

# PEPFAR

2015 Annual Report to Congress



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Front cover photo

*Lungile looks at her child who was born HIV-free in Swaziland*

Photo Credit: Elizabeth Glaser Pediatric AIDS Foundation

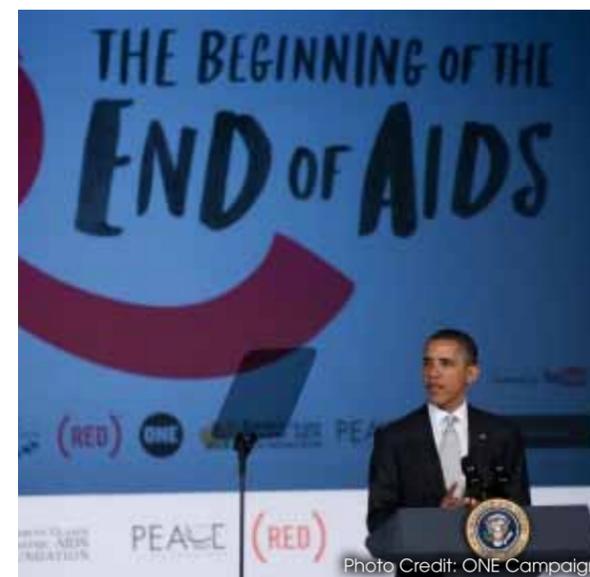
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President Barack Obama on World AIDS Day 2011

In July 1999, the first report to Congress on the impact of AIDS in Africa stated: “AIDS is a plague of biblical proportion with far reaching consequences for us all.” At that time, no one could have imagined the impact of the bold and unprecedented leadership by President George W. Bush and the United States (U.S.) Congress that resulted in the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). PEPFAR was a catalyst for investment and collaboration across communities and among nations, all in response to a single disease.

The return on this historic investment has been extraordinary. PEPFAR has saved millions of lives and prevented millions more HIV infections through lifesaving prevention, care, and treatment services. It has kept over a million babies from being born with HIV and provided compassionate care and support for millions of AIDS orphans and vul-

nerable children (OVC). PEPFAR’s impact far exceeds the reduction of suffering, death, and despair caused by one disease. PEPFAR has built infrastructure, strengthened local health systems, and provided invaluable lessons and experience that will continue to inform and improve responses to unforeseen health crises in the future.

The true success of PEPFAR continues to reveal itself in the compassion and commitment to serve those most in need; the knowledge that we can deliver cutting-edge prevention, care, and treatment in the most resource-limited places in the world with dignity and respect; and the willingness of governments, civil society, and a diverse group of stakeholders to work together until we end AIDS. In the far reaches of countries that have been hardest hit by the epidemic, PEPFAR is a demonstration of the compassion of the American people. It has become an iconic brand of U.S. government engagement in health, development, and diplomacy.

PEPFAR’s contribution to ending the HIV/AIDS epidemic is far from over. As President Barack Obama said: “This is a global fight and it’s one that America must continue to lead... Looking back at the history of HIV/AIDS, you’ll see that no other country has done more than this country, and that’s a testament to our leadership as a country. But we can’t be complacent.” The hard-won gains of the last decade can easily be lost without increased and focused commitment and thoughtful stewardship of our investments to ensure maximum impact. The good news is that we have the knowledge, tools, and experience we need to get the job done. If we stay the course and work together, we can indeed achieve the dream of an AIDS-free generation.

## The World Before PEPFAR

In 2003, HIV/AIDS was devastating families and communities around the world with disastrous social and economic consequences. The reports from those on the front lines of the epidemic were fraught with despair. Gains in global health and development were being lost; in the hardest hit regions of sub-Saharan Africa, infant mortality doubled, child mortality tripled, and life expectancy 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 efforts to provide HIV prevention, care, and treatment services, the epidemic continued to rage unabated as life-saving medications that might turn the tide were inaccessible



Photo Credit: David Snyder/CDC Foundation

Children play together in the community of Mikocheni in Dar es Salaam, Tanzania

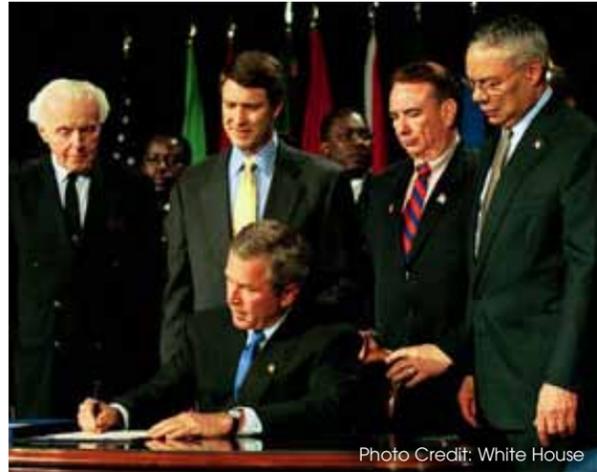


Photo Credit: White House

President George W. Bush signs PEPFAR into law in 2003

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.

In his 2003 State of the Union address, President Bush stated: "Today, on the continent of Africa, nearly 30 million people have the AIDS virus, including 3 million children under the age of 15. There are whole countries in Africa where more than one-third of the adult population carries the infection. More than 4 million require immediate drug treatment. Yet across that continent, only 50,000 AIDS victims—only 50,000—are receiving the medicine they need. Because the AIDS diagnosis is considered a death sentence, many do not seek treatment. Almost all who do are turned away." Following this call to action, 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.

## Changing Lives, Saving Lives

Thanks to ongoing generous support from the U.S. Congress and the strong commitments of both the Bush and Obama administrations, PEPFAR has saved millions of lives and improved the health and well-being of millions more. It remains the largest commitment in history by any nation to combat a single disease.

PEPFAR has transformed the global landscape of HIV/AIDS and halted the relentless escalation of new infections and climbing mortality rates. It has provided life-saving medicines; built and strengthened the capacity of country-specific responses in both government and civil society; and fostered collaboration among the U.S. government, key global partners, and national governments around the world, as well as grassroots organizations in some of the most remote locales. At its core, PEPFAR has offered hope, healing, and the possibility of health and life in place of sickness, suffering, and death.



Photo Credit: Karin Schermbrucker, courtesy of mothers2mothers

Mothers prepare to have their babies weighed at Busesa Health Centre IV in Central Uganda

## PEPFAR's Impact: Prevention of Mother-to-Child Transmission

### Florence



Photo Credit: Florence Ngoben

Florence and her son Kulani

In 1997, Florence Ngoben lost her five-month-old baby to AIDS. "I can tell you that losing a child to HIV is the worst thing a mother can go through," she says. "When I lost Nomthunzi, I cried for a long time. Then I decided to stand up and try to make a difference."

She was offered a job as a counselor at a hospital in South Africa. It could not have come at a better time.

Florence was ready to leave the house because everything reminded her of her loss. However, her new job was not without challenges. For the first few years, it was heartbreaking work. Her clients did not understand HIV/AIDS, and there was no treatment available.

That changed when PEPFAR became involved in South Africa. Soon, there was access to life-saving medication, and prevention of mother-to-child transmission services (PMTCT) became widely available. Finally, Florence felt like she could have the family she always wanted.

The next time she became pregnant, there was access to drugs to stop the transmission of HIV to her baby. Her son, Alex, was born healthy and HIV-negative—as was a second son, Kulani. "What an incredible gift it is to have a healthy baby, free of HIV. It's a gift that every mom deserves. And that's why we have to keep going until we end pediatric AIDS once and for all."

## PEPFAR's Impact: From Testing to Treatment

### Valentine

In 2011, Valentine could barely eat, much less care for her 10-year-old son. She remembers, "I could not even lift a spoon to feed myself. I had to be supported in everything, including feeding and bathing." She went from one traditional healer to another, but no one could diagnose what was wrong with her. Her husband, believing her illness was brought on by evil spirits, left her and their son. At a time where little was going right, a visit from a stranger would change the course of her life.

Domingas João Quembo was a peer educator with a PEPFAR-supported project. Domingas explained to Valentine the importance of HIV testing and counseling as a critical tool in preventing HIV infection and in linking people who test positive to care and treatment services. Some of what Domingas told Valentine rang true for her symptoms, and she decided to get an HIV test—with Domingas at her side. "The result came back positive. It made me very sad but having Domingas there to encourage me was helpful."

Valentine began antiretroviral therapy (ART). Soon after, Valentine and her son returned to live with her husband. She convinced her husband to get tested for HIV, and he started ART after a positive result. She promised herself that she would help other people in Mozambique, just like Domingas helped her, once she started to feel better. She now works as an HIV peer educator, using her experience to inform and support others in her community.

Since finding out her status, she has become a mother again—to a HIV-negative daughter—and she is living a healthy life. "Maybe God is rewarding me for the work I am doing in this community," she says. "HIV/AIDS is everybody's problem: family, community, and society, and we have to join hands and address the issue together."



Valentine and her two children outside their home



Former First Lady Laura Bush and First Lady Michelle Obama at the African First Ladies Summit in Dar es Salaam, Tanzania in 2013

### PEPFAR Over Time

PEPFAR was well named. The global HIV/AIDS pandemic was indeed an emergency. By 2003, over 20 million men, women, and children had died in sub-Saharan Africa alone. They were mothers, fathers, teachers, doctors, nurses, and in the wake of their untimely deaths, 14 million orphaned children were left behind.

In five short years, the United States and its partners had accomplished what seemed impossible. Hospitals and clinics were built, doctors and nurses were trained, and millions of people infected with the virus were provided treatment. Comprehensive HIV education programs were developed. Pregnant women received education and opportunities for testing; if they were HIV positive, they received treatment to prevent HIV transmission to their babies. Hundreds of thousands of babies born to mothers living with HIV came into the world free of the virus, and children who were infected were treated.

PEPFAR strengthened country capacity as promising national HIV/AIDS strategies were implemented and brought to scale. Prevention, care, and treatment were carried out in collaboration between national governments and their partners, including the U.S. and other donor nations, and organizations across civil society, including faith-based organizations (FBOs), private sector partners, foundations, and key multilateral organizations. Programs were improved by seeking the essential insights of those living with HIV, putting a face on the epidemic.

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—joint strategic roadmaps on HIV/AIDS, agreed to and signed by the U.S. and partner governments, promoting mutual accountability and sustainability of the HIV/AIDS response. PEPFAR signed 22 Partnership Frameworks 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: antiretroviral treatment (ART), prevention of mother-to-child transmission (PMTCT), voluntary medical male circum-



Two women visit outside their homes in the community of Mikocheni in Dar es Salaam, Tanzania



Mother and baby in Kenya

cision (VMMC), and comprehensive prevention programs that included the use of condoms were implemented with PEPFAR support in countries around the world.

Now, PEPFAR is heading into Phase III. In what may be the most challenging—but exciting—phase yet, PEPFAR is now strategically focused on sustainable control of the HIV/AIDS epidemic. The Joint United Nations Programme on HIV/AIDS (UNAIDS) has announced ambitious 90-90-90 global treatment targets—90 percent of people living with HIV diagnosed, 90 percent diagnosed on ART, and 90 percent of people on ART virally suppressed by 2020. To support these goals, PEPFAR is shifting the way it works. We can best control the epidemic by focusing on a data-driven approach that strategically targets populations at greatest risk in geographic areas with the highest HIV burden. As stated in the *PEPFAR Blueprint for Creating an AIDS-free Generation*, we must go where the virus is and put our resources where we can achieve the greatest impact.

On World AIDS Day 2014, we released *PEPFAR 3.0 — Controlling the Epidemic: Delivering on the Promise of an AIDS-free generation*, which outlines the strategy and goals for Phase III of the program and focuses on controlling the 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 U.S. 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.



Photo Credit: David Snyder/CDC Foundation

Young girl in Usoma, Kenya

- **Partnership Action Agenda**—strengthening partnerships to achieve sustainability and ultimately create an AIDS-free generation.
- **Human Rights Action Agenda**—securing and protecting human rights and addressing the human rights challenges of those affected by the disease.

### Improving Program Efficiencies and Effectiveness

We have learned many lessons in the past decade. We never forget that we are accountable to the U.S. Congress, which recently enacted P.L. 113-56, the *PEPFAR Stewardship & Oversight Act*, and also to 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. Committed to earning and maintaining that trust, PEPFAR has done just that.

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 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 has been equally important to bilateral engagement and ensuring successful implementation of the program.



Photo Credit: PEPFAR

Workplace HIV peer educator

As of September 2014, 7.7 million people have received life-saving ART due to PEPFAR support. Over one million babies have been born HIV-free to HIV-positive mothers. In Fiscal Year (FY) 2014, PEPFAR supported 56.7 million HIV tests, identified nearly 2.9 million HIV-positive individuals, and worked with millions of HIV-negative individuals on strategies to protect themselves, their partners, and their children from infection. These results are not just numbers; each individual reached through PEPFAR contributes to the health of his or her community and country. This is our ultimate measure of success.

We have been steadfast in the adoption of a data-driven, targeted approach to address one of the most complex global health issues in modern history. By taking evidence-based, community-focused HIV prevention, treatment, and care programs to scale in under-resourced settings, the U.S. 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's Impact: Voluntary Medical Male Circumcision—A Family Decision

#### Efrazia and Michael

For months, Efrazia Ngwabi had encouraged her husband Michael to get circumcised; unfortunately, her efforts were hampered by his belief that the practice was against tribal tradition.

Michael is a member of the Pangwa tribe in Tanzania, which believes mutilating any part of the body is sinful. "Every time I told him about it he switched to another subject, but as I talked more about it his stance softened," said the 39-year-old mother of three. Eventually, he agreed to visit a community health care worker who explained the benefits of circumcision in reducing his chance of contracting HIV, and the risk of his passing the human papillomavirus (HPV) to Efrazia.

"I was rather insisting to him that if you don't do it you will put me at risk of getting cervical cancer," Efrazia said. In her village, talking candidly about circumcision once would have been unthinkable, but as people's attitudes begin to change due to PEPFAR awareness campaigns, more women are actively speaking to their male partners to be circumcised. In Efrazia's case, her persistence worked, and Michael underwent the procedure. "It's a bit painful but I will be clean and protect my wife," he said shortly after the procedure. "I was very much against it but I realized it was out of ignorance. With counseling I have learned a lot about it and will spread the word."

Michael is just one of thousands of men who have volunteered for circumcision in Tanzania, thanks to a countrywide initiative supported by PEPFAR, and the Tanzanian government's policy that actively encourages rural women to encourage their partners to get circumcised.



Photo Credit: Courtesy of Jhpiego

Efrazia and Michael

## PEPFAR's Impact: Comprehensive Care for Orphans and Vulnerable Children

### Mercy Millicent



Photo Credit: Courtesy of Nyumbani

### Mercy Millicent

*"I could have been a past tense story to be told, and nobody could have ever known who Mercy Millicent is. But because of your love and care that you have shown unto me, it is what has enabled me to reach here today and above all receive God's love and protection."*

In 2008, 13-year-old Mercy Millicent found out that she was HIV-positive, but she did not accept her status. Her aunt brought her to a PEPFAR-supported community-based care program that extends care to orphans and HIV-positive children in the wider community, including through provision of a comprehensive home-based care package.

When she entered the program, Mercy Millicent was emotionally and physically unwell. She soon sought counseling and guidance in the program, and she is now a member of the mentorship program and is very involved in the support group. In school, she is active in drama club and takes part in narrative and cultural dances. Her ambition is to become a journalist or a news anchor. She has even started writing her own book entitled "Accept Yourself," designed to help people accept their diagnosis and to never give up in life. She says she values herself and desires to transform the lives of other children. She also believes that she will achieve all of her dreams, despite her HIV-positive status.

PEPFAR has pushed to become even more efficient and effective, driving down costs to deliver a greater return for each dollar invested. These efficiency gains—purchasing in bulk, shipping medications by ground instead of air, and finding ways to reduce the costs of drugs—have saved dollars, and they have saved lives.

Since its founding, PEPFAR has worked to build health infrastructure and strengthen capacity. These efforts not only support patients living with HIV/AIDS but also provide essential health systems that are leveraged for malaria, immunizations, and other health needs. In response to a congressionally-mandated target in P.L. 110-293, the *Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008*, as of the end of FY 2014, PEPFAR has trained more than 140,000 health care workers to deliver HIV and other health services. These efforts not only improve HIV care, they enable countries to improve the overall health of their citizens.

There are indirect economic benefits for treating people living with HIV before they develop full-blown AIDS. Healthy people 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. It has been proven 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 also will generate considerable economic returns.

## Going Where the Virus Is and Partnering for Success

There is perhaps no greater example of our efficiency than the efforts to focus our resources where the virus is. Children, adolescents, young women, and key populations remain a priority, and we are accelerating our efforts to prevent HIV infections in these populations. Data transparency, allowing increased data access and oversight, will allow for mutual accountability and innovation so that PEPFAR investments can have the greatest—and fastest—impact, while ensuring that each dollar is spent effectively.

With HIV/AIDS remaining the leading cause of death and disease in women of reproductive age, PEPFAR continues to invest heavily in programs for women, girls, and children. The results have been impressive:

- Over 1 million babies have been born HIV-free to HIV-positive mothers.
- In FY 2014, PEPFAR supported HIV testing and counseling for more than 14.2 million pregnant women.
- Over the past two years, more than 1.5 million HIV-positive pregnant women received prevention and treatment services to prevent mother-to-child transmission and improve maternal health.



Photo Credit: Veronica Davison

Secretary John Kerry and Ambassador Deborah L. Birx speak alongside PEPFAR country leaders at the UN General Assembly in 2014.



Photo Credit: USAID

Young beneficiary of PEPFAR-supported program for OVC in Mokhotlong, Lesotho

- In FY 2014, PEPFAR provided care and support for more than 5 million OVC.
- Through FY 2014, over 5 million women and girls have been placed on treatment with PEPFAR support, and over 32 million women were tested in FY 2014 alone.

Despite these successes, considerable work remains and critical gaps need to be addressed. Secretary of State John Kerry, when speaking to the United Nations General Assembly in September 2014, acknowledged this truth: *"In a tight budget environment—and everybody faces that—every dollar, yen, and euro counts. And that's why we need to focus on data, on mutual accountability, transparency for impact, and put our weight behind HIV prevention, treatment, and care interventions that work."* Underlying all of our programming must be a dedication to ensuring information and program data are understandable, digestible, and actionable. We need to be more nimble making program improvements for impact, and we need to act more rapidly based on data.

**We know** that PMTCT works, so we continue our efforts to see the day when no child is born HIV-positive and ensure that mothers remain healthy through expansion of Option B+ programming, or lifelong ART, for pregnant women.

**We know** OVC programs play a valuable role for both children and their caregivers, from contributing socio-economic support to providing key linkages to other services such as HIV treatment and prevention.

**We know** that 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 as likely to have HIV or other sexually transmitted infections. We need to continue to join forces with other programs and partners to prevent and respond to this deadly intersection.

**We know** that in 2013, 3.2 million children under the age of 15 were living with HIV globally. Of these children, 91 percent live in sub-Saharan Africa, and only 24 percent were receiving ART. 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. We must take action. That is why PEPFAR launched the Accelerating Children's HIV/AIDS Treatment (ACT) Initiative in August 2014—an ambitious \$200 million partnership with the Children's Investment Fund Foundation to double the total number of children receiving life-saving treatment in up to 10 priority African countries over the next two years. ACT will enable 300,000 more children living with HIV/AIDS to receive ART and have a better chance to grow up healthy.

**We know** that adolescent girls are disproportionately affected by HIV/AIDS. In 2013, nearly 60 percent of all HIV infections among

people aged 15-24 occurred among adolescent girls and young women, and every year, an astonishing 380,000 adolescent girls and young women are infected with HIV. That is why PEPFAR announced a partnership with the Bill & Melinda Gates Foundation and the Nike Foundation in December 2014. This \$210 million effort will reduce new HIV infections in young women in up to 10 priority African countries. The goal of the DREAMS partnership is to support girls in developing into Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe women.



*Sister Mary Owens of Nyumbani Children's Home in Nairobi, Kenya*

**We know** that stigma and discrimination continue to drive the rate of new infections and inhibit access to lifesaving information, testing, prevention, care, and treatment services. Reaching the goal of an AIDS-free generation not only requires robust clinical interventions but also requires addressing social, cultural, economic, and legal barriers that inhibit equal access to health services for all people living with and affected

by HIV/AIDS. 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 ensuring that partners receiving PEPFAR funds implement their programs in a way that supports promotion, protection, and respect for human rights.

Our collective ability to achieve an AIDS-free generation requires the ongoing translation of what we know into programs with impact.

### **Shared Responsibility**

We recognize that we cannot do this work alone. The United States, through PEPFAR, has provided tremendous leadership and will continue to lead, but the global HIV/AIDS response is a shared responsibility. Millions of lives have been saved through deeper collaboration and focused investment with partner governments in the 65 countries with PEPFAR bilateral and regional programs, other donor nations, civil society, FBOs, foundations, multilateral organizations, and people living with HIV/AIDS. PEPFAR builds strategic public-private partnerships to maximize the U.S. government's investment. In 2014 alone, private sector partners contributed \$264 million to increase the scale and impact of PEPFAR's work.

PEPFAR has prioritized key collaborations with multilateral organizations, particularly UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), and the World Health Organization (WHO). PEPFAR works closely with UNAIDS, drawing on the UNAIDS and host country epidemiologic technical resources and capacity. UNAIDS is the international standard bearer in global HIV/AIDS for setting critical goals in the global call to end the epidemic. Our collaboration with

UNAIDS supports countries in overcoming key policy, programming, and implementation challenges. PEPFAR strategically engages with the Global Fund 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 and of our programs through better, more efficient, and evidence-based use of funds; technical and programmatic equality to maximize outcomes; and collaboration to promote country-level sustainable solutions. WHO has been a critical partner in the global HIV/AIDS response since PEPFAR's launch in 2003. It provides evidence-based normative guidance to countries around the globe, which allows countries to take the bold steps needed to dramatically scale and improve the quality of HIV prevention and treatment programs.

Civil society organizations and FBOs have played a critical role in the HIV/AIDS response since the earliest days of the epidemic. They have provided an estimated 40 percent of health care services in sub-Saharan Africa. For example, in Kenya, FBOs provide more than 60 percent of antiretroviral medications in Nairobi and Mombasa, cities with high HIV prevalence rates.

The contributions of FBOs are particularly evident in OVC programs. A UNICEF study on the needs of this population noted that FBO-supported activities were widespread throughout Africa. Services include medical and social support for children and extended family members, support to strengthen extended family networks so that orphans can live with their families, holistic home-based programs for long-term care and support, and orphanages when sufficient family- and community-based options are not available.

**Conclusion**

Over the 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 always been guided by 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 recognize that maximizing impact and efficiency translates into more lives saved and improved. However, in order to reach our goals, we must work harder and smarter in the years to come.

We know that members of Congress come to Washington, D.C. to make a difference. Through PEPFAR they have. Within the global

response to the HIV/AIDS epidemic, PEPFAR has served as a remarkable example of cooperation across the breadth of our government and with partners worldwide. We are grateful for Congress’ leadership throughout multiple bipartisan authorizations of PEPFAR, which have guided our work to turn the tide on this devastating epidemic.

PEPFAR is not just a transformative global health program, it is also an outstanding extension of American diplomacy. Because of Congress’ investment, HIV/AIDS is no longer a story of devastation and despair, but one of healing and hope. Reflecting the enduring compassion of the American people, by sheer determination and the shared engagement of millions, we are truly working together to achieve an AIDS-free generation.



Photo Credit: David Snyder/CDC Foundation

Two girls in the Automeca camp in Port au Prince, Haiti

**APPENDIX A:  
How PEPFAR Calculates Results**

One of the ways that PEPFAR ensures impact is by thorough monitoring of 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, as well as expanding to impact indicators. PEPFAR is also changing how it defines and interprets program support to reflect increasing host country-specific direct investment in HIV services and the U.S. government support to joint quality assessment and improvement.

PEPFAR support definitions were revised in Fiscal Year (FY) 2014 to accommodate a greater cognizance of the scope of the program and to accord with the statutory requirements and reporting language of P.L. 113-56, the *PEPFAR Stewardship and Oversight Act of 2013*. 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 national 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 quality programming, to evaluate those effective sites, and to ensure all sites receive the same rapid feedback for continual improvement towards the most effective programs.

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, like South Africa, Namibia, Botswana, and Vietnam. There are two primary types of PEPFAR support:

- Technical Assistance for Service Delivery Improvement (TA-SDI) support—known as Otherwise Supported in P.L. 113-56—is defined by the provision of essential technical support to the site, which takes place at least on 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 1, was included in our FY 2014 results and is highlighted in Appendix V: Tables, which shows this transition from U.S. government direct support to technical assistance support in South Africa, Namibia, and Botswana. This evolution recognizes the leadership and financial investment by those countries.
- Direct Service Delivery (DSD) support requires PEPFAR direct financial investment towards 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 1). 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.

This revised approach was implemented for FY 2014 planning and reporting, alongside the new indicators found in PEPFAR’s Monitoring Evaluation and Reporting (MER) Indicator Reference Guide. Data submitted as part of the annual reporting process follow this approach and are now categorized as either TA-SDI or DSD. PEPFAR’s focus remains on the entirety of the program; however, these disaggregated and aggregated figures offer a comprehensive illustration of the support provided. Table 1 demonstrates the important evolution of the program towards sustainability. Subsequent tables address these different types of support, in terms of portfolio balance and program impact (see Appendix V: Tables).

Overall, PEPFAR’s revised approach to monitoring, evaluation, and reporting provides increased accountability of U.S. government investments, as well as 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. The U.S. Department of State’s Office of the Global AIDS Coordinator and Health Diplomacy is working with each U.S. implementing agency to ensure increasing data quality and validation of results at the site-level.

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 multi-billion dollar investment at risk, or one characterized by a new and focused effort that brings epidemic control while decreasing or stabilizing the need for long-term investment (Figure 1).<sup>1</sup> This example is further illustrated with new HIV infections and AIDS related deaths in Eastern and Southern Africa (Figure 2).

To reach UNAIDS’ 90-90-90 global targets—90 percent of people with HIV diagnosed, 90 percent of them on ART, and 90 percent of them virally suppressed by 2020<sup>2</sup>—we are

1 UNAIDS. (2014). *Fast-Track—Ending the AIDS epidemic by 2030*. Geneva.  
 2 UNAIDS. (2014). *90-90-90: An ambitious treatment target to help end the AIDS epidemic*. Geneva.

focusing on a data-driven approach that strategically targets populations at greatest risk in geographic areas with the highest HIV burden. PEPFAR will prioritize prevention, care, and treatment services in the areas of highest HIV incidence. These in-country analyses will be led by partner governments, in collaboration with PEPFAR, the Global Fund to Fight HIV, Tuberculosis and Malaria (the Global Fund), UNAIDS, the World Health Organization (WHO), and other multilateral and bilateral partners. UNAIDS supported the development of the country-specific investments investment framework analysis in countries during the development of the Global Fund Concept Notes. Ensuring the implementation of this prioritized approach to the epidemic will be essential to the control of the epidemic within the overall current funding envelope. This analytic approach and prioritization of specific high-transmission and high-disease burden areas has started in Kenya, who recently published their *HIV Prevention Roadmap*, and will be utilized in other countries as part of the 2015 Country Operational Plan (COP) development.

### APPENDIX B: Global Trends in New HIV Infections

PEPFAR will ensure that core HIV prevention and treatment interventions are strategically scaled-up to reduce the number of new HIV infections below the number of

Figure 1. UNAIDS Fast-Track: New HIV Infections in LMIC

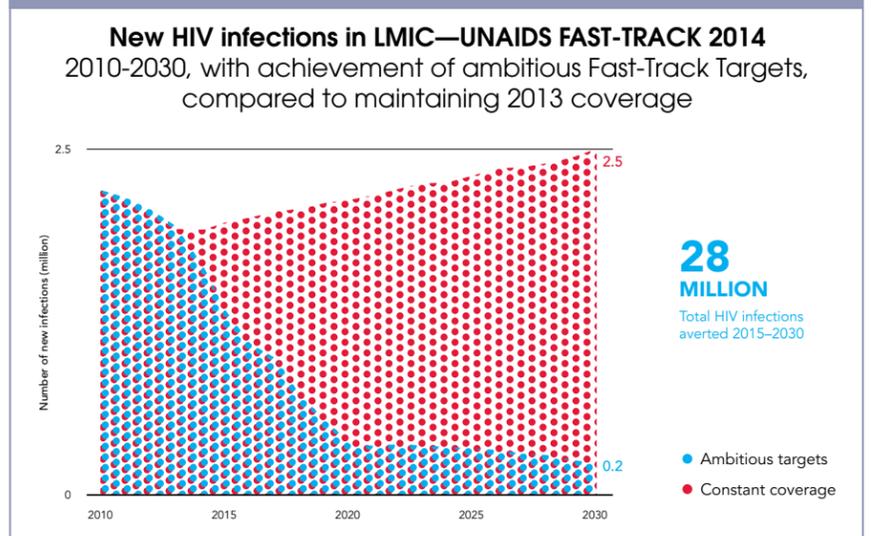
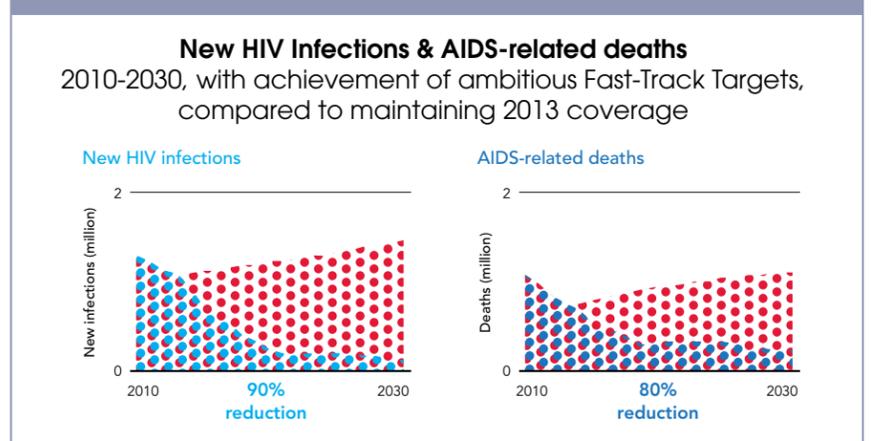


Figure 2. UNAIDS Fast-Track: New HIV Infections & AIDS-related Deaths in Eastern and Southern Africa



all-cause mortality among persons infected with HIV—an essential metric in demonstrating epidemic control (Figure 3). 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; 1,733,000 in 2012; and 1,638,000 in 2013; accelerating this downward trend is key to achieving an AIDS-free generation (Appen-

Table 1. 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 <i>Frequent, at least quarterly, support to improve quality of services</i>
Direct Service Delivery (DSD)
Individuals (individual-based indicators) and sites (site-based indicators) will be counted when PEPFAR support is used for <i>Provision of key staff or commodities AND Frequent, at least quarterly, support to improve quality of services</i>

Figure 3. The Right Things: Core, Near Core, and Non Core Activities

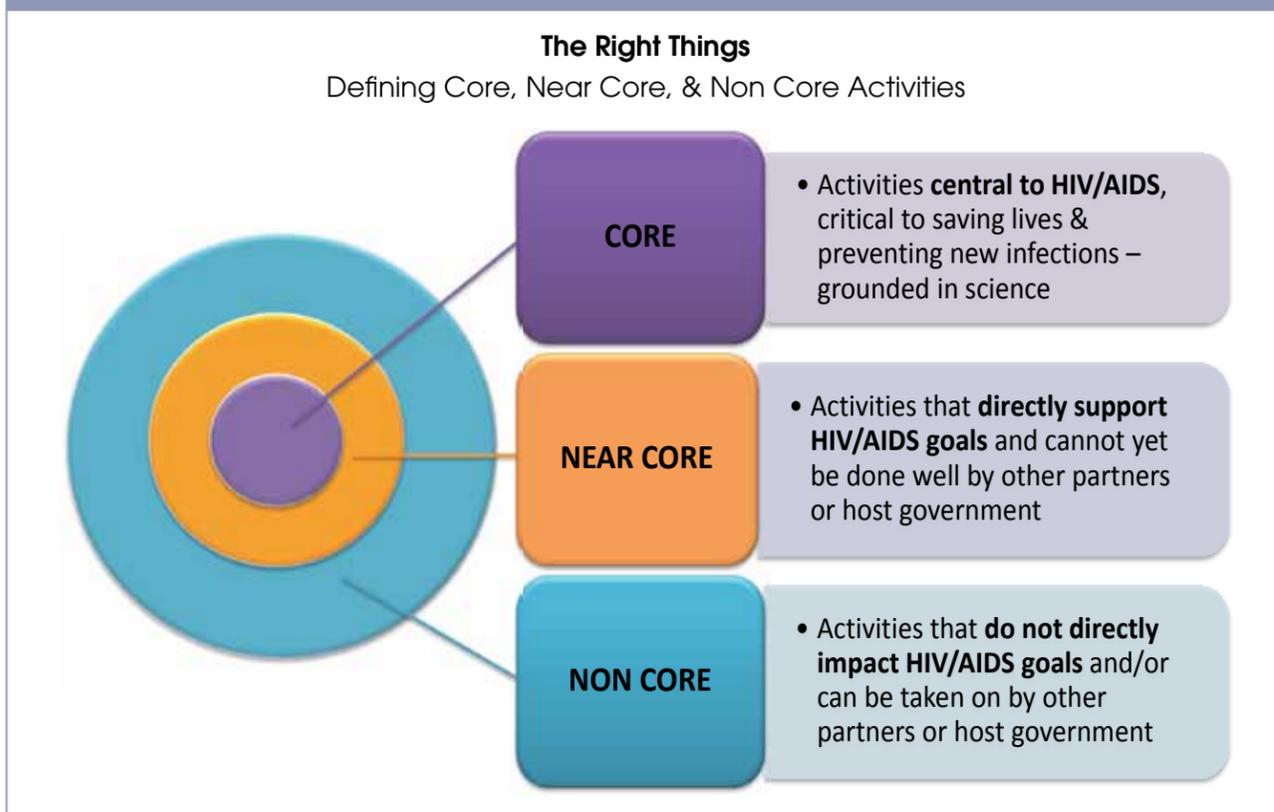
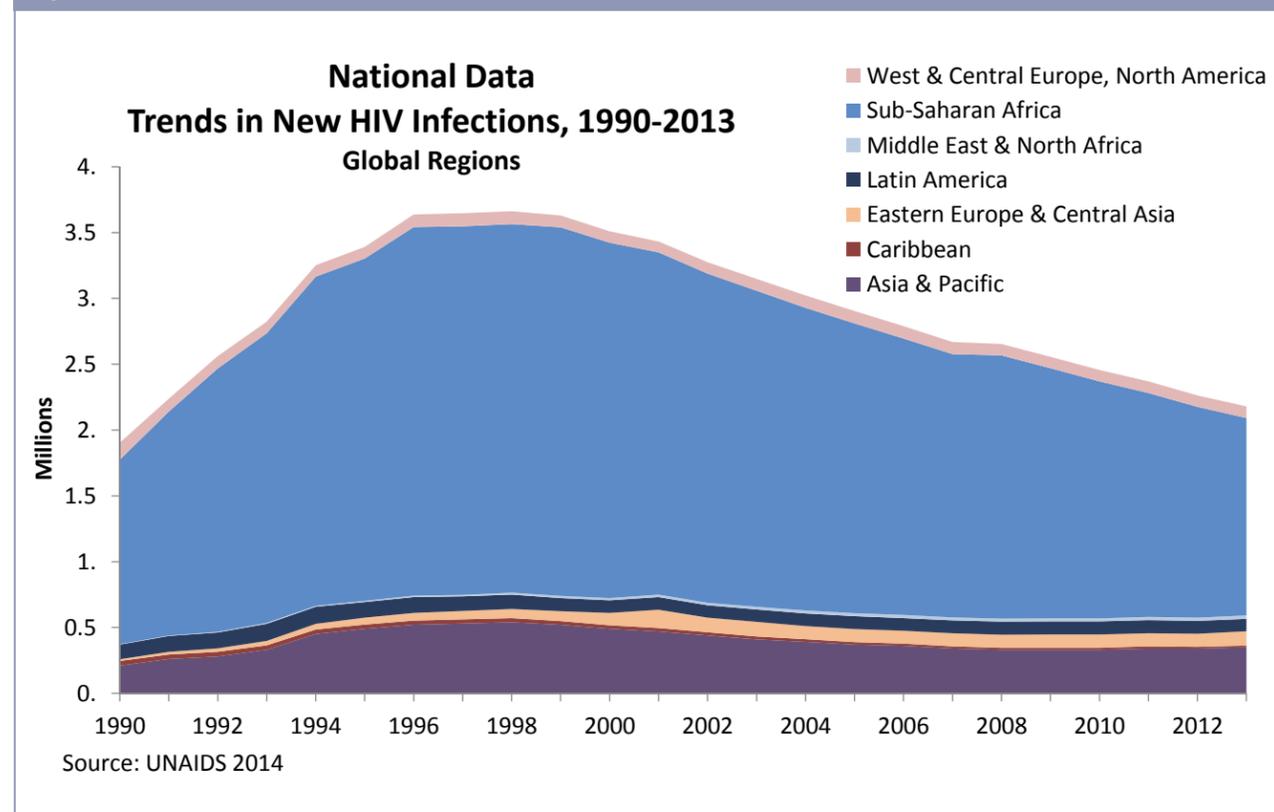


Figure 4. Global Trends in New HIV Infections, 1990–2013



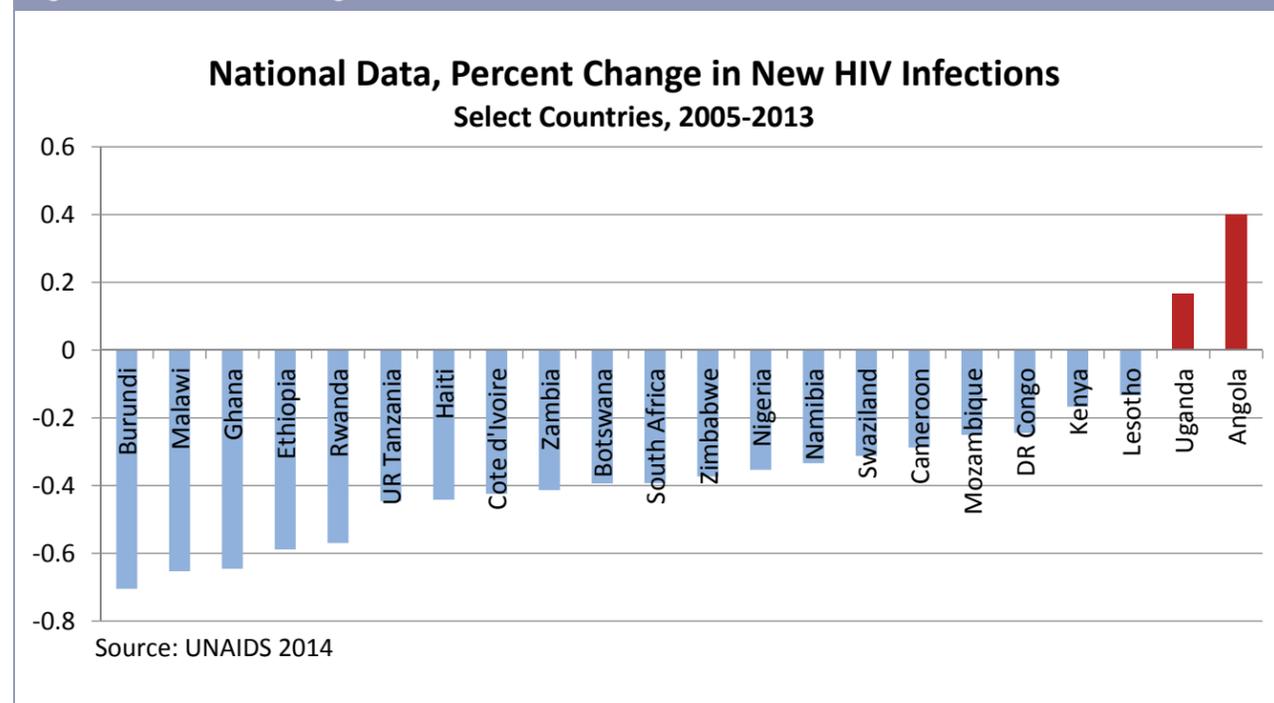
dix V-Table 1).<sup>3</sup> PEPFAR is focused on continuing to reduce new infections by working to saturate high burden areas at the sub-national level (county, district, and sub-district) with prevention and treatment services, including targeted HIV testing and counseling. By strategically refocusing, 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 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: discordant couples, TB/HIV co-infected patients, children, and specifically 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 4 and 5). This shift is the greatest in sub-Saharan Africa, where the epidemic has been the most costly and deadly, but results vary from country-to-country, 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 V-Table 1). In countries with ef-

<sup>3</sup> 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.”

Figure 5. Percent Change in New HIV Infections, Select Countries, 2005–2013



fective scale-up of combination prevention services, Botswana (Figure 6) and Tanzania (Figure 7), for example, new infection and mortality rates drop markedly; while those countries with more moderate scale-up, such as Kenya (Figure 8), follow a similar but less dramatic pattern of reductions. Countries with slow or stalled scale-up, like Uganda (Figure 9, see page 20), have incidence and mortality trends that have started to plateau, countering earlier momentum.

The focus on decreasing the absolute number of new infections—and 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. As many as 7,000 new infections occur per week in girls and young women in Eastern and Southern

Africa.<sup>4</sup> 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 increases, and our programs must be that much more effective each year to maintain the status quo. If we do not increase program effectiveness—either through more effective interventions or through enhanced geographic focusing—the actual burden of HIV in sub-Saharan Africa increases by 25-26 million more new infections by 2030,<sup>5</sup> 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 the host country, the Global Fund, or PEPFAR. We

4 UNAIDS. (2014). *The Gap report*. Geneva.

5 UNAIDS. (2014). *Fast-Track—Ending the AIDS epidemic by 2030*. Geneva.

Figure 6. Trends in New HIV Infections, AIDS Mortality, and HIV Prevalence, Botswana

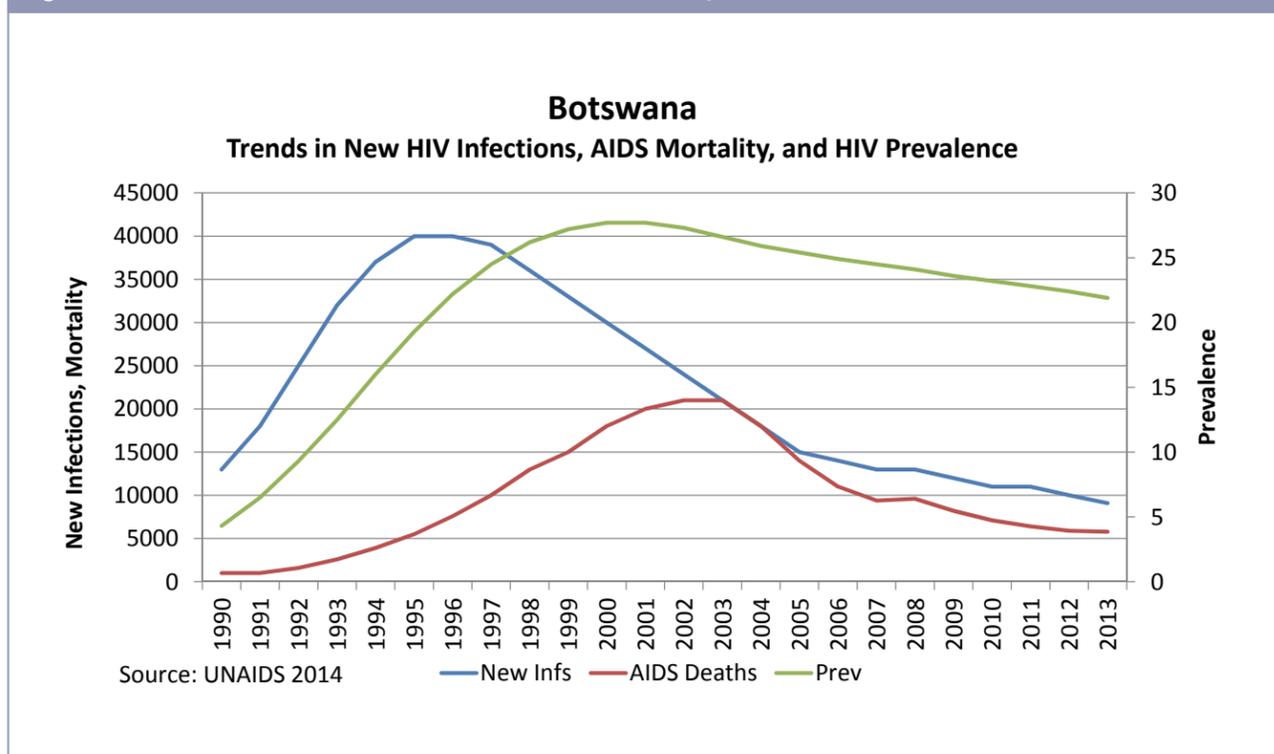


Figure 7. Trends in New HIV Infections, AIDS Mortality, and HIV Prevalence, Tanzania

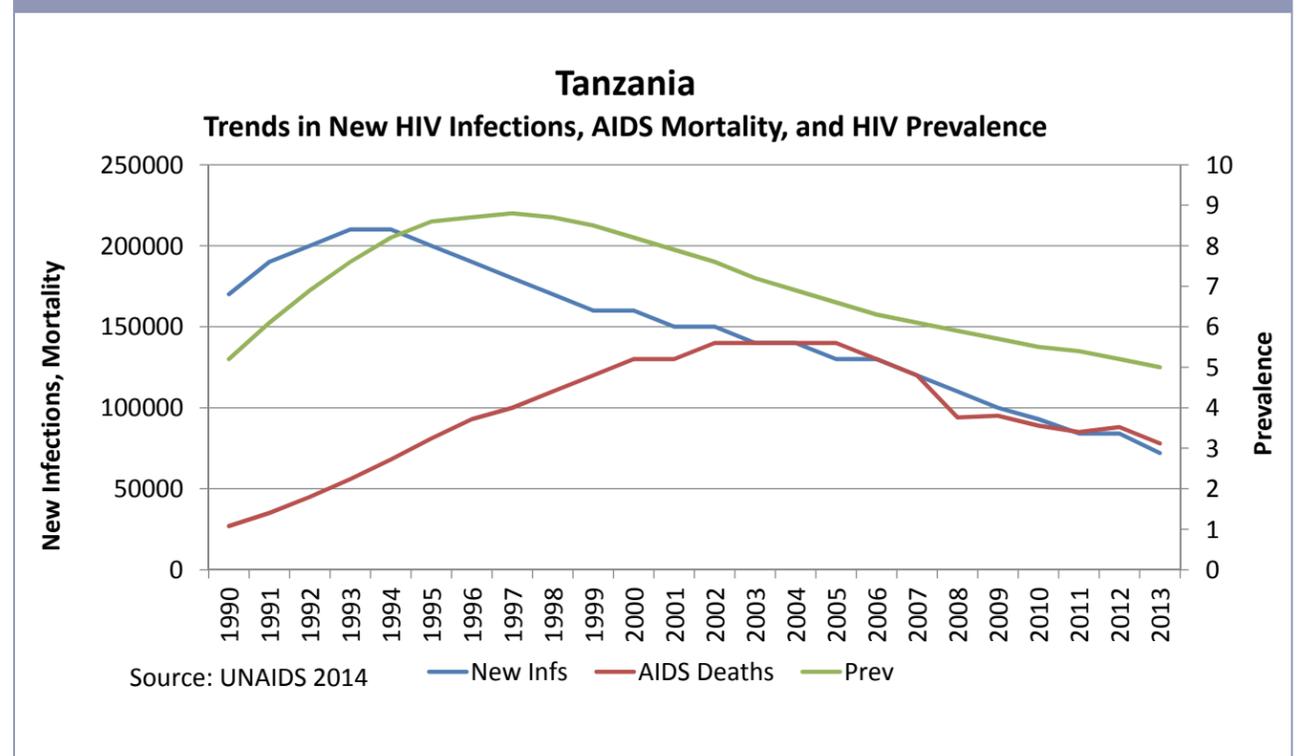


Figure 8. Trends in New HIV Infections, AIDS Mortality, and HIV Prevalence, Kenya

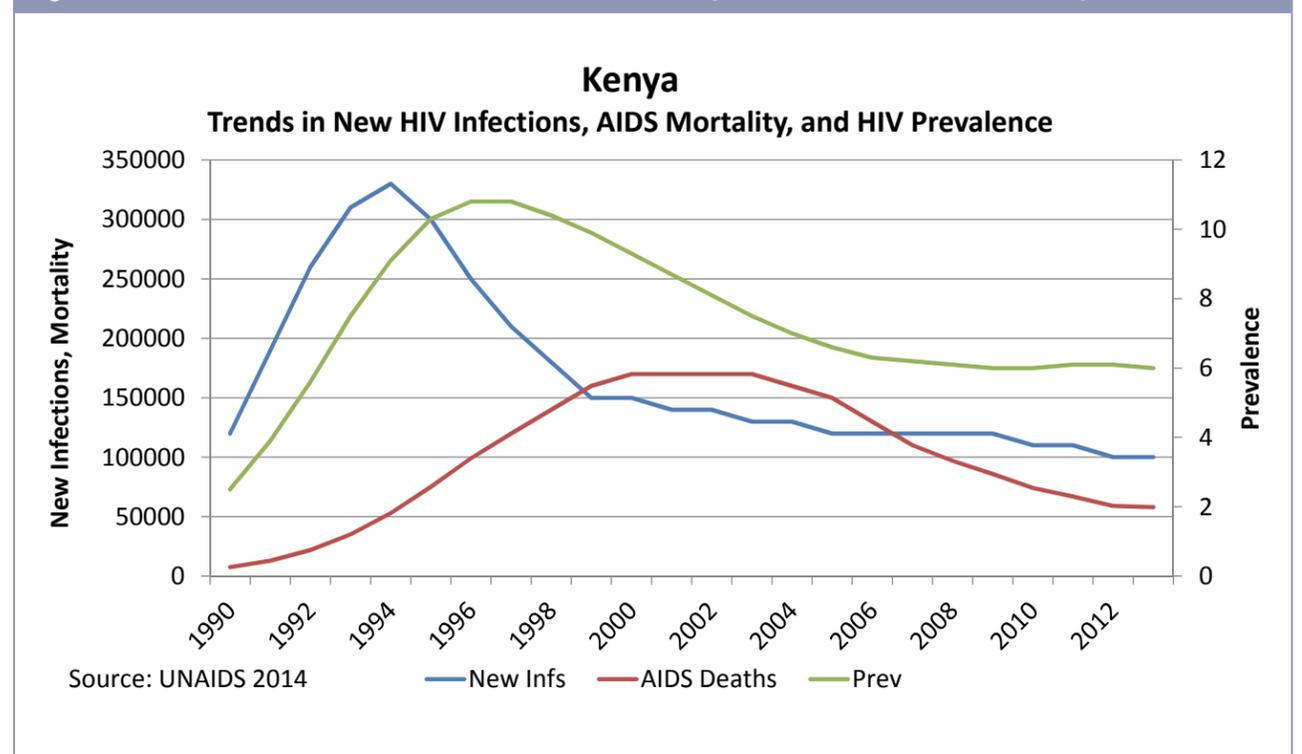


Figure 9. Trends in New HIV Infections, AIDS Mortality, and HIV Prevalence, Uganda

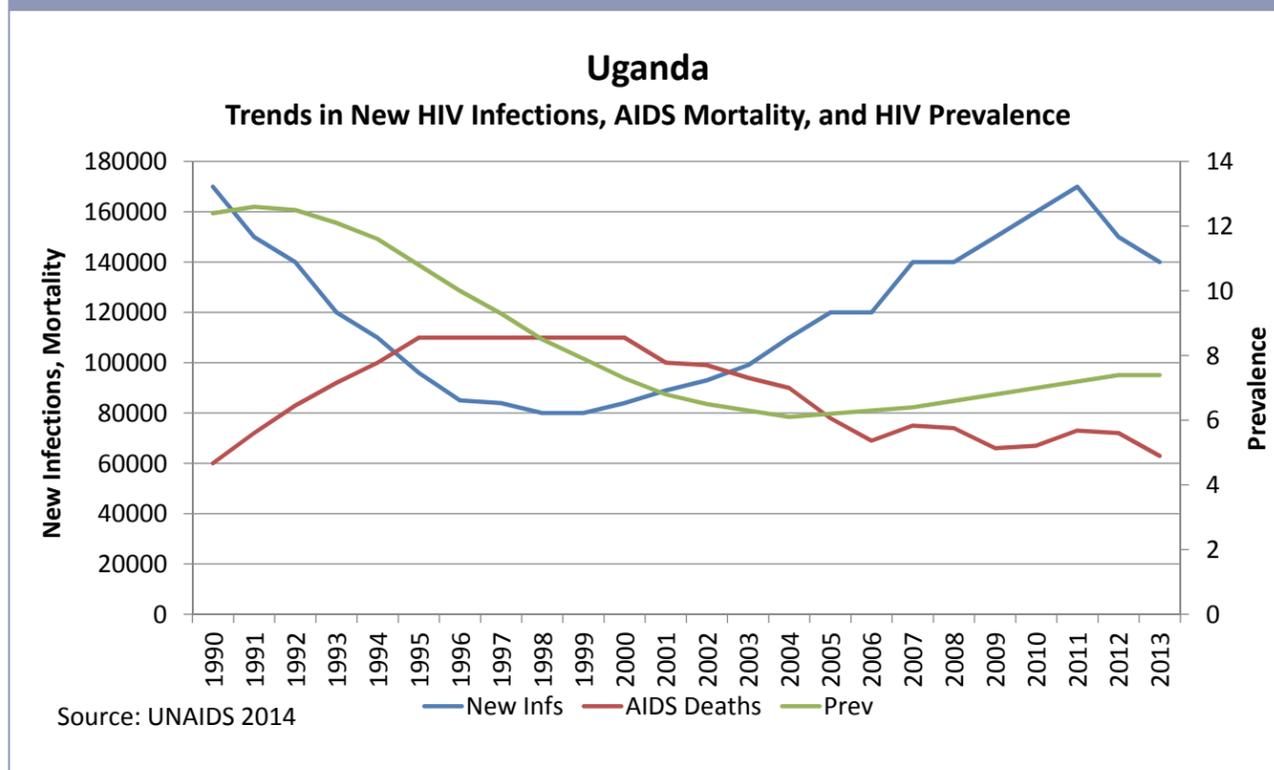
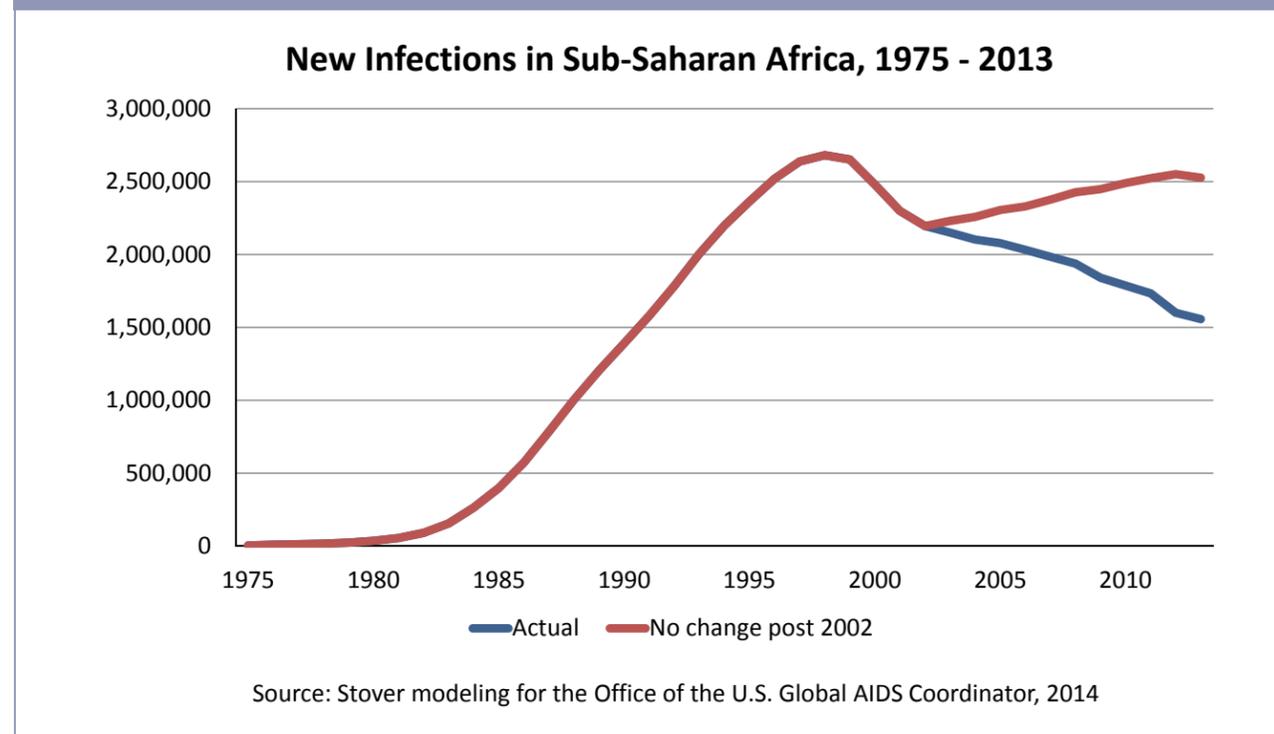


Figure 10. Modeling New Infection Trends, Continuing Intervention Scale-up vs. Stable Programming from 2002



are at a moment in time where 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 once again is spiraling out of control.

### APPENDIX C: Infections Averted

The documentation of infections averted is currently dependent on modeling but moving towards actual and validated data through impact assessments. PEPFAR is modeling partner countries results with the most recent national data available from UNAIDS using the Goals model, which developed a method for costing and resource allocation during the development of national HIV/AIDS strategic plans and investment framework.<sup>6</sup>

<sup>6</sup> Stover, J., Walker, N., Garnett, G., et al. (2002). Can we reverse the HIV/AIDS pandemic with an expanded response? *Lancet*, 360(9326), 73-77.

Preliminary work has been conducted for a global illustration with 2013 results (Figure 10). Figure 10 illustrates where the epidemic was headed without intervention, depicting the trend line of new HIV infections without over a decade of investments for 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 Botswana, Kenya, South Africa, Uganda, and Zambia launched under the leadership of Ambassador Eric Goosby, and second, through serial program impact assessments called HIV impact assessments (HIA).

### APPENDIX D: Global Prevalence

According to the UNAIDS' *Gap Report*, 15 countries account for more than 75 percent of the yearly 2.1 million new HIV infections that occurred in 2013.<sup>7</sup> 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.

<sup>7</sup> UNAIDS. (2014). *The Gap report*. Geneva.

On a country-by-country basis, there are four general patterns of prevalence (Appendix V- Table 6):

- The first category includes prevalence curves that exhibit a generally flat profile (e.g., Kenya (Figure 8, see page 19), Lesotho, Mozambique, Namibia, South Africa, 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 the new 2013 WHO Consolidated Guidelines on the use of antiretroviral drugs for treating and preventing HIV infection.

- 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 7, see page 19), Ethiopia, Ghana, Haiti, Malawi, 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. 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 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 6, see page 18), Nigeria, 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, and new infections continue despite significant investment from PEPFAR and the Global Fund, 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 is comprised of countries with a prevalence rate trending upward, and with a new infection rate that is significantly greater than the mortality; currently, only Uganda (Figure 9, see page 20) 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.

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 HIAs, which collect HIV prevalence, incidence, historic mortality and service coverage down to the household level (Table 2).

**Table 2. Implementation Timeline of HIV Impact Assessments**

Country	HIA Implementation Year (planned)
Malawi	2014-2015
Zimbabwe	2014-2015
Mozambique	2014-2015
Ethiopia	2015
Lesotho	2015
Namibia	2015
Uganda	2015
Zambia	2015
Nigeria	2015
Swaziland	2015-2016
DRC	2015-2016
Rwanda	2016
Tanzania	2016
Côte d'Ivoire	2016
Cameroon	2016
Kenya	2016
Haiti	2016

## APPENDIX E: 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; this does not include the number of new people started on treatment during this term. At the end of FY 2014, PEPFAR had an 81.3 percent retention rate at 12 months on treatment (Appendix V—Table 6).

Reviewing country-specific retention rates has helped PEPFAR treatment programs focus on gaps and ensure 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 the achieving an AIDS-free generation, as well as ensuring that transmission, incidence, and costs decline.

PEPFAR's Interagency Collaborative for Program Improvement (ICPI) is monitoring this carefully to ensure 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 analysis of viral load data and the inclusion of viral load monitoring in the HIA. These new indicators and HIA inform country teams and headquarters on overall program adherence and retention and effectively demonstrate how close a country is to epidemic control. 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.

## APPENDIX F: HIV/AIDS Guidance

WHO is the leading institution responsible for establishing normative guidance related to HIV/AIDS programs. The 2013 WHO Consolidated Guidelines significantly expand eligibility for treatment, which will result in more people on treatment and reduce HIV transmission and incidence (Figure 11). Additionally, these guidelines modify prevention of mother-to-child transmission (PMTCT) requirements, ensuring continued access to antiretroviral treatment (ART) for mothers during at least the pregnancy and breastfeeding period (Option B/B+). PEPFAR is supporting partner countries in their swift adoption of the 2013 guidelines.

In July 2014, WHO released new consolidated guidelines on HIV prevention, diagnosis, treatment, and care for key populations. These guidelines bring together all existing guidance relevant to five key populations—men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers, and transgender people. These guidelines advise countries to provide comprehensive HIV services for key populations, to increase prevention and treatment coverage, and to address current inequities in access. Countries need to consider their specific situations, taking into account current population sizes and reviewing current coverage levels and quality of programs. They will also need to assess and address social and legal barriers that may impede progress, to the extent that country-specific circumstances allow.

PEPFAR is working with WHO to increase program quality. Through analysis of data, including key health outcomes, revised guidance is then used for continuous HIV program quality improvement.

## APPENDIX G: HIV Burden and Treatment Response

There are an increasing number of people living with HIV/AIDS (PLHIV), which is consistent with the growth of the epidemic and the availability of life-saving treatment. At the end of 2013, 35 million people are living with HIV globally, including 24.7 million in sub-Saharan Africa; as treatment programs are implemented across partner countries, people living with HIV are living longer and more productive lives (Figure 12; Appendix V—Table 20).

The number of persons on treatment and lives saved dramatically increased with the creation of PEPFAR and the Global Fund from 2004-2013 (Figure 13 & 15; Appendix V—Table 22, see pages 26 & 27). In the large majority of countries, expansion of treat-

ment 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 swelled and have continued along these same trajectories through the current reporting periods. These rapid transitions are fundamental to the dramatic shifts in new infections and mortality rates, and ongoing success is dependent on continuing this momentum.

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 V—Table 17). As demonstrated by Figure 14, all partner countries are on an upward trend in their responses, although success varies country-by-country. 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.

One of the more important milestones towards 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. This shift in trends, while im-

portant in the ongoing effort to control the epidemic, does not imply that continuing efforts can relax. 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.

The sub-Saharan African countries illustrated in Appendix V—Table 11 represent wide diversity in terms of the new on treatment/new infections ratio. Before examining these ratios, it is important to recognize that countries do not report a 'new on treatment' figure. For example, to track coverage, a calculation is used in which the 'current on treatment' number for 2012 is subtracted from that of 2013. This result is labeled as 'net new', due to some new enrollees replacing the individuals lost in association with deaths

Figure 11. World Health Organization Treatment Guidelines, 2010 vs. 2013: Earlier Initiation of Treatment with Expanded Eligibility

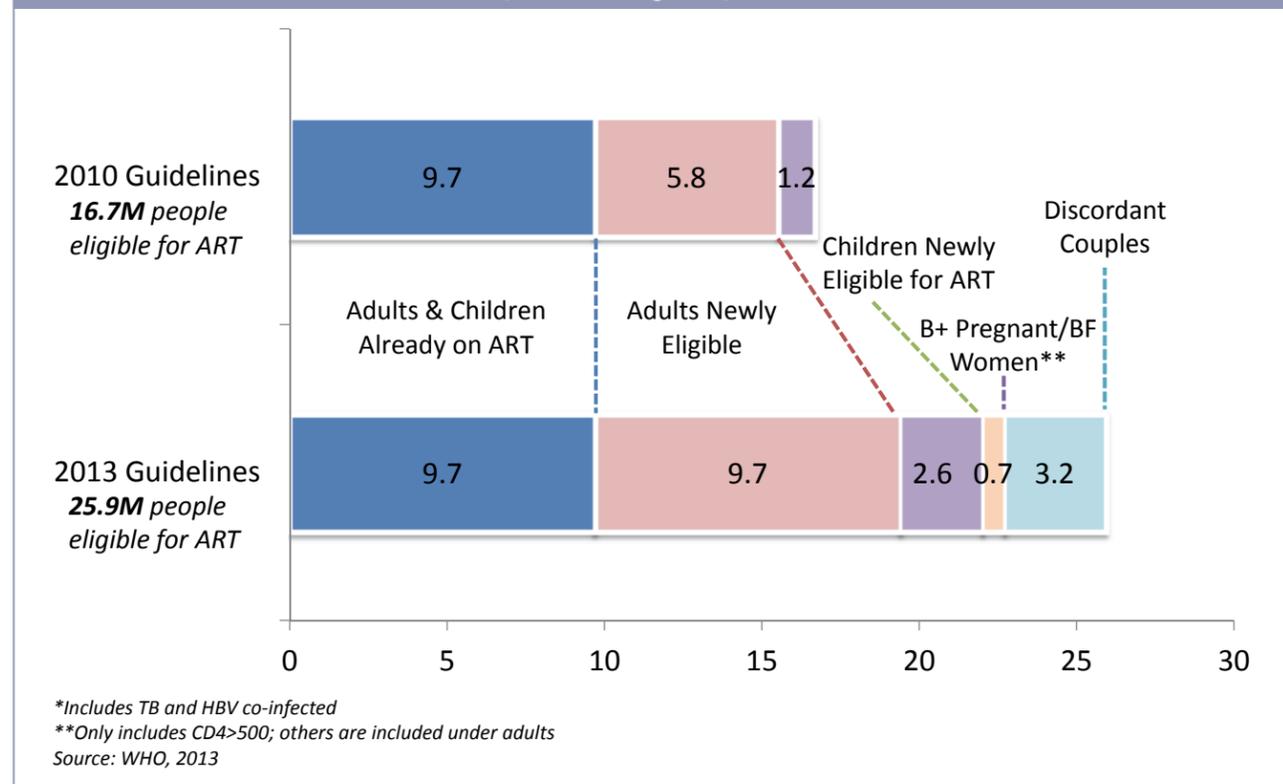


Figure 12. Cumulative Trends of Persons Living with HIV, Sub-Saharan Africa, 1990-2013

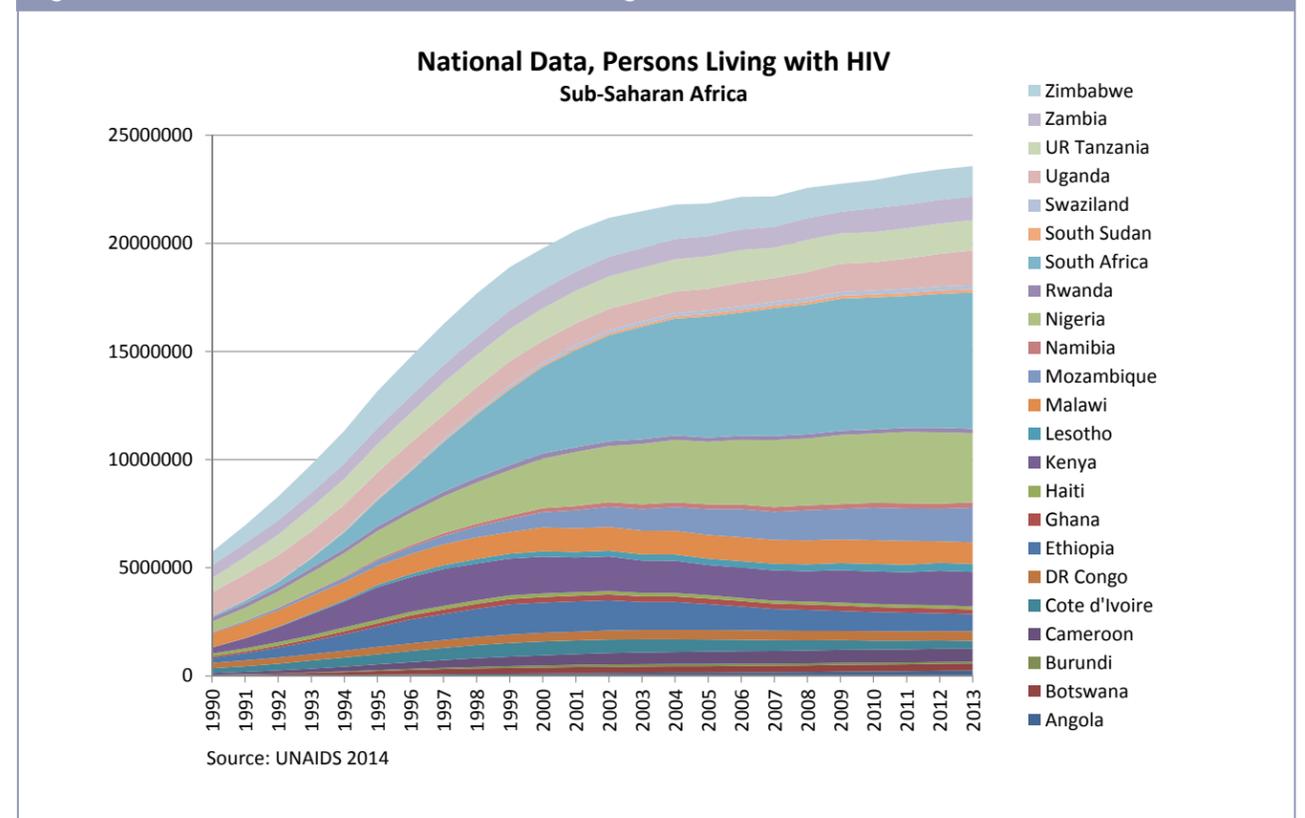
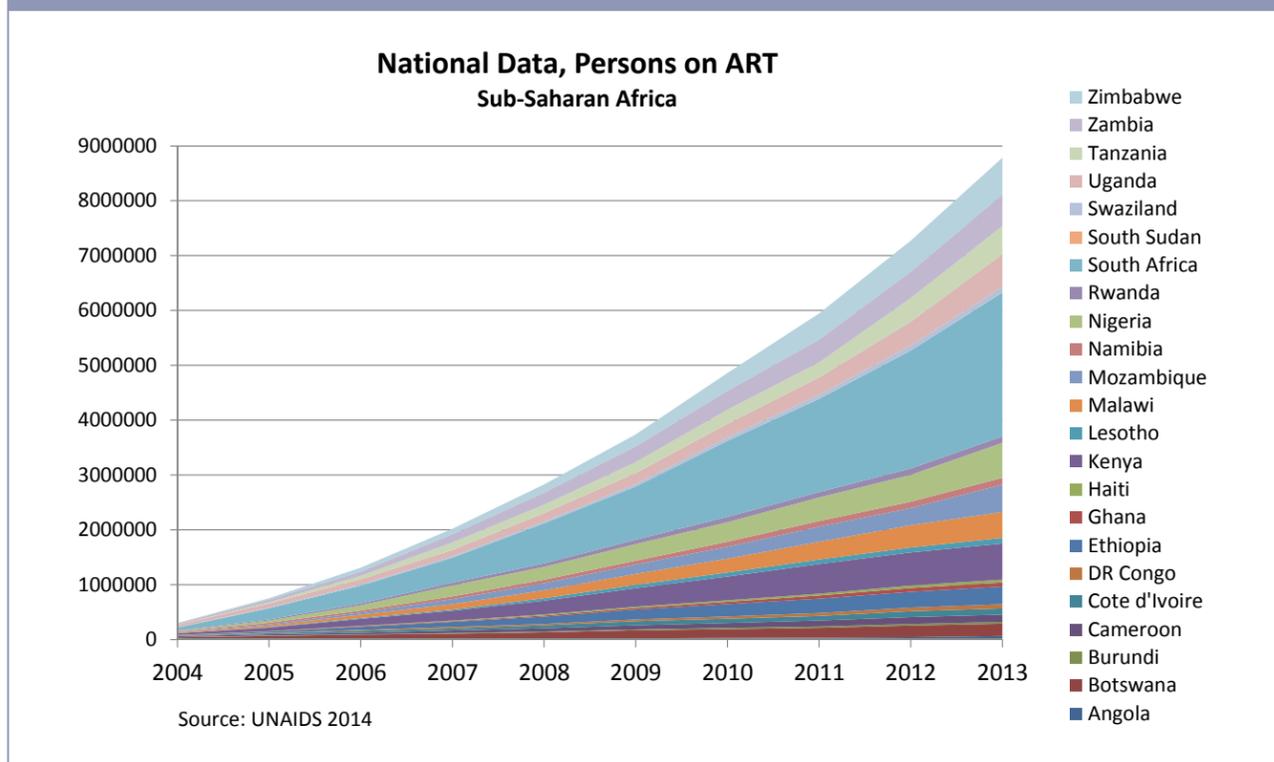


Figure 13. Cumulative Trends of Persons Receiving ART, Sub-Saharan Africa, 2004–2013



or lost-to-follow-up. As a surrogate for 'new', the 'net new' figure likely underestimates the actual 'new' number. In light of these caveats, just over half of the 22 countries included have ratios in which the number of new on treatment is greater than the number of new infections.

Continuing this momentum is critical for these countries, as is shifting more aggressively toward this transition point for the others. These efforts to lower viral load must be combined with our other prevention efforts including VMMC, PMCT, condom distribution, and the new DREAMS initiative focused on preventing HIV infection in young women and girls.

### APPENDIX H: 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 PLHIV. Four activities were identified as priority for the greatest impact on morbidity and mortality, considered core in PEPFAR 3.0. These interventions are supported by a strong evidence base and are universally applicable in every country and for every PLHIV (Appendix V—Table 2). They include:

- regular clinical and laboratory monitoring, including WHO clinical staging (assessment of immune status), and if possible, CD4 count and/or viral load;

Figure 14. Trends in ART Coverage, Select Countries, 2009–2013

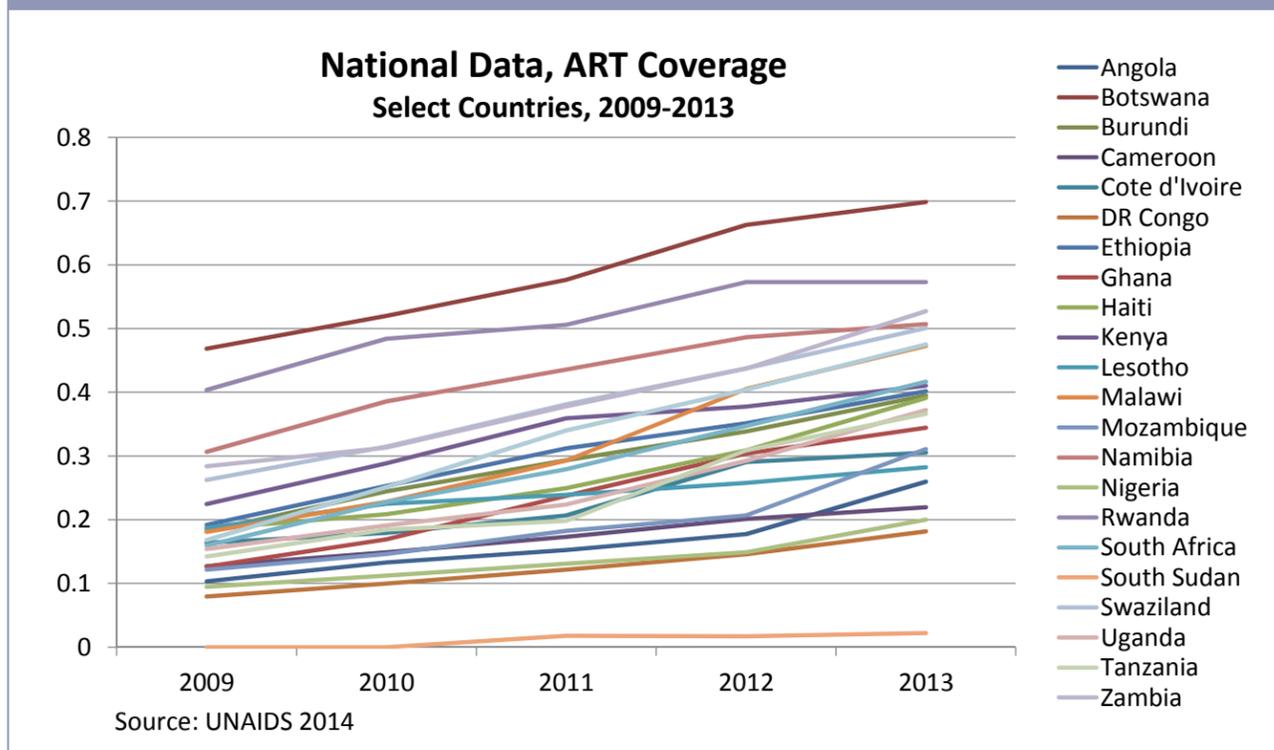
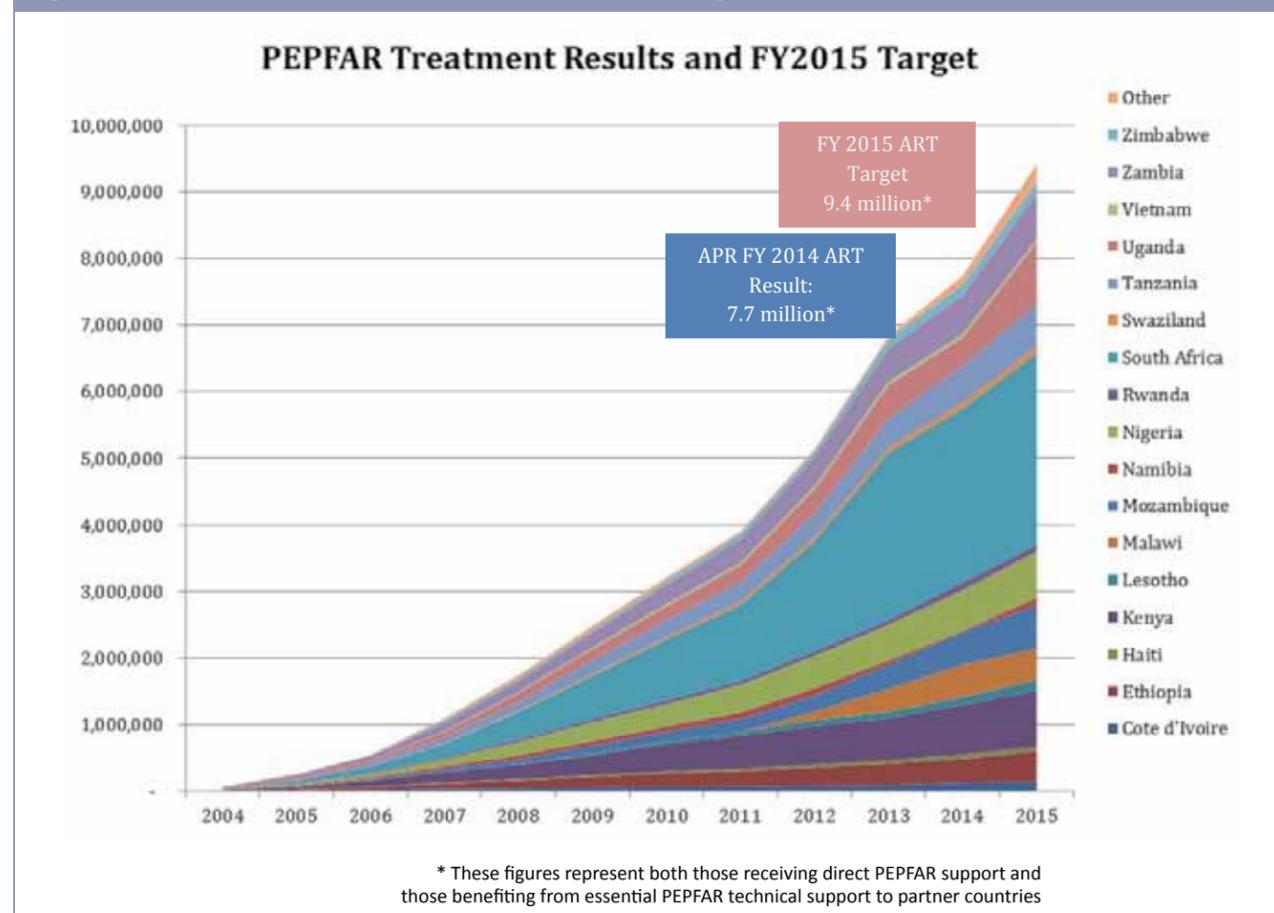


Figure 15. PEPFAR Treatment Results and FY 2015 Target



- screening for active tuberculosis (TB) with referral for treatment as appropriate;
- Cotrimoxazole (CTX) prophylaxis of opportunistic infections (OI) for those who are eligible; and
- evidence-based interventions (both clinical and non-clinical) to optimize retention and adherence for those in care and/or treatment.

Additional supportive care activities that are prioritized near core interventions by PEPFAR programs based on their country context include:

- malaria prevention;
- Water, Sanitation, and Hygiene (WASH);
- prevention of cryptococcal meningitis;
- screening and treatment to prevent cervical cancer, mental health illness, and substance/alcohol abuse;
- Positive Health, Dignity and Prevention (PHDP) programs/Prevention with PLHIV;
- viral hepatitis screening;
- pain and symptom management and palliative care; and
- social services, including economic strengthening and legal services, as well as Nutritional Assessment, Counseling, and Support (NACS).

- NACS is a critical component of comprehensive HIV care and treatment of PLHIV especially if patients are starting treatment at low CD4 cell counts or present with AIDS defining OIs. For the vast majority of PLHIV the priority for NACS is to link nutrition and dietary counseling and other support to improvements in patient engagement, adherence, and retention within the continuum of chronic care and treatment.
- There are four areas of programmatic focus within NACS:
  - Platform for improved engagement, adherence, and retention of HIV-infected adults and children in the continuum of care and treatment;
  - Integration of PMTCT/ART, maternal newborn and child health programs, and nutrition services for mother/infant pairs within the 1,000 day continuum of pregnancy and two years postpartum;
  - Referral of PLHIV to economic strengthening and livelihood services and support to improve household food security and resilience while maintaining adherence and retention in clinical care and treatment; and
  - Strengthening, monitoring, and evaluation of NACS activities in PEPFAR strategic information priorities.

## **APPENDIX I: PEPFAR and Prevention**

Prevention, treatment, and care have been the three pillars of PEPFAR programming since 2003; this comprehensive approach was mandated by Congress in the first legislation and was 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 HIV testing and counseling, PMTCT, VMMC, and TB testing. In FY 2014, PEPFAR supported 56.7 million HIV tests for men and women and identified nearly 2.9 million positive tests (Appendix V—Table 3). Through HTC, PEPFAR helped millions to know their HIV status and protect themselves, their partners and their children from HIV infection. These ambitious testing targets were set and achieved in conjunction with partner countries.

For optimal impact, prevention services are often grouped together in a comprehensive package. In FY 2014, PEPFAR reached over 12 million members of priority populations with these packages and over 1.4 million members of specific key populations (Appendix V—Tables 4 and 5).

### **Social and Behavioral Change (SBC)**

PEPFAR employs effective programs for social and behavioral change (SBC). SBC programs such as HTC, correct and consistent condom use, and drug regimen adherence all rely on behavioral components that have been proven successful. These components are often theory-driven but use evidence-based models to demonstrate potential efficacy. Ongoing monitoring will validate the effectiveness of these models in driving uptake of and adherence to the most easily measured activities, such as testing and counseling and care.

The impact of PEPFAR's combination prevention intervention package is currently being studied in three combination prevention trials ongoing in Uganda, Kenya, Zambia, South Africa, and Botswana. These studies will provide key evidence on the relationship of various services, interventions, and SBC on HIV incidence.

The *2011 PEPFAR Guidance for the Prevention of Sexually Transmitted HIV Infections* recognizes two desirable sets of outcomes of SBC and health communication programming. The first is minimized sexual risk and increased protection; the second is increased acceptability, demand for, and uptake of proven high-impact biomedical interventions.

SBC and health communication programs should incorporate the following best practices and carefully monitor HIV incidence rates to provide evidence of impact on new HIV infections:

- support biomedical interventions relevant to the population and setting;
- engage faith and traditional leaders;
- address social and gender norms;
- base program design and evaluation on evidence-based theory;
- address structural barriers to prevention;
- treat behavior change as a process; and
- link activities to clear behavioral objectives and document impact with biomarkers or appropriate surrogates for HIV infection.

Geographic refocusing is sharpening PEPFAR's testing programs to ensure that those who most need access to services—both for prevention and treatment—are identified and linked to care. In FY 2015, PEPFAR will support development of special

prevention packages for adolescent girls and young women in the highest prevalence areas, focused on reducing incidence in this highly vulnerable population.

PEPFAR's DREAMS initiative, announced on December 1, 2014, focuses specifically on preventing HIV infection in 15-24 year old women—a population that represents nearly 7,000 new infections per week.<sup>8</sup> It is a \$210 million initiative in up to ten countries, and the goal of the partnership is to help girls develop into Determined, Resilient, Empowered, AIDS-free, Mentored and Safe women. It will provide a core package of evidence-based interventions that have successfully addressed HIV risk behaviors, HIV transmission, and gender-based violence. Evidence shows that girls can reach their full potential and remain HIV-free when they have access to these interventions.

### Pre-exposure prophylaxis (PrEP)

Pre-exposure prophylaxis (PrEP) is an HIV prevention strategy that uses anti-retroviral medications (ARVs) in HIV-negative patients at high risk of becoming infected. When an HIV-negative person has adequate amounts of specific ARVs in his or her bloodstream, data shows that the risk of infection is substantially reduced.

PEPFAR is exploring the role of PrEP in young women at high risk of acquiring HIV. In some southern African communities up to 30 percent of females between the ages of 20-24 are HIV-positive,<sup>9</sup> and effective prevention methods for this population are poorly defined.

While adherence to the regimen can be challenging, evidence is growing that PrEP can be effective in specific populations. PrEP trials conducted in Kenya, Uganda, Botswana, and South Africa where one partner in a couple was HIV-positive showed the efficacy of taking ARVs daily in preventing new infections in the uninfected partner.<sup>10</sup> PEPFAR will work with other stakeholders to test the use of PrEP with highly vulnerable young women as part of a holistic package of HIV prevention interventions. It is critical that any effective program evaluate its impact, including adherence.

### Structural Interventions

National governments throughout the developing world are investing in cash transfers as a social protection instrument to reduce current and future vulnerability of their poor, marginalized, and at-risk populations. New research demonstrates cash transfers may play an important role in reducing the risk of new HIV infections in some priority populations.

Among adolescent girls and young women, a critical at-risk population, different types of cash transfers can boost school attendance rates, relieve the pressure to engage in transactional or age-disparate sex, and promote safer sexual behavior.<sup>11</sup> These effects are magnified when combined with complementary support, including mentoring and positive parenting that are already widely available through PEPFAR programs. In 2012, PEPFAR's guidance for OVC programming included the use of cash transfers, based on the evidence of impacts for highly vulnerable children. Since that time, PEPFAR has increased investments in technical assistance to strengthen, scale, and opti-

mize national-level programs for HIV-related outcomes. This provides a potential foundation for reducing vulnerability and averting HIV infections among adolescent girls and young women. Strengthening responses led and financed by governments, such as cash transfers, will also reach and sustain scale beyond PEPFAR's assistance.

### APPENDIX J: Prevention of Mother-to-Child Transmission (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. We remain fully committed to working towards the elimination of new HIV infections among children by 2015 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.

PEPFAR has invested significantly in PMTCT, sustaining a budget code funding level of \$310 million since 2010. PEPFAR has focused on 12 high-burden countries that are home to significant numbers of HIV-positive pregnant women without access to HTC services or ART to prevent HIV transmission to their infants. Efforts have focused 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 a HIV-negative baby and a mother with a negative viral load.

In FY 2014, PEPFAR directly supported HTC for more than 10 million pregnant women and provided technical support to clinics for an additional 3.5 million tested (Appendix V—Table 7). PMTCT service coverage, as well as an effective cascade of services, is variable and differs 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 test 95 percent of pregnant women receiving at least one antenatal care visit prioritized by HIV burden and expanded as fiscally possible.

PEPFAR is now utilizing the site-level data both to focus programming where the need is the greatest and to use the program data to map the epidemic and epidemic trends (Figures 16, 17, and 18, see page 32 and 33). Figure 15 illustrates how historically PEPFAR has supported testing in extraordinarily low-burden areas, where 60 percent of the sites have less than two positives in six months. This broad testing approach has led to inequity of availability services, as shown in Figure 16. Ninety percent of HIV-positive patients are concentrated in 28 percent of the sites—this is overwhelming certain sites and resulting in others without any patient volume. This means that HIV-positive women are not linked to necessary life-saving services for themselves, and there is no way to ensure their babies are born HIV-free. Similar data has been seen across multiple PEPFAR countries and its part of the PEPFAR 3.0 pivot to ensure access to lifesaving and prevention services in high HIV burden areas.

As a result of these findings, we are shifting 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, as illustrated by the Kenya map (Figure 18, see page 33). This initiative, conducted by ICPI, is being replicated across partner countries to further focus the HIV response and understand the evolving epidemic at a geographic and facility level.

8 UNAIDS. (2014). *The Gap report*. Geneva.

9 Bicego, G. T., et al. (2013). Recent patterns in population-based HIV prevalence in Swaziland. *PLOS ONE*, 8(10).

10 UNAIDS. (2014). *90-90-90: An ambitious treatment target to help end the AIDS epidemic*. Geneva.

11 UNAIDS. (2014). *The Gap report*. Geneva.

Figure 16. Geographic Refocusing Kenya: PMTCT

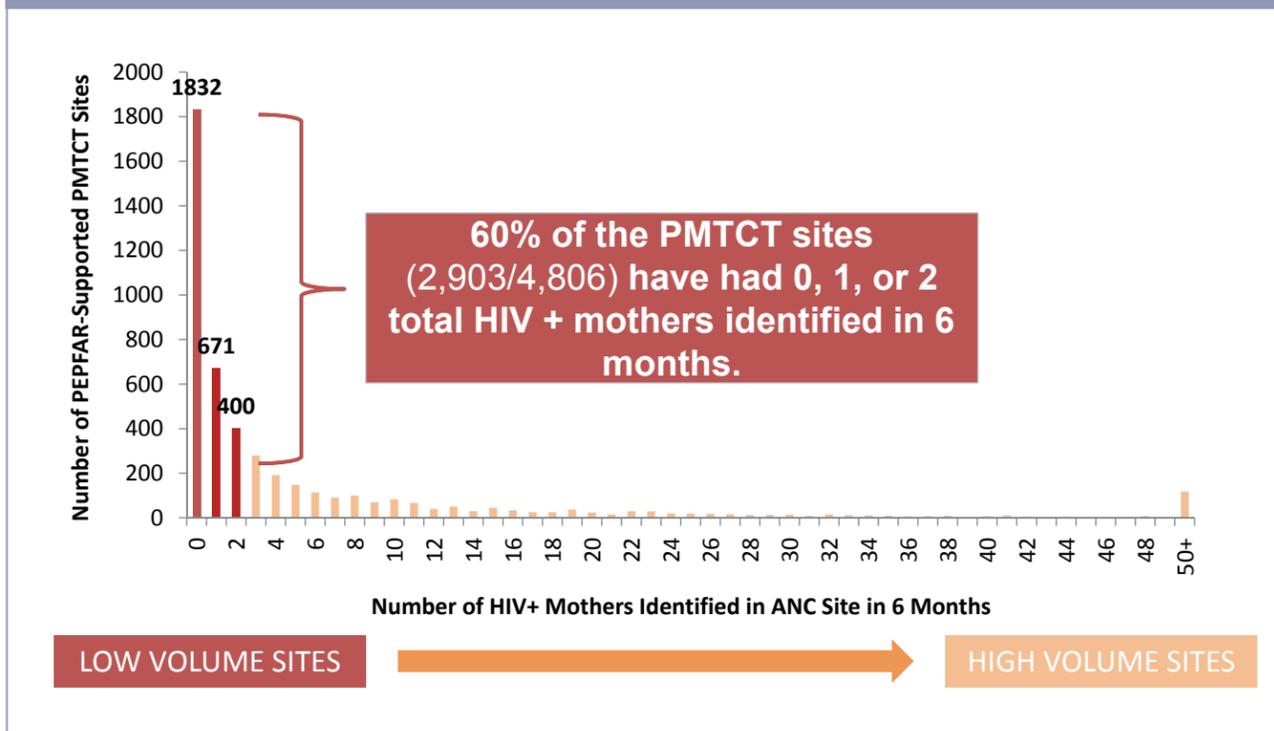


Figure 17. Geographic Refocusing in Kenya: Percent Positive Women Identified in PMTCT Sites

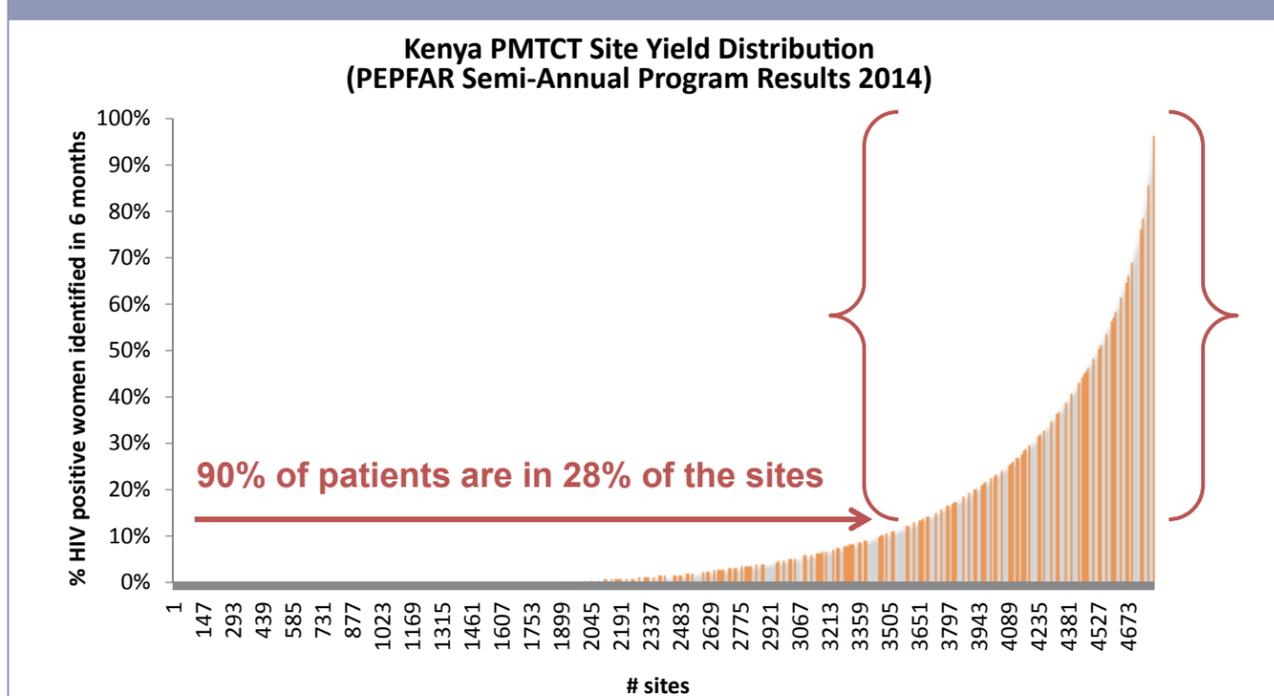
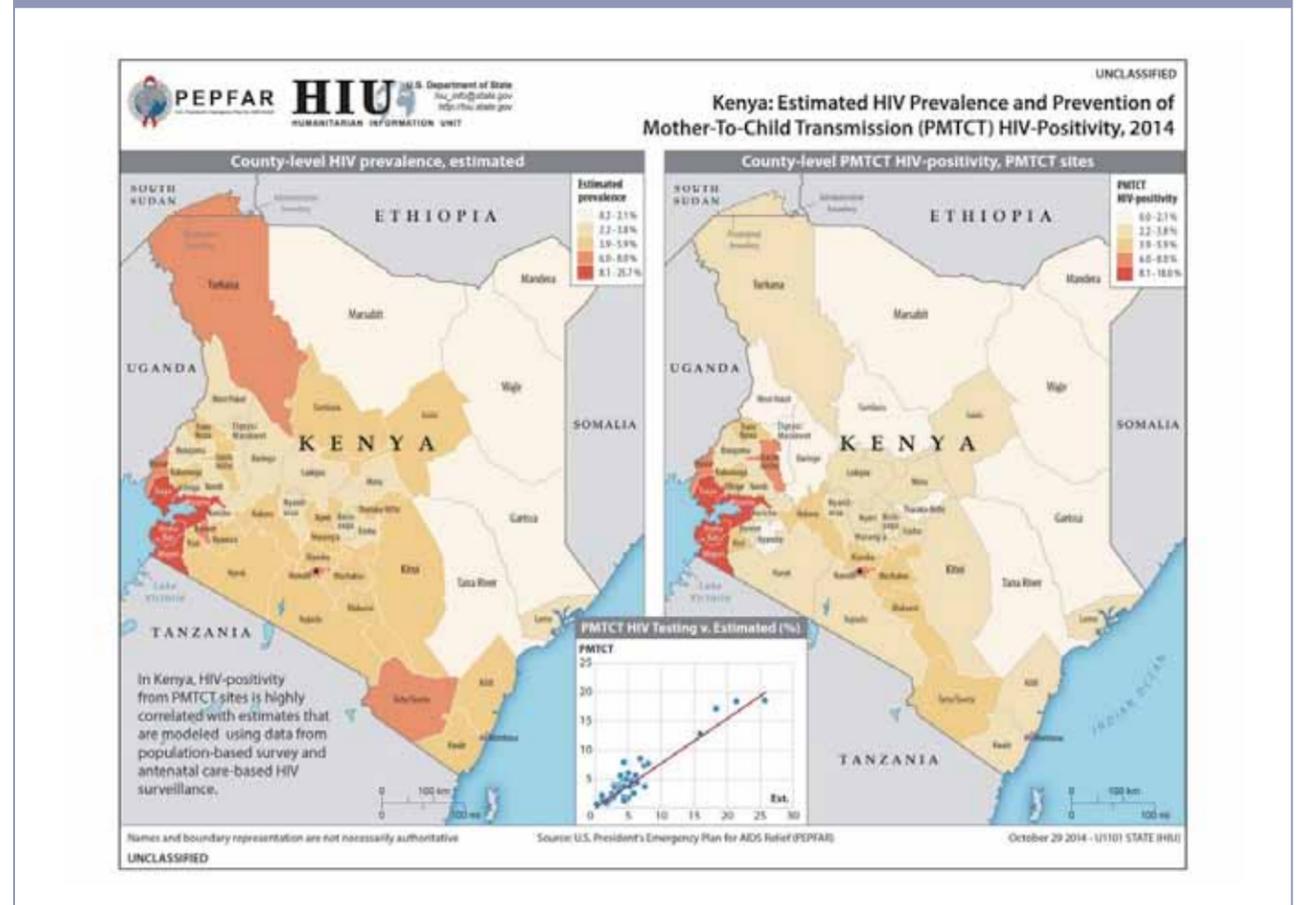


Figure 18. Kenya: HIV Prevalence, Model Output & PMTCT Site Prevalence



PEPFAR-supported countries implement various antiretroviral PMTCT treatment regimens (Figure 19). There are three PMTCT regimens used:

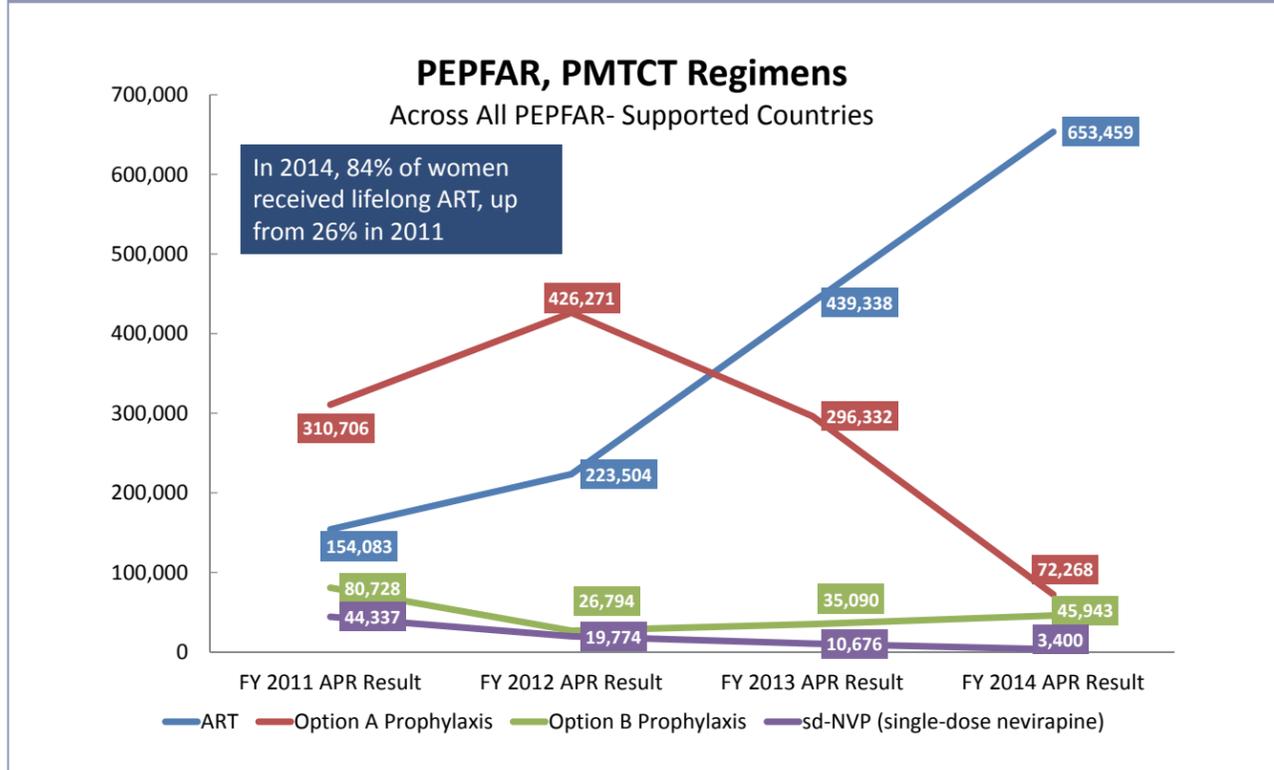
- Option A—single dose ARV;
- Option B—combination ART throughout the pregnancy and breastfeeding period; and
- Option B+—life-long ART.

Option A is a last resort, given the limitations of postnatal infant protection, risk of maternal drug resistance, and no maternal health benefits. Option B provides greater protection to the infant of an HIV-positive mother but has less maternal health value. Option B+ has the broadest benefits, maintaining the mother's health, providing lifelong re-

duction of HIV transmission to uninfected sexual partners, and supporting PMTCT in future pregnancies.

Option B and Option B+ are the preferred and required regimens. By FY 2014, all PEPFAR-supported countries had adopted B/B+ policy, giving more pregnant women the opportunity to live healthy lives and to deliver HIV-free babies. Across all PEPFAR-supported countries, the proportion of pregnant women initiating lifelong therapy on Option B+ has increased from 26 percent in 2011 to 84 percent in 2014; as of September 30, 2014, 623,023 pregnant and breastfeeding women are receiving lifelong HIV therapy in these countries (Figure 19). At the end of FY 2014, 10 PEPFAR-supported countries still used Option A for small portions of HIV-positive pregnant women. In FY 2015,

Figure 19. PEPFAR PMTCT Regimens



no PEPFAR resources will be used to support Option A, and PEPFAR has taken the necessary steps in working with national governments to ensure that Option A will be entirely phased out by the end of 2015.

ART reduces mother-to-child transmission at birth to less than 5 percent. 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 twelve months after initiation of lifelong therapy. During 2014, PEPFAR's retention rate in nine countries was 59.5 percent (Appendix V—Table

6). Increased efforts are being directed at the retaining women in care and treatment and providing testing for their infants to allow for early treatment of infected infants.

### APPENDIX K: Voluntary Medical Male Circumcision (VMMC)

VMMC is a one-time, low-cost intervention shown to reduce men's risk of HIV by approximately 60 percent in randomized controlled trials, and that preventive effect has been maintained over time. 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. At the end of FY 2014, after seven years of VMMC programming, PEPFAR had supported more than 6.5 million VMMC procedures in 14 Eastern and Southern African countries (Figures 20 and 21, Appendix V—

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 overarching strategies for epidemic control.

### APPENDIX L: Prioritizing Women and Children

In low- and middle-income countries, HIV remains the leading cause of death and disease in women of reproductive age.<sup>12</sup> In sub-Saharan Africa, 60 percent of those living with HIV are women, and in some of these countries, prevalence among young women aged 15-24 years is three times higher

than among men of the same age (Figure 22). 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.<sup>13</sup> One in three women will experience gender-based violence (GBV) in her lifetime.<sup>14</sup> Women account for two-thirds of the world's 774 million adults who are 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.<sup>15</sup> All of these factors negatively impact the overall health and wellbeing of women,

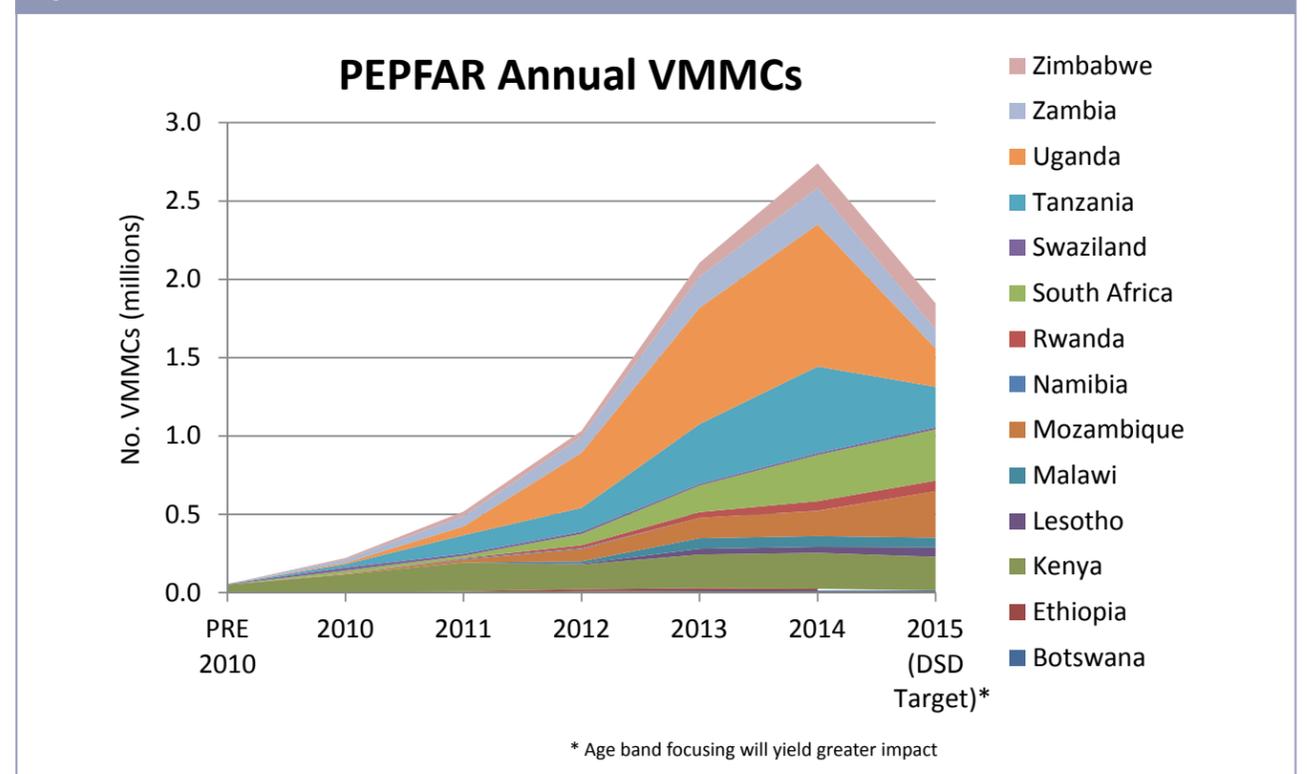
12 UNAIDS. (2014). *The Gap report*. Geneva.

13 World Health Organization. (2015). *Women's health*. Geneva.

14 United States Agency for International Development. (2015). *Report on gender equality and women's empowerment*. Washington, DC.

15 UNAIDS. (2010). *The world's women 2010: Trends and statistics*. Geneva.

Figure 20. PEPFAR Annual VMMC Results



while placing adolescent girls and young women at heightened risk for HIV infection, and HIV-positive women at heightened risk for maternal mortality.

Since its inception, PEPFAR has prioritized care and treatment for women and children; in FY 2014, over 32 million women and girls were tested and more than five million women and girls are in treatment. PEPFAR is dedicated to continued implementation of its 2013 *Gender Strategy*, 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.

GBV and HIV are intricately linked. Girls who experience violence are three times more likely to have an unwanted pregnancy and up to three times as likely to have HIV or other sexually transmitted infections. Sexual violence against pre-adolescents and ado-

lescents is alarmingly high, with 28 to 39 percent of girls reporting an unwanted sexual experience before they turn 18.<sup>16</sup>

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 and adding two gender-equality indicators; these indicators measure the number of people receiving post-GBV care and the number of people

<sup>16</sup> World Health Organization. (2014). *Global status report on violence prevention 2014*. Geneva.

Figure 21. PEPFAR Cumulative VMMCs, 2009–2014

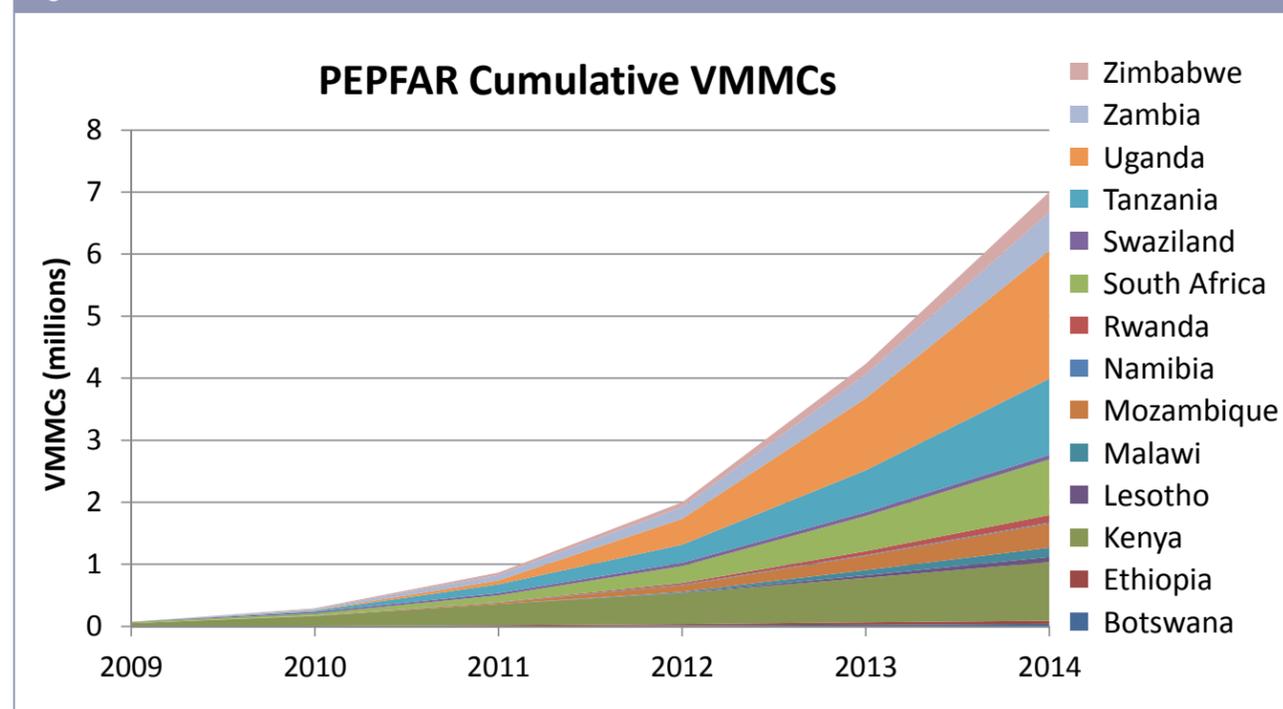
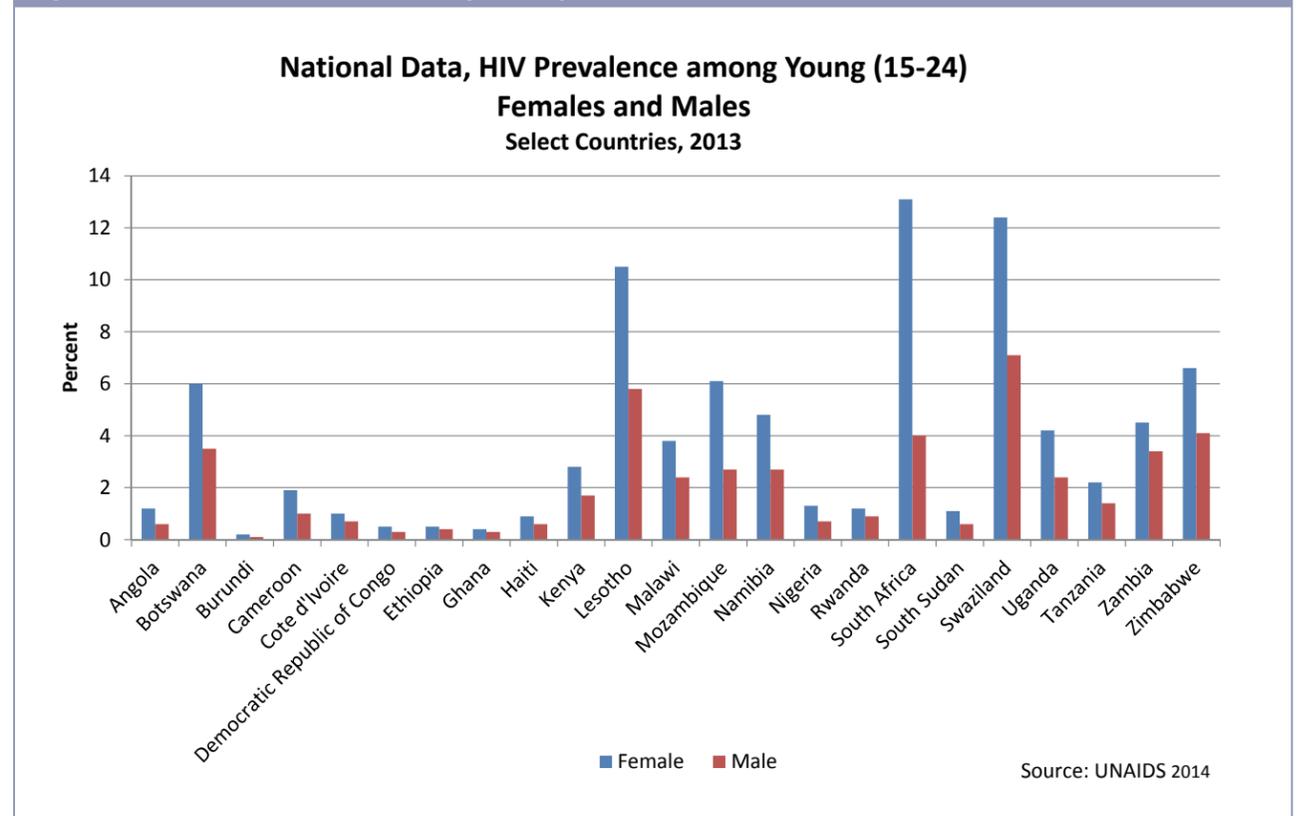


Figure 22. HIV Prevalence Among Young Females and Males



completing an activity pertaining to changing gender norms. In the past five years, PEPFAR reached over 125,400 individuals in 19 countries with post-exposure prophylaxis to prevent HIV for sexual violence survivors (Appendix V—Table 12).

### APPENDIX M: Pediatrics: Orphans and Vulnerable Children

#### Pediatrics

In 2013, 3.2 million children under the age of 15 were living with HIV globally—91 percent in sub-Saharan Africa.<sup>17</sup> Only 24 percent of these children were receiving ART. Children living with HIV are one-third less likely to receive ART compared to adults, and without

<sup>17</sup> UNAIDS. (2014). *The Gap report*. Geneva.

ART, half of the children living with HIV will die before their second birthday, and 80 percent will die before their fifth birthday.

In August 2014, U.S. Deputy Secretary of State Heather Higginbottom announced the *Accelerating Children's HIV/AIDS Treatment (ACT)* initiative, a partnership between PEPFAR and the Children's Investment Fund Foundation. ACT is an ambitious \$200 million, two-year initiative to double the total number of children receiving life-saving ART across ten priority African countries. This investment will enable 300,000 more children living with HIV to receive ART. ACT will target the countries with the highest burden of pediatric HIV, the lowest access to pediatric treatment, and the greatest disparity in treatment coverage for children compared to adults living with HIV.

In order to make ACT a successful initiative, adoption of the WHO guidelines on universal access to treatment for children under five is a critical step in breaching the gap between HIV-positive children and linking them to care. PEPFAR is focused on ensuring all vulnerable children have access to HIV testing, care, and treatment by expanding the OVC platform to ensure testing and linkages to life saving services.

### Orphans and Vulnerable Children: Strengthening Children's Resilience and Supporting an AIDS-free Generation

OVC programs remain central to achieving an AIDS-free generation. The programs respond to socioeconomic issues in the lives of children and, through their work with communities, create an enabling environment for children—and their parents—to access other services, including HIV treatment and prevention services. PEPFAR has worked to continue 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 analysis, and outcomes. To achieve an AIDS-free generation, strengthening the resilience of OVC—especially adolescent girls—their families, and communities is a core priority to act upon, so that all children can survive, thrive, and fulfill their dreams.

The specific goals of PEPFAR's OVC program are to:

- strengthen families as primary caregivers of children;
- strengthen child welfare systems to support country ownership, including community ownership;

- prioritize and focus interventions to address vulnerable children and adolescent's most critical care needs;
- ensure that children with and vulnerable to HIV are identified and provided with a continuum of care services ensuring HIV testing and access to care and treatment services; and
- support progress towards an AIDS-free generation through enhanced HIV prevention.

PEPFAR's OVC investments will be increasingly focused on strengthening the resilience of children, preventing new infections among vulnerable adolescent girls and young women, and ensuring HIV-positive children receive life-saving care and treatment. Specifically, investments are focused on:

- ensuring co-location of OVC programs and services to support integration of mitigation efforts with HIV prevention, detection, care and treatment;
- ensuring strong linkages to care and ART treatment services for referral and retention;
- prioritizing family-centered care;
- prioritizing the delivery of interventions geographically in high HIV prevalence areas and with underserved populations; and
- prioritizing mitigation activities that also contribute to the goals of reduced HIV infection and improved treatment uptake among children.

PEPFAR will work with OVC implementing partners to ensure that all vulnerable children receive appropriate HIV testing and access to life-saving services. PEPFAR is evaluating 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. Thus far, more than five million children have benefited from PEPFAR's services (Appendix V—Table 13)—including two million children who did not become orphans through the treatment of parents and caregivers living with HIV.

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 to 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.

PEPFAR has established new monitoring, evaluation, and reporting indicators for OVC that include tracking the number of children and caregivers served (disaggregated by age and sex), as well as 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 wellbeing.

### APPENDIX N: 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 entered a new phase—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 Agenda focuses on:

- the policy, administrative, and legal environment that would ensure access to services and social protection for vulnerable populations;
- the finance 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 key component of the Sustainability Action Agenda is the development and use of the Sustainability Index, which provides an annual snapshot of the state of the elements central to a sustained and controlled epidemic. The use of the Index will allow PEPFAR to objectively track progress towards sustainability goals. These goals are "owned" by

the country and have been supported by PEPFAR. The Index targets five key domains:

- data availability;
- domestic service delivery;
- finance and strategic investment;
- accountability and transparency, including civil society engagement; and
- enabling environment—political will and commitment for sustainability analyzed through 16 sub-elements.

These indicators and milestones selected include areas such as mobilizing sufficient data resources and allocating those resources strategically; 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.

To ensure increased participation and integration of civil society in HIV/AIDS planning and implementation, PEPFAR Interagency Teams were mandated by the Department of State to convene a minimum of two civil society consultations during the FY 2014 COP process—the first to solicit input and the second to provide feedback.

In FY 2014, PEPFAR began to collect information on governmental and local non-governmental capacity to sustain positive outcomes by monitoring the percent of PEPFAR funding going to local implementing partners as well as the percent of PEPFAR results attributable to local implementing partners. This ensures that a quantitative metric is available to directly intervene with measures to improve partner country capacity to succeed. In FY 2014, efforts were targeted to laboratory strengthening, strategic information, and Human Resources for Health (HRH).

For countries undergoing a transition of responsibilities previously held by PEPFAR, we are piloting a new approach called the Country Health Partnership (CHP) model. Secretary Kerry unveiled the CHPs with the presidents of Namibia, Rwanda, and South Africa in September 2013. The CHP model is centered on data accessibility and used to inform performance-based decision-making for impact, as well as shifts toward greater host-country financing and management as deemed necessary to achieve epidemic control.

The Sustainability Index will define the baseline and PEPFAR teams in country will work with the host country government and civil society to develop and track clear milestones towards increasing sustainability as measured by the index. The areas of joint work and engagement will form the basis of CHP for each country moving forward.

### **APPENDIX O: 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 achieve 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 enables policy makers and program planners to better coordinate donor 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 partnership frameworks 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 empowers more informed planning and country-driven decision making.

A full analysis of site-level results, including the cost of achieving those results and quality of the data will allow PEPFAR to identify the sites with the most efficient programs, and apply best practices from these sites to less efficient ones.

### **Coordination with the Global Fund**

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 to construct a framework for comparable expenditure datasets between the two organizations. With the inception of the 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.

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 early 2013, the PEPFAR Finance and Economic Work Group initiated partnerships with UNAIDS and WHO to develop technical crosswalks between U.S. government expenditure analysis (EA) tools and the NASA

and NHA tools. Standard guidance for how PEPFAR results and data can be used and input into national spending tracking efforts has been developed. In FY 2014, PEPFAR negotiated technical guidance with UNAIDS that serves as a protocol for countries requesting PEPFAR data for use in their NASAs. In 2013 and 2014, EA data was prepared in the NASA format for ten countries, representing \$2.9 billion worth of expenditures. PEPFAR is currently in the final stages of negotiations with WHO on a similar framework for standard reporting into the NHA/SHA framework.

### **Expenditure Analysis (EA)**

The PEPFAR EA Initiative was institutionalized in 2012; the EA is being phased in over a three-year period. In 2013, 19 PEPFAR operating units reported comprehensive expenditure data representing 95 percent of the PEPFAR COP budget. Data were reported in 2013 and represented expenditures between October 1, 2012 and September 30, 2013. PEPFAR expanded the EA to include all countries in 2014; results will be available in early 2015 and used for all COP development.

Table 3 outlines the total expenditures reported by countries in core intervention areas. Table 4 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 contributes to implementation of national HIV programs (e.g., the 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.

Table 3. Total Report PEPFAR Expenditures by Program Area

Total Reported PEPFAR Expenditures by Program Area, 2013 USD (millions)												
Country	Facility-Based Care, Treatment, and Support	Community-Based Care, Treatment, and Support	PMTCT	VMMC	HTC	Sexual and Other Risk Prevention—General Population	Sexual and Other Risk Prevention—Key Populations	Other Bio-medical Prevention	OVC	Lab	Strategic Information	Total
Botswana	\$20.1	\$1.2	\$1.8	\$6.0	\$5.9	\$2.6	\$1.7	\$1.9	\$4.4	\$3.3	\$3.1	\$52.1
Cameroon	\$0.8	\$0.0	\$5.0	\$0.0	\$1.2	\$0.3	\$1.1	\$1.3	\$0.6	\$1.6	\$0.6	\$12.5
Cote d'Ivoire	\$25.2	\$4.7	\$9.7	\$0.0	\$5.9	\$4.6	\$4.0	\$4.1	\$10.4	\$10.9	\$3.3	\$82.9
Ethiopia	\$58.6	\$17.6	\$22.9	\$0.5	\$18.5	\$11.2	\$18.7	\$10.3	\$29.0	\$28.1	\$20.8	\$236.3
Haiti	\$40.4	\$11.0	\$9.5	\$0.0	\$12.4	\$5.5	\$2.1	\$7.8	\$3.0	\$20.8	\$3.9	\$116.4
Kenya	\$214.5	\$28.9	\$28.9	\$15.5	\$36.2	\$27.3	\$18.3	\$20.7	\$43.5	\$25.1	\$13.5	\$472.3
Lesotho	\$7.7	\$1.3	\$3.1	\$4.4	\$3.3	\$2.8	\$1.3	\$1.0	\$5.0	\$3.8	\$0.4	\$34.1
Malawi	\$12.5	\$2.4	\$8.6	\$8.5	\$5.4	\$7.4	\$1.3	\$2.5	\$4.6	\$6.6	\$4.1	\$63.9
Mozambique	\$70.5	\$14.1	\$30.8	\$16.1	\$16.0	\$21.9	\$7.4	\$11.2	\$14.7	\$22.1	\$9.3	\$234.1
Namibia	\$9.4	\$6.4	\$4.8	\$2.4	\$6.8	\$5.8	\$4.1	\$0.8	\$4.0	\$5.0	\$8.5	\$58.0
Nigeria	\$153.6	\$25.5	\$49.0	\$0.0	\$24.6	\$7.0	\$18.4	\$25.6	\$27.4	\$73.8	\$9.5	\$414.5
Rwanda	\$30.8	\$2.8	\$5.4	\$1.3	\$8.9	\$2.3	\$3.5	\$5.6	\$10.3	\$13.2	\$1.0	\$85.1
South Africa	\$136.5	\$29.9	\$33.0	\$39.0	\$39.6	\$30.2	\$10.7	\$16.1	\$28.9	\$9.7	\$8.8	\$382.2
Swaziland	\$8.0	\$2.7	\$3.8	\$4.6	\$2.5	\$2.0	\$0.9	\$0.9	\$3.5	\$2.7	\$0.7	\$32.4
Tanzania	\$80.1	\$22.4	\$38.2	\$16.9	\$22.3	\$23.9	\$14.5	\$13.0	\$24.2	\$23.0	\$11.4	\$290.0
Uganda	\$110.4	\$9.1	\$36.5	\$29.8	\$20.1	\$4.8	\$5.5	\$6.1	\$23.6	\$20.4	\$17.7	\$284.1
Vietnam	\$23.2	\$2.6	\$1.4	\$0.0	\$3.0	\$3.9	\$12.0	\$1.2	\$0.7	\$5.3	\$3.4	\$56.7
Zambia	\$77.1	\$13.3	\$22.5	\$14.1	\$27.8	\$30.1	\$3.2	\$6.5	\$16.2	\$36.1	\$4.9	\$251.7
Zimbabwe	\$20.7	\$2.9	\$5.8	\$8.1	\$5.7	\$1.6	\$0.2	\$1.6	\$5.2	\$5.2	\$3.0	\$59.8
<b>Total</b>	<b>\$1,100.0</b>	<b>\$198.8</b>	<b>\$320.9</b>	<b>\$167.1</b>	<b>\$266.1</b>	<b>\$195.3</b>	<b>\$128.7</b>	<b>\$138.3</b>	<b>\$259.3</b>	<b>\$316.6</b>	<b>\$127.8</b>	<b>\$3,219.1</b>

Table 4. PEPFAR Unit Expenditure for Core Interventions

PEPFAR Unit Expenditure for Core Interventions, 2013 USD (millions)									
Country	Adult ART	Pediatric ART	Pregnant Women Tested	Pregnant Women on ARVs	HTC	VMMC	OVC	Gen Pop Prevention	Other Key Pops Prevention
Botswana	\$1,737	\$1,252	\$0	\$0	\$39	\$422	\$248	\$14	\$126
Cameroon	\$0	\$0	\$10	\$705	\$10	\$0	\$8,131	\$59	\$0
Cote d'Ivoire	\$305	\$0	\$4	\$315	\$5	\$0	\$72	\$27	\$64
Ethiopia	\$176	\$151	\$3	\$528	\$2	\$27	\$49	\$9	\$34
Haiti	\$681	\$499	\$14	\$583	\$13	\$0	\$110	\$3	\$9
Kenya	\$290	\$199	\$7	\$142	\$4	\$65	\$72	\$17	\$48
Lesotho	\$41	\$41	\$27	\$98	\$22	\$122	\$125	\$98	\$1,860
Malawi	\$40	\$32	\$3	\$85	\$2	\$97	\$17	\$13	\$2
Mozambique	\$184	\$95	\$6	\$122	\$9	\$104	\$63	\$17	\$59
Namibia	\$0	\$0	\$6	\$83	\$11	\$0	\$76	\$72	\$63
Nigeria	\$317	\$193	\$7	\$406	\$3	\$0	\$37	\$47	\$21
Rwanda	\$407	\$0	\$7	\$421	\$4	\$30	\$124	\$3	\$32
South Africa	\$43	\$29	\$6	\$43	\$5	\$125	\$117	\$7	\$29
Swaziland	\$67	\$64	\$21	\$149	\$8	\$444	\$49	\$5	\$25
Tanzania	\$209	\$66	\$5	\$257	\$4	\$42	\$73	\$64	\$18
Uganda	\$211	\$129	\$4	\$156	\$2	\$38	\$67	\$2	\$12
Vietnam	\$458	\$143	\$2	\$292	\$3	\$0	\$93	\$0	\$169
Zambia	\$170	\$51	\$7	\$118	\$10	\$61	\$39	\$31	\$18
Zimbabwe	\$129	\$25	\$0	\$44	\$5	\$80	\$29	\$4	\$0
<b>Total</b>	<b>\$5,465</b>	<b>\$2,969</b>	<b>\$139</b>	<b>\$4,547</b>	<b>\$161</b>	<b>\$1,657</b>	<b>\$9,591</b>	<b>\$492</b>	<b>\$2,589</b>

## **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 reversed, the total value of the taxes incurred are provided to the Department of State, and the Office of the Global AIDS Coordinator reduces the country funding levels by the value of the taxes paid. In FY 2013, a total of \$523,482 was paid in import taxes across 13 countries. FY 2014 PEPFAR funding levels to the 13 countries were reduced accordingly.

## **APPENDIX P: Partnership Frameworks: 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, 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 for the CHP approach. Lessons learned include 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 the 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, candid dialogue, transparency, and rewarding good governance. The challenges and opportunities of the PFs influenced the design of the CHP pilot.

In FY 2014, PEPFAR tested the CHP concept in three partner countries. The cornerstone of the CHP is the use of information and data for joint programming and mutual accountability. Key lessons learned during this pilot phase included:

- the importance of documenting agreements with a clear path to how they could be operationalized;
- the significance of multi-year indicative financing to the Ministry of Finance and the critical role the Ministry plays in negotiations; and
- greater clarity on U.S. government red-lines on resource allocation and use.

The sustainability index and the specific joint focus elements will form the basis of the CHP moving forward where objective progress together can be mapped and sustained.

## **APPENDIX Q: Engaging Faith-Based, Locally-Based, and Minority Partners**

It is critical that the domestic and global HIV/AIDS communities work in tandem as we all strive to reach an AIDS-free generation. Sharing best practices and strengthening ties are top priorities for PEPFAR and domestic AIDS efforts. In 2014, PEPFAR initiated a series of engagements across the United States to update civic leaders, academic and research partners, and elected officials on PEPFAR's progress and its forward vision for controlling the epidemic. Through this series, PEPFAR is also forming new opportunities to collaborate with local, nongovernmental partners.

Faith-based organizations are among PEPFAR's central partners in the delivery of care and treatment services. Since 2004, PEPFAR has invested \$1.965 billion to support clinics, hospitals, schools, and community service programs operated by both U.S.-based and international religious organizations. In December 2014, PEPFAR and the Global Fund held a joint roundtable discussion with representatives from diverse leaders of the faith community to inform and guide our work.

Also of critical importance are the United States Minority Serving Institutions (MSI), which have been at the forefront of the global HIV/AIDS response. MSIs, including historically black colleges and universities, bring particular strength and expertise in the delivery of HIV prevention, care, and treatment services in resource-limited environments and to vulnerable populations. In 2014, PEPFAR held a series of meetings with the Association of Minority Health Professions schools and continues to engage in regular dialogue with this leadership as we strives to forge a stronger relationship with these institutions and expand their important role within PEPFAR.

In January 2015, PEPFAR undertook a process to reconstitute and reinvigorate its Scientific Advisory Board in order to ensure broader and more diverse engagement with the scientific and research communities across the multiple sectors. The stakeholders all have critical roles in achieving an end to the HIV epidemic.

## **APPENDIX R: Engaging International and Nongovernmental Partners**

In 2014, PEPFAR launched and/or implemented several initiatives that focused on the role of new partners and civil society organizations.

- 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. The further developing of both organizational and technical capacity will allow PEPFAR to address HIV/AIDS in a sustainable manner and to ensure coordination, direct linkages, and support for local government entities engaged in the HIV response. LCI engages with organizations that are capable of working effectively in the prevention and care, with a focus on those with the capacity to support and strengthen local health systems.
- Robert Carr Civil Society Network Fund: This Fund was created to provide support to civil society networks working at global and regional levels and to ensure they have sufficient and predictable resources to enhance the quality, effectiveness, and gender equity of the HIV response. Priorities include universal access to prevention, treatment, care, and support—absent of stigma and discrimination. The

Fund targets its work to reaching inadequately served populations at the local level. To date, PEPFAR has awarded \$4 million to this Fund to support the activities of global and regional civil society networks.

- Key Populations Challenge Fund: During FY 2014, PEPFAR awarded \$19,020,281 through this fund to support projects in six partner countries—Cambodia, Ghana, Nepal, Senegal, Swaziland, and Zimbabwe—and four regional programs—Asia, Central Asia, West Africa and Central America. The funds support programs that are contributing to a sustainable, evidence-based HIV response for key populations, including projects that promote enabling environments.

## **APPENDIX S: Addressing the Co-Infections and Co-Morbidities of HIV/AIDS**

### **TB-HIV Co-infection**

Tuberculosis is the leading cause of death among PLHIV in sub-Saharan Africa, accounting for more than 1,000 lives lost each day. Given this enormous human toll, PEPFAR continues to address the deadly links between TB and HIV as a top policy and programmatic priority. PEPFAR aims to dramatically reduce the impact of HIV-associated TB through a combination of early identification and treatment of TB, preventive therapy, and infection control activities. PEPFAR is also working to accelerate access to early ART for co-infected patients. By the end of FY 2014, PEPFAR tested 4.9 million HIV-positive persons in care for TB (Appendix V—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.

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

- ensure all patients with presumptive TB or actual TB receive HIV testing;
- provide immediate access to ARTs 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 PLHIV, ensure diagnostic follow-up for PLHIV with presumptive TB and TB treatment for PLHIV with TB disease, and provide isoniazid preventive therapy for PLHIV who do not have active TB disease;
- support TB infection control measures to prevent transmission in healthcare and community settings;
- expand interventions, including Xpert MTB/RIF assay, to improve early diagnosis and treatment of TB among PLHIV; and
- 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 U.S. Agency for International Development (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. As of September 30, 2014, a total of 3,553 GeneXpert instruments and 8,807,910 Xpert MTB/TIF cartridges had been procured in the public sector in 110 countries.

### **Cervical Cancer**

Given the established link between HIV and cervical cancer, PEPFAR has supported screening and treatment to prevent cervical cancer in HIV-positive women since 2006, termed “screen and treat,” and has worked with countries and the Vaccine Alliance (GAVI) to increase access to increased 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 currently invests approximately \$4 million per year in cervical cancer screening and treatment for women infected with HIV, with support for programming in 15 countries; in FY 2014, these countries were Botswana, Cote d’Ivoire, Ethiopia, Guyana, Haiti, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe. In a number of these countries, PEPFAR has been instrumental in developing and implementing cervical cancer screening and treatment programs, laying 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 and focused on combatting 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 to promote education and early detection for breast cancer.

## **APPENDIX T: Strengthening Health Training**

PEPFAR supports partner countries in increasing 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 UNAIDS 90-90-90 targets. PEPFAR 3.0’s HRH Strategy focuses future investments on supporting the delivery of HIV services to priority populations in priority PEPFAR 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 at those sites and geographic areas.

The strategy includes a \$16.5 million commitment over three years to increase the supply of clinicians available to provide HIV services (through an expanded role of the Global Health Service Partnership program), as well as leveraging HRH investments to address drivers of HIV and other health epidemics (through a \$100 million commitment over the next 5 years to expand the quantity and quality of health workforces in fragile states experiencing HIV and/or other epidemics). As of November 2014, PEPFAR support has enabled 141,677 new health professionals to provide HIV services (Appendix V—Table 16).

PEPFAR also improves HRH availability by helping countries increase employment and improve retention.

- In Uganda, PEPFAR support in human resource management resulted in increased proportion of approved cadres filled in its 112 districts (from less than 48 percent in 2009 to 61 percent by 2013) and increased governmental resources for the health sector by \$19 million (permitting recruitment of over 7,200 new professionals).
- In Kenya, PEPFAR’s support for the Kenya Health Workforce Information System resulted in creating 10,500 new health worker posts. Kenya also increased the retirement age—retaining thousands of employees in the process in the public health system.
- In Lesotho, support to a Nurse Rural Retention program resulted in 96 percent of 46 rural health facilities achieving a full staffing complement.
- In Malawi, PEPFAR support has gone to over 400 Global AIDS Interfaith Alliance nursing scholars and has resulted in 97 percent of graduates who are currently working in the public sector or have completed their service agreement.

Translating these pockets of excellence across the PEPFAR investment countries will be the focus of the next 12 months and form the basis of the new HRH strategy.

## APPENDIX U: Evaluation Standards of Practice

In January 2014, PEPFAR published new Evaluation Standards of Practice, which articulate a common definition of evaluation—the “systematic collection and analysis of information about the characteristics, outcomes, and impact of programs and projects”—and eleven standards of practice to which all PEPFAR evaluations must adhere.

### The Standards of Practice

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

1. Engage stakeholders
2. Clearly state evaluation questions, purpose, and objectives
3. Use appropriate evaluation design, methods, and analytical techniques
4. Address ethical considerations and assurances
5. Identify resources and articulate budget
6. Construct data collection and management plans
7. Ensure appropriate evaluator qualifications and independence
8. Monitor the planning and implementation of evaluations
9. Produce quality evaluation reports
10. Disseminate results
11. Use findings for program improvement

Since each PEPFAR implementing agency possessed different business practices and legacies in the realm of evaluation, variations in the application of these standards among the agencies was to be expected. The committee reviewed these differences where they occurred, and committed to producing an accompanying operational guidance to assist country teams understand, apply, and interpret these standards.

## Findings

FY 2014 is the initial year for submission of evaluation results. Submissions for the FY 2014 Annual Program Results (APR) reflected the completion of 63 PEPFAR evaluations during this year (Table 5). The majority of these evaluations started in years prior to the release of the Evaluation Standards of Practice; as such, the assessment of adherence was done retrospectively. PEPFAR will use the FY 2014 findings as a baseline.

Nearly 70 percent of the 63 evaluation reports are on a publicly-available website. The remaining reports are not online for a range of reasons, including sensitive information, pending publication, intent to use findings for internal program improvement, and lack of understanding of the need to make the report publically available. However, all PEPFAR implementing agencies now are mandating public reporting, and the reports that are not currently online will be published online in the near future.

### Adherence to Standards

Even though the standards were applied retrospectively to PEPFAR-funded evaluations, the evaluations were found to adhere to six of the eleven standards of practice (Table 5). This pattern suggests that the large majority of these studies were developed

on a relatively strong foundation, consistent with the characteristics of high quality evaluations.

Key Findings: Describing resources and budgets (Standard 5), as well as evaluator qualifications and independence (Standard 7), are often completed before an evaluation has been initiated. Including these data in a final report is a relatively new practice and was not consistent. A similar statement can be made for how evaluation results were used for program improvement (Standard 11).

The relatively poorer adherence results for the production of quality evaluation reports (Standard 10) and wider dissemination of results (Standard 11) was not expected. These two practices are fundamental to the utility of evaluation research, so the lower levels of compliance are particularly concerning. These gaps are being actively analyzed, appropriate policies and requirements modified and re-emphasized to all implementing partners to ensure improved adherence.

The headquarters evaluation committee will work closely with headquarters and country teams to improve the quality of evaluations and expand the availability of results. In addition, greater attention will focus on stronger evaluation portfolios, integrating U.S. government agency and host country priorities and issues.

Table 5. PEPFAR Evaluation Standards of Practice

Adherence	1	2	3	4	5	6	7	8	9	10	11
Yes	57	54	51	49	25	58	29	43	38	19	33
Partial	2	9	12	7	9	3	27	6	25	28	16
No	4	0	0	7	29	2	7	14	0	16	14

Note: Green signifies high levels of compliance, yellow indicates mid-level, and red reflects low.

Please visit: [www.pepfar.gov](http://www.pepfar.gov)  
to access Appendix V: PEPFAR 2015 Annual Report Tables.

## Glossary

<b>ACT</b>	Accelerating Children's HIV/AIDS Treatment Initiative	<b>LGBT</b>	Lesbian, Gay, Bisexual, and Transgender
<b>ART</b>	Antiretroviral treatment	<b>MCC</b>	Millennium Challenge Corporation
<b>ARV</b>	Antiretroviral medications	<b>MSM</b>	Men who have Sex with Men
<b>CDC</b>	Centers for Disease Control and Prevention	<b>NACS</b>	Nutritional Assessment, Counseling, and Support
<b>CHPs</b>	Country Health Partnerships	<b>NIH</b>	National Institutes of Health
<b>CIFF</b>	Children's Investment Fund Foundation	<b>OVC</b>	Orphans and Vulnerable Children
<b>COP</b>	Country Operational Plan	<b>PEPFAR</b>	U.S. President's Emergency Plan for AIDS Relief
<b>CTX</b>	Cotrimoxazole	<b>PF</b>	Partnership Frameworks
<b>DHHS</b>	U.S. Department of Health and Human Services	<b>PHDP</b>	Positive Health, Dignity, and Prevention programs
<b>DOD</b>	Department of Defense	<b>PLHIV</b>	People living with HIV/AIDS
<b>DREAMS</b>	Determined, Resilient, Empowered, AIDS-free, Mentored, Safe	<b>PMTCT</b>	Prevention of Mother-to-Child Transmission
<b>DSD</b>	Direct Service Delivery	<b>PPP</b>	Public-Private Partnerships
<b>EA</b>	Expenditure Analysis	<b>PreP</b>	Pre-exposure prophylaxis
<b>FBOs</b>	Faith-Based Organizations	<b>PRRR</b>	Pink Ribbon Red Ribbon
<b>FY</b>	Fiscal Year	<b>ROP</b>	Regional Operational Plan
<b>GAIA</b>	Global AIDS Interfaith Alliance	<b>SBC</b>	Social and Behavioral Change
<b>GAVI</b>	Global Alliance for Vaccines and Immunization	<b>TA-SDI</b>	Technical Assistance for Service Delivery Improvement
<b>GBV</b>	Gender-Based Violence	<b>TB</b>	Tuberculosis
<b>Global Fund</b>	The Global Fund to Fight AIDS, Tuberculosis and Malaria	<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>HIA</b>	HIV/AIDS Impact Assessment	<b>UNICEF</b>	The United Nations Children's Fund
<b>HIV</b>	Human Immunodeficiency Virus	<b>USAID</b>	United States Agency for International Development
<b>HRH</b>	Human Resources for Health	<b>VACS</b>	Violence Against Children Surveys
<b>HRSA</b>	Health Resources and Services Administration	<b>VMMC</b>	Voluntary Medical Male Circumcision
<b>HSS</b>	Health Systems Strengthening	<b>WASH</b>	Water, Sanitation, and Hygiene
<b>HTC</b>	HIV Testing and Counseling	<b>WHO</b>	World Health Organization
<b>LCI</b>	Local Capacity Initiative		



Photo Credit: David Snyder/CDC Foundation

*Mother and daughter in Mombasa, Kenya*



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

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