained on treatment to maintain viral load suppression and epidemic control.

- The third category includes countries with curves trending slightly downward but not as sharply as those in the previous class. This category includes a mix of countries that have new infection rates that are slightly greater than mortality rates (e.g., Botswana [Figure 22], Nigeria, and Rwanda). Some countries, like Botswana and Rwanda, have excellent service coverage and marked decreases in deaths due to AIDS, but epidemic control has not been achieved due to the rate of new infections. In Nigeria, where core service coverage is poor, high AIDS mortality persists, new infections continue despite significant investment from PEPFAR and the Global Fund, and costs will continue to escalate so long as service coverage remains inadequate. PEPFAR and Nigeria have been in long-term discussions on increasing focus to demonstrate impact.
- The final category comprises countries with a prevalence rate trending upward and with a new infection rate that is significantly greater than the mortality; currently, only Uganda (Figure 25) falls into this category. Uganda demonstrates how easily progress can be reversed and previous gains lost. Bringing this expanded epidemic under control will be costly and is a warning for all countries of what can occur if continual analysis and focus is not maintained. Since FY 2012 and the programmatic realignment (see Appendix A), the tide has begun to turn in Uganda.

Table 3. Implementation Timeline of HIV Impact Assessments

Country	HIA Implementation Year (planned)	Status
Malawi	2015	Data collection began November 2015
Zimbabwe	2015	Data collection began October 2015
Mozambique	2015	Data collection completed
Lesotho	2016	Protocol drafted
Namibia	2016	Protocol drafted
Uganda	2016	Protocol under ethics review
Zambia	2016	Field pilot in December 2015
Nigeria	2016	Protocol under ethics review (Kaduna state)
Swaziland	2016	Protocol under ethics review
Cameroon	2016	Protocol in development
Tanzania	2016	Protocol under ethics review
Côte d'Ivoire	2017	Protocol in development
Ethiopia	2017	Protocol in development
Kenya	2017	In planning
Haiti	2017	In planning
DRC	TBD	Protocol under ethics review

Additional core measures of success in the global HIV/AIDS response are incidence and mortality rates. These two data points provide the most direct evidence of how well an epidemic is transitioning in a country and how well the combination prevention services are controlling this movement. Prevalence rates are more complex in structure, and consequently so are their interpretations. In PEPFAR 3.0, we show outcomes through PHIAs, which collect HIV prevalence, incidence, historic mortality, and service coverage data down to the household level (Table 3).

APPENDIX F: Rates of Adherence and Retention

PEPFAR evaluates rates of adherence and retention across all supported countries by examining the total number of people on treatment from one year to the next to determine how many have stopped their treatment regimen, have been lost to follow-up, or have potentially died. Generally, this involves monitoring a cohort of individuals who have been on ART for 12, 24, and 36 months or longer. At the end of FY 2015, PEPFAR had a 77 percent retention rate at 12 months on ART (Appendix W: Table 6).

Reviewing country-specific retention rates has helped PEPFAR treatment programs focus on gaps and ensure that individuals who start their treatment remain on treatment. Lesotho had a treatment retention rate of 71.7 percent in 2013, but after deploying strategic interventions, like ensuring a consistent stock of drugs and supplies, appropriate clinical staff support training on retention issues, improvements in loss-to-follow-up, and contact tracing, the program's retention rate increased to 83.6 percent in 2014. Treatment adherence and retention are critical to achieving an AIDS-free generation and ensuring that transmission, incidence, and costs decline. ICPI is monitoring this carefully to ensure that retention rates are closely tracked at six-month intervals. Countries that drop below 80 percent retention are evaluated, and immediate steps are taken to improve programmatic treatment retention.

PEPFAR also looks at the rate of viral suppression by scaling viral load testing over the next few years. Routine viral load monitoring is now recommended by WHO and forms the cornerstone of the third "90" of the UNAIDS 90-90-90 goals. People living with HIV who are known to have an undetectable viral load can safely space out clinic visits and pharmacy drug refills, thus reducing the burden on them and decongesting health services. Effective prevention programs, alongside treatment and viral suppression in 90 percent of HIV-infected individuals in geographically prioritized areas, will prevent the majority of transmissions and lead to eventual epidemic control. PEPFAR has provided six countries with catalytic funds for viral load scale-up in 2015 and will look to expand to all PEPFAR-supported countries in 2016 with site-level availability of viral load testing, national planning, and use of results to provide differentiated patient care.

A mother and daughter walk home arm in arm in Malawi.

APPENDIX G: How New WHO Guidelines Impact the HIV/AIDS Epidemic, and Policy Change as Part of Shared Responsibility

The World Health Organization (WHO) is the leading institution responsible for establishing normative guidance related to HIV/AIDS programs. On September 30, 2015, WHO released new guidance that recommends ART for all persons living with HIV irrespective of clinical or immunologic status.[14] Widespread adoption of these guidelines will increase the number of persons eligible for treatment, and will also provide an individual as well as population-level benefit, as persons who start ART early remain healthier and greatly reduce their risk of transmitting the virus to others (Figure 28).

Also on September 30, 2015 WHO released new guidance related to PrEP that now recommends that oral PrEP containing tenofovir should be offered as an additional prevention choice for people at substantial risk.[15] This recommendation enables a wider range of populations to benefit from this additional prevention option. It also allows the offer of PrEP to be based on individual assessment, rather than risk group, and it is intended to foster implementation that is informed by local epidemiological evidence regarding risk factors for acquiring HIV.

On December 1, 2015, WHO released the executive summary of revised guidelines for the use of ARVs, with full guidance expected shortly.[16] These guidelines offer important recommendations for reconceptualizing service delivery models to offer more streamlined services to patients who are clinically well (stable on ART or

World Health Organization logo

newly initiating with few symptoms) and more intensive services to those who need it (patients with clinical disease or who are failing therapy). These guidelines also promote more patient-friendly services and the community-based models. For stable patients (who may account for as much as 80 percent of all persons on ART), spacing out clinic visits and drug refills offers an important opportunity to treat more patients with existing resources (Figure 29). As the costs of ARVs have declined over the last decade, the costs of provided ART are now driven by service delivery costs and not drug costs.

WHO guidance released in 2014–2015 on key populations, consolidated approaches to strategic information, and HIV testing services also offer important new recommendations, including the use of lay providers for HIV testing and the possibility of HIV self-testing. Key populations guidance for men who have sex with men (MSM), transgender persons, people who inject drugs (PWID), sex workers, and prisoners provides important recommendations on reaching these vulnerable populations with evidence-based interventions using appropriate, peer-led service delivery models.[17, 18] The Consolidated Strategic Information guidelines for HIV provides a global framework with 10 global indicators for monitoring the HIV response using a "results chain" approach, and brings together all existing strategic information recommendations into a single, harmonized document.[19]

14 WHO. (2015). *Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV.* Available at: http://apps.who.int/iris/bitstream/10665/186275/1/9789241509565_eng.pdf

15 WHO. (2015). *Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV.* Available at: http://apps.who.int/iris/bitstream/10665/186275/1/9789241509565_eng.pdf

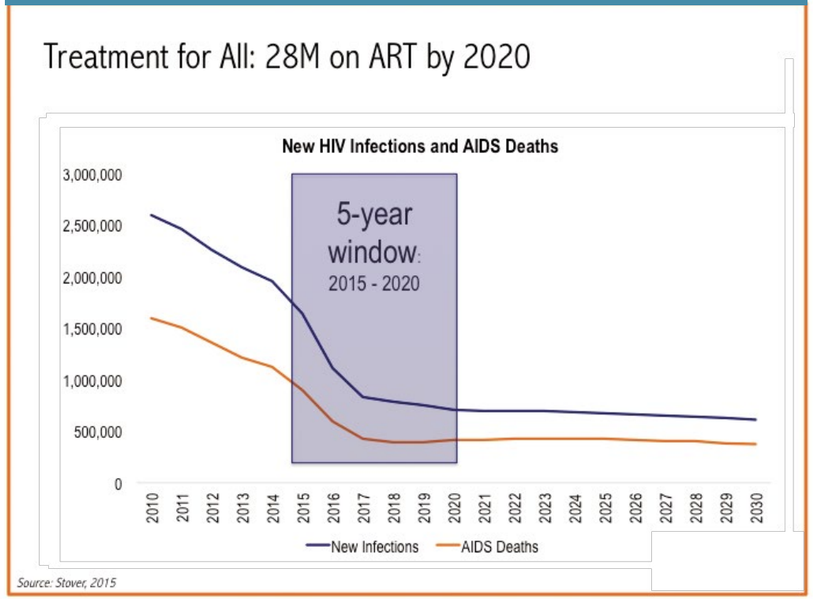
16 WHO. (2015). *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: what's new.* Available at: http://www.who.int/hiv/pub/arv/policy-brief-arv-2015/en/

17 WHO. (2014). *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations.* Available at: http://www.who.int/hiv/pub/guidelines/keypopulations/en/

18 WHO. (2015). *Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations; Supplement to the 2014 Consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations.* Available at: http://www.who.int/hiv/pub/toolkits/kpp-monitoring-tools/en/

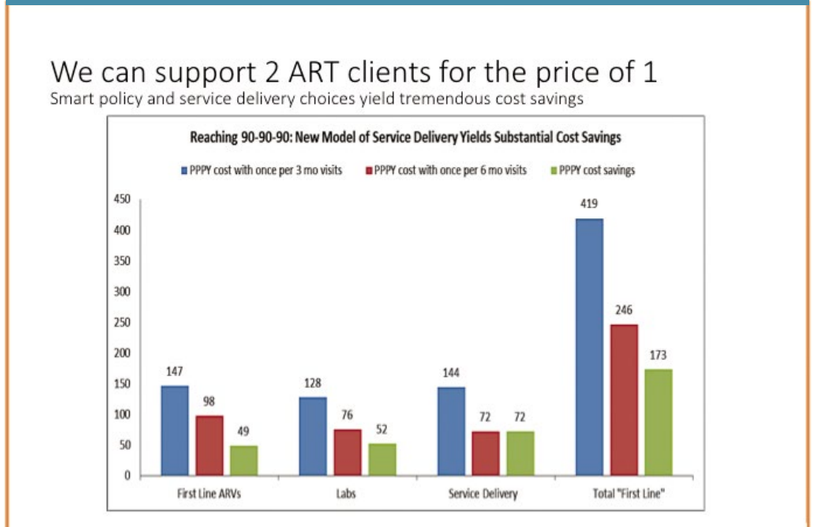
19 WHO. (2015). *Consolidated strategic information guidelines for HIV in the health sector.* Available at: http://www.who.int/hiv/pub/guidelines/strategic-information-guidelines/en/

Figure 28. New HIV Infections and AIDS Deaths with 5-Year Window for Treatment for All (28M on ART by 2020)



Source: Stover, 2015

Figure 29. Cost of Serving One ART Client with 1-3 Month Follow-Up vs. Two Clients with 6-12 Month Follow-Up



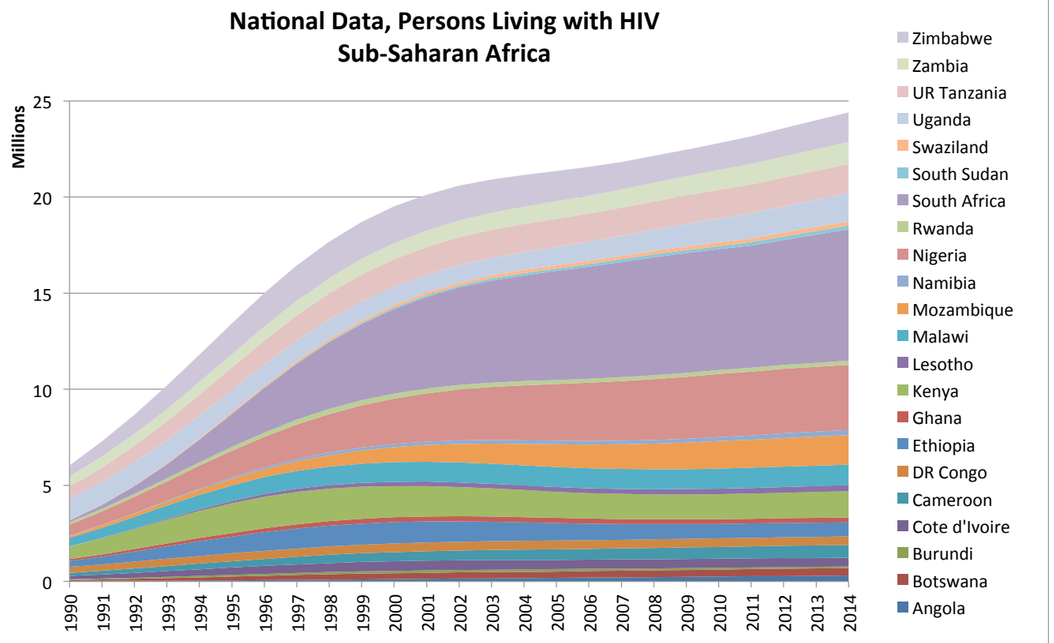
APPENDIX H: HIV Burden and Treatment Response

There are an increasing number of people living with HIV/AIDS, which is consistent with the growth of the epidemic and the availability of lifesaving treatment. At the end of 2014, 36.9 million people were living with HIV globally, including nearly 25 million in sub-Saharan Africa (Figure 30; Appendix W: Table 20). As treatment programs are implemented across partner countries, people living with HIV are living longer and more productive lives. The PEPFAR-supported treatment cohorts are also aging, with 10–15 percent of patients on treatment over 50 years old. Today, with effective treatment, far fewer people living with HIV will die due to AIDS-related causes.

The number of persons on treatment and lives saved dramatically increased with the creation

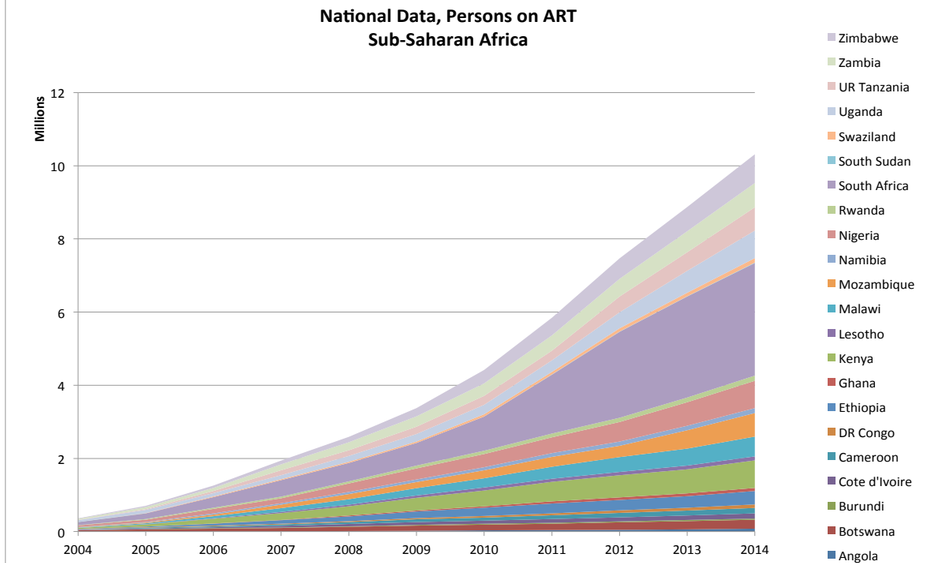
Young women at South Africa DREAMS launch

Figure 30. Cumulative Trends of Persons Living with HIV, Sub-Saharan Africa, 1990-2014



Source: UNAIDS 2015

Figure 31. Cumulative Trends of Persons Receiving ART, National Level Data Sub-Saharan Africa, 2004-2014



Source: UNAIDS 2015

Figure 32. Cumulative Trends of Persons Receiving ART, PEPFAR Specific Data Sub-Saharan Africa, 2004-2015

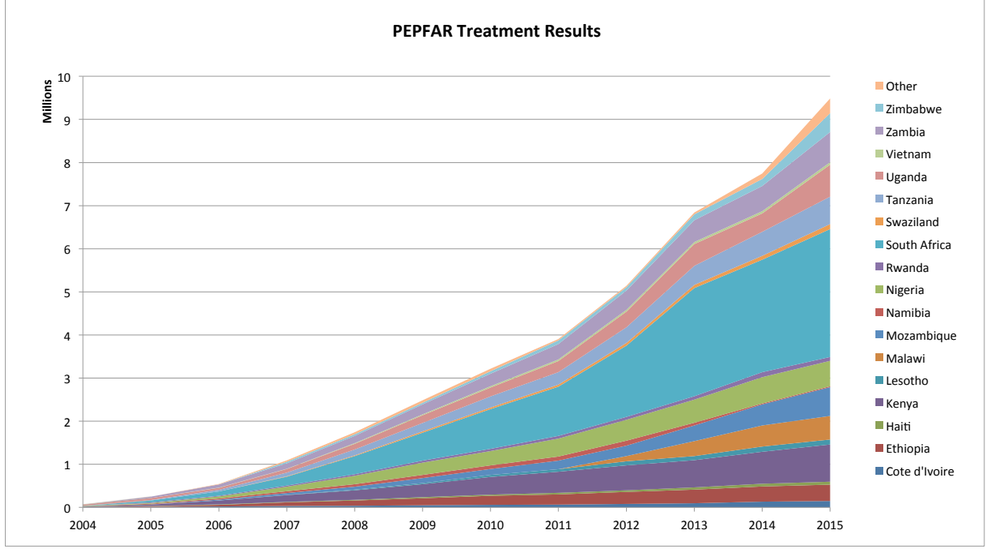
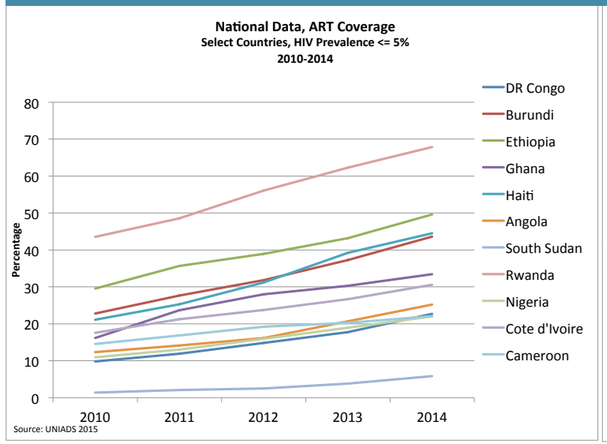


Figure 33. Trends in ART Coverage, Select Countries, 2010-2014



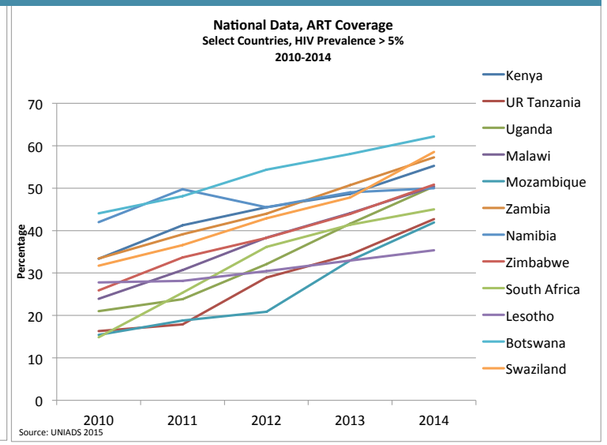
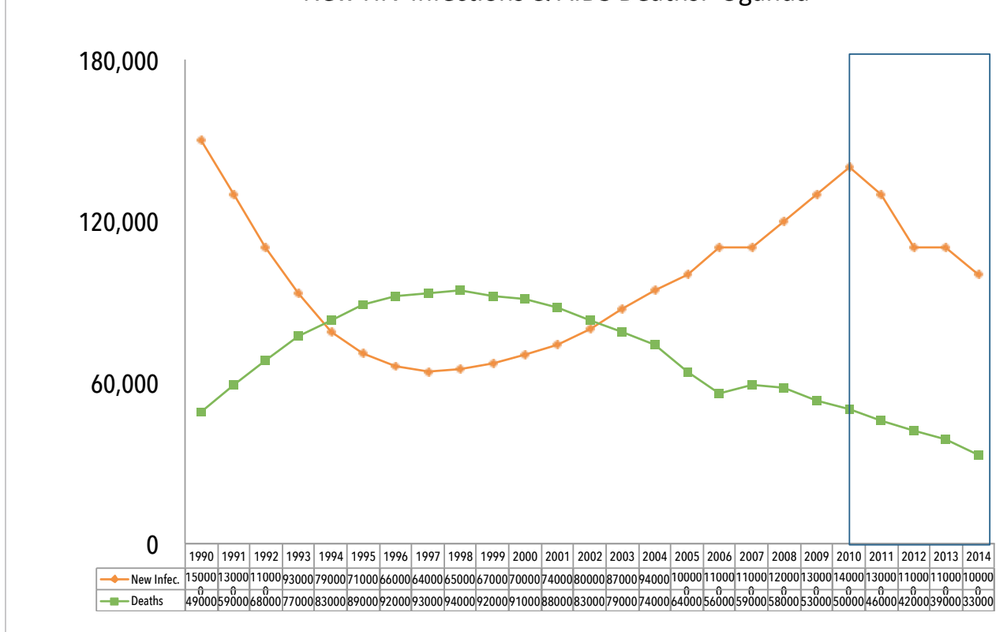


Figure 34. New Infections and AIDS Deaths, Uganda



Source: UNAIDS How AIDS changed everything – http://aidsinfo.unaids.org/

and expansion of the investments by PEPFAR and the Global Fund from 2004–2014 (Figure 31; Appendix W: Table 22). In the large majority of countries, expansion of treatment was slow but steady from 2004 to 2007 (PEPFAR Phase I), after which enrollments increased. From 2008 to 2010 (beginning of PEPFAR Phase II), enrollments rapidly increased and have continued along these same trajectories through the current reporting periods (Figure 32). The rapid implementation of evidenced-based interventions is fundamental to the dramatic shifts in new infections and mortality rates, and ongoing success toward the creation of an AIDS-free generation is completely dependent on continuing this momentum.

As shown in the Figure 32, there was a flattening of the treatment expansion slopes in the 2013–2014 timeframe. The slope recovered in 2014–2015 with the realignment of resources in adherence with the 50 percent care and treatment directive included in P.L. 113-56. PEPFAR is closely tracking both the slope of scale-up of services as well as the geographic coverage to ensure that community viral load levels are suppressed to undetectable. It is clear that both speed-to-coverage and percent coverage is important in controlling the HIV epidemic. This saves lives as well as decreases transmission.

ART coverage rates combine the figures for persons on treatment and those who need ART (as modeled by countries and UNAIDS as all persons with HIV infection). These rates provide a telling story of progress in each country (Appendix W: Table 17). As demonstrated by Figure 33, all partner countries are on an upward trend in their responses. Some indications suggest that countries with HIV prevalence greater than 5 percent are improving at a slightly accelerated rate. Considerable variation exists on a country-by-country basis. Some countries are making tremendous progress while others are progressing very slowly. This provides further evidence supporting PEPFAR's strategy to utilize its resources to support services in settings with the greatest need and potential for greatest impact. This pivot remains a priority to ensure that countries are capable of aggressively addressing their epidemics within the current envelope of global HIV/AIDS funding. Viral loads must be suppressed to create an AIDS-free generation and allow communities and countries to thrive.

One of the more important milestones toward controlling the epidemic is when new enrollments in treatment start to outnumber the estimated new infections in a given year once overall treatment coverage reaches 80 percent at the national level. This transition point reflects a care and treatment scale-up rate that is successfully limiting the transmission of HIV to uninfected persons. A lower number of new infections suggests that the future influx of patients requiring treatment will be more manageable, smaller, and cheaper, and that the epidemic will begin to contract. This shift in trends, while important in the ongoing effort to control the epidemic, does not imply that continuing efforts can lapse. Any faltering of national treatment efforts might easily allow the trend lines to return to an earlier, more negative pattern, and new HIV infections will increase once again. Any drop in adherence or retention will result in increasing viral loads and substantial surges in HIV transmission.

As illustrated in Uganda, PEPFAR refocused the program when new infections were rising, and there was dramatic increase in VMMC and PMTCT through rapid rollout of B+ programming (initiating lifelong ART for pregnant women) and treatment expansion. The realignment substantially changed results and impact on new infections (Figure 34).

APPENDIX I: Supportive Care

In February 2014, PEPFAR developed a strategy for the prioritization of care and support interventions. This strategy was based upon an extensive, in-depth review of evidence and best practices for people living with HIV. Four activities were identified as priority for the greatest impact on morbidity and mortality, considered core services in PEPFAR 3.0. These interventions are supported by a strong evidence base and

Hospital worker in Kenya provides support to a new mother.

are universally applicable in every country and for every person living with HIV (Appendix W: Table 2). They include:

- regular clinical and laboratory monitoring;
- screening for active TB with referral for treatment as appropriate;
- cotrimoxazole (CTX) prophylaxis for opportunistic infections (OI) per country guidelines; and
- evidence-based interventions (both clinical and nonclinical) to optimize retention and adherence, including support groups for people living with HIV in the community.

Based on the evolution of WHO guidelines for the care and treatment of people living with HIV where treatment for all is recommended, care and treatment will now be one entity to be consistent with the guidelines. The care focus will be on TB co-infection and preventing TB reactivation.

APPENDIX J: PEPFAR and Prevention Interventions—PMTCT, VMMC, DREAMS

- ***PMTCT: Preventing HIV Infection in Babies—Appendix K***
- ***VMMC: Ensuring Young Men Remain HIV-Free—Appendix L***
- ***DREAMS: Ensuring Young Women Remain HIV-Free—Appendix M***

Prevention, treatment, and care have been the three pillars of PEPFAR programming since 2003; this comprehensive approach was mandated by Congress in PEPFAR's authorizing legislation, P.L. 108–25, the "United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003," and it has been included in each subsequent reauthorization.

PEPFAR's implementation of evidence-based HIV prevention is fundamental to the control of the epidemic, and our methods of prevention have changed as the epidemic has evolved. PEPFAR supports prevention services including HTS, PMTCT, DREAMS, and VMMC. In FY 2015, PEPFAR supported HIV testing and counseling for more than 68.2 million people, providing a critical entry point to prevention, treatment, and care. (Appendix W: Table 3). Through HTS, PEPFAR helped millions to know their HIV status and to protect themselves, their partners, and their children from HIV infection. These testing targets were set and achieved in conjunction with partner countries and are key to achieving 90 percent of all people living with HIV knowing their status by 2020, in line with UNAIDS 90-90-90 global goals.

For optimal impact, prevention services are often grouped together in a comprehensive package. In FY 2015, PEPFAR reached more than 19.8 million members of priority populations with these packages and more than 1.5 million members of specific key populations (Appendix W: Tables 4 and 5).

PEPFAR has been enormously successful in PMTCT implementation, dramatically decreasing new pediatric infections and helping mothers with HIV thrive. These programs will continue to be a cornerstone of PEPFAR. Protecting babies and ensuring they remain HIV-free has resulted in significant improvements in the under five survival rates in progress toward the Millennium Development Goals. But these babies must remain HIV-free. Over the past 18 months, PEPFAR has prioritized preventing HIV infections in young men and young women through VMMC and DREAMS programming respectively.

Figures 20 and 21 demonstrate that there has been dramatic improvement in keeping babies HIV-free, but much less impact in adult new infections, thus the refocusing on preventing infections in young adults.

APPENDIX K: PMTCT

In June 2013, Secretary of State John Kerry announced that more than one million babies had been born HIV-free due to PEPFAR support, and by September 2015 this number reached 267,000 in one year alone. We remain fully committed to working toward the elimination of new HIV infections among children and keeping their mothers alive as outlined in the ***Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive***, announced at the United Nations in June 2011.[20] Since the inception of the ***Global Plan***, the number of new HIV infections in infants each year has dropped by nearly 50 percent in Global Plan countries.

PEPFAR has invested significantly in PMTCT and has provided extensive support for the use of lifelong ART for all HIV-infected pregnant and breastfeeding women, an approach that

20 UNAIDS. Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive. 2011. Available at: http://www.unaids.org/en/resources/documents/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf

Pregnant women accessing HIV/AIDS services at clinic in Namibia

leads to the best outcomes for women, their partners, and their children. After release of the 2013 WHO Consolidated Treatment Guidelines recommending combination ART for pregnant women, PEPFAR supported countries in rapidly implementing ART for pregnant women. In FY 2014 alone, the proportion of pregnant women receiving ART, rather than zidovudine prophylaxis, increased from 60 percent to 90 percent, and now stands at 98 percent. With release of the 2015 WHO Guideline on When to Start Antiretroviral Therapy and on Pre-exposure Prophylaxis for HIV,[21] which recommends lifelong ART for all pregnant women living with HIV, PEPFAR will work to ensure that all supported countries are providing lifelong ART to pregnant women living with HIV.

PEPFAR has focused efforts on providing funding and technical support to improve every step of the treatment and care continuum, from HIV testing to treatment for mothers and follow-up testing for babies. This ensures an effective PMTCT cascade, resulting in an HIV-negative baby and a mother with a suppressed viral load. In addition, PEPFAR will increase the focus on keeping pregnant women who test negative for HIV free from infection through increased partner testing. This will enable PEPFAR to identify and provide immediate treatment for men living with HIV and referral for VMMC for those who are negative, and will also allow PEPFAR to educate and empower women to protect themselves.

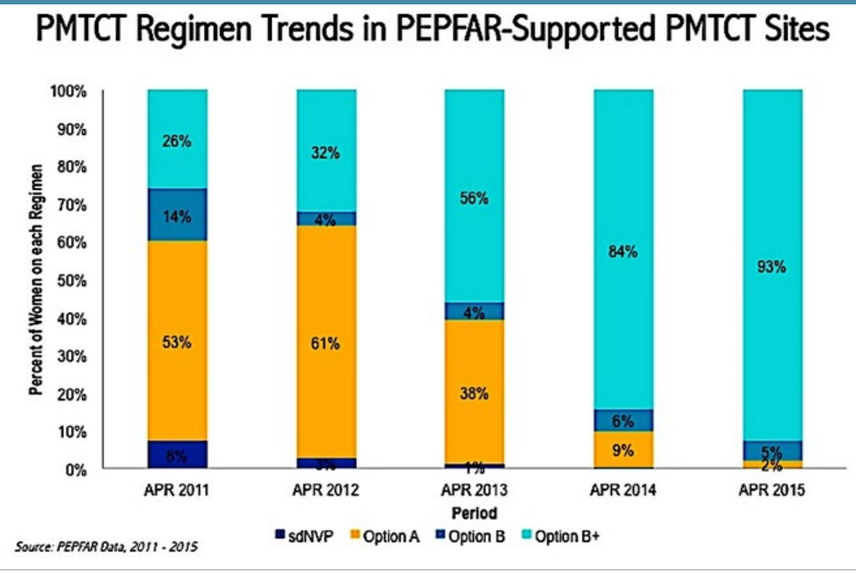
In FY 2015, PEPFAR directly supported HIV testing for more than 14.7 million pregnant women and provided technical support to clinics for an additional 3.5 million tested (Appendix W: Table 7). PMTCT service coverage, as well as an effective cascade of services, are variable and differ greatly between communities. PEPFAR uses site-specific data to ensure resources are focused in the highest-burden areas with the greatest need to maximize the impact on babies and their mothers. Countries are required to focus investments and to increase their targets in high-burden areas. Ultimately, the goal is to increase antenatal care attendance and to test 95 percent of pregnant women receiving an antenatal care visit.

PEPFAR has continued to shift resources from low-burden to high-burden areas to ensure strong linkages for HIV-positive pregnant women to the continuum of care. An additional benefit of this site-level analysis is the utilization of program data to geographically map the HIV epidemic at a granular level. This initiative, conducted by ICPI, is being replicated across partner countries to further focus the HIV response and to gain understanding of the evolving epidemic at a geographic and facility level.

In FY 2015, 14.7 million pregnant women learned their HIV status with PEPFAR support, 92 percent received ARVs during their pregnancy to reduce vertical transmission, and of these, 93 percent received Option B+—initiation of lifelong ART—and an additional 5 percent received triple combination regimens for prevention (Figure 35). ART reduces mother-to-child transmission at birth to less than 5 percent. Transmission rates under 1 percent are seen among women who conceive while on ART and who continue their ART throughout pregnancy. While 95 percent of babies are born HIV-free, if their mothers do not remain on treatment, there is a 15–25 percent risk for infection to be transferred to the infant during the breastfeeding period. Therefore, the breastfeeding period is a high-risk time for women to be lost from care. PEPFAR recognizes the need for data on retention of pregnant and breastfeeding women and is now requiring partner countries to report the percentage of women known to be alive and on treatment 12 months after initiation of lifelong therapy. During 2015, PEPFAR's retention rate in nine countries with the highest number of pregnant women was 63 percent (Appendix W: Table 6). Increased efforts are being directed at retaining pregnant and breastfeeding women in care and treatment and providing testing for their infants to allow for early treatment of infected infants. PEPFAR programs are working closely with civil society organizations and OVC programs to provide support to breastfeeding women and their families to maintain them on ART and ensure follow-up for their infants.

21 WHO. (2015). *Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV*. Available at: http://apps.who.int/iris/bitstream/10665/186275/1/9789241509565_eng.pdf

Figure 35. PEPFAR PMTCT Regimens: Ensuring the Most Effective Regimens to Save Mothers and Ensure Babies Are Born HIV-Free



The new WHO 2015 guidelines provide PEPFAR with a unique opportunity to change the message of PMTCT programs. Moving forward, all HIV-positive pregnant and breastfeeding women should be offered lifelong ART both for their own health and to prevent HIV infection in their babies.

APPENDIX L: Preventing New HIV Infections in Young Men—VMMC

VMMC is a one-time, low-cost intervention shown to reduce men's risk of HIV by approximately 60 percent in randomized control trials, and that preventive effect has been maintained over time. Recent evidence from Uganda (Rakai District) demonstrated that the HIV-preventive effect of VMMC continues to increase, rather

Popular Zimbabwean musician, Jah Prayzah signing a pride board at a male circumcision site soon after getting circumcised. He was part of a campaign to create demand for VMMC.

Figure 36. Significant Impact Is Assured with Greater Efficiencies When Targeting VMMC to the 15-24 Year Age Band

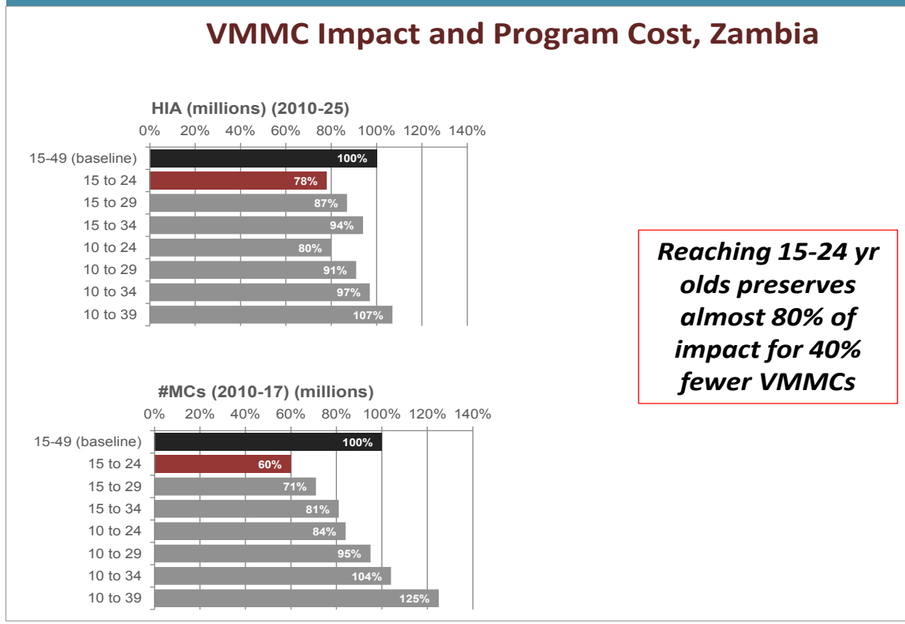
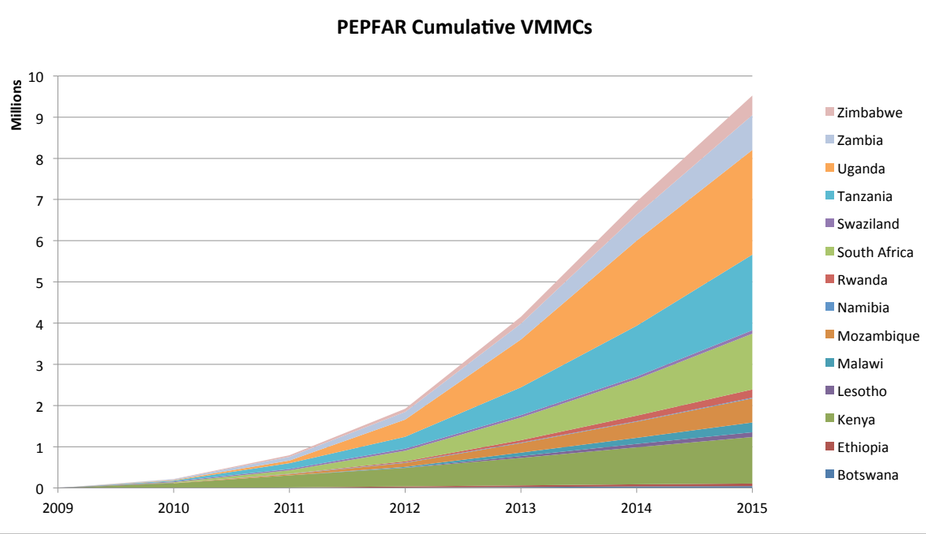


Figure 37. PEPFAR Cumulative VMMC Results, 2009-2015, Accelerated Slope Continues Across the Program



President Obama during historic visit to Kenya and Ethiopia speaking at the African Union.

"We're working together to ensure that girls have access to education and that women are protected from violence. Today, I can announce that Kenya will be part of our DREAMS initiative to help keep adolescent girls safe and AIDS-free. And across Africa, Kenya and the United States will keep working to strengthen public health systems and deal with outbreaks and diseases before they become epidemics."

–President Barack Obama, July 25, 2015

than decline.[22] VMMC has the potential to prevent millions of new infections and to save millions of lives and billions of dollars. Importantly, the procedure brings men into health services, some for the first time. As of September 30, 2015, PEPFAR has supported more than 8.9 million VMMC procedures in eastern and southern African countries (Figures 36 and 37; Appendix W: Table 9). PEPFAR programs strive to achieve 80 percent adult male circumcision coverage, prioritizing the high transmission areas among these 14 countries to maximally and efficiently reduce HIV incidence in the shortest period of time possible and contribute to PEPFAR's over-arching strategies for epidemic control. PEPFAR aims to support a cumulative 11 million VMMCs by the end of FY 2016 and a cumulative 13 million VMMCs by the end of FY 2017. Assuming each country reaches the 90-90-90 HIV treatment targets, modeling analysis projects that VMMCs conducted to date will avert more than 240,000 HIV infections by 2025. PEPFAR continues to prioritize this one-time intervention by increasing central funding to this intervention in 2015.

22 Gray, R. H., et al. (2012). The Effectiveness of Male Circumcision for HIV Prevention and Effects on Risk Behaviors in a Post-Trial Follow up Study in Rakai, Uganda. *AIDS 26*(5), 609–615. Available at: http://doi.org/10.1097/QAD.0b013e3283504a3f

APPENDIX M: Prioritizing Prevention of New HIV Infections in Women, Adolescent Girls, and Children

HIV remains the leading cause of death and disease in women of reproductive age, leading to increased risk of death for orphaned children as well.[23] In sub-Saharan Africa, 60 percent of those living with HIV are women, and in some of these countries, prevalence among young women ages 15–24 is three times higher than among men of the same age (Figures 38 and 39). Maternal mortality is the second leading cause of death, resulting in an estimated 287,000 deaths each year; 99 percent of these women live in low-income countries, and is higher among women living with HIV.[24] Without adequate treatment, women living with HIV are eight times more likely to die during pregnancy, delivery, or the early postpartum period.[25] One in three women will experience GBV in her lifetime.[26] Women account for two-thirds of the world's 774 million adults who are

23 Ortblad, K. F., Lozano, R., Murray, C. J.. (2013). The burden of HIV: insights from the Global Burden of Disease Study 2010. AIDS 27(13), 2003–2017.

24 WHO. (2015). Women's Health. Geneva.

25 Calvert, C., Ronsmans, C. (2013). The contribution of HIV to pregnancy-related mortality: a systematic review and meta-analysis. AIDS 27(10), 1631–1639.

26 United States Agency for International Development. (2015). Report on Gender Equality and Women's Empowerment. Washington, DC. January 2015.

Figure 38. HIV Prevalence Among Young Females and Males

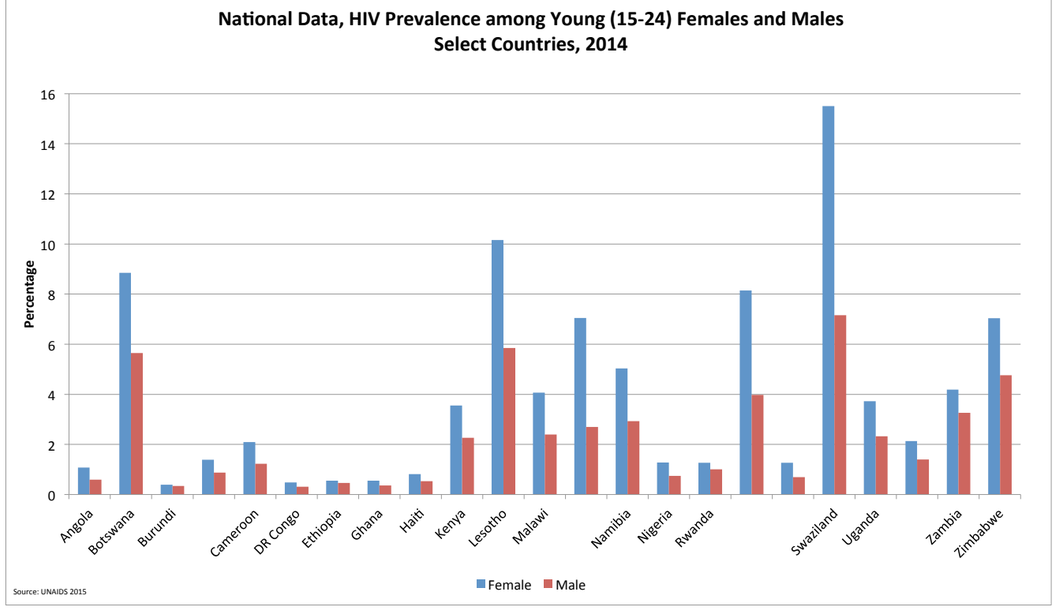
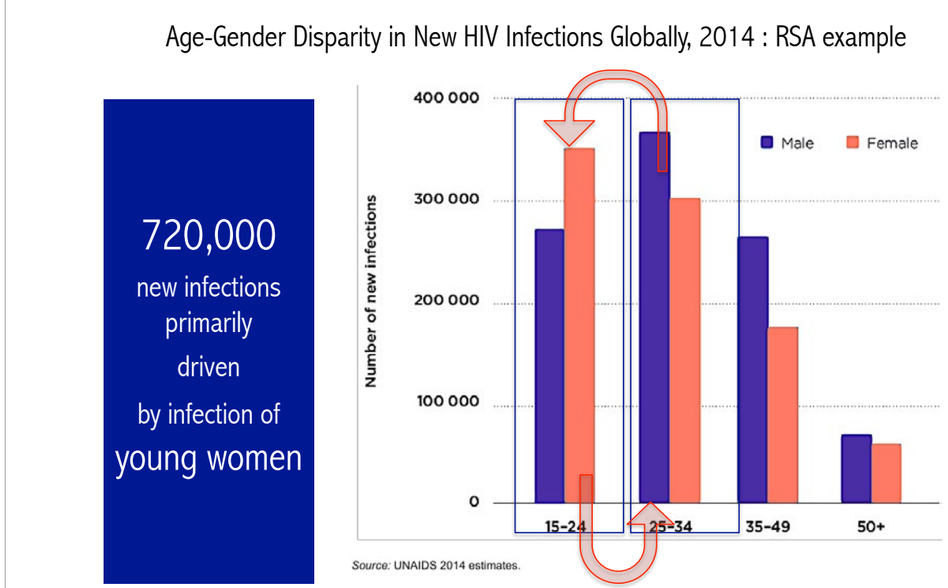


Figure 39. Age-Gender Disparity in New HIV Infections Globally, 2014




Josh Estey/CARE

A young woman smiles for the camera in a classroom in rural Malawi.

illiterate, 54 percent of the 72 million children who are out of school, and 98 percent of all cross-border trafficking victims in sex exploitation cases.[27] All of these factors negatively impact the overall health and well-being of women, while placing adolescent girls and young women at heightened risk for HIV infection and HIV-positive women at increased risk of maternal mortality.

Since its inception, PEPFAR has prioritized care and treatment for women and children; in FY 2015 more than 35 million women and girls were tested, and more than 5.4 million women and girls are in treatment. PEPFAR is dedicated to continued implementation of its ***2013 Gender Strategy***,[28] which calls for increasing gender equity in HIV/AIDS programs and services, including reproductive health, preventing and responding to GBV, engaging men and boys to address social norms and behaviors, and improving gender-related legal protections.

Every year, an astonishing 380,000 adolescent girls and young women are infected with HIV—7,000 every week, more than 1,000 every day. Girls and young women account for 71 percent of new HIV infections among adolescents in sub-Saharan Africa. That is why PEPFAR, the Bill & Melinda Gates Foundation, and Girl Effect were founding members of the DREAMS partnership. The goal of DREAMS is to reduce new HIV infections in adolescent girls and young women in the hardest-hit areas of 10 sub-Saharan Africa countries by helping girls become Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe women. The administration announced that DREAMS is targeting a 40 percent reduction in new HIV infections among adolescent girls and young women within DREAMS geographic areas—the hardest-hit areas of 10 sub-Saharan Africa countries—by the end of 2017.

DREAMS—Increasing Effective Targeted Prevention Interventions

In July 2015, President Obama, during his historic trip to Kenya and Ethiopia, announced the 10 countries participating in DREAMS: Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. The 10 DREAMS countries account for nearly half of all the new infections that occurred among adolescent girls and young women globally in 2014. DREAMS is about multiple solutions surrounding one problem, delivering a core package that combines evidence-based approaches that go beyond the health sector, addressing the structural drivers that directly and indirectly increase girls' HIV risk, including poverty, gender inequality, sexual violence, and a lack of education (Figure 40).

Many adolescent girls and young women lack a full range of opportunities and are too often devalued because of gender bias, leading them to be seen as unworthy of investment or protection. Social isolation, economic disadvantage, discriminatory cultural norms, orphanhood, GBV, and school dropout all contribute to girls' vulnerability to HIV. DREAMS has the potential to change how we work together to ensure an AIDS-free future for adolescent girls and young women.

27 UNAIDS. (2010). The World's Women 2010: Trends and Statistics. Geneva.

28 PEPFAR. (2013). *Updated Gender Strategy*. Available at: http://www.pepfar.gov/documents/organization/219117.pdf

Kenya: The DREAMS Vision Translated into Action

In Kenya, DREAMS is implemented in four high-priority counties: Nairobi, Homa Bay, Siaya, and Kisumu, as shown in Figure 41. Selection of focus counties was based on their proportional geographic HIV/AIDS burden and on HIV incidence in high transmission zones in subcounties and informal settlements (Figure 41). This selection of these four counties aligns with Kenya's plan for geographic focus proposed during FY 2015 COP and coincides with the ACT initiative and VMMC scale-up counties. The layering of a combination of effective interventions will allow DREAMS partners to leverage targeted services for male sexual partners of adolescent girls and young women and effectively link adolescent girls and pregnant adolescent girls as well as young women who test positive to adolescent-friendly HIV care and treatment sites through the ACT Initiative.

The core package of interventions for each of the selected DREAMS counties is broadly outlined in Table 4. New interventions include provision of PrEP, strengthening family interventions and characterization of male partners.

The planning and proposal development portion of DREAMS was completed at the end of FY 2015, and implementation started at the beginning of FY 2016. In Kenya, DREAMS partners were providing some services within the DREAMS core package, and through the addition of DREAMS resources these partners will expand their availability. In cases where DREAMS partners do not offer the outlined services, they will coordinate with other PEPFAR partners in the area to ensure effective linkages.

PEPFAR Kenya will work with its partners to ensure that appropriate populations are reached and that implementing partners provide the agreed-upon interventions with a series of capacity building activities. Each DREAMS implementing partner will participate in a comprehensive DREAMS workshop that outlines the vision, technical strategy, and monitoring and evaluation framework. Partners will also participate in intervention-specific training for new programs to ensure implementation fidelity across partners.

Figure 40. The DREAMS Core Package

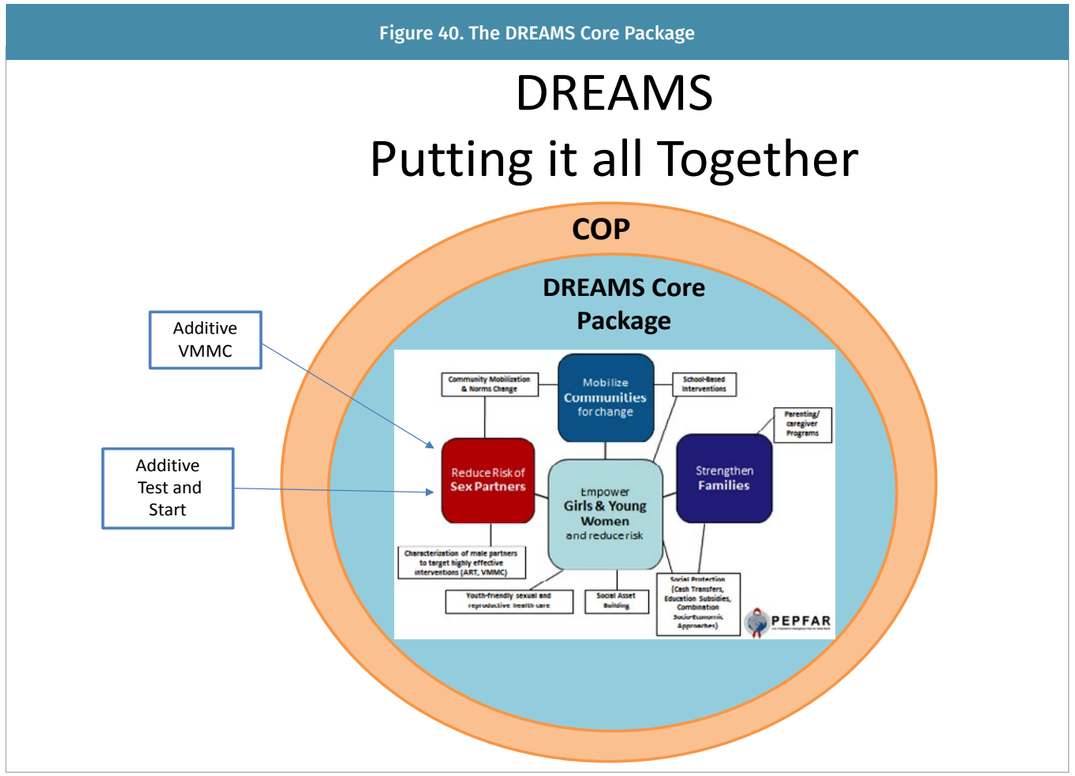
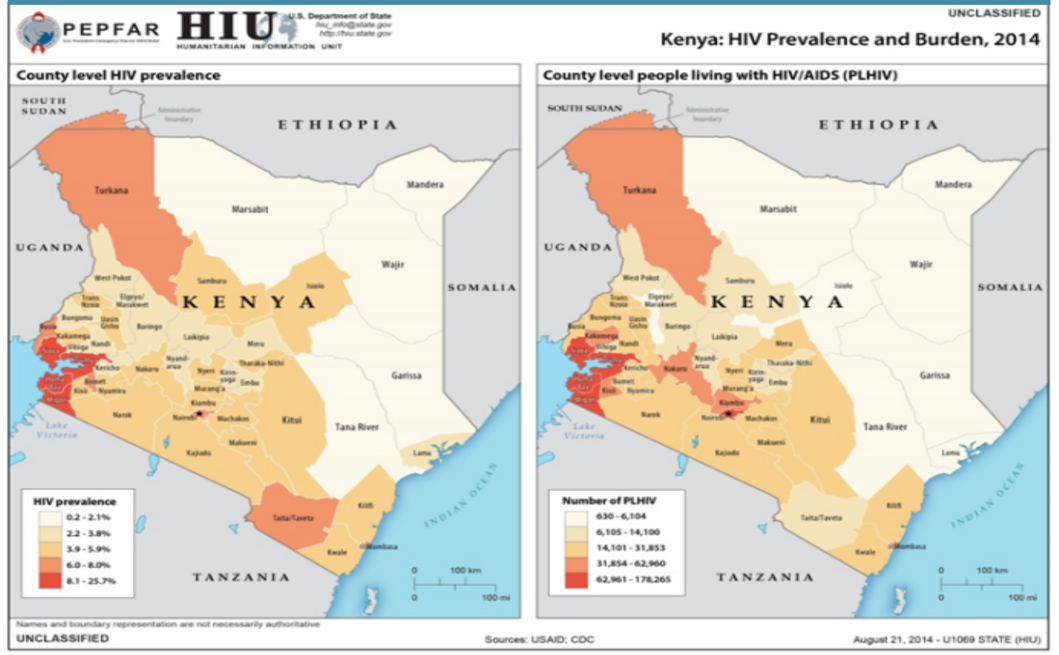
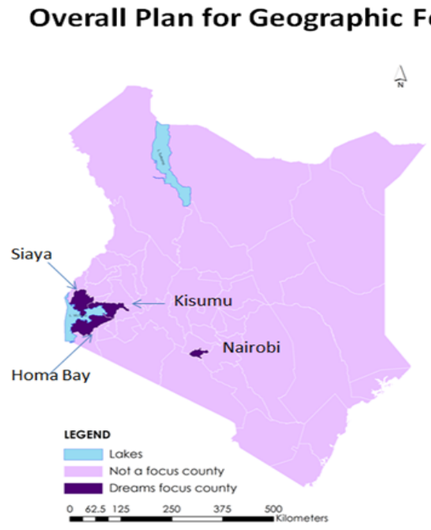


Figure 41. HIV Disease Burden by County and Location of DREAMS Focus Counties: Kenya





How Does the Kenya Vision for DREAMS Depart from Business as Usual?

The packages of services for DREAMS are clearly defined, comprehensive, and evidence-informed, and integrate education, contraception, and social and economic interventions. With DREAMS support, Kenya will develop an adolescent girls and young women-centered approach to service delivery and will reduce risk among this group by understanding their sexual networks.

Table 4. DREAMS, Kenya Summary of Interventions, Kenya by County

Category and Code	Intervention
Empower Girls and Young Women (EG&YW)	Condom promotion and provision (male and female) [No promotion or provision for 10-14 year olds in interventions.]
	HIV Testing Services
	PrEP [not offered in Year 1]
	Post-Violence Care
	Expand and Improve Contraceptive Method Mix
	Social Asset Building
Mobilize Communities (MoCom)	School-based HIV and violence prevention
	Community mobilization and norms change
Strengthen Families (SF)	Parenting/Caregiver Programs
	Cash Transfers
	Education Subsidies
	Combination Socioeconomic Approaches
Decrease risk in sex partners (Part)	Characterization of male partners (for AGYW ages 15-24)

Augmenting the combination prevention interventions of DREAMS, supporting the reduction in incidence of HIV among adolescent girls and young women is the additive VMMC as well as to find more men and initiate them on treatment (Figure 42). Additional funding has been allocated to expand VMMC programs, in particular targeting young men in the age 15–24 cohort in the DREAMS focus areas. This group represents the next generation of older males who are sexual partners of young females; keeping these males HIV-free with VMMC will further strengthen and protect the young women with whom they will engage in sexual relations.

DREAMS
WORKING TOGETHER FOR AN AIDS-FREE FUTURE FOR GIRLS & WOMEN

DREAMS logo

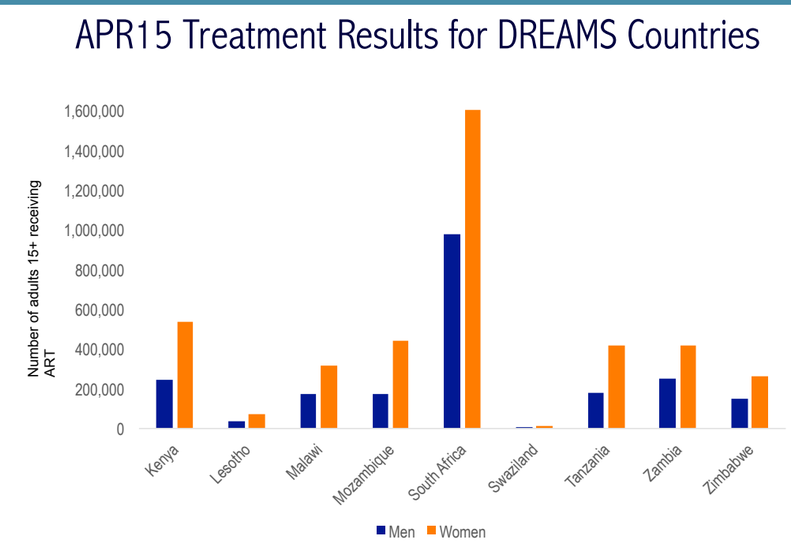
A more generalized strategy attempting to provide VMMC to all eligible males (e.g., 15–49 years old) would improve overall coverage but is not cost efficient. For example, modeling in Zambia supports the proposition that targeting the 15–24-year-old age band ensures approximately 80 percent of the impact for 40 percent fewer procedures (Figure 36). This efficiency can move VMMC programs rapidly toward significant reductions in new infections and can also be used to further leverage support for expanded programming. Combining this VMMC initiative with the VMMC component of the DREAMS program offers critical additive value to the entire goal of reducing new infections among adolescent girls and young women.

DREAMS also includes a strong monitoring and evaluation plan, in which data will be monitored monthly and quarterly so as to allow for timely course correction if needed. Semiannual program review meetings will also be held for partners to share best practices and address challenges.

DREAMS Innovation Challenge

On World AIDS Day 2015, PEPFAR and several private sector partners announced new investments in DREAMS, including through the new DREAMS Innovation Challenge, bringing the total investment to $385 million, subject to approval by the U.S. Congress. PEPFAR committed $80 million from within its existing FY 2014 and 2015 budgets for this Innovation Challenge Fund, and Johnson & Johnson, Gilead Sciences, and ViiV Healthcare joined the call to action, committing $25 million to support both the DREAMS partnership and Innovation Challenge Fund. The DREAMS Innovation Challenge Fund is designed to build upon existing evidence-based approaches and infuse additional resources and innovative approaches to better meet the urgent and complex needs of adolescent girls and young women in sub-Saharan Africa.

Figure 42. Significant Impact Is Assured with Greater Efficiencies When Targeting VMMC to the 15-24 Year Age Band



Source: PEPFAR FY15 report to Congress. Results for Uganda were unavailable at time of reporting

The DREAMS Innovation Challenge will invite investment ideas in the following core areas:

- Strengthening leadership and capacity of community-based organizations to support the expansion of interventions included in the DREAMS Core Package.
- Keeping girls in secondary school by ensuring their transition and access to enrollment and addressing underlying retention issues.
- Pioneering new ways to find young and adult men and link them to HIV counseling and testing, treatment, and VMMC services.
- Supporting PrEP interventions by identifying adolescent girls and young women appropriate for PrEP initiation and adherence services.
- Providing a postsecondary school bridge to employment for young women (ages 19–24) to decrease their risk for transactional sex and HIV.
- Increasing the availability and use of Data4Dreams to inform policy and increase program impact, with support from the Millennium Challenge Corporation (MCC).

A peer educator speaking to fellow students at a school in Kenya.

DREAMS Evaluation

The DREAMS initiative has developed a monitoring and evaluation (M&E) framework as a reference for all DREAMS countries. This framework follows a logic model that guides how programs are monitored and evaluated. This model lays out the epidemiologic and sociologic context that puts adolescent girls and young women at higher risk of HIV infection, the interventions proposed to address these contextual factors, the expected outputs and outcomes of these interventions, and the overall impact of those interventions in combination. The logic model is purposely high level, as it applies to DREAMS across all 10 countries, and it can be adapted to fit specific country plans, context, and encompassing M&E frameworks. The structure of this framework reflects the fundamentals of the overall PEPFAR M&E strategy, using the same data sources, indicators, and analytical processes. The differences rest in additional metrics, other data collection processes, and analyses that are linked to the specific objectives of this initiative.

From left to right: Steve Letsike, Chairperson, South African National AIDS Council's Civil Society Forum, Aaron Motsoaledi, Minister of Health, South Africa, Ambassador Birx, Patrick Gaspard, U.S. Ambassador to South Africa, Luiz Loures, UNAIDS Deputy Executive Director at the South African DREAMS Launch.

The evaluation of processes and outputs will address questions pertaining to the achievement of DREAMS targets, to reaching the correct populations, to successful rollout of interventions, and to delivery of quality interventions. Additional in-depth studies will be conducted to explore three primary questions: 1) how well are programs identifying and linking adolescent girls and young women to programs and services; 2) how well are programs identifying and linking male partners of adolescent girls and young women to decrease their risk; and 3) what are appropriate and effective strategies for the use of PrEP among adolescent girls and young women?

Outcomes also will be examined, reflecting behavioral changes associated with the intervention objectives. These will include educational attainment, levels of violence and victimization, unplanned pregnancies, sexual risk behaviors, and changes to community norms, among others. Ultimately, the goal is to achieve a reduction in HIV incidence among adolescent girls and young women, the impact of this overall agenda. Evaluation of the impact will employ proxy indicators (e.g., PMTCT program data, prevalence among 15–24-year-old females) and modeling. Another special study will be implemented to directly monitor changes in incidence, employing existing surveillance platforms and supporting additional research as needed. This study will target four locations, two in Kenya and one each in South Africa and Zimbabwe.

PEPFAR's Investments to Combat GBV

Gender-based Violence and HIV are intricately linked. Girls who experience violence are three times more likely to have an unwanted pregnancy and up to three times more likely to have HIV or other sexually transmitted infections. Sexual violence against preadolescents and adolescents is alarmingly high, with 28 to 39 percent of girls reporting an unwanted sexual experience before they turn 18.[29]

29 WHO. (2014). Global Status Report on Violence Prevention 2014. Geneva.

Adolescent girls say "no" to gender-based violence and HIV in Ethiopia.

PEPFAR is working with U.S. implementing agencies, partner countries, civil society groups, the Global Fund, and other multilateral partners to comprehensively address GBV and HIV prevention for adolescent girls. This means bringing together relevant approaches from multiple sectors—education, health, economic, and psychosocial—to establish a core package of evidence-based interventions.

PEPFAR has strengthened its gender indicators by including more refined age by sex-disaggregated categories to their two gender-equality indicators; these indicators measure the number of people receiving post-GBV care and the number of people completing an activity pertaining to changing gender norms. PEPFAR continues to reach tens of thousands of women a year with postexposure prophylaxis to prevent HIV for sexual violence survivors (Appendix W: Table 12).

Investing in adolescent girls and young women is not only the right thing to do, it's the smart thing. If we can impact their lives, we can contribute to progress for their families and communities. Simultaneously, PEPFAR is focused on finding and testing HIV-positive men, linking them immediately to lifesaving treatment, and ensuring they achieve viral suppression to break the life cycle of HIV. This will require rapid adoption of the 2015 WHO guidelines.

APPENDIX N: Pediatrics and OVC—Focusing the Program Toward Achieving an AIDS-Free Generation and Healthy Children

Pediatrics

Over the last five years there has been a dramatic decline in new pediatric infections, but the children that have been born HIV-positive are in critical need of HIV treatment to save their lives. In 2014, 2.6 million children under age 15 were living with HIV/AIDS—nearly 90 percent of whom live in sub-Saharan Africa. One new pediatric HIV infection occurred approximately every three minutes. Without ART, 50 percent of children living with HIV/AIDS will die before their second birthday and 80 percent will die before their fifth birthday. Children living with HIV/AIDS are one-quarter as likely to receive treatment compared with adults.

In August 2014, the U.S. Department of State announced the ACT initiative at the U.S. African Leaders Summit. ACT is a two-year initiative to double the total number of children receiving lifesaving ART in nine high-priority countries in sub-Saharan Africa. The nine ACT countries (Cameroon, Democratic Republic of the Congo, Kenya, Lesotho, Malawi, Mozambique, Tanzania, Zambia, and Zimbabwe) are among those with the lowest access to pediatric treatment. These countries also have some of the greatest disparities in treatment coverage for children compared with adults living with HIV/AIDS. The $200 million initiative represents a joint investment by PEPFAR and the Children's Investment Fund Foundation (CIFF) that will enable 300,000 more children living with HIV in these countries

An HIV awareness banner created by children infected and affected by HIV in Ukraine.

to receive ART. This is more than the right thing to do; it is the best way to ensure not only an AIDS-free Generation, but a strong and stable sub-Saharan Africa. Healthy children will grow economies, create jobs, and strengthen their communities for decades to come.

PEPFAR has established new MER indicators for OVC that include tracking the number of children and caregivers served (disaggregated by age and sex) and supporting referrals to HIV clinical services made possible by OVC programs. In addition, a new package of outcome indicators is collected biennially through special studies. These indicators are drawn from the 2013 OVC Survey toolkit that was designed to assist programs with measurement of child and household well-being.

PEPFAR will work with OVC implementing partners to ensure that most vulnerable, at-risk children receive appropriate HIV testing and access to lifesaving services. PEPFAR regularly evaluates OVC programs to ensure they adapt to the changing demographics of the epidemic and the shifting evidence for core interventions. PEPFAR sets aside 10 percent of its program funding to address the diverse, complex, and often critical needs of OVC. This year alone, more than five million children have benefited from PEPFAR's services (Appendix W: Table 13)—plus, there are two million children who did not become orphans because of the treatment of parents and caregivers living with HIV.

The first year of implementation of ACT has shown strong results. As of September 30, 2015, PEPFAR is supporting 498,000 children ages 0–19 years with lifesaving ART, putting ACT on track to achieving the fiscal year 2017 target of 600,000 children on lifesaving treatment. The number of children ages 0–14 years who received HIV testing and counseling services and their test results has more than doubled during the first year of ACT compared with the previous year, increasing to 4.3 million in FY 2015 from 2.1 million in FY 2014. Countries will continue to receive technical support to accelerate pediatric treatment scale-up in FY 2016.

In order to make ACT a successful initiative, adoption of the WHO guidelines to treat all HIV-infected children and adolescents is a critical step in bridging the gap between HIV-positive children and linking them to care. PEPFAR is focused on ensuring that all vulnerable children have access to HIV testing, care, and treatment by expanding the OVC platform to ensure testing and linkages to lifesaving services.

OVC: Strengthening Children's Resilience and Supporting an AIDS-Free Generation

OVC programs remain central to achieving an AIDS-free generation. Worldwide, more than 13.3 million children are living without one or both parents due to AIDS, down from 14.3 million at the height of the epidemic.[30] As care and treatment programs have expanded, parents are living successfully with HIV/AIDS, and PEPFAR continues to refine the services for OVC in high prevalence communities. The programs respond to socioeconomic issues that negatively impact the lives of children. Through strategic efforts to strengthen the capacity of OVC, their families, their communities, and systems of care and support, OVC programs create an environment for children—and their parents and caregivers—that enables them to access other services, including core HIV treatment and prevention services.

30 UNAIDS. (2015). *How AIDS changed everything – MDG6: 15 years, 15 lessons of hope from the AIDS response.* Available at: http://www.unaids.org/sites/default/files/media_asset/MDG6Report_en.pdf

Adolescents in Swaziland

PEPFAR continues to maximize the impact of the OVC platform by focusing on an approach that strengthens children's resilience. This focuses investments on scaling up evidence-based interventions; linking community and clinical services; enhancing family-centered care; and strengthening the measurement of quality improvement, cost data, and monitoring program outcomes.

PEPFAR's support to these programs must continue to meet the evolving needs of OVC. In countries with substantial declines in HIV mortality over the past decade, OVC are aging into adolescence as the number of orphans dramatically declines. This is a success for PEPFAR-supported programs. However, the incidence of new infections among girls in many of these countries has not declined, and girls remain 60 percent more likely to become HIV-infected than their male counterparts. The focus in these countries must shift to preventing HIV infection among vulnerable young girls and ensuring strong linkages to a comprehensive continuum of care. These services should provide HIV-positive adolescents with the necessary social support to complement access to treatment. The focus is two-fold: adhering to treatment and living a happy, healthy, AIDS-free future. In addition to focusing on adolescent girls, PEPFAR's OVC programs must reach the very young children—children less than two years old—to ensure that children exposed to or infected with HIV have access to care and treatment while integrating early childhood interventions to mitigate the impact of HIV on cognitive, physical, emotional, and social development.

In FY 2015, PEPFAR supported several high-level consultations related to OVC. In February, PEPFAR convened an OVC Forum with United States government and implementing partners to build an understanding of PEPFAR's Monitoring, Evaluation, and Reporting (MER) indicators, including the outcomes monitoring survey to be conducted biannually. The participants also discussed geographic prioritization and transitioning of OVC activities to Scale Up districts for activities. In September 2015, during the ACT Regional meeting held in Zambia, U.S. government and implementing partners identified OVC program contributions to the ACT goals. Participants at the meeting focused on

best practices for identifying children infected by HIV through targeted testing of children and families in OVC programs, as well as providing psychosocial support to HIV-positive children and their families, which improves retention and adherence.

APPENDIX O: Driving a Sustainability Agenda with Country Partners

Phase II of PEPFAR emphasized country-led sustainable responses as the end goal, where partner countries will lead, manage, coordinate, and increasingly finance the efforts needed to achieve an AIDS-free generation and an effective, efficient, and durable response. This has not stopped just because PEPFAR has entered a new phase. In fact, it has expanded; one of the five pillars of PEPFAR 3.0 is the Sustainability Action Agenda, whereby the U.S. government aims to engage both partner governments and civil society in service and systems strengthening.

PEPFAR's Sustainability Action Agenda focuses on:

- the policy, administrative, and legal environment that would ensure access to services and social protection for vulnerable populations;
- rapid adoption of the 2015 WHO guidelines that will substantially increase the effectiveness of PEPFAR investments;
- the financing and delivery of necessary HIV/AIDS services and what can be done to support increased domestic investment in these areas;
- the systems and capabilities to facilitate the strategic use of data; and
- the accountability of partner country governments to be responsive to stakeholders for achieving results and to be good stewards of HIV/AIDS monies.

A student proudly wears his HIV/AIDS ribbon on World AIDS Day while listening to a presentation at his primary school in Cambodia on health and HIV/AIDS.

A key component of the Sustainability Action Agenda is the development and use of the Sustainability Index and Dashboard (SID), a measurement tool that provides a periodic snapshot of the elements central to a sustained and controlled epidemic. The implementation of the SID allows PEPFAR to objectively track progress toward PrEP sustainability goals. These goals are "owned" by the country and have been supported by PEPFAR. The Index targets 15 elements organized under four overarching domains:

- Governance, Leadership, and Accountability;
- National Health System and Service Delivery;
- Strategic Investments, Efficiency, and Sustainable Financing; and
- Strategic Information

The specific indicators and milestones included within the SID measure key areas, such as the extent to which partner countries are mobilizing domestic financial resources for their HIV/AIDS response and allocating those resources strategically and efficiently; collecting, analyzing, and using the right types of data for decision making; and ensuring a secure, reliable, and adequate supply and distribution of drugs and other commodities for eventually achieving sustainable epidemic control.

The SID was implemented for the first time in 33 countries during the PEPFAR COP meetings in 2015 and was received enthusiastically by many stakeholders who engaged in the process. Based on the lessons learned from that initial experience, the tool has been revised and refined for implementation during COP 2016 ("SID 2.0"), the results from which are intended to serve as the baseline going forward. The findings from periodic implementation of the SID will contribute to a shared understanding of each country's sustainability landscape; help identify strengths, gaps, and weaknesses within the national HIV response; and inform the annual planning of PEPFAR investments.

Recognizing the importance of full participation by nongovernmental partners, including the private sector, to the success and sustainability of efforts to combat HIV, the revised SID more explicitly reflects and assesses the role these groups play in national HIV responses. In addition, to further ensure increased participation and integration of civil society in HIV/AIDS planning and implementation, all PEPFAR countries were directed to actively involve civil society throughout the development of their annual Country/Regional Operational Plans. During the COP 2015 in-person reviews, each country was empowered to invite members of civil society, host country governments, multilaterals, and other stakeholders to participate in discussions with Ambassador Birx around the annual PEPFAR planning process. Additionally, in November 2015, PEPFAR posted its draft 2016 Country/Regional Operational Plan (COP/ROP) Guidance online to collect feedback from all stakeholders, including civil society organizations. The comments directly informed the final guidance, posted online on December 1, 2015.

Treatment can be expanded in a revenue-neutral manner if the new WHO guideline for Test and Start treatment begins immediately and new differentiated models of care are adopted by host countries. These changes will result in a more than 50 percent decline in new infections and deaths from HIV. Test and START allows simplification of the process of starting newly identified persons living with HIV on treatment, reducing costs, and increasing retention in care. For clients who are asymptomatic at treatment initiation, less frequent follow-up is possible, allowing treatment of two clients for the same cost as treating one using previous guidelines and models of care. Treatment for all prevents sexual transmission to uninfected partners, leading to rapid declines in new infections.

APPENDIX P: Strengthening Program Cost Effectiveness

Informed by economic and financial data, PEPFAR designs and redesigns sustainable models of service delivery that adapt to changing circumstances. To attain epidemic control and an AIDS-free generation, PEPFAR is implementing programmatic changes to achieve efficiency gains that deliver greater results for its investments.

Accurate cost and expenditure data enable policy makers and program planners to better coordinate donors, especially the Global Fund and host-country funding; assess gaps in coverage; reduce duplication and redundancy; direct resources to high-impact interventions, regions, service providers, and populations; determine resources required to sustain programs in the future; and advocate for additional support, both from external and internal sources. These data are also essential inputs for developing national strategic plans and PFs for HIV and health. PEPFAR, as the largest source of support in many countries and as the one-third contributor to the Global Fund, has committed to sharing financial data with our partner country counterparts to strengthen sustainability. PEPFAR also harmonizes our

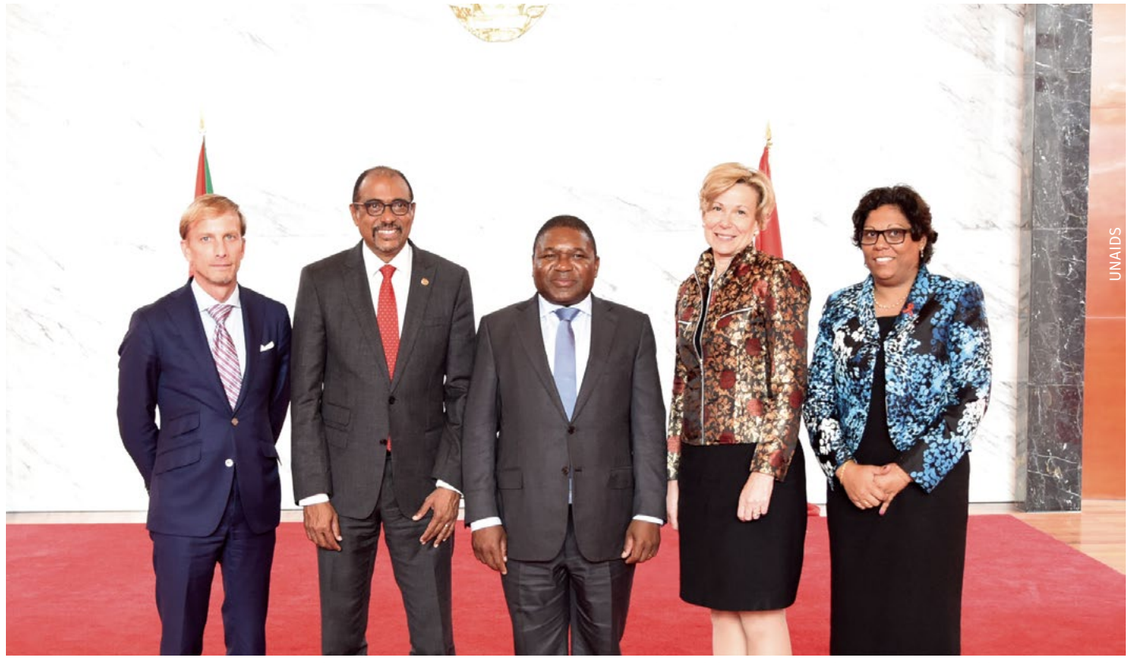
efforts with those of other donors and stakeholders to produce routine and comparable spending data that empower more informed planning and country-driven decision making. This approach facilitates the identification of positive and negative outliers for expanding program innovation and corrective actions for program improvement. This is an ongoing process and PEPFAR is now completing detailed analyses quarterly.

The analysis of site-level results, the cost of achieving those results, and the quality of the results are essential to identifying the sites with the most efficient programs. The best practices of the most efficient programs can then be scaled up and replicated to improve all sites.

Coordination with Multilaterals

As part of a broader collaborative strategy to improve coordination between the Global Fund and PEPFAR, we have been working with the Global Fund since early 2012 to harmonize financial monitoring and construct a framework for comparable expenditure datasets between the two organizations. With the inception of the Global Fund New Funding Model, these efforts have been concretized through a minimum dataset capturing financial data from both the Global Fund and PEPFAR within the year. Over the past 18 months, PEPFAR has dramatically increased its engagement with the Global Fund Secretariat at all levels.

The U.S. government and the Global Fund are committed to controlling HIV, TB, and malaria through a shared approach. Practically speaking, this means aligning ourselves to do the right things, in the right places, right now. It requires a special focus on key and vulnerable populations, with both the U.S. government and the Global Fund stepping up to jointly lead efforts that target geographic areas and populations with the greatest burden, including adolescent girls and young women. Together, we are also leveraging the comparative advantage of each organization. For example, we are ensuring an integrated HIV response through PEPFAR's direct support for the provision of technical care and treatment services, and the Global Fund using its bulk pricing and purchasing power to procure key commodities, including test kits and lifesaving medicines.



From left: Executive Director of the Global Fund Mark Dybul, Michel Sidibe, Executive Director of UNAIDS, Filipe Jacinto Nyusi, President of Mozambique, Amb. Deborah Birx, Nazira Abdula, Minister of Health, Mozambique.

We have enhanced coordination to support the development and success of national health strategies and national strategic plans for impact. The U.S. government has been actively involved with the Global Fund's grant development process, most notably through active engagement with country-level multi-stakeholder partnerships, to ensure that they develop technically sound funding requests that complement U.S. government programs. PEPFAR has also invited the Global Fund and other external stakeholders to attend and provide input at in-person PEPFAR Country Operational Plan reviews. In addition, PEPFAR has seconded personnel to the Global Fund headquarters to enhance communication and collaboration.

To improve program implementation, we continue to communicate weekly at the headquarters level to discuss strategy and program alignment. We have instituted headquarters-to-headquarters meetings to update and analyze progress through core joint-investment countries multiple times per year. In addition, the Global Fund's Geneva-based Fund Portfolio Managers meet with PEPFAR in-country teams during each of the former's monthly country visits. For example, in Tanzania, these regular monthly meetings have led to greater program alignment between PEPFAR and the Global Fund, and enhanced the quality of HIV service provision and early detection of and rapid response to grant implementation bottlenecks. In Haiti, PEPFAR country teams and the Global Fund have worked together to map all ART sites, giving a full picture of the geographic locations where implementing partners are present. In Mozambique, PEPFAR and other partners have worked with the Global Fund to produce epidemic models that illustrate the impact of treatment scale-up under various funding scenarios, which are used to inform decision making during the Global Fund's grant process. These are a few of the many examples of the ongoing collaboration and coordination between PEPFAR and the Global Fund to improve program implementation and health outcomes.

PEPFAR and the Global Fund are each maximizing our use of data to drive decision making, and sharing what we learn. Through site-level monitoring, PEPFAR's country teams have employed the SIMS to increase the impact of PEPFAR programs by monitoring the quality of support at the site level (e.g., health facility, ward, district, etc.). The data collected through SIMS will be made publically available, enabling the Global Fund and other partners to best utilize resources in a complementary manner.

From the country perspective, host governments are working to better understand how donor resources—from PEPFAR, the Global Fund, and other sources—are matched with local resources and translate to the delivery of HIV services and support. Standard international tracking tools that are available include the National AIDS Spending Assessment (NASA), developed by UNAIDS, and the National Health Accounts (NHA)/System of Health Accounts (SHA), developed by WHO.

In 2015, PEPFAR worked with UNAIDS to provide data to inform the global resource needs estimates in the Global AIDS Report. PEPFAR also is working with the Global Fund, World Bank, UNAIDS, WHO, and The Bill & Melinda Gates Foundation to identify countries to support joint reporting of HIV/AIDS expenditures.

Expenditure Analysis (EA)

The PEPFAR Expenditure Analysis (EA) Initiative was institutionalized in 2012. EA is an important tool for better understanding where resources are going and what outputs are produced by these investments. In 2014, PEPFAR expanded the EA to include all countries; results were used as part of the evidence-based budgeting process in 2015 for COP development. In the fall of 2015, the

PEPFAR EA Initiative continued its phased expansion to include expenditures related to central initiatives that accelerate the delivery of priority HIV/AIDS interventions, such as VMMC and Key Populations Fund (Appendix S).

Table 5 outlines the total expenditures reported by countries in core intervention areas, and Table 6 presents the unit expenditure observed for achieving results in core intervention areas. Unit expenditure does not equal unit cost; rather, it represents the cost to PEPFAR to deliver services and support to reported beneficiaries. In practice, the true unit cost is higher when considering all the sources of support that typically contribute to implementation of national HIV programs (e.g., Global Fund, host country government). Though not the full unit cost, these data provide an evidence base for building budgets and specifically identifying areas for increased technical and productive efficiencies.

Many factors contribute to the range of the unit expenditure across countries, such as the extent of PEPFAR's support and the number of beneficiaries reached. From a global perspective, PEPFAR reviews the range to gain a better understanding of the potential variance in the type of support provided for certain interventions. For example, the PEPFAR spend per person on treatment is $33 and $324 in South Africa and Côte d'Ivoire, respectively. In South Africa, the government of South Africa finances most of the HIV/AIDS effort; therefore, PEPFAR's support can be leveraged to benefit more individuals on treatment.

PEPFAR has used EA data to identify potential efficiencies and improve portfolio management. During the annual COP process, data are used to validate proposed budgets and evaluate the past year's performance. For example, one country team compared their past year's budget estimate with their performance and found that the PEPFAR spend per person reached was higher than what was budgeted for the proposed targets. The team was able to evaluate the reasons for the variance and reprogram accordingly.

Teams have also used the data to identify data quality gaps. When spending is linked with results, this has highlighted potential data quality issues. For example, when the team reviewed the data and found one partner was an outlier with high spend per beneficiary, it was then determined that the reason for the result was that the partner had not appropriately reported its results. This did not come to light until the results were linked to spending and partner performance did not align with the team's expectations.

PEPFAR also shared its data with host governments and multilateral partners to improve coordination of resource planning and improve reporting. The expenditure data are collected once by partners and are used for internal performance monitoring, but also provide high-quality and consistent data to the National AIDS Spending Assessments and the National Health Accounts. PEPFAR EA data benefit not only the PEPFAR program to improve efficiency, but also the global community in its resource planning.

Import Duties and Internal Taxes Imposed on Commodities

An important part of the program efficiency gains has been optimizing the costs of commodities; one aspect of this is ensuring that commodities do not have internal import taxes imposed. By and large, PEPFAR-procured commodities are imported tax-free in countries where PEPFAR is supporting the national HIV response, but in certain cases, commodities are taxed. In such situations, the PEPFAR country teams work with partner governments to reverse taxation charges and avoid future import duties. If import or internal taxes are imposed and not reimbursed, the Department of State would comply with any related and applicable legal restrictions on future assistance to that country.

Table 5. Total Report PEPFAR Expenditures by Program Area

Country	Facility Based Care, Treatment and Support	Community Based Care, Treatment and Support	PMTCT	VMMC	HTC	Lab	OVC	General Population Prevention – GP- PREV	Key Population Prevention - persons who inject drugs - KP-PWID	Key Population Prevention - female sex workers - KP-FSW	Key Population Prevention - men who have sex with men and transgender - KP-MSMTG	Strategic Information	Total
Angola	$0.00	$1.40	$1.70	$0.00	$2.30	$0.60	$0.00	$2.00	$0.00	$1.90	$0.40	$0.50	$10.80
Botswana	$13.60	$0.70	$0.80	$4.50	$5.50	$5.10	$4.50	$3.90	$0.00	$0.30	$0.10	$4.60	$43.60
Burma	$2.00	$0.00	$0.00	$0.00	$0.10	$0.00	$0.00	$0.20	$0.03	$0.70	$0.70	$0.00	$3.73
Burundi	$1.20	$0.40	$6.50	$0.06	$1.50	$0.90	$0.08	$0.40	$0.00	$0.10	$0.00	$0.10	$11.24
Cambodia	$1.30	$1.80	$0.30	$0.00	$0.90	$0.60	$0.30	$0.70	$0.20	$1.50	$1.40	$0.20	$9.20
Cameroon	$1.20	$0.01	$7.00	$0.00	$0.30	$3.00	$0.20	$0.10	$0.00	$0.60	$0.50	$1.70	$14.61
Cote d'Ivoire	$37.00	$6.60	$11.30	$0.00	$6.60	$18.80	$10.30	$5.10	$0.01	$1.30	$0.50	$4.50	$102.01
Dominican Republic	$1.10	$0.70	$1.50	$0.00	$0.60	$1.40	$0.02	$0.70	$0.30	$1.10	$1.30	$2.40	$11.12
DRC	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Ethiopia	$38.10	$12.80	$14.40	$0.40	$12.80	$24.80	$21.20	$15.40	$0.00	$4.90	$0.00	$21.60	$166.40
Ghana	$0.40	$1.60	$0.20	$0.00	$1.30	$1.80	$0.30	$0.20	$0.01	$1.80	$1.50	$0.03	$9.14
Guyana	$2.20	$0.30	$0.40	$0.00	$1.30	$0.30	$0.20	$0.20	$0.02	$0.20	$0.10	$0.30	$5.52
Haiti	$39.90	$10.50	$10.60	$0.00	$13.70	$17.50	$4.20	$6.40	$0.00	$0.50	$0.30	$5.80	$109.40
India	$3.70	$0.03	$0.30	$0.00	$0.20	$1.30	$0.01	$2.50	$0.40	$1.40	$0.50	$6.30	$16.64
Indonesia	$0.20	$0.50	$0.30	$0.00	$0.40	$0.30	$0.00	$1.80	$0.20	$1.10	$0.70	$2.10	$7.60
Kenya	$218.60	$17.60	$25.30	$15.30	$29.30	$20.50	$30.90	$17.80	$1.40	$6.30	$2.50	$29.40	$414.90
Lesotho	$6.00	$2.40	$3.00	$6.50	$3.40	$1.90	$2.20	$3.00	$0.00	$0.00	$0.00	$0.70	$29.10
Malawi	$11.70	$4.00	$8.20	$10.10	$4.00	$6.50	$3.80	$7.50	$0.00	$0.50	$0.40	$7.10	$63.80
Mozambique	$113.10	$18.00	$35.10	$25.50	$18.70	$14.90	$16.00	$13.20	$1.30	$2.20	$0.40	$9.20	$267.60
Namibia	$10.70	$4.00	$3.20	$4.00	$7.00	$3.90	$3.10	$9.40	$0.00	$1.40	$0.40	$9.30	$56.40
Nigeria	$143.00	$18.80	$81.60	$0.07	$37.70	$36.10	$33.20	$6.30	$2.80	$5.50	$2.80	$8.70	$376.57
Papua New Guinea	$0.60	$0.00	$0.00	$0.00	$0.40	$0.20	$0.00	$0.00	$0.00	$0.60	$0.60	$0.30	$2.70
Rwanda	$44.10	$1.40	$5.20	$1.60	$9.00	$14.70	$10.50	$1.10	$0.05	$0.90	$0.60	$1.20	$90.35
South Africa	$142.60	$24.60	$28.30	$54.20	$28.00	$9.00	$25.50	$32.40	$0.30	$2.40	$1.60	$33.90	$382.80

Table 5 continued

Table 5. Total Report PEPFAR Expenditures by Program Area

Country	Facility Based Care, Treatment and Support	Community Based Care, Treatment and Support	PMTCT	VMMC	HTC	Lab	OVC	General Population Prevention – GP- PREV	Key Population Prevention - persons who inject drugs - KP-PWID	Key Population Prevention - female sex workers - KP-FSW	Key Population Prevention - men who have sex with men and transgender - KP-MSMTG	Strategic Information	Total
South Sudan	$1.30	$0.30	$1.70	$0.00	$2.40	$0.40	$0.00	$0.20	$0.01	$1.10	$0.00	$0.10	$7.51
Swaziland	$10.00	$1.90	$4.60	$2.80	$3.10	$3.10	$3.40	$2.60	$0.00	$0.40	$0.40	$1.60	$33.90
Tanzania	$114.50	$21.60	$44.30	$24.50	$21.20	$24.50	$22.20	$18.70	$2.20	$3.00	$1.20	$9.70	$307.60
Uganda	$121.30	$10.10	$18.70	$29.30	$13.70	$32.10	$21.10	$6.00	$0.05	$1.20	$0.80	$11.70	$266.05
Ukraine	$1.10	$0.20	$0.10	$0.00	$1.80	$0.60	$0.00	$0.06	$1.20	$0.20	$0.70	$2.60	$8.56
Vietnam	$22.30	$1.30	$1.10	$0.00	$3.40	$5.30	$0.70	$0.06	$1.70	$1.20	$0.70	$4.80	$42.56
Zambia	$87.50	$8.40	$27.60	$16.00	$29.10	$24.40	$15.10	$34.30	$1.10	$1.00	$0.30	$6.70	$251.50
Zimbabwe	$35.20	$3.80	$5.70	$18.00	$6.10	$5.30	$7.10	$1.60	$0.00	$0.10	$0.00	$3.70	$86.60
Asia Regional Program													
China	$0.20	$0.20	$0.00	$0.00	$0.10	$0.07	$0.00	$0.00	$0.00	$0.06	$0.07	$0.08	$0.78
Laos	$0.01	$0.10	$0.02	$0.00	$0.80	$0.01	$0.00	$0.00	$0.00	$0.01	$0.03	$0.03	$1.01
Thailand	$0.40	$0.70	$0.10	$0.00	$3.70	$0.05	$0.00	$0.00	$0.01	$0.03	$0.10	$0.30	$5.39
Caribbean Regional Program													
Antigua and Barbuda	$0.03	$0.04	$0.00	$0.03	$0.00	$0.10	$0.00	$0.10	$0.00	$0.20	$0.10	$0.40	$1.01
Bahamas	$0.05	$0.00	$0.03	$0.00	$0.08	$0.20	$0.00	$0.40	$0.00	$0.10	$0.20	$0.20	$1.26
Barbados	$0.04	$0.03	$0.01	$0.00	$0.07	$0.20	$0.01	$0.40	$0.00	$0.20	$0.20	$0.06	$1.21
Belize	$0.50	$0.07	$0.00	$0.00	$0.20	$0.03	$0.00	$0.07	$0.00	$0.10	$0.20	$0.20	$1.37
Dominica	$0.10	$0.02	$0.01	$0.00	$0.04	$0.10	$0.01	$0.10	$0.00	$0.08	$0.07	$0.10	$0.62
Grenada	$0.01	$0.01	$0.01	$0.00	$0.01	$0.10	$0.01	$0.07	$0.00	$0.08	$0.07	$0.04	$0.40
Jamaica	$1.80	$0.20	$0.10	$0.00	$0.40	$0.20	$0.02	$0.70	$0.00	$0.80	$1.20	$0.04	$5.46
Saint Kitts and Nevis	$0.10	$0.02	$0.01	$0.00	$0.01	$0.10	$0.01	$0.06	$0.00	$0.01	$0.01	$0.04	$0.36
Saint Lucia	$0.10	$0.00	$0.01	$0.00	$0.04	$0.30	$0.01	$0.06	$0.00	$0.01	$0.01	$0.01	$0.54
Saint Vincent	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Table 5 continued

Table 5. Total Report PEPFAR Expenditures by Program Area

Country	Facility Based Care, Treatment and Support	Community Based Care, Treatment and Support	PMTCT	VMMC	HTC	Lab	OVC	General Population Prevention – GP- PREV	Key Population Prevention - persons who inject drugs - KP-PWID	Key Population Prevention - female sex workers - KP-FSW	Key Population Prevention - men who have sex with men and trans-gender - KP-MSMTG	Strategic Information	Total
Suriname	$0.04	$0.00	$0.01	$0.00	$0.03	$0.10	$0.05	$0.30	$0.00	$0.07	$0.06	$0.09	$0.75
Trinidad and Tobago	$0.10	$0.09	$0.00	$0.00	$0.03	$0.10	$0.02	$0.20	$0.00	$0.20	$0.30	$0.50	$1.54
Central America Regional Program													
Costa Rica	$0.04	$0.02	$0.00	$0.00	$0.00	$0.04	$0.00	$0.05	$0.00	$0.10	$0.20	$0.10	$0.55
El Salvador	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Guatemala	$0.80	$0.07	$0.00	$0.00	$0.20	$0.20	$0.00	$0.10	$0.02	$0.40	$0.70	$0.30	$2.79
Honduras	$0.70	$0.00	$0.20	$0.00	$0.60	$0.20	$0.00	$0.00	$0.00	$0.00	$0.50	$0.30	$2.50
Nicaragua	$0.10	$0.06	$0.01	$0.00	$0.20	$0.20	$0.00	$0.08	$0.00	$0.20	$0.80	$0.20	$1.85
Panama	$0.40	$0.07	$0.00	$0.00	$0.07	$0.20	$0.00	$0.06	$0.00	$0.30	$0.40	$0.20	$1.70
Central Asia Regional Program													
Kazakhstan	$0.30	$0.10	$0.00	$0.00	$0.20	$0.20	$0.00	$0.01	$0.30	$0.05	$0.07	$0.40	$1.63
Kyrgyzstan	$0.40	$0.30	$0.00	$0.00	$0.40	$0.20	$0.00	$0.07	$0.60	$0.20	$0.10	$0.40	$2.67
Tajikistan	$0.30	$0.20	$0.00	$0.00	$0.20	$0.20	$0.00	$0.00	$0.80	$0.40	$0.10	$0.40	$2.60
Turkmenistan	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Uzbekistan	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.10	$0.00	$0.00	$0.00	$0.10
TOTAL	$1,232.02	$178.04	$349.50	$212.86	$273.18	$282.90	$236.23	$196.65	$15.12	$49.00	$26.89	$195.22	$3,247.60
South Africa	$142.60	$24.60	$28.30	$54.20	$28.00	$9.00	$25.50	$32.40	$0.30	$2.40	$1.60	$33.90	$382.80

Table 6. PEPFAR Unit Expenditure for Core Interventions											
Country	Adult ART	Pediatric ART	Pregnant Woman Tested	Pregnant Woman on ARV	HTC	VMMC	OVC	General Population Prevention – GP- PREV	Key Population Prevention - persons who inject drugs - KP-PWID	Key Population Prevention - female sex workers - KP-FSW	Key Population Prevention - men who have sex with men and trans-gender - KP-MSMTG
Cameroon	n/a	n/a	$2	$409	$12	n/a	$350	$11	n/a	$123	$254
Cote d'Ivoire	$324	$328	$4	$188	$5	n/a	$48	$17	n/a	$38	$34
DRC	$305	$356	$9	$781	$9	n/a	$116	$6	n/a	$29	$135
Ethiopia	$211	$221	$3	$655	$4	$46	$47	$43	n/a	$72	n/a
Haiti	$550	$621	$12	$868	$12	n/a	$72	$143	n/a	$41	$93
Kenya	$279	$327	$4	$161	$4	$61	$41	$15	$101	$34	$202
Lesotho	$34	$34	$14	$59	$9	$147	$25	$39	n/a	n/a	n/a
Malawi	$25	$39	$2	$50	$3	$130	$12	$17	n/a	$42	$245
Mozambique	$228	$247	$3	$223	$9	$134	$48	$52	$2,387	$78	$1,189
Nigeria	$209	$224	$8	$403	$6	n/a	$42	$28	$153	$52	$72
Rwanda	$437	$458	$4	$189	$4	$18	$73	$20	n/a	$52	$461
South Africa	$33	$39	$4	$39	$4	$160	$64	$292	$111	$154	$59
South Sudan	$135	$135	$51	$497	$54	n/a	n/a	$2	n/a	$594	n/a
Swaziland	$44	$101	$18	$270	$13	$227	$53	$25	n/a	$445	$1,144
Tanzania	$213	$221	$4	$340	$4	$40	$56	$17	$191	$42	$82
Uganda	$181	$189	$3	$84	$2	$30	$47	$3	n/a	$16	n/a
Zambia	$173	$187	$7	$114	$20	$59	$19	$11	$37,888	$100	$2,478
Zimbabwe	$46	$46	$2	$29	$14	$108	$42	n/a	n/a	n/a	n/a


Sarah Day Smith/PEPFAR

A family in Mozambique.

APPENDIX Q: Engaging Partner Governments and Civil Society

The 22 Partnership Frameworks (PFs) established between PEPFAR and its partner countries during Phase II marked the shift from an emergency response to a sustainable response. This initiated a new level of consultation with partner countries that prioritized country-led management, coordination, and implementation, as well as increased financing of the national HIV/AIDS response where it was appropriate, while sustaining programmatic quality and coverage goals.

Several PFs expired between 2012 and 2014, which provided valuable lessons. These lessons included the importance of focusing on key investments required to accelerate and sustain gains for epidemic control and the consequences of not negotiating PFs with entities such as Ministries of Finance. Another lesson learned was the impact of a lack of data use and transparency in the decision making process for resource allocation. There were also positive lessons from the PFs, including recognizing the value of a high-level, bilateral consultation to resolve disagreement, and of candid dialogue, transparency, and rewarding good governance.

Developing a shared responsibility through ongoing diplomatic and programmatic relations with host country governments is critical to reaching the 90-90-90 goals and sustained HIV epidemic control. In doing so, governments will need to demonstrate political will and mobilize resources to establish and effectively implement fundamental policy and programmatic reforms to increase access to lifesaving ARV medications. This specifically includes adopting WHO's Test and START guidelines, improving efficiencies in the delivery of HIV care and treatment services within the existing HIV care system, specifically prescriptive and

diagnostic practices at the clinic level. These reforms will require both systematic and institutional reforms within the national human resource environment regarding the types and roles of community health care workers for HIV testing and drug dispensing, as well as the mobilization of additional domestic resources to address the current funding gaps in the drug supply. PEPFAR has extensive experience working with host governments to develop and implement these types of reforms. Our engagement will result in stronger government-to-government relations to enhance shared responsibilities toward epidemic control.

Given the lessons learned from the PFs and the current budget environment, PEPFAR is partnering with the U.S. Department of the Treasury to leverage its bilateral economic dialogue with finance ministries, deploy Department of the Treasury Technical Assistance advisors to work with partner finance ministries, and access the Department of the Treasury's expertise in economic and fiscal analysis. To support the Treasury engagement, PEPFAR will provide funding for two headquarters staff and for full-time Office of Technical Assistance (OTA) advisors in up to six countries, plus additional short-term staff. Treasury will work with finance ministries to channel new funding commitments into productive investments and support the longer-term transition to country management and financing of HIV treatment. The agreement with Treasury is flexible and will enable PEPFAR and Treasury to reorient efforts both within countries and between countries as needs change.

In April 2015, PEPFAR and the U.S. Department of the Treasury co-hosted a roundtable with African finance ministers and other international partners during the World Bank/IMF Spring Meetings in Washington, D.C., to discuss the economic and fiscal challenges of the HIV/AIDS epidemic. Participants in the roundtable included: senior Finance Ministry representatives from Malawi, Mozambique, Uganda, and Zambia, along with senior representatives from UNAIDS, the Global Fund, the IMF, the World Bank, and the African Development Bank. PEPFAR and Treasury staff are creating HIV expenditure committees in partnership with ministries of finance to better coordinate all sources of funding. The goal is to increase efficiency, increase domestic resources, and deploy those domestic resources in the most effective and coordinated manner.

The April 2015 roundtable marked the first of many important discussions—among donors, between donors and partner country governments, and within partner country governments—so that practical steps can be taken to deliver on the promise of a healthier and more prosperous future for the people of sub-Saharan Africa and around the globe.

PEPFAR, in collaboration with UNAIDS, recently initiated a Sustainability Working Group with the Global Fund and World Bank. Each institution has put sustainability front and center, given not only the flat funding environment, but also the increased capacities and movement toward epidemic control in many mid-level income countries. The group's objective is to foster a common understanding of how each institution approaches sustainability within its investments. The working group will focus initially in three to four countries to mutually influence progress on identified needed dimensions (e.g., health insurance as part of sustainable domestic resource mobilization) to ensure sustained epidemic control.

PEPFAR is also opening its data to drive program efficiency, transparency, coordination, and mutual accountability. In 2015, PEPFAR released a range of additional data on the PEPFAR Dashboards, including for the first time PEPFAR procurement transaction data from the U.S. Agency for International Development Supply Chain Management System (SCMS). These data provides a more complete picture of global spending on HIV/AIDS medical commodities and allows all stakeholders to make data-driven decisions. The SCMS dataset is particularly valuable for understanding ranges and trends in pricing for specific commodities, as well as trends in the types of commodities that have been delivered to various countries.

Rev. Canon Gideon Byamugisha shares a moment with community members at PEPFAR-supported faith-based consultation in Kenya.

APPENDIX R: Engaging Faith-Based, Locally Based, and Minority Partners

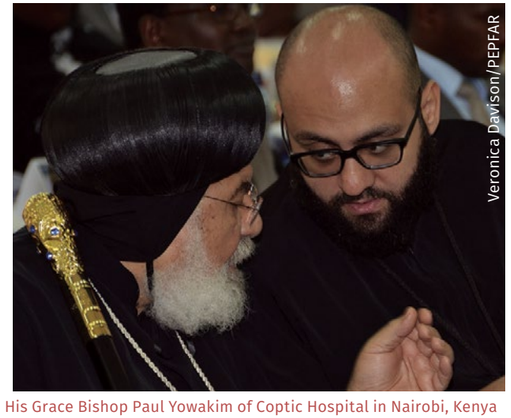
The significant contributions of academic institutions, FBOs, and other stakeholders to the global response to HIV/AIDS are essential to reaching an AIDS-free generation. The domestic and global HIV/AIDS communities are working together in a focused, coordinated, data-driven manner (focusing on doing the right things, in the right places, right now) to achieve epidemic control.

FBOs

FBOs are among our central partners in the development of policies guiding PEPFAR, as well as the delivery of care and treatment services. In April 2015, PEPFAR, in cooperation with academic institutions, brought together more than 50 religious and FBO leaders from Kenya, Rwanda, Uganda, and Tanzania to discuss how to strategically work together in the response to HIV. Participants discussed a number of issues, including how to best serve key and vulnerable populations, combat GBV, and ensure the health and well-being of OVC, including adolescent girls and young women. At the conclusion of the consultation, participants drafted 10 recommendations on how to maximize the capacities of FBOs in a coordinated, sustained way (Table 7). The recommendations focus on expanding the availability of data, increased accountability, and greater collaboration between FBOs and other stakeholders, including global partners.

At the United Nations General Assembly meeting in September 2015, PEPFAR and UNAIDS launched a two-year, $4 million initiative, informed by the report ***"Building on Firm Foundations: The 2015 Consultation on Strengthening Partnerships Between Faith-Based Organizations and PEPFAR to Build Capacity for Sustained Responses to HIV/AIDS."*** The first phase of the initiative will strengthen partnerships with FBOs in up to five countries across five focus areas:

1. **Collect, analyze, and disseminate data** on health care services provided by FBOs.
2. **Address stigma and discrimination** in communities and health care settings.
3. **Demand creation and retention in care**; build capacity for joint action between communities of people living with HIV and FBOs.
4. **Strengthen HIV and AIDS-related service provision** for networks of faith-based health service providers to reach the most marginalized populations with



His Grace Bishop Paul Yowakim of Coptic Hospital in Nairobi, Kenya converses with Fr. Mena Attwa at PEPFAR-supported faith-based consultation.

comprehensive, equitable HIV testing, prevention, and treatment services.

5. **Bolster FBO leadership and advocacy** for the UNAIDS Fast-Track approach and a sustained response to end the global AIDS epidemic by 2030.

United States Minority Serving Institutions (MSI)

United States Minority Serving Institutions, including Historically Black Colleges and Universities (HBCUs), bring particular strength and expertise in the delivery of HIV prevention, care, and treatment services in resource-limited environments and to vulnerable populations. In 2015 and early 2016, the U.S. Global AIDS Coordinator Ambassador Birx directly engaged with students, faculty, and administrators of Spelman College, Morehouse College, Meharry Medical College, and Charles R. Drew University of Medicine and Science, to strengthen our collaborative partnerships.

Table 7. Ten Recommendations Made by FBO Leaders at the April 2015 Consultation

1. Leverage the trust that has developed between FBOs and local communities to build strong, inclusive, integrated HIV prevention efforts.
2. Develop the capacity for FBOs to advocate for improved health care for all citizens and hold governments accountable.
3. Maximize the existing organizational infrastructure of faith-based health systems to reach communities impacted by HIV.
4. Strengthen the capacity of FBOs to develop systems and tools for gathering, sharing and utilizing data for decision making and advocacy.
5. Actively solicit community input and investment into FBO administration and programming.
6. Develop mechanisms to support the organizational development of FBOs.
7. Increase FBOs' capacities to develop and implement effective programs and systems.
8. Broaden participation among diverse FBOs.
9. Ensure strong monitoring and evaluation for all FBO programs.
10. Strengthen leadership development initiatives to better equip the next generation of leaders.

Table 8. Members of the PEPFAR Scientific Advisory Board

Name	Institution
Quarraisha Abdool Karim	University of KwaZulu-Natal; Centre for the AIDS Programme of Research in South Africa (CAPRISA); Columbia University
Judith Auerbach	University of California, San Francisco, School of Medicine
Peter Berman	Harvard University School of Public Health
Connie Celum	University of Washington, School of Medicine
Judith Currier	University of California, Los Angeles, School of Medicine
Carlos del Rio	Emory University
Sofia Gruskin	University of Southern California
Mark Harrington	Treatment Action Group (TAG)
Mark Heywood	Section 27
Musimbi Kanyoro	Global Fund for Women
Etienne Karita	Rwanda Zambia HIV Research Group, Project San Francisco
Jennifer Kates	Kaiser Family Foundation
Lejeune Lockett	Charles Drew University of Medicine and Science
Ruth Macklin	Yeshiva University
Celia Maxwell	Howard University
Kenneth Mayer	Fenway Institute; Harvard University; Beth Israel Deaconess Medical Center
Jesse Milan	Altarum Institute
Angela Mushavi	Ministry of Health and Child Welfare, Zimbabwe
Christine Nabiryo	Transforming Communities: A Village at a Time
Nyambura Njoroge	Ecumenical HIV and AIDS Initiatives and Advocacy, World Council of Churches
Jean Pape	Weill Medical Cornell College; GHESKIO
David Peters	Johns Hopkins University
Edwin Sanders	Metropolitan Interdenominational Church of Nashville
Fredrick Sawe	Kenya Medical Research Institute/Walter Reed Project
Albert Siemens	FHI Foundation
Carole Treston	Association of Nurses in AIDS Care
Mitchell Warren	AVAC: Global Advocacy for HIV Prevention

Scientific Advisory Board (SAB)

Ambassador Birx announced new members of PEPFAR's Scientific Advisory Board in 2015 in order to ensure broader and more diverse engagement with scientific communities across multiple sectors (Table 8). In March 2015, PEPFAR SAB's charter was renewed.

New members of the Scientific Advisory Board (SAB) include experts affiliated with HBCUs, such as Dr. Celia Maxwell of Howard University and Dr. Lejeune Lockett of Charles Drew University of Medicine and Science, and the faith community, such as Reverend Edwin Sanders of the Metropolitan Interdenominational Church of Nashville and Dr. Nyambura Njoroge of the World Council of Churches. The Board issued recommendations this year in two broad critical areas for PEPFAR: (1) ***Recommendations for use of Pre-Exposure Prophylaxis (PrEP) for all Populations, and (2) Recommendations Regarding Provision of ART for all Persons Living with HIV (Test and START***). For further information, please see: http://www.pepfar.gov/sab/

APPENDIX S: Engaging International and Nongovernmental Partners

In 2015, PEPFAR launched and/or implemented several initiatives that focused on bolstering the role of new partners and civil society organizations—core leaders in the HIV/AIDS response and in protecting human rights so that all people have access to HIV/AIDS services without the fear of stigma and facing discrimination.

- **Inclusive PEPFAR Planning Process**: PEPFAR committed to engaging, empowering, and supporting civil society at every step of the Country and Regional Operational planning process in 2015. All PEPFAR countries were directed to actively involve civil society throughout the development of their annual plans. During the COP 2015 in-person reviews, each country was required to invite members of civil society, host country governments, multilaterals, and other stakeholders to participate in discussions with Ambassador Birx around our annual PEPFAR planning process. Additionally, in November 2015, PEPFAR posted its draft 2016 COP/ROP Guidance online to collect feedback from all stakeholders, including civil society organizations. The comments directly informed the final guidance, posted online on World AIDS Day 2015.
- **Gender and Sexual Diversity Trainings**: PEPFAR headquarters staff and Health Policy Project[31] staff together trained more than 1,200 PEPFAR staff and more than 1,000 of implementing partner staff on the importance of understanding the impact of gender on the HIV epidemic, especially high-burden sexual minorities. Many PEPFAR programs operate in countries where gender and sexual minorities face increasing violence, legal sanctions, and a disproportionate burden of HIV, and are further imperiled under hostile social and political conditions, making our efforts to scale up HIV programs increasingly difficult. To ensure that PEPFAR and partner staff understand existing constructs around gender and sexual diversity, the PEPFAR Gender and Sexual Diversity Training was conducted in 39 PEPFAR countries.
- **PEPFAR's Local Capacity Initiative (LCI)**: LCI provides funding to local nongovernmental organizations in 14 PEPFAR countries to support and build their capacity to address the HIV/AIDS epidemic through legal and policy advocacy, stigma and discrimination reduction, and planning and implementation of country programs. In November 2015, LCI held an African Advocacy

31 The Health Policy Project is a partner of USAID that works to strengthen policy, advocacy, governance, and finance for strategic, equitable, and sustainable health programming.

workshop that was designed to bring together African LCI grantees to share their advocacy experiences and provide a deeper understanding to civil society organizations and others of the role of advocacy, appropriate advocacy interventions, and how to implement advocacy activities to improve the quality and uptake of HIV/AIDS services for vulnerable and key populations. The meeting facilitated south-to-south exchanges of information and best practices, and was an opportunity for LCI grantees to further develop skills in essential advocacy competencies, as well as share lessons learned and best practices from implementation of LCI activities.

- **Robert Carr Civil Society Network Fund**: In September 2015, PEPFAR announced that it will make a $10 million contribution to the Robert Carr Civil Society Networks Fund (RCNF) over the next three years to support and build the capacity of global and regional civil society networks as strong partners in the delivery of HIV services and champions of human rights. This investment will help to bring often marginalized populations out of the shadows and into prevention services and health care clinics. As co-chairs of the RCNF Replenishment, UNAIDS and PEPFAR will help ensure access to HIV prevention, treatment, and care services through the partnership of the networks with local organizations to achieve the UNAIDS 90-90-90 goals and Fast-Track strategy. The RCNF is especially important to supporting efforts aimed at key populations that include MSM (such as through the Global Forum on MSM & HIV), sex workers, PWID, and all people living with HIV—from young people who have lived with HIV since birth to older men and women who have now survived for more than a decade due to the success of treatment.

Adolescents advocating for sexual abuse victims during a “Shout the Silence” forum in Kenya.

Demonstration by men who have sex with men in Mozambique

- **Investing in Key Populations**: PEPFAR ensures countries are targeting funds for expanding HIV services delivery and technical assistance to key populations. PEPFAR will continue to do so through implementing targeted initiatives for key populations, including the Key Populations Challenge Fund, a $33 million program designed to stimulate a greater programmatic response for and commitment to key populations.

- Partnership with the Elton John Foundation: In November 2015, PEPFAR and the Elton John AIDS Foundation (EJAF) announced the launch of a $10 million partnership to provide grants to organizations working to meet the HIV-related needs of Lesbian, Gay, Bisexual and Transgender (LGBT) people, with an initial focus on sub-Saharan Africa. The new partnership will see EJAF and PEPFAR each invest $5 million to improve access to HIV services for LGBT people and help to create nonstigmatizing environments by working with community leaders, civil society, and service providers, and targeting projects that support LGBT people within countries with a high HIV burden.

APPENDIX T: Addressing the Co-Infections and Co-Morbidities of HIV/AIDS

TB-HIV Co-infection

TB is the leading cause of death among people living with HIV in sub-Saharan Africa, accounting for more than 1,000 lives lost each day. In 2014, an estimated 9.6 million people developed TB, of whom 1.2 million were people living with HIV; 1.5 million people died from TB, of whom 390,000 (26 percent) people living with HIV. By the end of 2014, despite a 37 percent reduction in TB-related mortality among people living with HIV compared with 2004 (570,000 deaths), TB/HIV still accounts for one-third of the estimated 1.2 million AIDS deaths among people living with HIV. For a person living with HIV, ART reduces the risk of developing TB by around 65 percent, and when combined with isoniazid preventive treatment, this prevention impact increases to around 90 percent. Additionally, ART reduces the mortality for people living with HIV who develop TB by approximately 50 percent. PEPFAR can have the biggest impact on the HIV/TB epidemic by adopting the new WHO treatment guidelines and beginning HIV treatment immediately upon diagnosis and preventing TB.

Given this enormous human toll, PEPFAR continues to address the deadly links between TB and HIV as a top policy and programmatic priority. PEPFAR, in alignment with the goals of the ***National Action Plan for Combating Multidrug-Resistant Tuberculosis (National Action Plan),***[32] aims to dramatically reduce the impact of HIV-associated TB through a combination of expanded access to early HIV diagnosis and treatment, preventive therapy with isoniazid, infection control activities, and early identification and treatment of TB. Implementation of the National

32 The White House. (2015). *National Action Plan for Combating Multidrug-Resistant Tuberculosis*. Available at: https://www.whitehouse.gov/sites/default/files/microsites/ostp/national_action_plan_for_tuberculosis_20151204_final.pdf

Action Plan and achievement of its goals and objectives will depend not only on sustained coordination among U.S. agencies to ensure a strategic, whole-of-government approach, but also on close collaboration with other nations' Ministries of Health, the WHO, the Stop TB Partnership, the Global Fund, and other domestic and global partners in the fight against TB.

Collaborative TB/HIV activities offer important opportunities to achieve the ambitious 90-90-90 goals—testing TB patients for HIV and providing immediate ART contributes to 90-90-90 and epidemic control. By the end of FY 2015, PEPFAR had screened 12.1 million HIV-positive persons in care for TB (Appendix W: Table 15). In all efforts, PEPFAR closely coordinates with national TB and AIDS programs, multilateral institutions, and other partners to strengthen systems that address both diseases. The Global Fund decision in 2013 requiring the 38 highest TB and HIV burden countries to submit a single concept note for both diseases has improved co-investment and opportunities for better coordination and enhanced impact through joint program planning and funding for HIV, TB, and HIV-associated TB. Stakeholders engaged in HIV and TB have jointly developed programs.

Tugela Ridley/USAID

Health care volunteers work to end stigma and discrimination while providing essential services.

Across the cascade of TB/HIV services, PEPFAR-supported programs reflect the following priorities:

- Achieve 90-90-90 goals, which will have a significant impact on the TB epidemic (ART is the most powerful HIV-associated TB prevention measure).
- Ensure all patients with presumptive TB or actual TB receive HIV testing.
- Provide immediate access to ART for patients with TB who are infected with HIV, with the goal of providing universal (100 percent) ART coverage among HIV-infected TB patients.
- Support integration of TB/HIV care and treatment to ensure linkage and retention.
- Implement, track, and report on TB screening among people living with HIV, ensure diagnostic follow-up for people living with HIV with presumptive TB and TB treatment for people living with HIV with TB disease, and provide isoniazid preventive therapy for people living with HIV who do not have active TB disease.
- Support TB infection control measures to prevent transmission in health care and community settings.
- Expand interventions, including Xpert MTB/RIF assay, to improve early diagnosis and treatment of TB among people living with HIV.
- Strengthen TB/HIV program monitoring and evaluation.

PEPFAR continues its efforts to support scale-up of the Cepheid GeneXpert MTB/RIF test, an innovative, fully automated molecular diagnostic test for TB. This test enables programs to diagnose TB quickly, which can help reduce transmission and decrease mortality. PEPFAR and the USAID are partnering closely with UNITAID and the Bill & Melinda Gates Foundation in an innovative public-private partnership to reduce the cost of Xpert MTB/RIF cartridges by 40 percent.


Paul Hansel

A state-of-the-art GeneXpert machine in South Africa provides TB diagnosis in hours rather than weeks.

Cervical Cancer

Given the established link between HIV and cervical cancer—especially the most aggressive form of cervical cancer in HIV-positive women—PEPFAR has supported screening and treatment to prevent cervical cancer in HIV-positive women since 2006, termed "screen and treat." PEPFAR has also worked with countries and the Vaccine Alliance (GAVI) to increase access to primary prevention of cervical cancer through HPV vaccination. PEPFAR specifically focuses on secondary prevention of cervical cancer, providing screening and treatment for precancerous lesions to prevent the development of invasive cancer. These cervical cancer programs build on the HIV platform to leverage existing systems and maximize synergies and efficiencies. In most programs, cervical cancer screening and treatment are offered in HIV care and treatment settings, providing integrated service delivery and optimizing accessibility for HIV-positive women. PEPFAR's work developing and implementing cervical cancer screening and treatment programs has laid the groundwork for governments and other partners to build and expand programming to serve broader populations.

PEPFAR is also a founding member of Pink Ribbon Red Ribbon (PRRR), a public-private partnership launched in 2011 focused on combating cervical and breast cancer in developing nations in sub-Saharan Africa and Latin America. Led by the founding partners—the George W. Bush Institute, PEPFAR, Susan G. Komen for the Cure, and UNAIDS, along with multiple private-sector partners and foundations—PRRR works to expand the availability of prevention, screening, and treatment for cervical cancer and promote education and early detection for breast cancer. PEPFAR currently supports cervical cancer programming through PRRR in Zambia, Botswana, and Tanzania, with planning underway for expansion into Ethiopia and Namibia. Zambia is considered a flagship program, with cervical cancer screening and treatment now available in all 10 provinces at 37 fixed sites, with mobile units reaching an additional 48 sites. Since the inception of PEPFAR/PRRR programming in Zambia, Botswana, and Tanzania, nearly 200,000 women have been screened for cervical cancer. Importantly, PRRR has served as a catalyst, working closely with host countries to move from pilots to scale and full-country funding. This cycle is being completed in less than five years with PEPFAR support in Botswana and Zambia.


Pink Ribbon Red Ribbon

Volunteers register women for cervical cancer screenings in the Iringa region of Tanzania.

APPENDIX U: Strengthening Health Training and Data Systems

Human Resources for Health (HRH)

PEPFAR supports partner countries in increasing human resources for health (HRH) in order to deliver HIV services where the epidemic is most acute. Our HRH investments ensure that health workers with the right skills are in the right places to scale up HIV services at the right time to achieve the UNAIDS 90-90-90 goal. PEPFAR 3.0's HRH Strategy focuses investments on supporting the delivery of HIV services to priority populations in PEPFAR-supported sites and geographic areas by:

- assessing HRH capacity;
- supporting HRH supply and retention;
- improving service quality; and
- ensuring sustainable financing for health workers providing HIV services.

To support this PEPFAR committed $116.5 million to strengthen the capacity of health workers to address HIV/AIDS across Africa with a particular focus on some of the world's most fragile states. This funding will support an increase in the supply of skilled clinicians available to provide HIV services by expanding the role of the Peace Corps Global Health Service Partnership program and by supporting NIH/FIC in increasing capacity of key training institutions in Africa. HRH investments will be leveraged to address drivers of HIV and other health epidemics through a five-year commitment with Health Resources and Services Administration (HRSA) that will expand the quantity and quality of health workforces in fragile states. In addition, funding will support implementation science by NIH/DAIDS to continue to ensure PEPFAR invests in evidence-based interventions. Past HRH investments by PEPFAR have yielded important results, including the following:

A new class of health care workers completes their training in Malawi.

- Implementation of the HRH Strategy has enhanced HRH programming; helped to increase the availability, quality, and retention of health care workers; and resulted in improved delivery of HIV/AIDS services. As of September 30, 2015, PEPFAR is supporting training (including preservice training) for more than 190,000 new health care workers in PEPFAR-supported countries to deliver HIV and other health services.
- Interagency visits to Liberia and DRC were undertaken to assess gaps, identify priorities, and ensure a harmonized U.S. government approach to addressing the country's HRH issues following the Ebola epidemic.
- In Tanzania, faculty incentives and recruitment efforts have helped grow the number of medical school faculty from 96 to 167 in less than five years.
- In Malawi, PEPFAR supported training for clinicians in detection, diagnosis, and treatment of HIV-associated cancers. The services were implemented in three clinics, reaching 15,000 HIV-infected women per year.
- In Malawi, PEPFAR support has gone to more than 400 Global AIDS Interfaith Alliance nursing scholars and resulted in 97 percent of graduates currently working in the public sector or having completed their service agreement.
- Translating these pockets of excellence across the PEPFAR investment countries will be the focus of the next 12 months and will form the basis of the new HRH Strategy.

Strengthening Data Systems for Sustainability

PEPFAR is leading by example and forging innovative partnerships to support countries in strengthening their data systems, and is leveraging these systems to accelerate, focus, and sustain the response to HIV/AIDS.

- **Global Partnership for Sustainable Development Data**: PEPFAR has joined public, private, and civil society partners through the Global Partnership for Sustainable Development Data (Global Partnership) to fill critical data gaps and invest in capacity building so data can be optimally analyzed and used. PEPFAR, on behalf of the United States, will provide $3 million as part of a consortium of funders to seed this initiative. PEPFAR will focus on data efforts to achieve an AIDS-free generation, linkages with global health, and accelerating gender equality programming.
- **Data Collaboratives for Local Impact:** PEPFAR and the MCC are partnering to invest $21.8 million in multistakeholder Data Collaboratives for Local Impact in sub-Saharan Africa. These Collaboratives will use data on HIV/AIDS, global health, gender equality, and economic growth to improve programs and policies. The Tanzania Data Collaborative is being established in Dar es Salaam as an innovative work space and technology platform to share, combine, and use data from multiple sectors and sources to inform health and development programs and build local capacity and demand around data. The "Data for Local Impact" Innovation Challenge will identify, support, and mobilize innovative, high-impact approaches to fill data gaps and improve data for decision making at the subnational level.

APPENDIX V: Evaluation Standards of Practice

In September 2015, PEPFAR published Evaluation Standards of Practice Version 2,[33] which elaborated on the original standards presentation with additional clarity and more details regarding requirements for the Annual Report and for the Country/Regional Operational Plans. The fundamental principles constructed on a common definition of evaluation—the "systematic collection and analysis of information about the characteristics, outcomes, and impact of programs and projects"—remained the same, as have the 11 standards of practice (SOP) to which all PEPFAR evaluations must adhere.

The Standards of Practice (SOP)

These evaluation standards were identified and defined by an interagency committee. Full descriptions for each standard can be found in the document cited above.

- Engage stakeholders
- Clearly state evaluation questions, purpose, and objectives
- Use appropriate evaluation design, methods, and analytical techniques
- Address ethical considerations and assurances
- Identify resources and articulate budget

33 PEPFAR. (2015). *Evaluation Standards of Practice – Version 2.0*. Available at: http://www.pepfar.gov/documents/organization/247074.pdf

Teachers participate in a candlelight vigil after receiving training on HIV/AIDS in Ukraine.

- Construct data collection and management plans
- Ensure appropriate evaluator qualifications and independence
- Monitor the planning and implementation of evaluations
- Produce quality evaluation reports
- Disseminate results
- Use findings for program improvement

Findings

FY 2015 is the second year for submission of evaluation results and offers an opportunity to compare results with those of the previous year. Submissions for the FY 2015 Annual Program Results (APR) reflected the completion of 26 PEPFAR evaluations during this year (Table 9). Similar to last year, these evaluations started in years prior to the release of the Evaluation Standards of Practice; as such, this assessment of adherence was conducted for projects that started before the release of the standards.

Fifty percent of the 26 evaluation reports are on a publicly available website. The remaining reports are not online for a range of reasons, including outstanding feedback from Operating Units (OU). Since all PEPFAR implementing agencies now mandate public reporting, the reports that are not currently online will be published online in the near future.

Adherence to Standards

Determining compliance with standards is dependent on a review of an evaluation final report and responding to a question or series of questions associated with each standard (see the Evaluation Standards of Practice V.2). Responses to these questions were limited to "Yes," "Partial," and "No." For composite standards based on several questions, if all answers were "yes," the final score was "yes"; if all were "no," the final score was "no"; and any other combination of answers was given a "partial" score. Data completion for these reviews was nearly complete, with a very few missing responses.

The total number of completed evaluations documented in FY 2015 included 26 studies. These evaluations were conducted in 11 countries, eight in Africa (19 evaluations) and three in Asia (7 evaluations). PEPFAR support was provided by CDC for 14 of the studies and by USAID for 12.

Examining these same studies in the aggregate according to each standard—employing arbitrary cutoff criteria consistent with those used in FY 2014 (see note in Table 9)—the evaluations were found to adhere to five of the eleven SOP (Table 9). This pattern suggests that while many of these studies were developed on a relatively strong foundation, considerable improvement is still necessary. We anticipate stronger patterns to become evident in the next few years as more evaluations are launched, fully guided by these SOP.

Table 9. Aggregate Adherence Patterns for PEPFAR Evaluation Standards of Practice, 2014

PEPFAR Evaluation Standards of Practice - FY 2015											
Adherence	SOP1	SOP2	SOP3	SOP4	SOP5	SOP6	SOP7	SOP8	SOP9	SOP10	SOP11
Yes	20	24	19	15	3	22	4	19	11	7	15
Partial	4	2	6	8	1	3	17	1	15	15	5
No	2	0	1	3	22	1	0	6	0	4	6

Note: Green signifies high levels of compliance with a standard (Yes =61% or greater of total); yellow indicates mid-level (Yes = 41-60% of total); and red reflects low-level (Yes = 40% or less of total).

Consideration by Standards

Relatively poor scores are assigned to SOPs 5, 7, and 10. Describing resources and budgets (Standard 5) and dissemination of results (Standard 10) also scored poorly last year, while evaluator qualifications and independence (Standard 7) scored in the mid-level last year and low-level this year. Recognizing that these standards are relatively new for already implementing and terminating evaluations, some of these practices still should be easy to remedy even for evaluations near completion. These particular practices will receive considerably greater attention this next year through specific technical assistance from the PEPFAR implementing agencies.

The mid-level scores for ethical considerations (Standard 4), quality reports (Standard 9), and uses of findings (Standard 11) are also of concern. Standards 9 and 11 scored similarly last year, while Standard 4 was found adherent last year. This pattern of decreasing adherence for ethical considerations is especially important, while the continuing mid-level trends for reports and use of findings demand more focused interventions with the evaluation implementers.

Compared with results from FY 2014, the overall quantity of FY 2015 studies is lower. In obvious respects this trend is concerning, yet some of this pattern might be associated with the fact that most of the older evaluations from multiple years were documented last year as a cumulative total; conversely, the current year submission represented a more limited time period of execution. In both cases, all of these evaluations were initiated before the introduction of the standards, although some of the standard guidance might have been better integrated into the ongoing work.

The headquarters evaluation committee will continue to work closely with headquarters and country teams to improve the quality of evaluations and expand the availability of results. These gaps are being actively analyzed, appropriate policies and requirements will be modified, greater engagement of headquarter and OU staff with the evaluators will be pursued, and further work to re-emphasize these SOP to all implementing partners to ensure improved adherence will be initiated. Agencies are integrating more formal evaluation requirements tied to the standards into contracts, and monitoring efforts as evaluations are conducted are increasing. These results also highlight that the public dissemination of reports and data need greater attention, and the interagency evaluation work group is reviewing agency policies and practices to ensure they are consistent and share the same ultimate objective of public access. This year, greater attention will be focused on stronger and better configured evaluation portfolios, while integrating U.S. government agency and host country priorities.

Figures and Tables in this Report

Glossary

ACT	Accelerating Children's HIV/AIDS Treatment Initiative
ART	Antiretroviral Therapy
ARV	Antiretroviral Medications
CDC	Centers for Disease Control and Prevention
CIFF	Children's Investment Fund Foundation
COP	Country Operational Plan
CTX	Cotrimoxazole
DOD	Department of Defense
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe Women
DSD	Direct Service Delivery
EA	Expenditure Analysis
FBOs	Faith-Based Organizations
FY	Fiscal Year
GAVI	The Vaccine Alliance
GBV	Gender-Based Violence
Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HHS	Department of Health and Human Services
HIA	HIV/AIDS Impact Assessment
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HRSA	Heath Resources and Services Administration
HSS	Health System Strengthening
HTS	HIV Testing Services
LCI	Local Capacity Initiative
LGBT	Lesbian, Gay, Bisexual, and Transgender

MCC	Millennium Challenge Corporation
MER	Monitoring, Evaluation, and Reporting
MSM	Men who have Sex with Men
NACS	Nutritional Assessment, Counseling and Support
NIH	National Institutes of Health
OGAC	Office of the U.S. Global AIDS Coordinator & Health Diplomacy
OVC	Orphans and Vulnerable Children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PF	Partnership Frameworks
PHIA	Population HIV/AIDS Impact Assessment
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Public-Private Partnerships
PrEP	Pre-exposure Prophylaxis
PRRR	Pink Ribbon Red Ribbon
ROP	Regional Operational Plan
TA-SDI	Technical Assistance for Service Delivery Improvement
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	The United Nations Children's Fund
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

Peace Corps

Peace Corps volunteers in Lesotho help local children stay active and healthy.

PEPFAR

U.S. President's Emergency Plan for AIDS Relief

The Office of the U.S. Global AIDS Coordinator and Health Diplomacy

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