



PEPFAR

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

PEPFAR

THE U.S. GOVERNMENT'S RESPONSE TO
GLOBAL/HIV AIDS

Office of the U.S. Global AIDS Coordinator & Health Diplomacy

U.S. Department of State | December 2016

The AIDS virus swept across the world, silently, before we even knew it existed. The epidemic was well underway by 1981, when AIDS was first recognized and was given a name.

- Dr. Jonathan M. Mann, MD, MPH

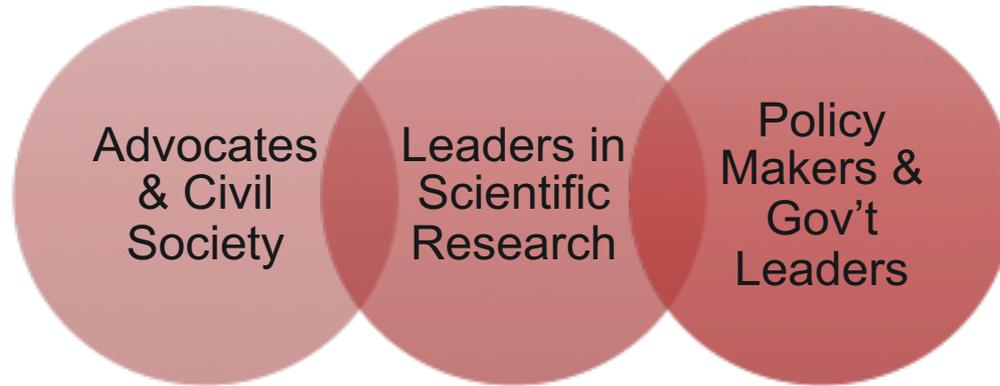
Director, Special Program on AIDS, World Health Organization

Statement to the United Nations, October 1987

The earliest days of the epidemic

- On June 5, 1981, the Centers for Disease Control and Prevention's *Morbidity and Mortality Weekly Report* made passing mention of a rare form of pneumonia, known to only infect those that are severely immunosuppressed.
- Within a month, *The New York Times* reported on 41 cases of Kaposi's Sarcoma, a rare cancer, affecting homosexual men in New York and San Francisco. Doctors cautioned that this could be "rather devastating."
- The first case of what would come to be known as AIDS was reported in rural Uganda in 1982, with possible origins in Tanzania.
- AIDS, or Acquired Immune Deficiency Syndrome, was defined in September 1982: "A disease at least moderately predictive of a defect in cell-mediated immunity, occurring in a person with no known case for diminished resistance to that disease."

The First Responders



- It may be easiest to think of HIV as three separate but intertwined epidemics:
 - Preventing of HIV infection
 - Care and treatment of people infected with HIV
 - Social, cultural, economic, and political reaction to people living with HIV
- From the very beginning of the epidemic, it was clear that AIDS and its underlying causes – epidemiologic and otherwise – would require a unique response. In this instance, it started from the community-level and escalated from there.

Advocacy and the U.S. Response

We condemn attempts to label us as ‘victims,’ a term that implies defeat, and we are only occasionally ‘patients,’ a term that implies passivity, helplessness, and dependence upon the care of others. We are ‘People With AIDS.’

– The Denver Principles, June 9, 1983

From Day 1, advocacy groups mobilized, organized, and demanded change.

1982: Gay Men’s Health Crisis, the first community-based service provider, is founded in New York City

1987: National Black Leadership Commission on AIDS begins providing services specifically for people of color

1988: ACT UP (AIDS Coalition to Unleash Power) demands the FDA accelerate the AIDS drug approval process, and in doing so, shut down the agency for a day in the largest demonstration since the Vietnam War

1990: ACT UP protests at NIH, demanding more HIV treatments, as well as the expansion of clinical trials to include more women and people of color



Advocacy and the Global Response

1983: Brazilian civil society successfully pushed their government to adopt the first national AIDS program

1986: Global Network of People Living with HIV (GNP+) is established

1987: AIDS Support Organization (TASO) is established in Uganda with a multi-pronged mission statement: prevent infection, restore hope, and improve quality of life for those living with HIV



1992: International Community of Women Living with AIDS is established, with the aim of bringing the issues facing women living with HIV to the center of the discussion

Understanding the disease



- **September 1983:** CDC identifies all major routes of HIV transmission and more importantly, rules out transmission by casual contact, food, water, air, or environmental surfaces
- **June 1984:** Dr. Robert Gallo (National Cancer Institute) and Dr. Luc Montagnier (Pasteur Institute) announced the discovery of a retrovirus that causes AIDS. This would come to be known as Human Immunodeficiency Virus, or HIV.
- **March 1987:** FDA approves the first antiretroviral drug (AZT) and creates priority category for AIDS therapies

Early U.S. Government Response

By August 1989, the CDC reported that the number of AIDS cases in the United States had reached 100,000.

The U.S. government had started to fund research into HIV in 1983, and by 1987, had started to explore greater government involvement and oversight. However, the response at this juncture was mainly driven by advocates and community-based organizations like AID Atlanta, AIDS Project Los Angeles, and Gay Men's Health Crisis filled the gaps.

The epidemic was widely seen as one that affected mainly a small, marginalized population – that is, until Ryan White.

Thank you, Commissioners.

My name is Ryan
White. I am sixteen
years old. I have
hemophilia, and I
have AIDS.

- Ryan White

Testimony before the President's Commission on AIDS,
1988



Early U.S. Government Response

Ryan White became a national poster child for HIV in the United States after the news that he was not allowed to attend public school because of HIV status spread. Ryan was a hemophiliac who was diagnosed with HIV after a contaminated blood transfusion. At that time, AIDS was poorly understood.

The attention that Ryan garnered while sharing his story, combined with the eight-page letter on HIV prevention sent by U.S. Surgeon General C. Everett Koop to all American households and advances in treatment, well characterize the response in the late 1980s – the public will was there, while financial support was lacking. Sadly, Ryan died in 1990, one month before his high school graduation.

In 1990, President George H. Bush signed the **Ryan White CARE Act** into law – the first federal funding for community-based care and treatment services.



Convinced that the global spread of AIDS is reaching catastrophic dimensions, the Clinton administration has formally designated the disease for the first time as a threat to U.S. national security that could topple foreign governments, touch off ethnic wars and undo decades of work in building free-market democracies abroad.

- *AIDS is Declared Threat to US National Security*

The Washington Post, April 30, 2000

The 1990s

Following the passage of the Ryan White CARE Act, the focus of the U.S. government remained domestic. AIDS was the leading cause of death for all Americans ages 25 – 44 by 1994. However, scientific advances began to shift the tide by the middle of the decade.

In 1996, there was finally cause for hope. The advent of HAART, or highly active antiretroviral therapy, shifted the prognosis. A diagnosis of HIV no longer meant certain fatality; the disease became a chronic condition.

While treatment became more widely available in the United States, it was increasingly evident that the epidemic in sub-Saharan Africa was spreading out of control.

Orphans and Vulnerable Children: A Global Concern

In 1997, a groundbreaking report – *Children on the Brink* – was released by USAID. It was the first to document the staggering effect of HIV/AIDS on children worldwide, estimating that 15.6 million children would have lost one or both of their parents by 2000 due to the epidemic. To respond to this, the Leadership and Investment in Fighting an Epidemic (LIFE) Initiative was established in 1999, and for the first time, the U.S. government was financially contributing to the global response to HIV/AIDS.



We cannot restore to [these children] all they have lost, but we can give them a future -- a foster family, enough food to eat, medical care, a chance to make the most of their lives by helping them stay in school.

- President Bill Clinton
World AIDS Day, 1998

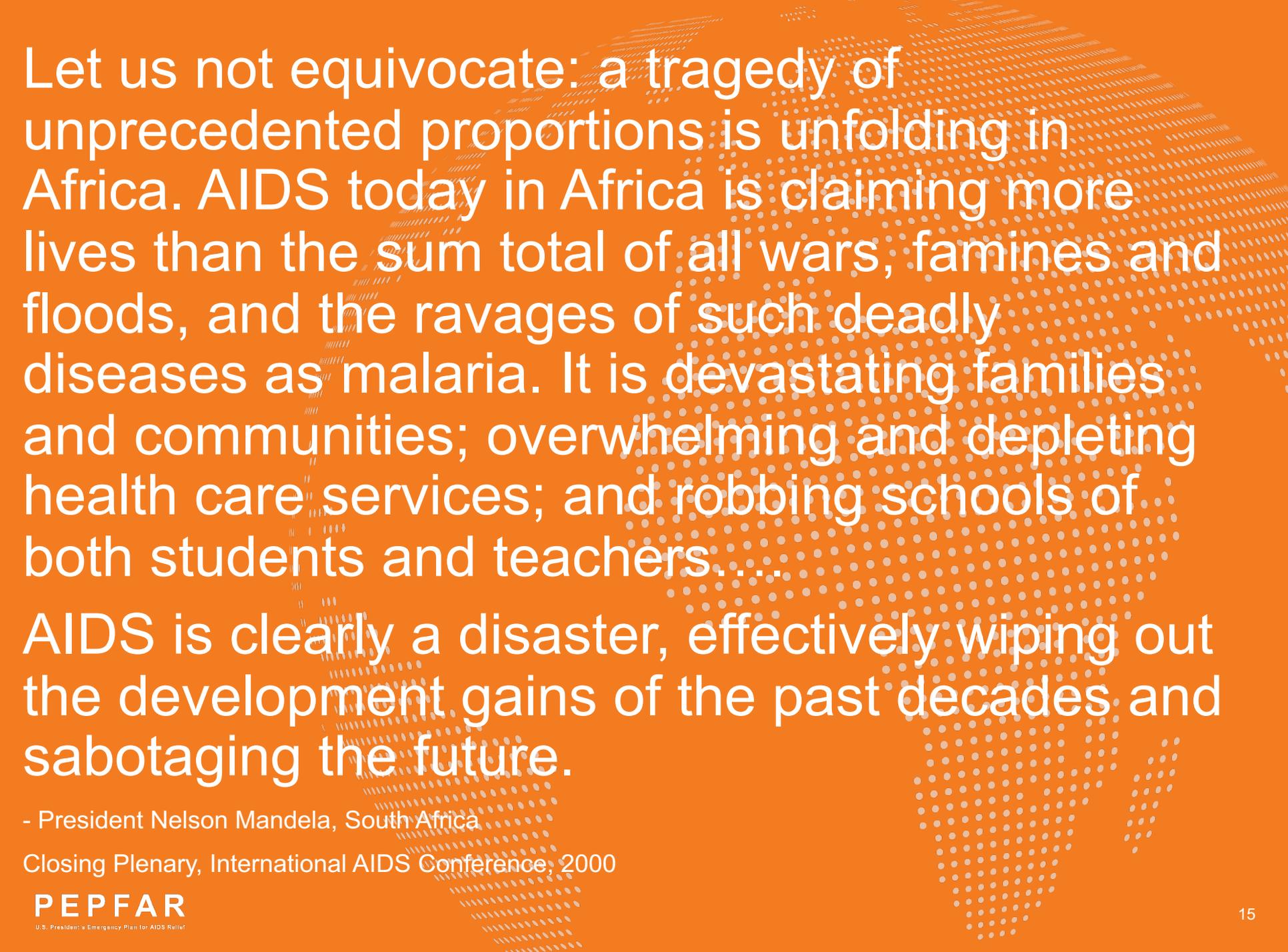
Securing our Future

By 2000, it was clear that the HIV was a much larger threat to the U.S. than even the most dismal models showed, largely due to the damage it was doing worldwide. The Clinton administration, gravely concerned by the effects of the global spread, designated the disease a threat to U.S. national security.

Not only was AIDS orphaning children worldwide, it was undoing decades of development work. A National Security Estimate, prepped in January 2000, predicted a “demographic catastrophe” in some of the hardest-hit countries.

This will further impoverish the poor and often the middle class and produce a huge and impoverished orphan cohort unable to cope and vulnerable to exploitation and radicalization.

As a result, the U.S. government more than doubled its investment in global HIV/AIDS, while establishing an interagency task force that included domestic leaders, Congress, scientific bodies, and the National Security Council.



Let us not equivocate: a tragedy of unprecedented proportions is unfolding in Africa. AIDS today in Africa is claiming more lives than the sum total of all wars, famines and floods, and the ravages of such deadly diseases as malaria. It is devastating families and communities; overwhelming and depleting health care services; and robbing schools of both students and teachers....

AIDS is clearly a disaster, effectively wiping out the development gains of the past decades and sabotaging the future.

- President Nelson Mandela, South Africa

Closing Plenary, International AIDS Conference, 2000

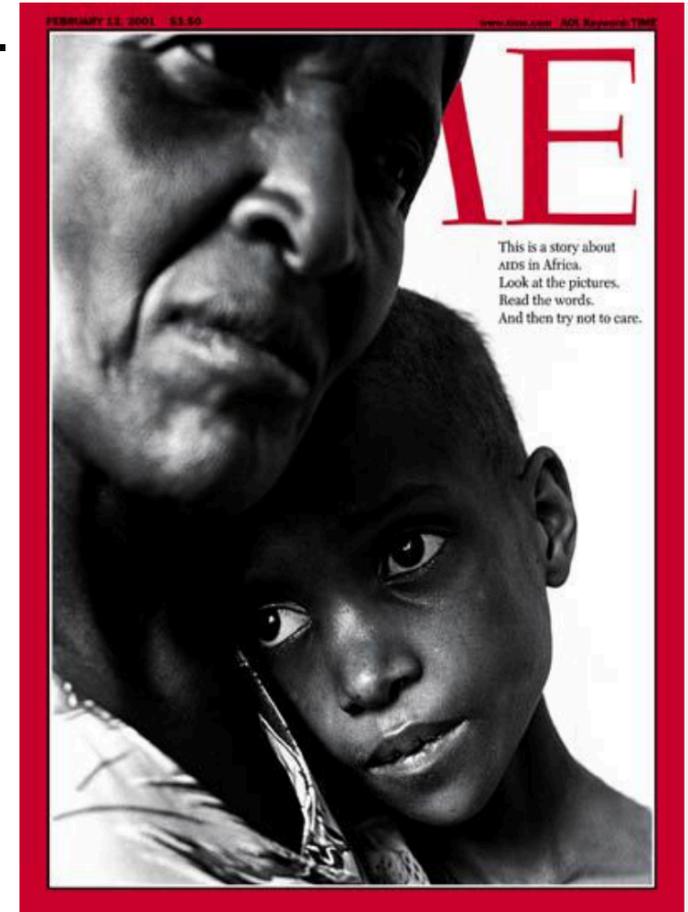
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U.S. President's Emergency Plan for AIDS Relief

Changing the Game

Following President Mandela's closing plenary at the Durban conference, the world began to better understand the impact of the epidemic on Africa. In many ways, AIDS 2000 was a game changer. It started an era of global focus.

In short order, the UN passed Security Council Resolution 1308, the first to address the impact of HIV/AIDS worldwide, and Congress passed the Global AIDS Tuberculosis Relief Act. Heads of state began to convene on how to best address the epidemic, and the private sector increased its involvement. Between 2000 and 2002, the funding for global AIDS programming tripled.



As our nation moves troops and builds alliances to make our world safer, we must always remember our calling, as a blessed country, is to make the world better.

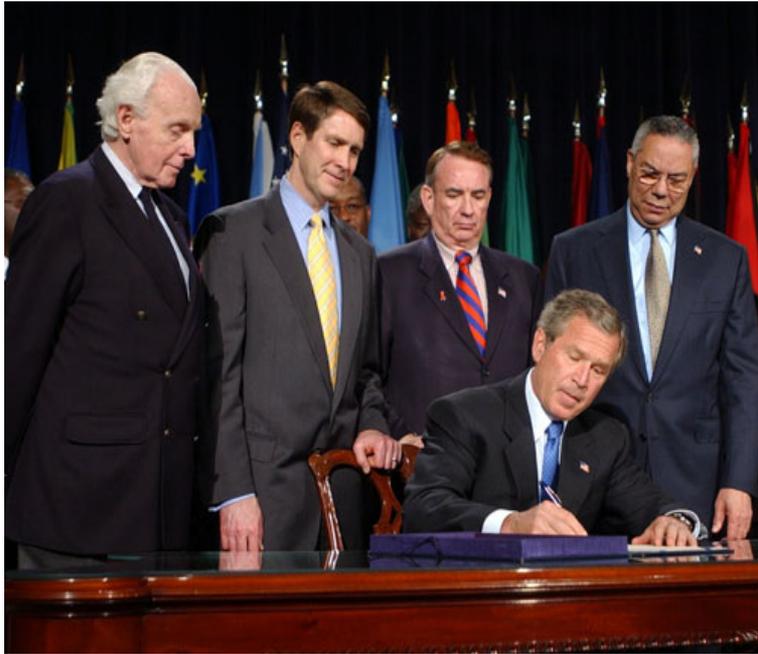
Ladies and gentlemen, seldom has history offered a greater opportunity to do so much for so many. We have confronted, and will continue to confront, HIV/AIDS in our own country. And to meet a severe and urgent crisis abroad, tonight I propose the Emergency Plan for AIDS Relief, a work of mercy beyond all current international efforts to help the people of Africa.

This nation can lead the world in sparing innocent people from a plague of nature.

- President George W. Bush

2003 State of the Union Address

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



At the 2003 State of the Union address, President George W. Bush called on Congress to take action against the global HIV/AIDS epidemic, and they responded with PEPFAR, or the U.S. President's Emergency Plan for AIDS Relief. This bipartisan bill provided \$15 billion for focused efforts in 15 low-

resource countries, as well as \$1 billion for the recently-created Global Fund to Fight AIDS, Tuberculosis and Malaria. The legislation also established the Office of the Global AIDS Coordinator, housed within the U.S. Department of State, to manage the broad U.S. response. PEPFAR is the largest commitment by any nation to combat a single disease.

The PEPFAR Model

Under the leaderships of the U.S. Global AIDS Coordinator, new structures have been established at every level of the U.S. Government to ensure a unified strategy and approach to ending HIV/AIDS.

Seven U.S. government agencies contribute to the PEPFAR response:

- U.S. Department of State
- U.S. Agency for International Development (USAID)
- U.S. Department of Health and Human Services (HHS)
- U.S. Department of Defense
- U.S. Department of Labor
- Peace Corps
- U. S. Department of the Treasury

This model ensures that the strengths of all implementing agencies are properly channeled into the U.S. government's response.



PEPFAR 1.0: 2003 - 2007

At the beginning, PEPFAR was truly an *emergency* response. In 2003, people were dying by the thousands in Africa because treatment was not available. It was estimated that 1/3 of the population in some countries were infected, and at that point, over 20 million had died, leaving behind 14 million orphans and vulnerable children.

The first program goals were the 2/7/10 goals:

- To provide ART to 2 million HIV-infected people
- To prevent 7 million new infections
- To support care for 10 million people

Initially, the hope was that these would be accomplished by 2010; in fact, they were achieved by World AIDS Day 2008.

Prevention, treatment, and care were the hallmarks of the early response. Though this, health systems in partner countries were expanded and strengthened.

The work could not have been done alone. The U.S. government did – and still does – share responsibility with other donor nations, civil society, faith-based organizations, the private sector, foundation, multilateral organizations, and people living with HIV.



PEPFAR 2.0: 2008 - 2014

By the time that PEPFAR was reauthorized by a bipartisan Congress in July 2008, the response had shifted from an emergency to sustainable response. There were two main components:

- Shared responsibility and country-driven programs
- Scaling up core interventions, like ART, PMTCT, and voluntary medical male circumcision for impact

During this period, PEPFAR established Partnership Frameworks, which were joint strategic plans signed between the United States government and partners governments, ushering a new era of mutual accountability in the HIV/AIDS response.



An AIDS-Free Generation

*Scientific advances and their successful implementation have brought the world to a tipping point in the fight against AIDS. The United States believes that by making smart investments based on sound science, and a shared global responsibility, we can save millions of lives and achieve an **AIDS-free generation**.*

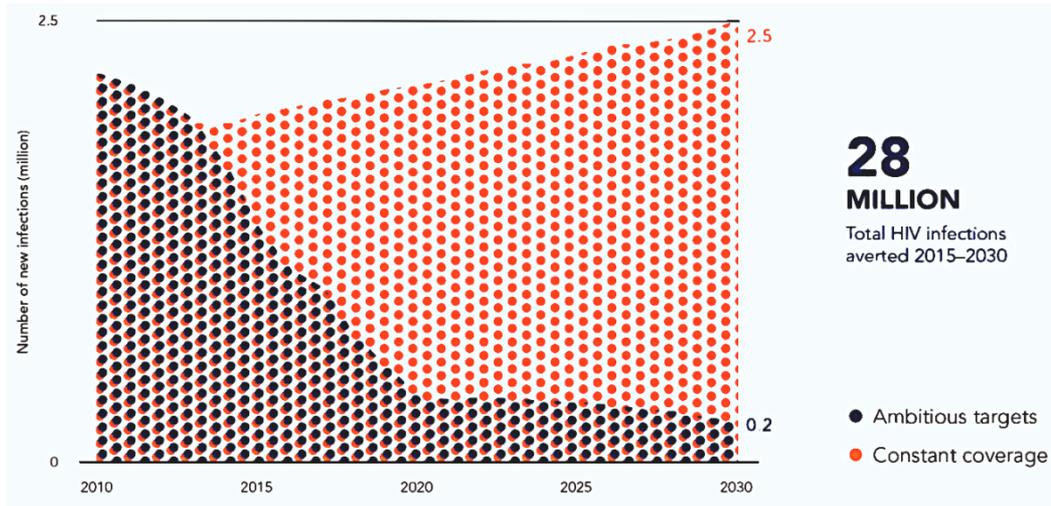
PEPFAR Blueprint: Creating an AIDS-free Generation

The U.S. made a bold call to action in 2011: that the world could, and should, be able to create an AIDS-free Generation, due in large part to landmark scientific advancements:

- Voluntary Medical Male Circumcision (VMMC) reduces male risk of HIV infection by more than 60%
- PrEP, or preexposure prophylaxis, dramatically decreases HIV infection risk
- Option B+
 - This approach offers all HIV-positive pregnant or breastfeeding women ART for their entire lives. Option B+ reduces the chance for mother-to-child transmission in future pregnancies, reduces transmission to uninfected partners, and maintains the mother's health.
- Treatment as Prevention
 - In May 2011, the NIH demonstrated for the first time that treatment also works as an extraordinary effective tool to prevent infection – up to 96%, if used correctly.

These advances, combined with the increasingly affordable cost of treatment, strengthened health systems in partner countries, and the shared efforts of global partners, made it so that an AIDS-free generation is within reach.

A Five Year Window



We have a fragile five-year window to build on the rapid results that have been made. The next five years will determine the next 15.

UNAIDS Gap Report 2014

In 2014, UNAIDS released two documents that shifted the focus of the global response: The Gap Report and 90-90-90. Data showed that if the response continued "as usual," the growth of the epidemic would soon outpace the resources allotted to it. However, by focusing on the most at-risk populations and targeting the right areas, 28 million infections could be averted. Providing treatment, with a focus on human rights, is a cornerstone of this; the 90-90-90 goals aim to achieve the following by 2020:

- 90% of all people living with HIV will know their HIV status
- 90% of all people with diagnosed HIV infection will receive sustained treatment
- 90% of all people receiving treatment will have viral suppression

PEPFAR 3.0:

Right Things, Right Place, Right Time, Right Way

On World AIDS Day 2014, PEPFAR released its current strategy: *PEPFAR 3.0 – Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation*. PEPFAR 3.0 focuses on sustainable control of the epidemic.

We can best control the epidemic by pivoting to a data-driven approach that strategically targets geographic areas and populations where we can achieve the most impact for our investments.

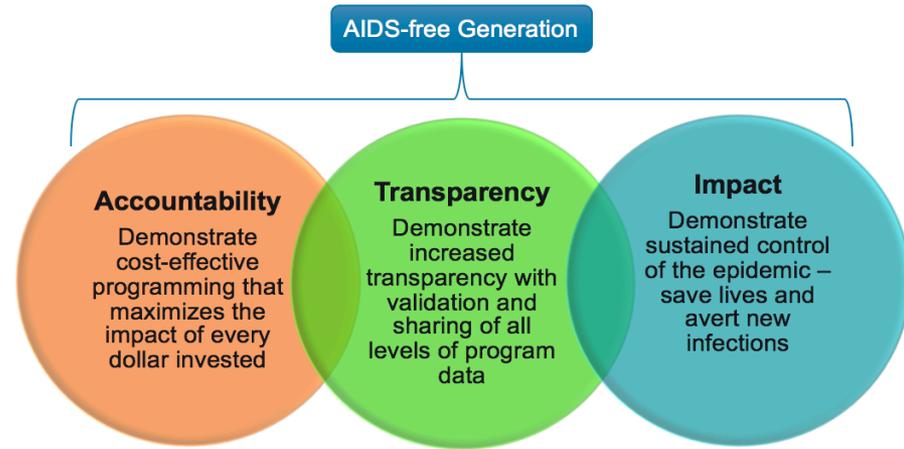
PEPFAR's plan to control the epidemic is based on five action agendas:

- Impact
- Efficiency
- Sustainability
- Partnership
- Human Rights

Action Agendas

The action agendas are underscored by three guiding tenants:

- Sustainability & shared responsibility
- Quality, oversight, transparency, & accountability for impact
- Accelerating core interventions for epidemic control



Impact Agenda focuses resources and

leverages finances to address the most vulnerable populations.

Efficiency Agenda aims to increase transparency, oversight, and accountability across PEPFAR and its interagency partners to ensure each dollar is optimally spent. This includes access to data, which has steadily increased since 2014.

Sustainability Agenda emphasizes a core concern: that once epidemic control has been reached, PEPFAR countries have the services, systems, financing, and policies required to maintain it.

Partnerships Agenda commends existing partnerships as the cornerstone of the U.S. response, while recognizing that ending HIV can only be accomplished through deeper collaboration and focused investment by all involved.

Human Rights Agenda notes that, without protecting human rights and addressing the human rights challenges of people living with HIV, there will continue to be an HIV epidemic.

PEPFAR Targets

At the UN General Assembly Meeting in 2015, President Obama set ambitious targets for PEPFAR and the U.S. government response. By 2017, PEPFAR aims to:

- Support 12.9 million people on life-saving ART, which nearly doubles the amount of people on treatment since 2013
- Provide 13 million male circumcisions for HIV prevention
- Reduce HIV incidence by 40 percent among adolescent girls and young women within 10 African countries: Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe



Additional Power Points are available for each section

Future progress and continued success will be guaranteed by successes in our priority areas:

- Adolescent Girls and Young Women
- Children
- Data for Impact
- Sustainability and Partnerships
- Human Rights and Key Populations

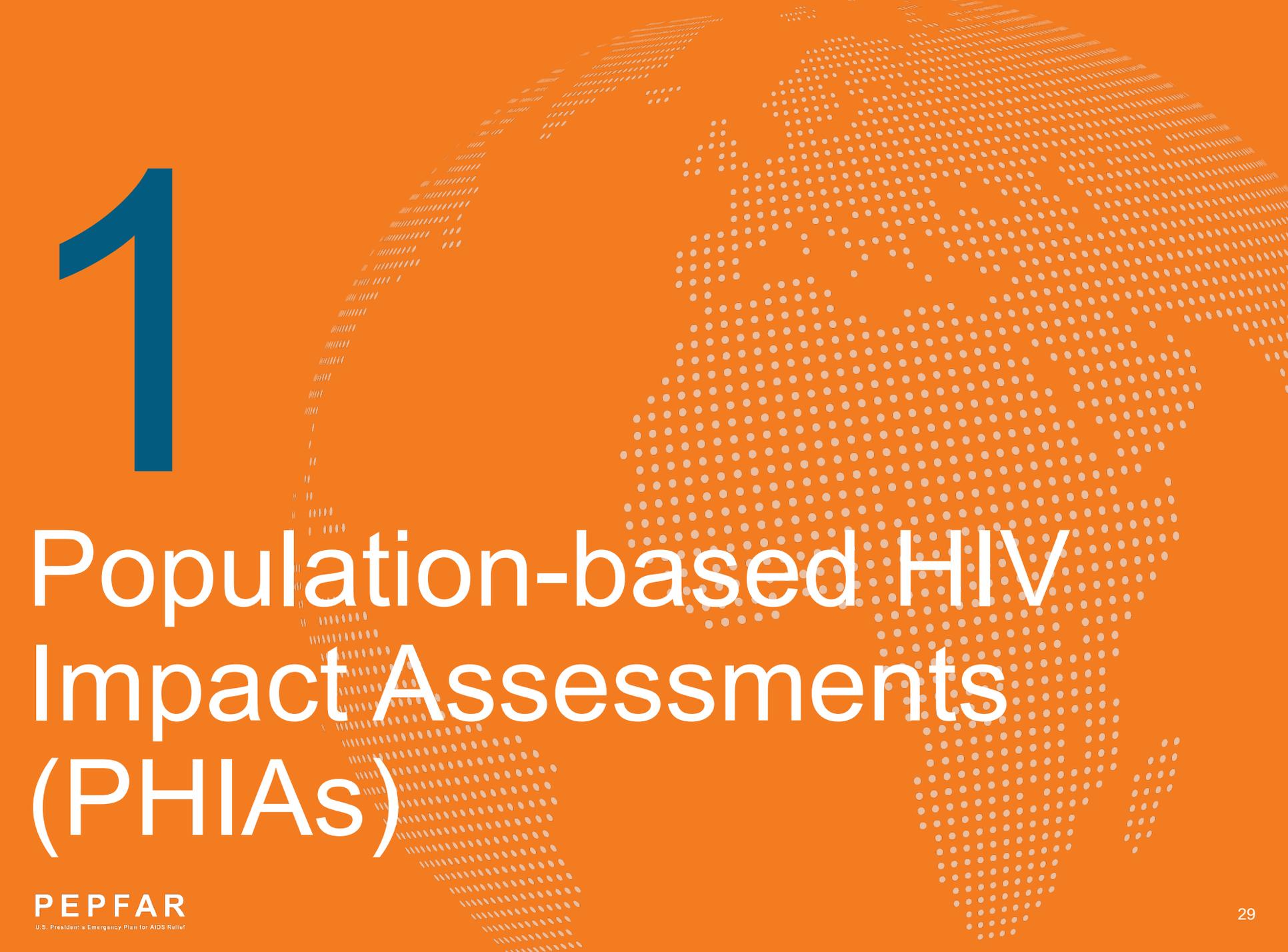


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Optimizing Results in PEPFAR

AMB Deborah L. Birx, MD December 1, 2016



1

Population-based HIV Impact Assessments (PHIAs)

Population-based HIV Impact Assessments PHIA Project

- CDC award to plan and implement household-based HIV-focused national surveys in the general population of selected African countries between 2014-2019
- Project Goals:
 - **Describe the epidemic** in specific PEPFAR-supported countries at a given point in time
 - **Build capacity** in targeted countries to design, conduct, analyze and disseminate results of PHIA



Westat



Rollout of 13 PHIA Surveys





Survey Objectives & Methods

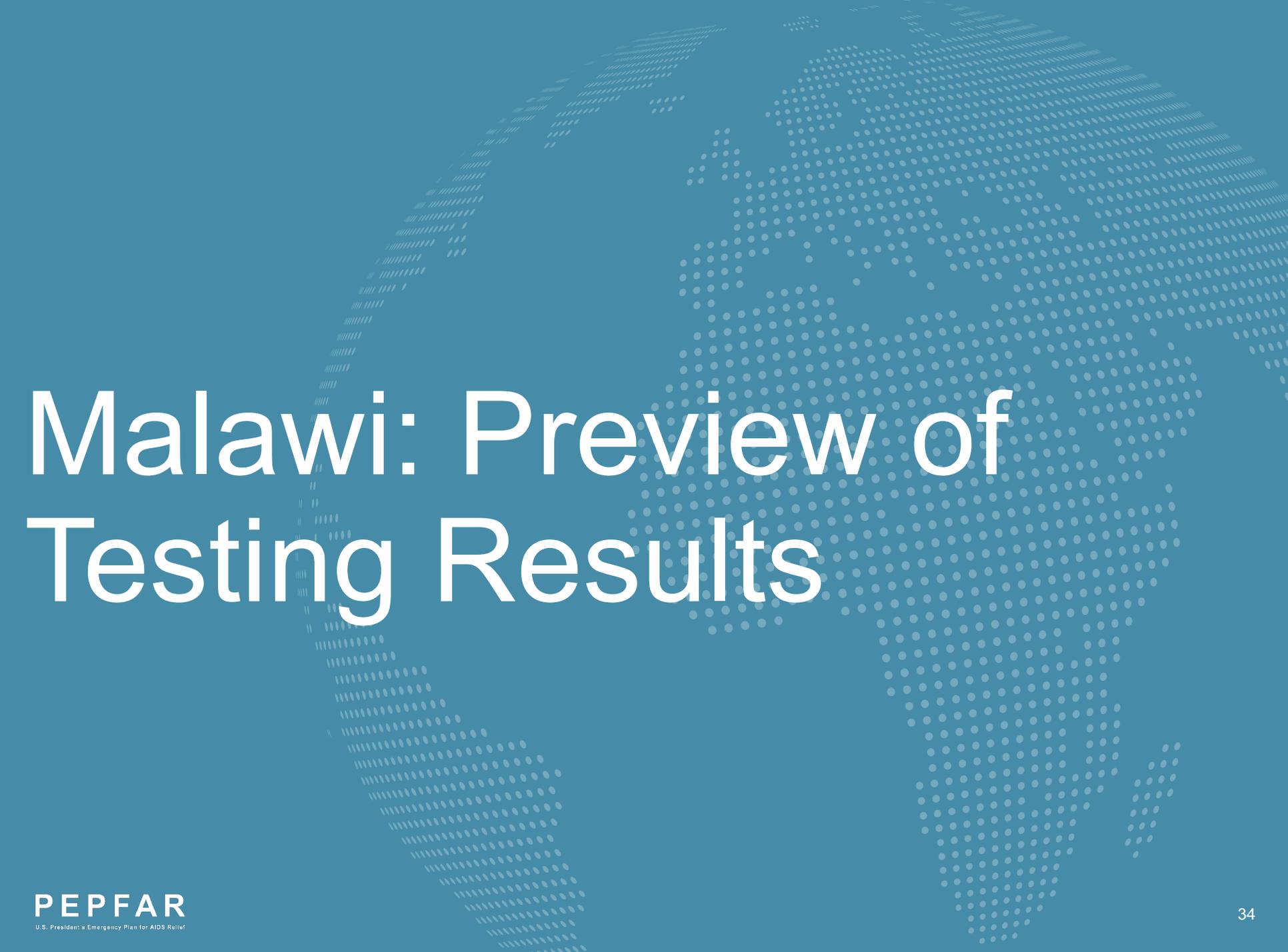
Measuring Incidence and Viral Load Suppression are the Primary Objectives

Primary:

- To estimate national incidence among adults age 15 years and above
- To estimate national and subnational prevalence of viral load suppression [HIV RNA <1000 c/ml] among adults age 15 years and above

Secondary (among others):

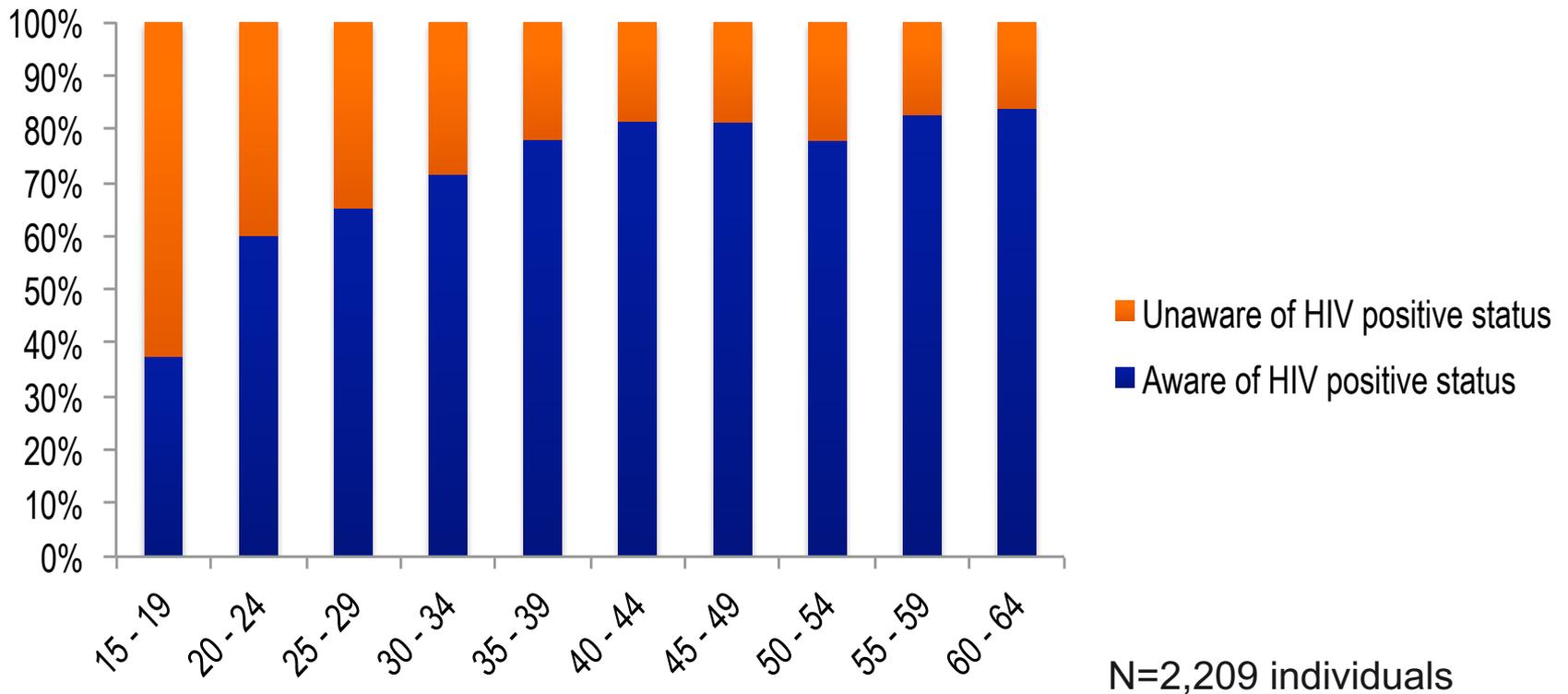
- To estimate national prevalence of HIV among children 0–14 years
- To estimate national and subnational prevalence of HIV among adults
- In PLHIV: CD4 count distribution, detectable ARVs, transmitted drug resistance

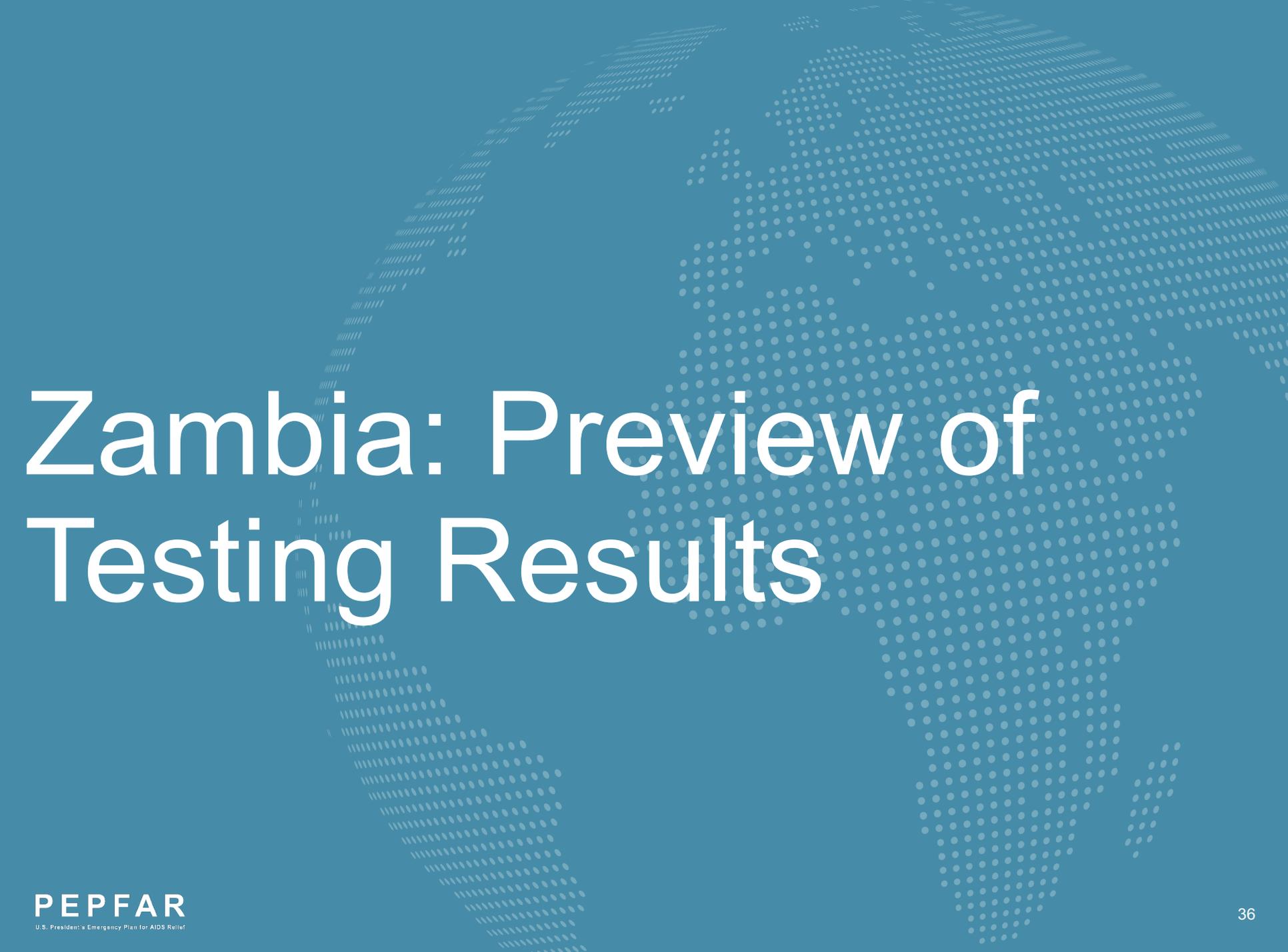


Malawi: Preview of Testing Results

Malawi: Awareness of HIV positive status by age

Malawi: Percent of HIV positive individuals aware of their HIV status, by age, 2016

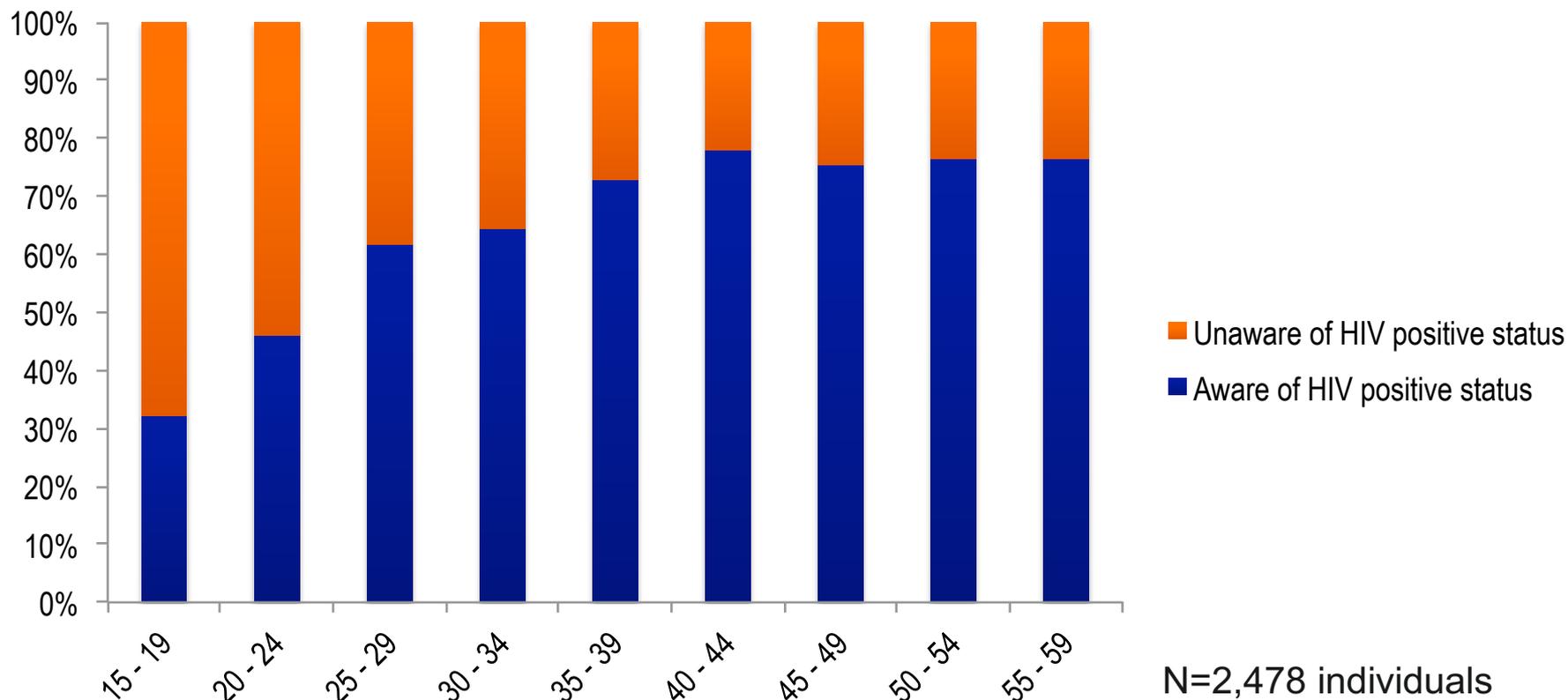


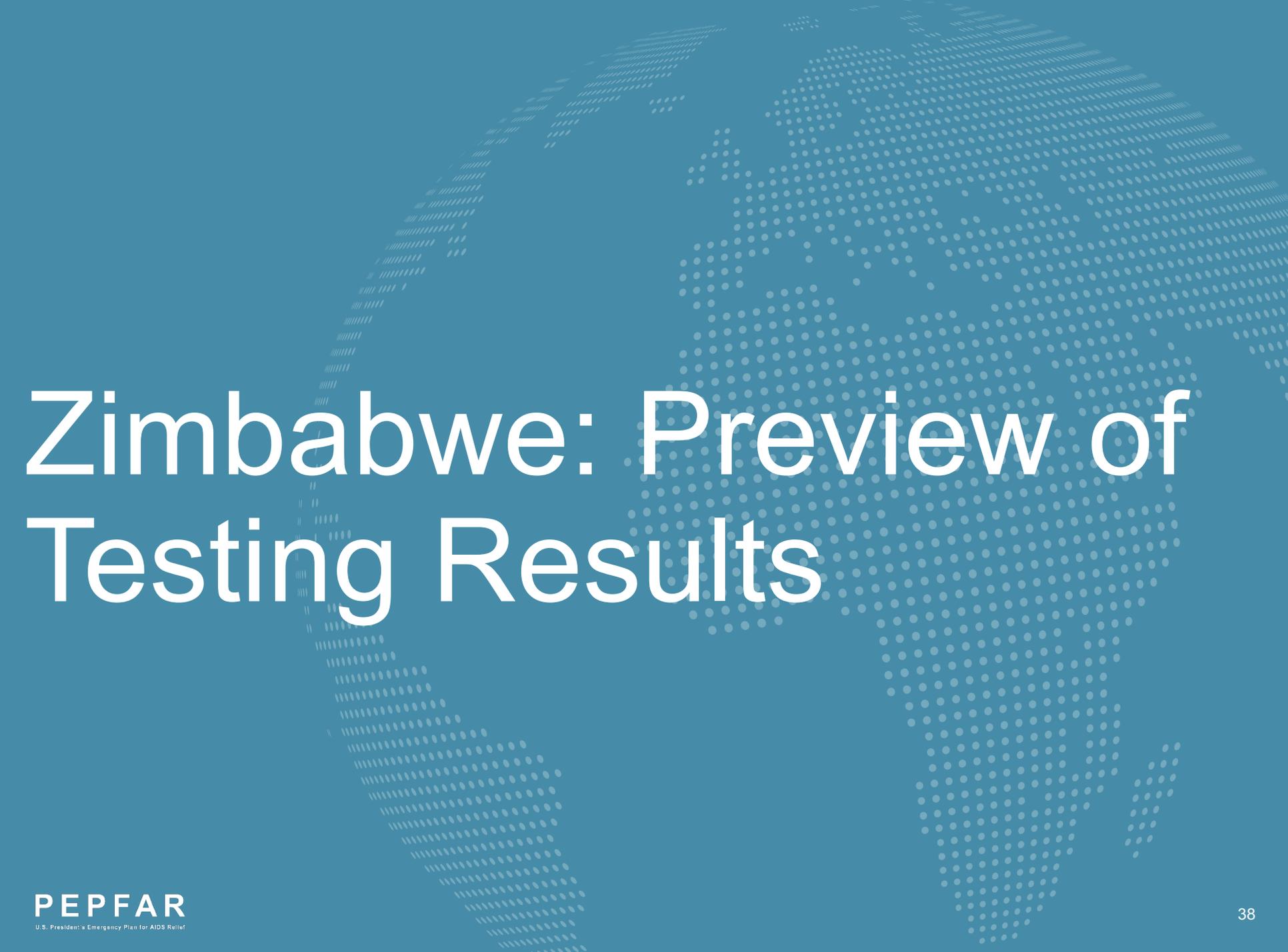


Zambia: Preview of Testing Results

Zambia: Awareness of HIV positive status by age

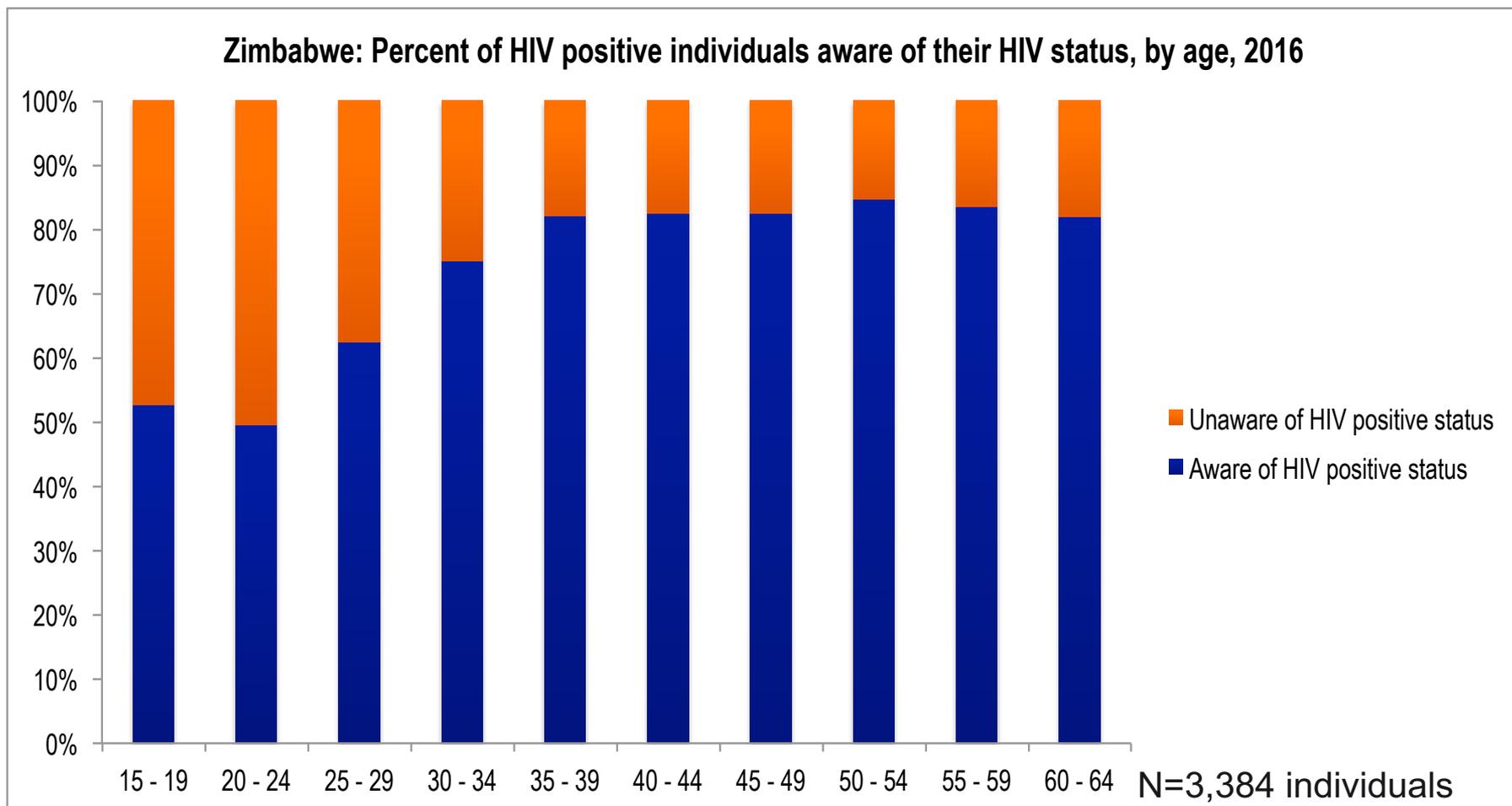
Zambia: Percent of HIV positive individuals aware of their HIV status, by age, 2016





Zimbabwe: Preview of Testing Results

Zimbabwe: Awareness of HIV positive status by age

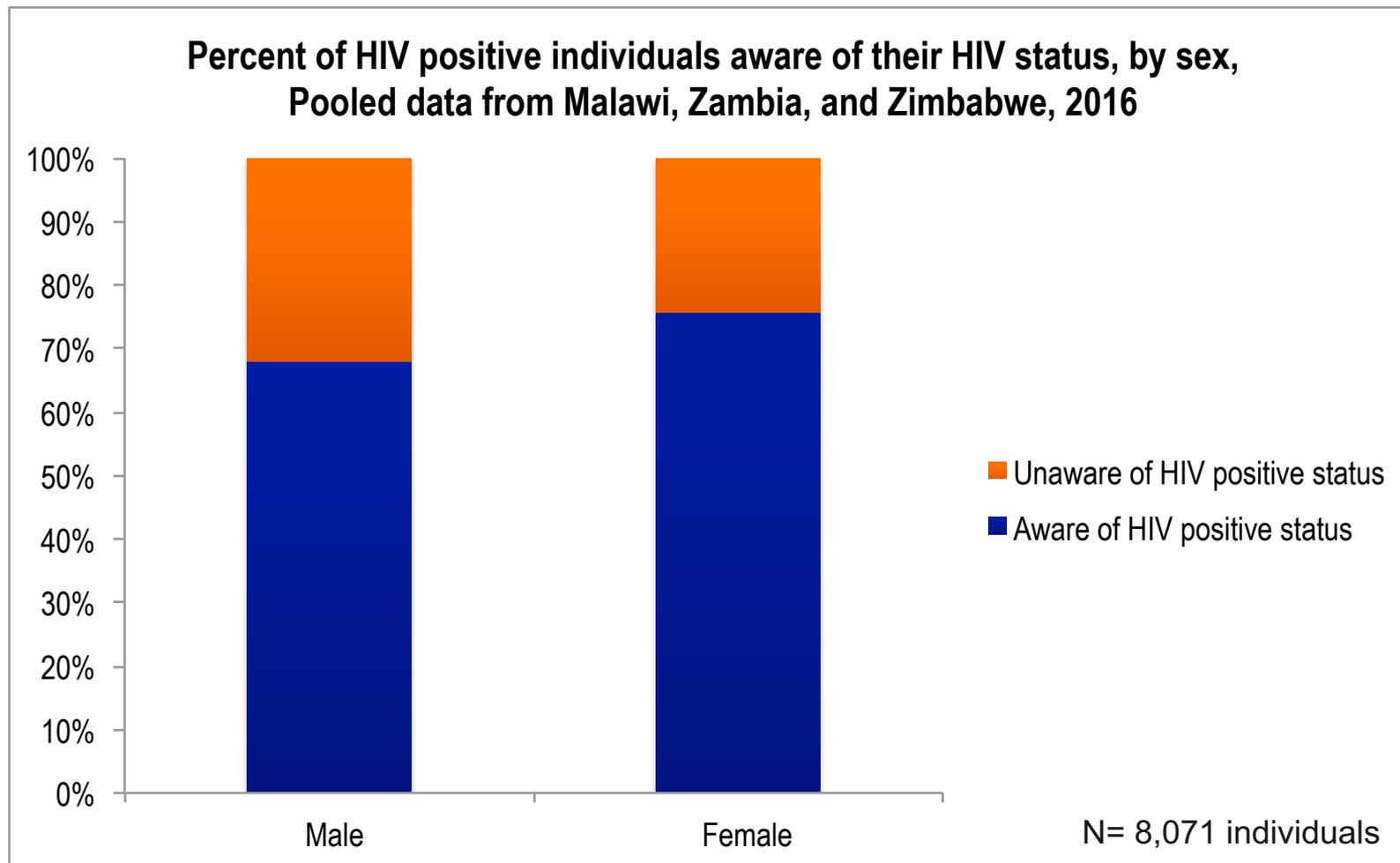




Total (combined)

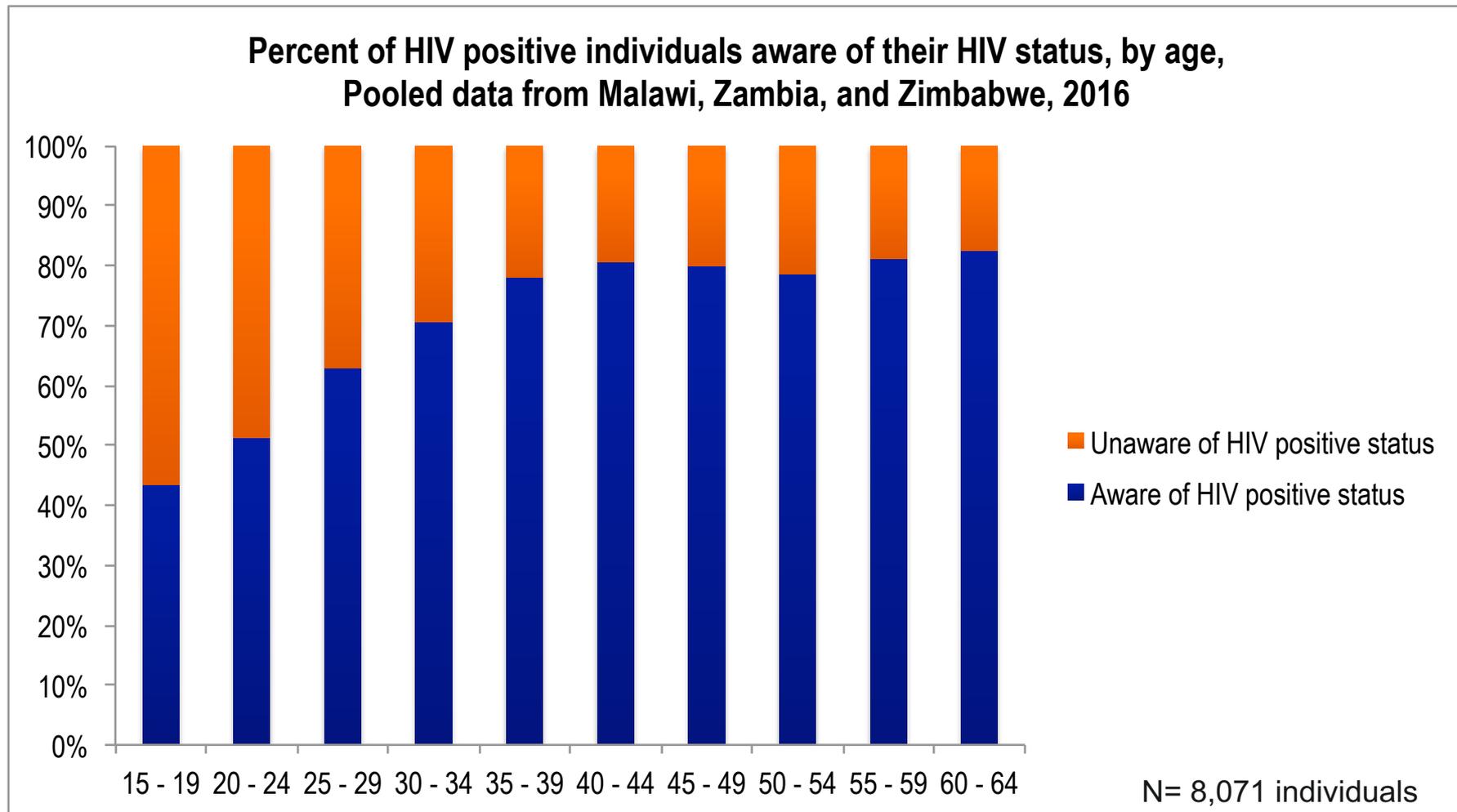
Awareness of HIV positive status by sex

Pooled data from Malawi, Zambia, & Zimbabwe



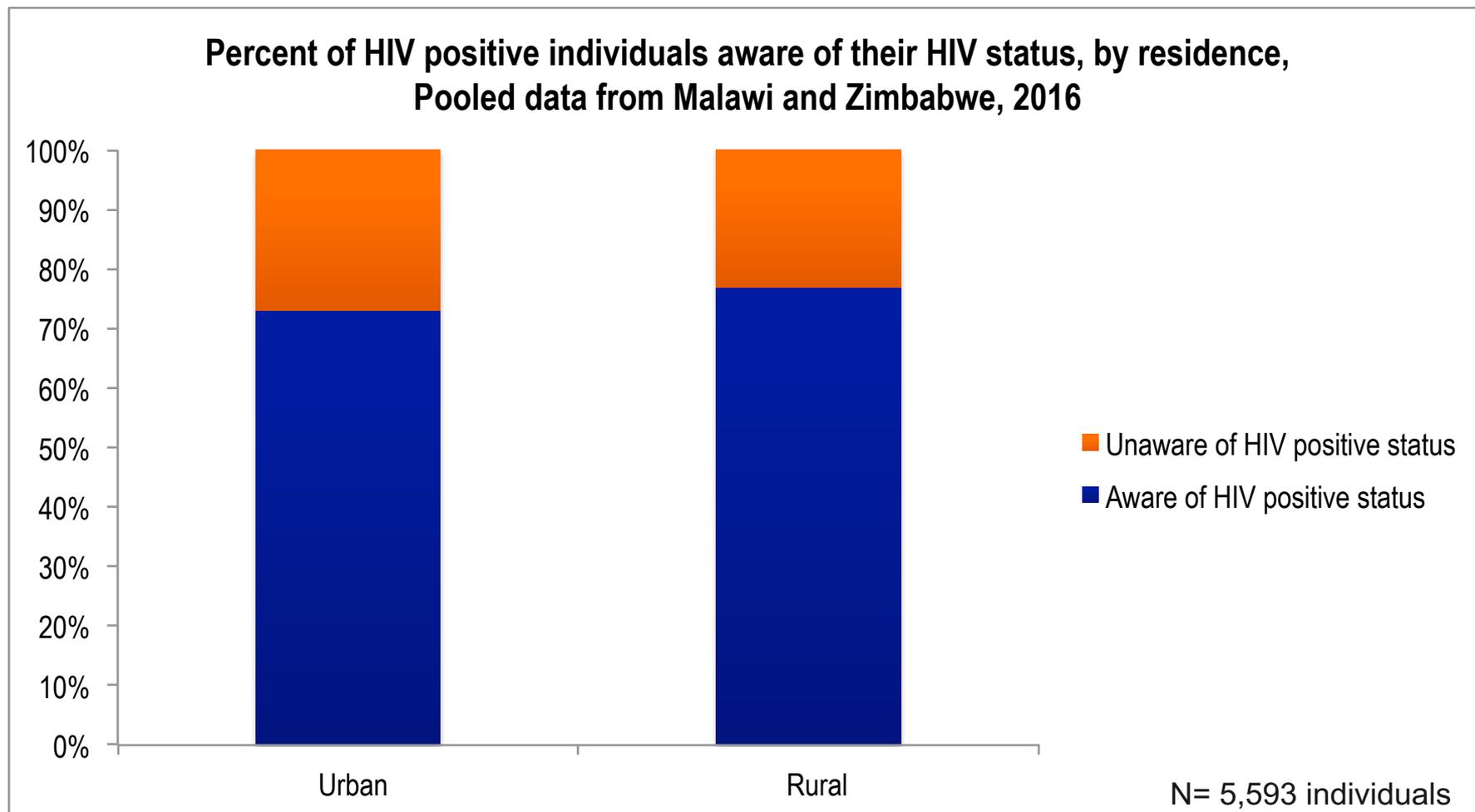
Awareness of HIV positive status by age

Pooled data from Malawi, Zambia, & Zimbabwe



Awareness of HIV positive status by residence

Pooled data from Malawi & Zimbabwe



November 18th: web page



PHIA
PROJECT

A **DROP** THAT COUNTS



SEARCH

HOME

ABOUT

METHODOLOGY

COUNTRIES

DATA

RESOURCES

NEWS



The PHIA Project

The PHIA Project, led by ICAP at Columbia University in partnership with the US Centers for Disease Control and Prevention (CDC), is measuring the reach and impact of HIV programs in PEPFAR-supported countries through national surveys. Each population HIV impact assessment (PHIA) survey



Celebrating the remarkable success of PEPFAR, GFATM, and the global HIV/AIDS response

Since the beginning of the epidemic, HIV prevalence has declined by

- 28% in Zimbabwe
- 30% in Malawi
- 19% in Zambia

Remarkable declines in rates of new HIV infections

Since the beginning of the epidemic, HIV incidence has declined by

67% in Zimbabwe

76% in Malawi

51% in Zambia



Impact Data – validation of UNAIDS Spectrum Model

Country	HIV prevalence 15-49	Percent decline in Prevalence 2003-2015	HIV incidence 15-49	Percent decline in Incidence 2003-2015	Overall Community Viral Load suppression	Community Viral Load suppression 15 to 24	Community Viral Load suppression 25 years and older
Zimbabwe							
2003 UNAIDS	20.4		1.44				
2015 UNAIDS	14.7		0.88				
2016 IMPACT results	14.6	28%	0.48	67%	60%	45.6%	62.5%
Malawi							
2003 UNAIDS	15.2		1.33				
2016 UNAIDS	9.1		0.38				
2015 IMPACT results	10.6	30%	0.32	76%	67%	47.9%	69.6%
Zambia							
2003 UNAIDS	14.6		1.44				
2015 UNAIDS	12.9		0.85				
2016 IMPACT results	11.9	19%	0.70	51%	59%	34.4%	63.6%

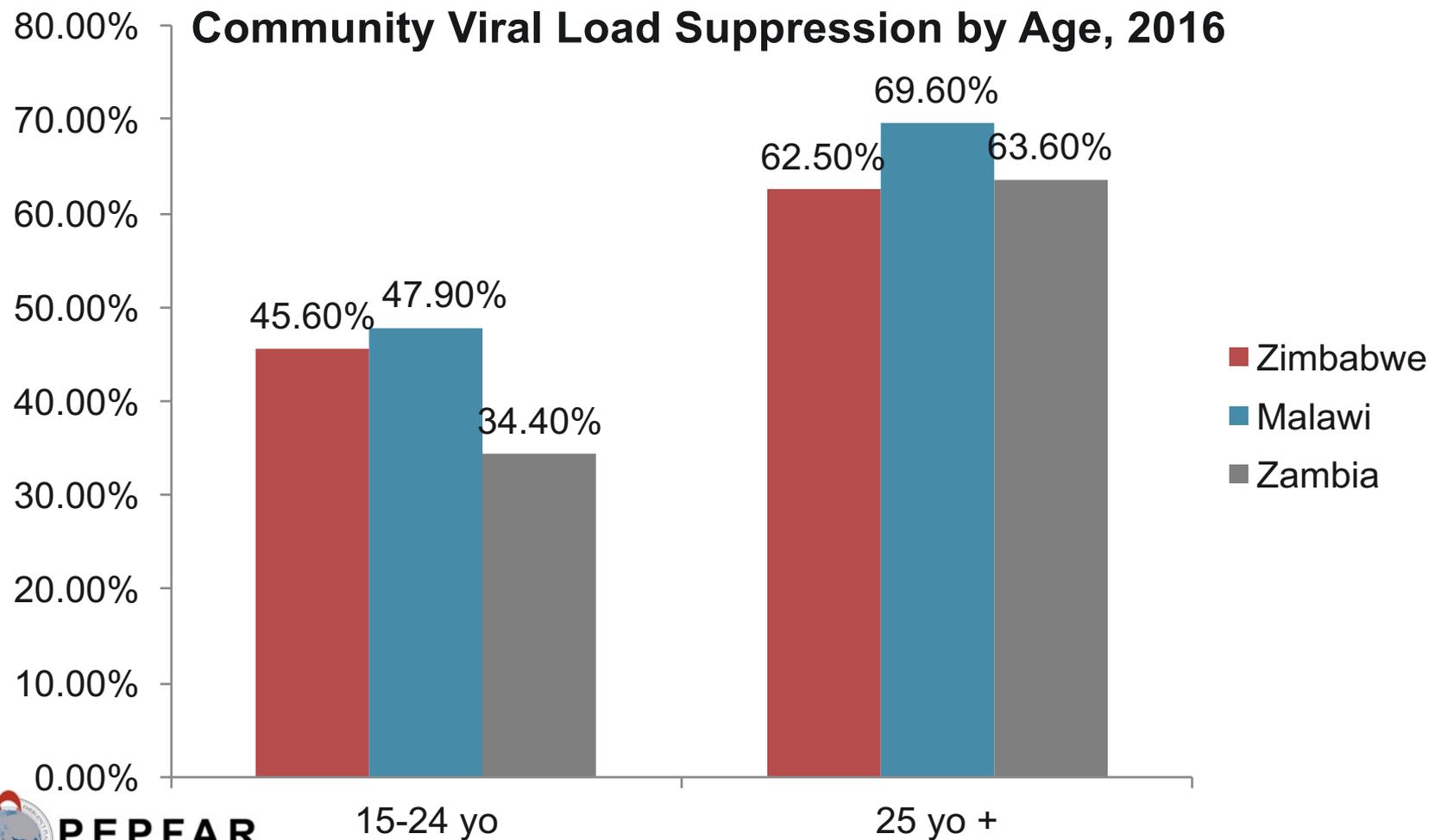
Remarkable durability of first line ART and adherence for those who are on treatment

86% viral suppression in Zimbabwe

91% viral suppression in Malawi

89% viral suppression in Zambia

Viral Load Suppression in the community by age groups



Young women are at elevated risk for HIV infection

Compared to young men,
the rate of new HIV infections
in young women is

5 times greater in Zimbabwe

8 times greater in Malawi

14 times greater in Zambia



Acknowledgments for Impact Surveys

SGAC

CDC – Atlanta

ICAP – New York

**Ministry of Health and Child
Care, Zimbabwe**

CDC – Zimbabwe

ICAP in Zimbabwe

Ministry of Health, Malawi

CDC – Malawi

ICAP in Malawi

Ministry of Health, Zambia

CDC – Zambia

ICAP in Zambia

This project is supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through CDC under the terms of cooperative agreement #U2GGH001226. The contents are the responsibility of ICAP and do not necessarily reflect the views of the United States Government.



2

World AIDS Day Results

PEPFAR Results for 2016

74.3 Million

People were tested & counseled for HIV

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PEPFAR Results for 2016

11.5 Million

Men, Women, & Children on Treatment

1.1 Million

Children on Treatment – a 97% increase in 2 years

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PEPFAR Results for 2016

11.7 Million
VMMC
(voluntary medical
male circumcisions)

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PEPFAR Results for 2016

Nearly **2 Million**

Babies born HIV Free

6.2 Million Orphan
and Vulnerable Children
received care and support

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PEPFAR Results for 2016

1 Million

adolescent girls and
young women were
reached through
DREAMS programming

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PEPFAR Results for 2016

220,000 new health
care workers trained and
laboratory and health
systems strengthened

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3

DREAMS

for adolescent girls and young women

Young women and girls
account for

75%

of new HIV infections
among adolescents in sub-Saharan Africa

This must change.



Determined

Resilient

Empowered

AIDS-Free

Mentored

Safe



We created DREAMS to break the cycle of HIV infection

- Launched on World AIDS Day 2014 for 10 countries
- Initial \$385 million partnership
 - 2014 Launch Partners PEPFAR, Bill & Melinda Gates Foundation, and Girl Effect
 - In 2015 we added Johnson & Johnson, ViiV Healthcare and Gilead Sciences
- DREAMS countries received additional funding requests to scale up VMMC and treatment for men in DREAMS districts
- Innovation Challenge Fund winners announced in July 2016
 - 800 ideas, 56 winners (60% small CBOs)
 - Additional information at: <http://www.dreamspartnership.org/winners>



DREAMS is a \$385M partnership to help girls develop into girls that are:

Determined
Resilient
Empowered
AIDS-Free
Mentored
Safe

Core Package of Interventions

1

Empower Girls and Young Women

Interventions for this population aim to empower girls and to reduce their risk for HIV and violence.

2

Reduce Risk of Sex Partners

This activity aims to characterize “typical” sexual partners of adolescent girls and young women in order to target highly effective HIV interventions.

3

Strengthen Families

Interventions for this population aim to strengthen the family economically, as well as in their ability to parent positively.

4

Mobilize Communities for Change

These interventions aim to educate girls, young women, and young men, as well as mobilize communities.



Determined

Resilient

Empowered

AIDS-Free

Mentored

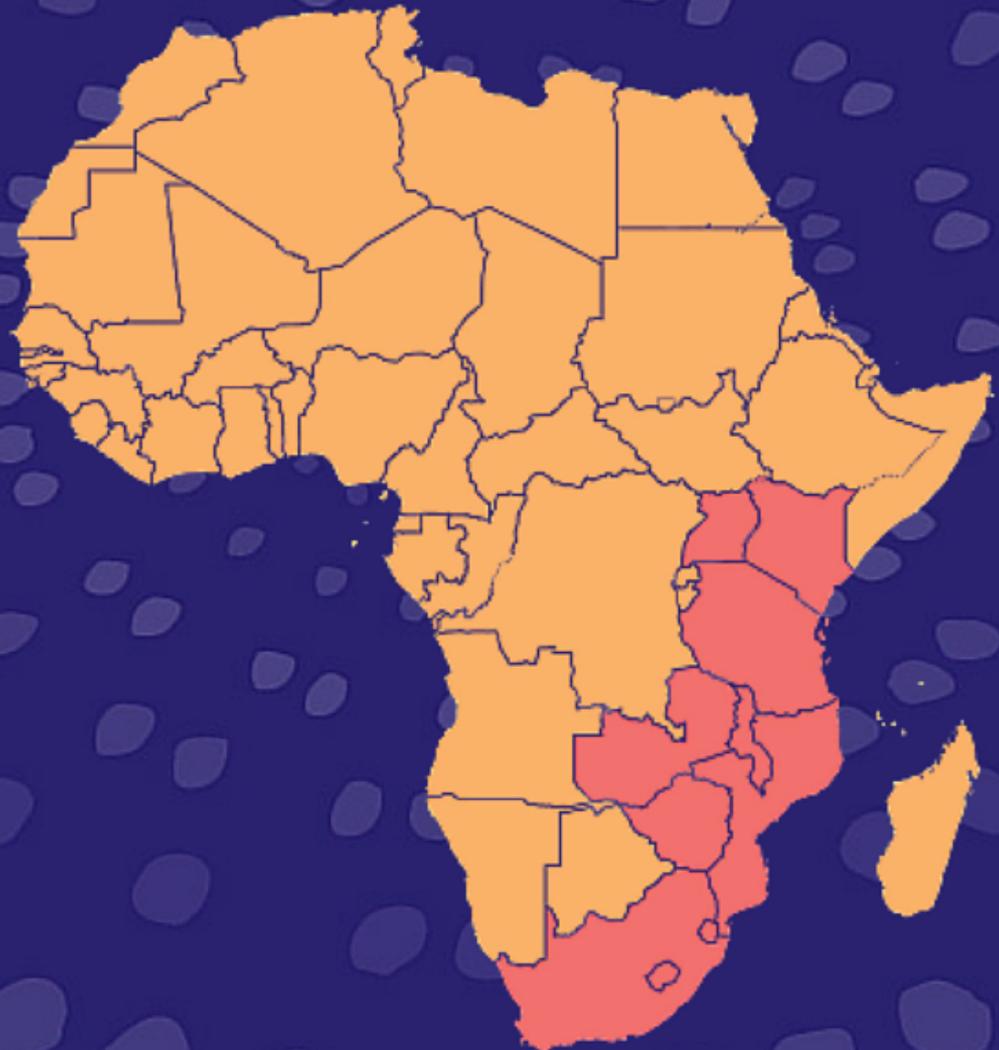
Safe

DREAMS

COUNTRIES

Solutions must be ready for rapid implementation in one or more of the 10 DREAMS countries

-  Kenya
-  Lesotho
-  Malawi
-  Mozambique
-  South Africa
-  Swaziland
-  Tanzania
-  Uganda
-  Zambia
-  Zimbabwe



Determined

Resilient

Empowered

AIDS-Free

Mentored

Safe

DREAMS Programming

STRENGTHEN THE FAMILY

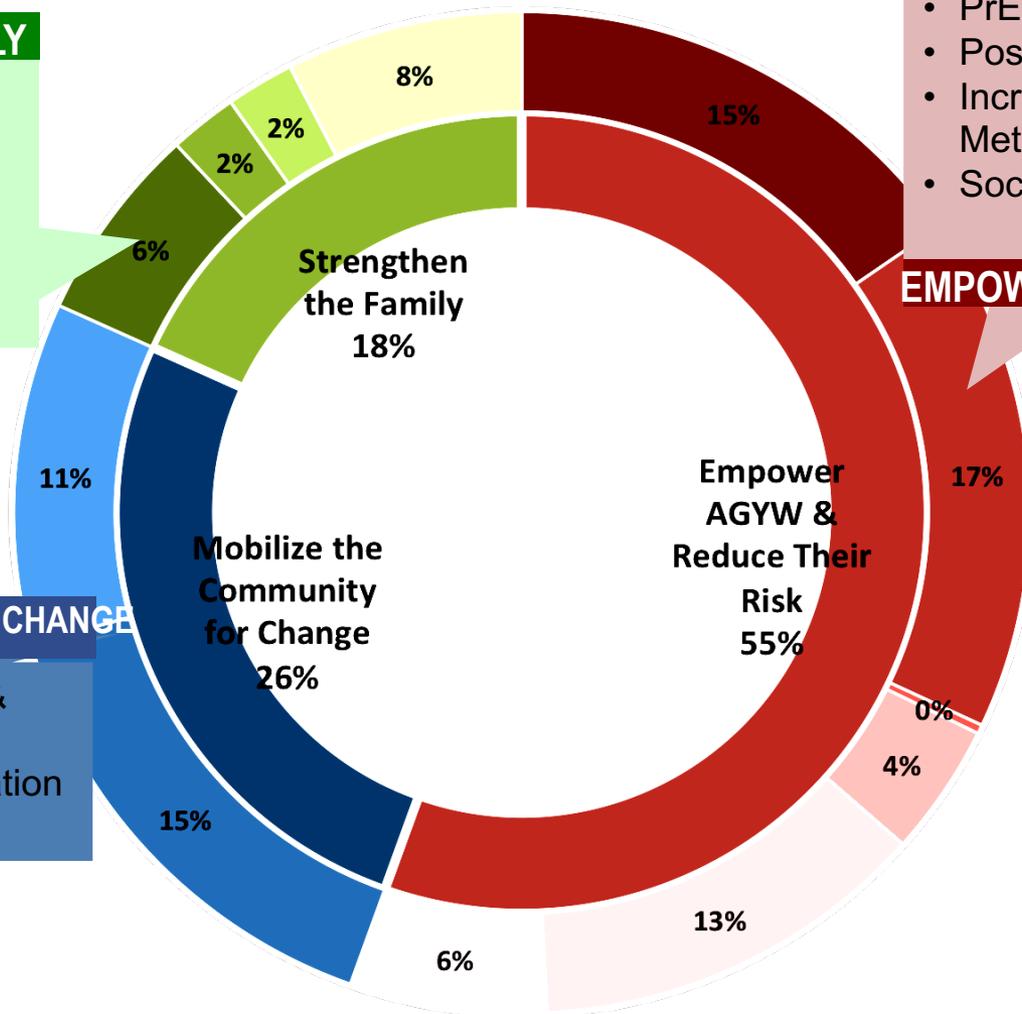
- Parenting/Caregiver Programs
- Cash Transfers
- Education Subsidy
- Socioeconomic Approaches

- Condom Promotion & Provision
- HIV Testing & Counseling
- PrEP
- Post-Violence Care
- Increased Contraceptive Method Mix
- Social Asset Building

MOBILIZE COMMUNITY FOR CHANGE

- School-Based HIV & Violence Prevention
- Community Mobilization & Norms Change

EMPOWER AGYW & REDUCE RISK



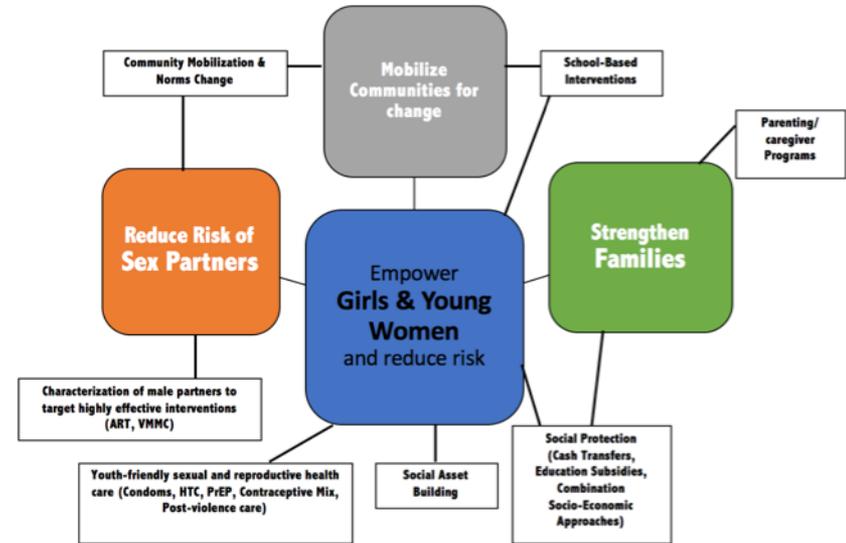
DREAMS Package of Interventions

Core package:

- Empowering girls and young women
- Reducing risk of sexual partners
- Strengthening families
- Mobilizing communities for change

Because of the aims of the core package, there are a number of positive complementary activities that benefit the whole community:

- Strengthening community-based partners
- Testing of male partners
 - If HIV-positive, linking to treatment
 - If HIV-negative, linking to VMMC services
- Bridge to employment

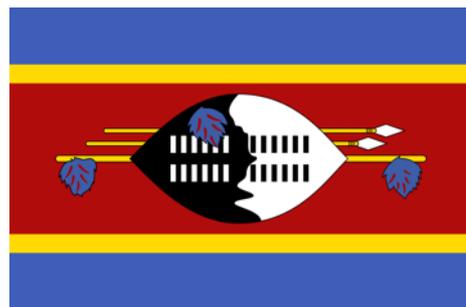


DREAMS is elevating the issue globally

DREAMS is an incredible advocacy contribution, and this is the first time there has been this level of investment on the issue of AGYW. DREAMS has singlehandedly made sure this is on everybody's radar screens, and countries are responding by expanding the investment.



South Africa: DREAMS has inspired national focus on AGYW, resulting in rollout of a national campaign entitled She Conquers and new National Strategic Plan focusing on AGYW



Swaziland: Joining forces with Global Fund & National Emergency Response Council on HIV/AIDS (NERCHA) resulting in close to national coverage

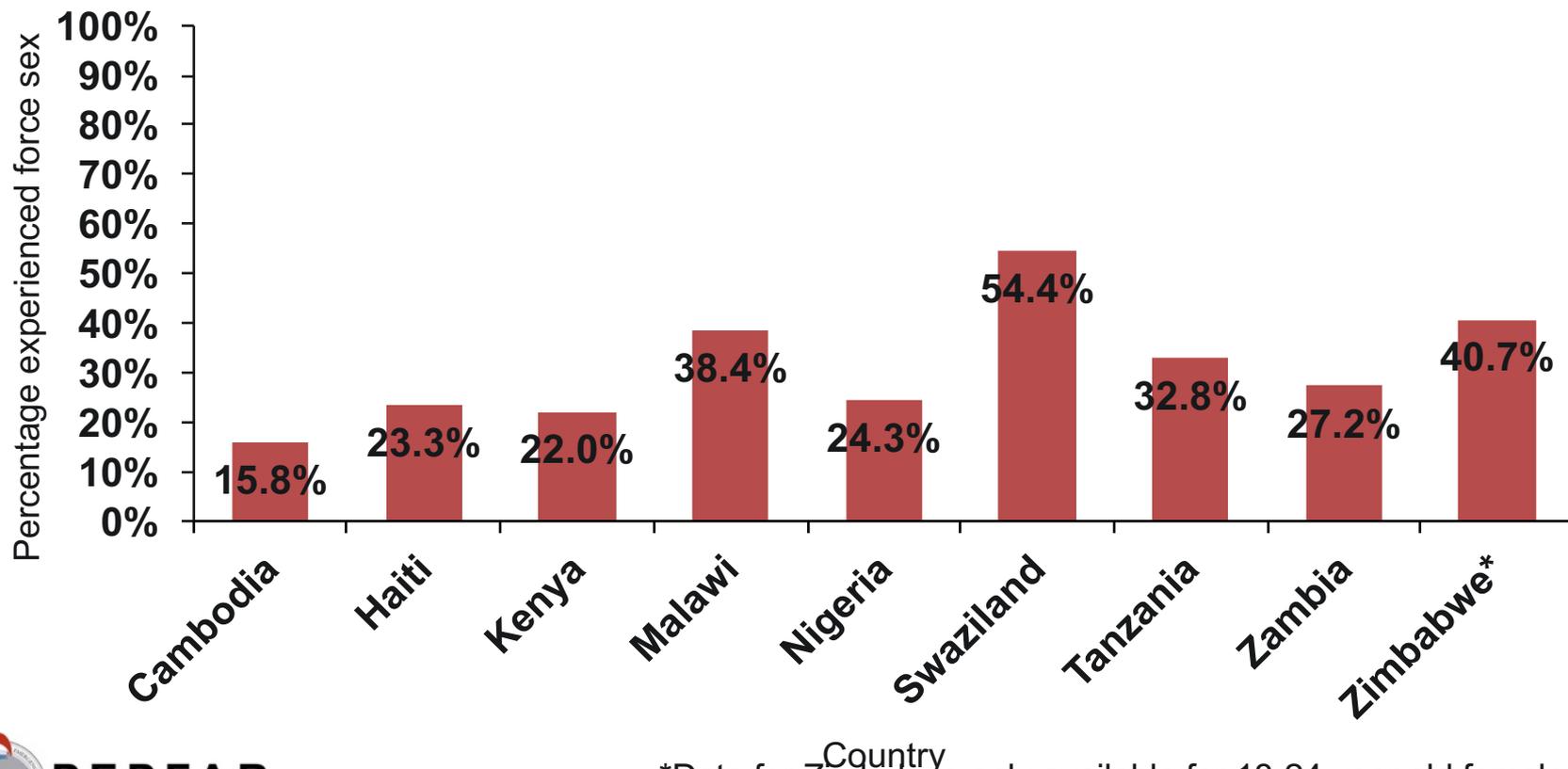
Using Data in New and Better Ways

- Use **Girl Roster™** to find the universe of girls in the program area, and identify those most vulnerable based on age, schooling, marriage, childbearing and living arrangements
- Look at data that is divided by age and sex to ensure DREAMS is reaching the right adolescent girls and young women
- Track **program data based on age and sex** to ensure that DREAMS is reaching the groups it is intending to reach
- **Collect data** (Violence Against Children Surveys, Public Health Impact Assessments) **on factors that put young women at risk**, such as gender based violence, early pregnancy, early marriage, and education status



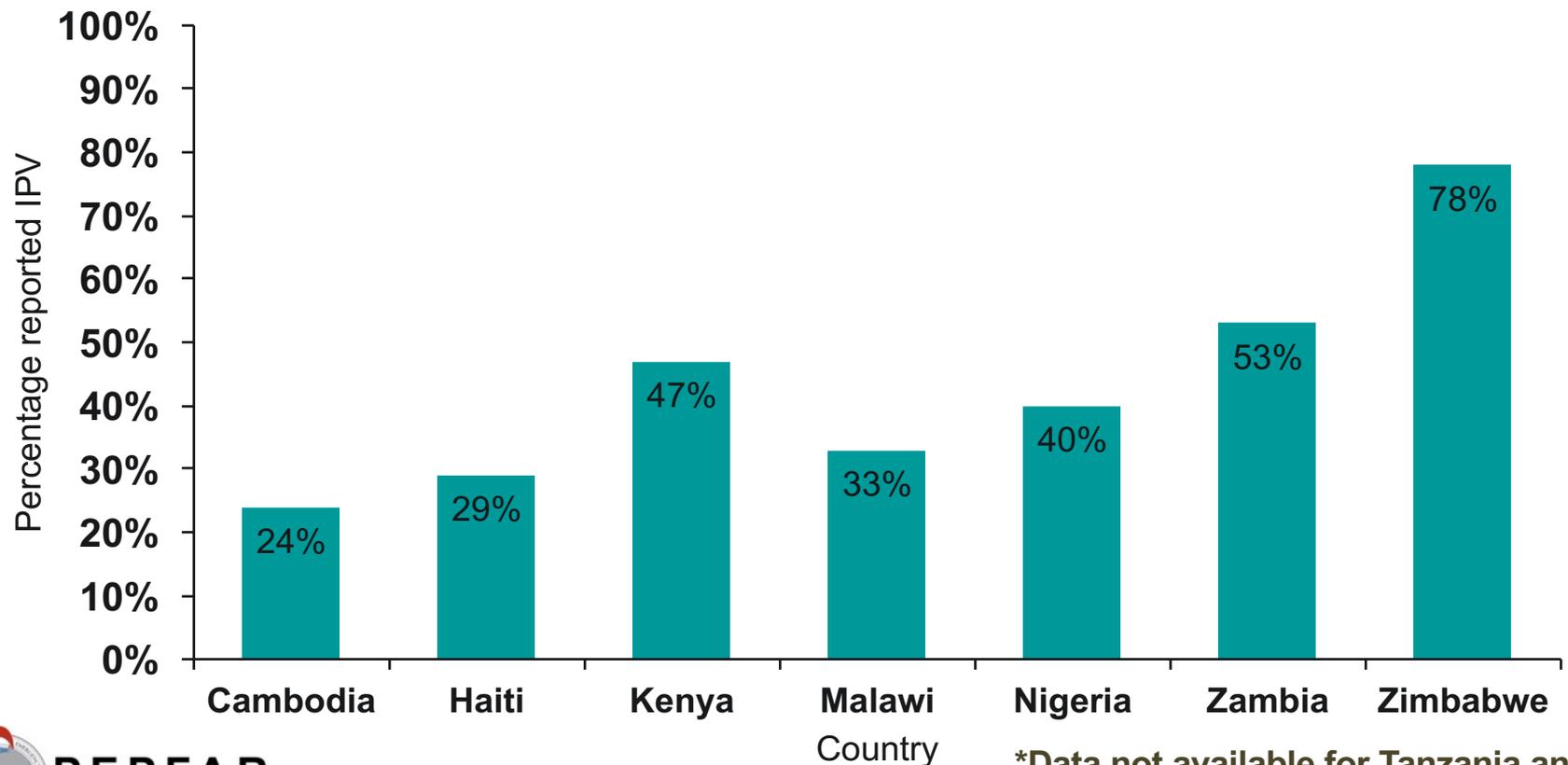
Violence Against Children Surveys (VACS)

Percentage of 13-24 Year Old Female Respondents Who Reported First Sex as Forced/Coerced -RAPE



Violence Against Children Surveys (VACS)

Percentage of Females Reporting First Sexual Violence Incident Prior to Age 18 was Perpetrated by a Boyfriend/Partner

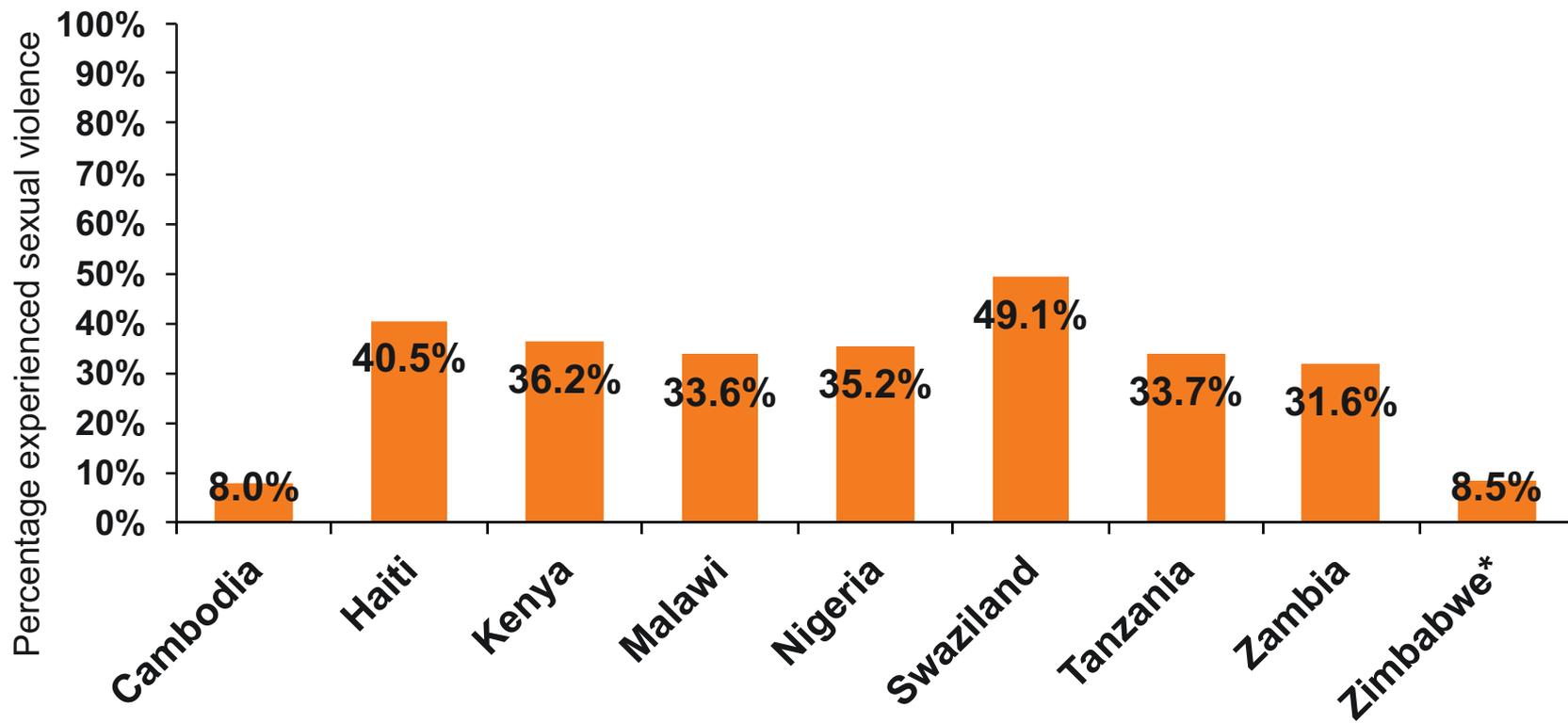


Source: CDC VACS, 2016

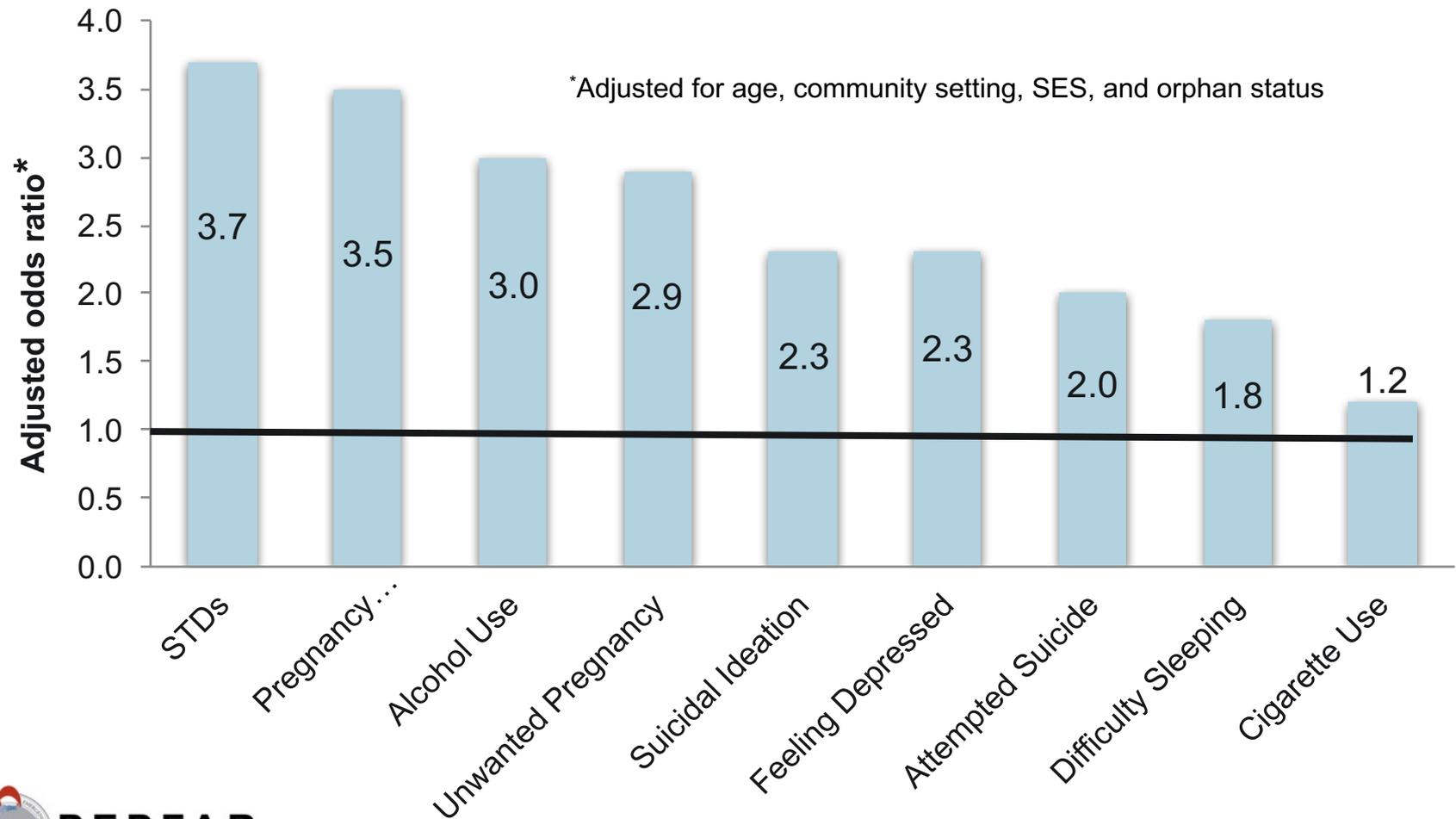
*Data not available for Tanzania and Swaziland

Violence Against Children Surveys (VACS)

Sexual Violence among 13-24 Year Old Female Respondents
Within the Past 12 Months



Association Between Childhood Sexual Violence and Selected Health Conditions, Females 13 to 24 Years of Age, Swaziland, 2007



1 in 3 girls
in the developing world are
married
before age 18

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

Source: *Girls Not Brides*, www.girlsnotbrides.org, 2016

PEPFAR

Community Mobilization & Norms Change and Post Violence Care in **DREAMS** districts

The DREAMS core package required countries to use evidence based programs to increase community mobilization and post violence care. Both interventions are key to adolescent girls and young women remaining HIV free.

In the 10 DREAMS countries PEPFAR is supporting over \$11 million in **community mobilization and norms change** activities targeting over 728,000 adolescent girls and young women.

DREAMS is supporting \$10.5 million in **post violence care** and expecting to serve over 132,000 AGYW.



Every Hour Matters & PEPFAR



PEPFAR is joining with EHM to ensure that adolescent girls and young women are safe, and that they have access to quality post-rape care when they do experience sexual violence.



A **global campaign** to raise awareness about the importance of **comprehensive post-rape care**





Determined

Resilient

Empowered

AIDS-Free

Mentored

Safe

DREAMS

INNOVATION

CHALLENGE

Innovating for an
AIDS-free future for
girls and women



BILL & MELINDA
GATES foundation

GirlEffect

Johnson & Johnson



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Transparency & Accountability in PEPFAR

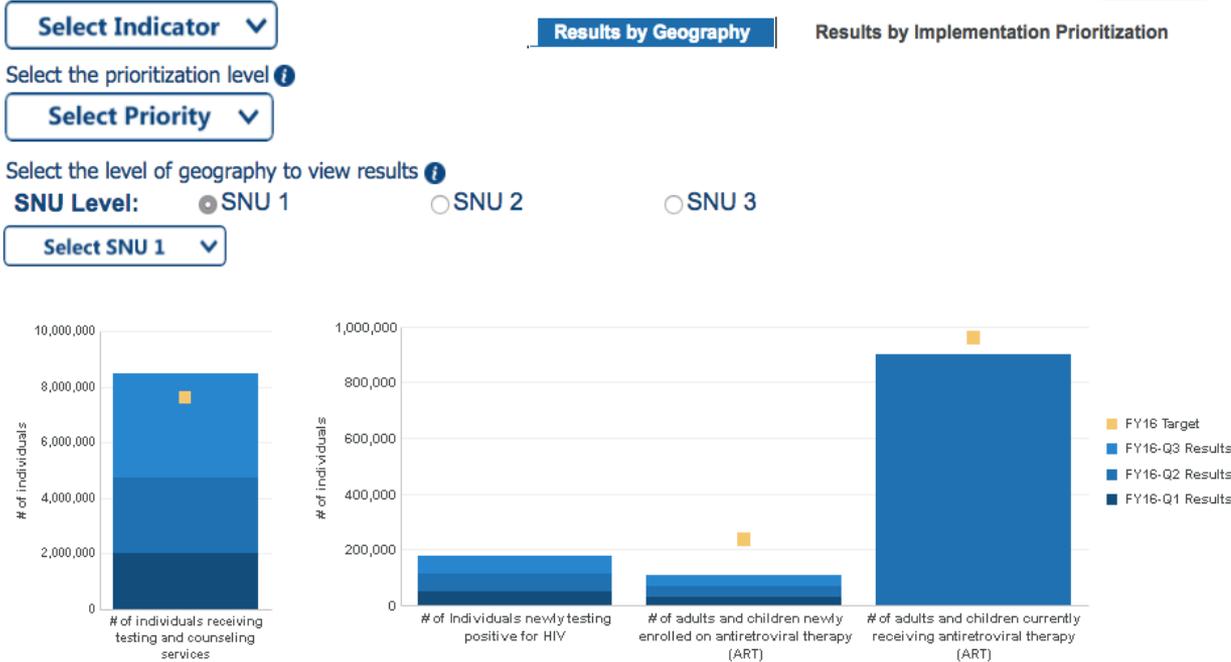
Incredible strides in Transparency, Accountability, & Impact

Transparency

- **Data dashboards, Panorama, & Panorama Spotlight** make quarterly data accessible and easily digestible within PEPFAR and beyond;
- **Civil society and host government partners** more involved in COP planning than ever before;
- **Targets and budgets** developed in inter-agency space using expenditure analysis data and agreed-upon unit costs

Transparency: Panorama Spotlight

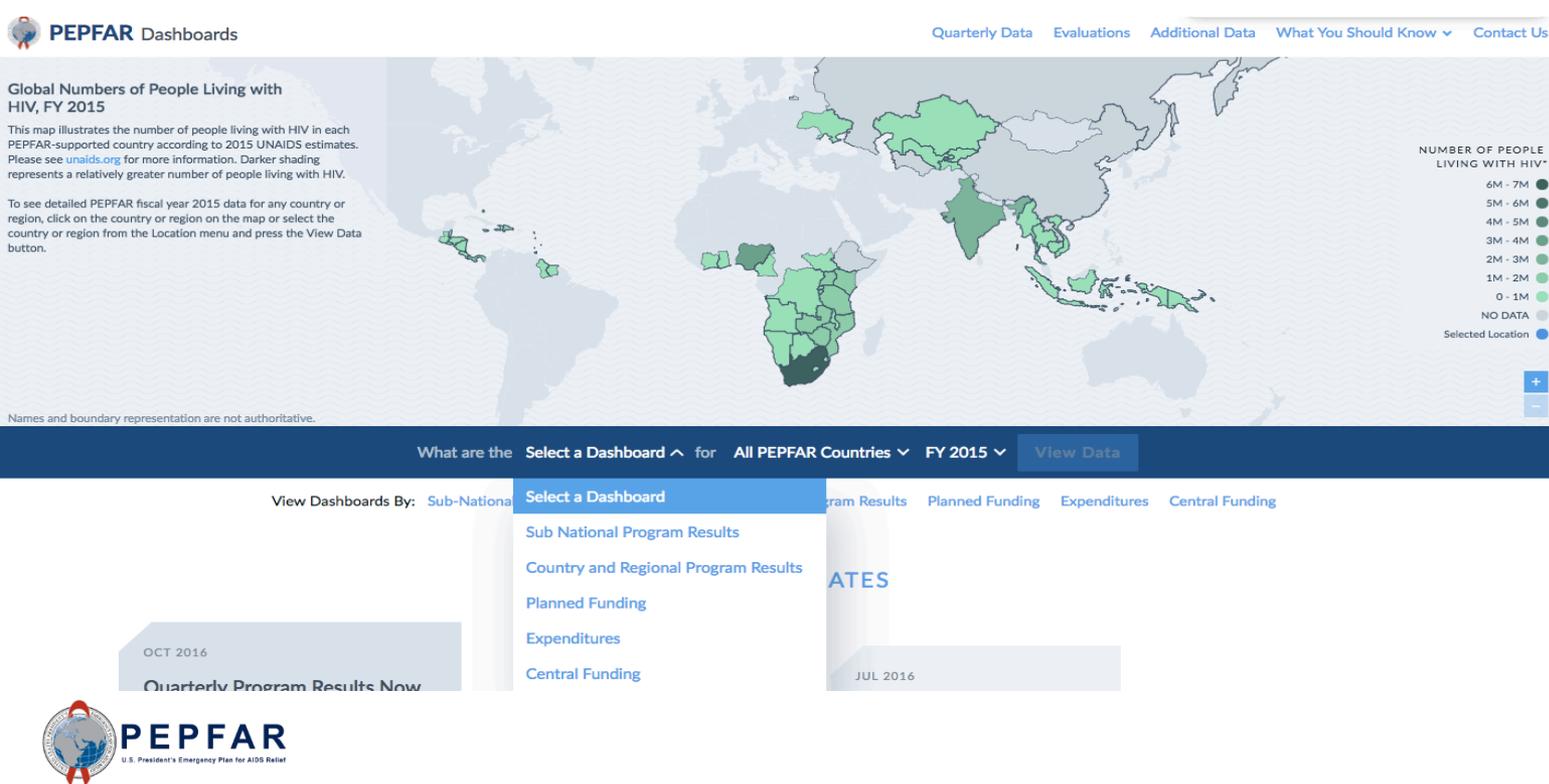
PEPFAR recently launched Panorama Spotlight, which is the first time we have publicly released quarterly data. We believe that the routine collection and review of data promotes timely use of the data to ensure impact. Making it accessible on a quarterly basis allows the data to be used as a timely change agent in country programming.



Data Transparency for Improved Programs

Sharing and utilizing data effectively is essential for improving programs and holding one another accountable for impact.

The PEPFAR Dashboards enable all stakeholders, including U.S. citizens, civil society organizations, U.S. government agencies, donors, and host-country governments, to view and utilize PEPFAR data in an accessible and easy-to-use format.



Incredible strides in Transparency, Accountability, & Impact

Accountability

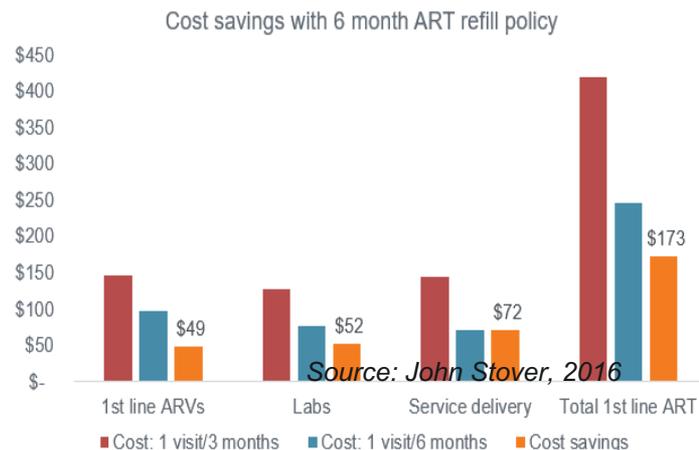
- **Expenditure analysis** data collected and used for decision-making
- **Site Improvement & Management System (SIMS)** data collected for continuous quality improvement; allows PEPFAR to ensure the highest level of quality at all supported sites

Expenditure Analysis

PEPFAR takes its responsibility to be a good steward of American taxpayer dollars seriously, and it is with that in mind that we plan our global programming. In 2015, the World Health Organization released treatment guidelines that, once adopted, will have the greatest impact in achieving our 2020 and 2030 goals. We can make our limited resources twice as effective with respect to lives saved and infections averted if these changes are appropriately implemented. By altering service delivery patterns and expanding treatment eligibility, we will be able to reduce the number of infections and reduce treatment costs. This will also allow us to reduce the out-year costs of controlling the HIV/AIDS pandemic.

We can support 2 ART clients for the price of 1

Smart policy and service delivery choices yield tremendous cost savings



EA data allows for routine financial monitoring of PEPFAR portfolio, and expenditure data can be linked to routinely collected PEPFAR program data to calculate a unit expenditure. This is key to effectiveness and impact.

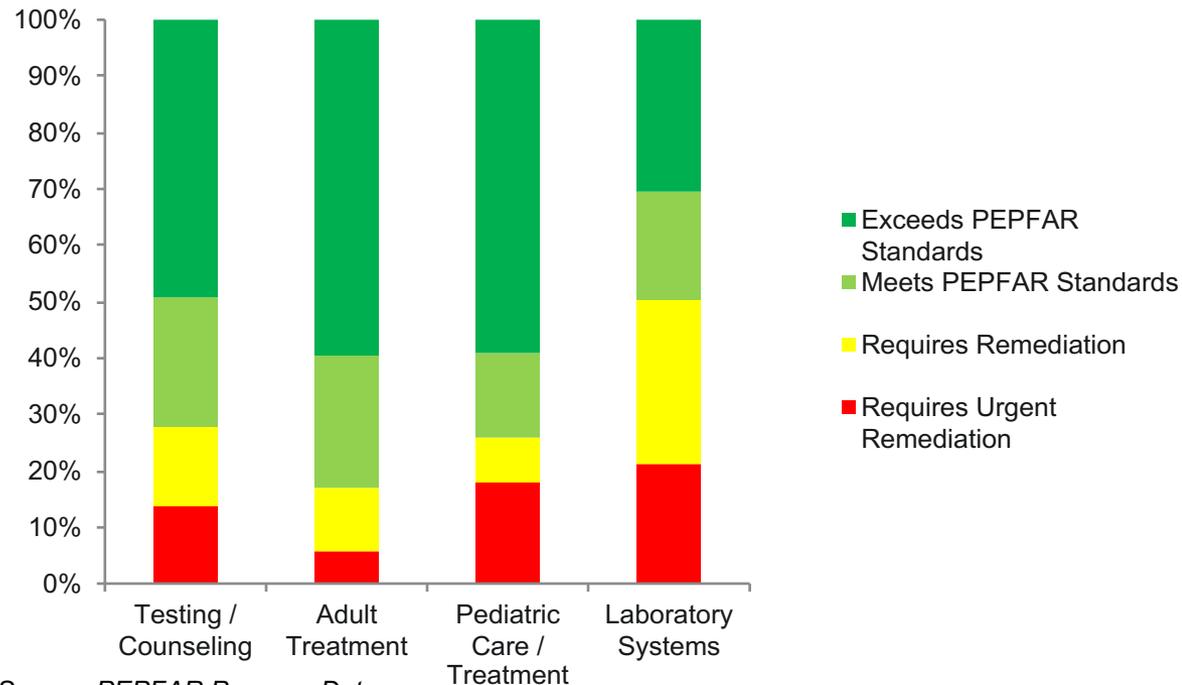
SIMS: Site Improvement through Monitoring System

Goal: To increase the impact of PEPFAR programs by introducing a standardized approach to monitoring program quality and performance at PEPFAR-supported sites. Provide accountability of U.S. Government (USG) investments in HIV globally.

Primary Objectives:

- 1) Monitor our capacity to provide high-quality HIV/AIDS services in all PEPFAR supported program areas
- 2) Provide data for regional, national, and global programmatic decision making
- 3) Facilitate use of these data to improve services

FY 2015 (36 Countries)



Source: PEPFAR Program Data

Incredible strides in Transparency, Accountability, & Impact

Impact

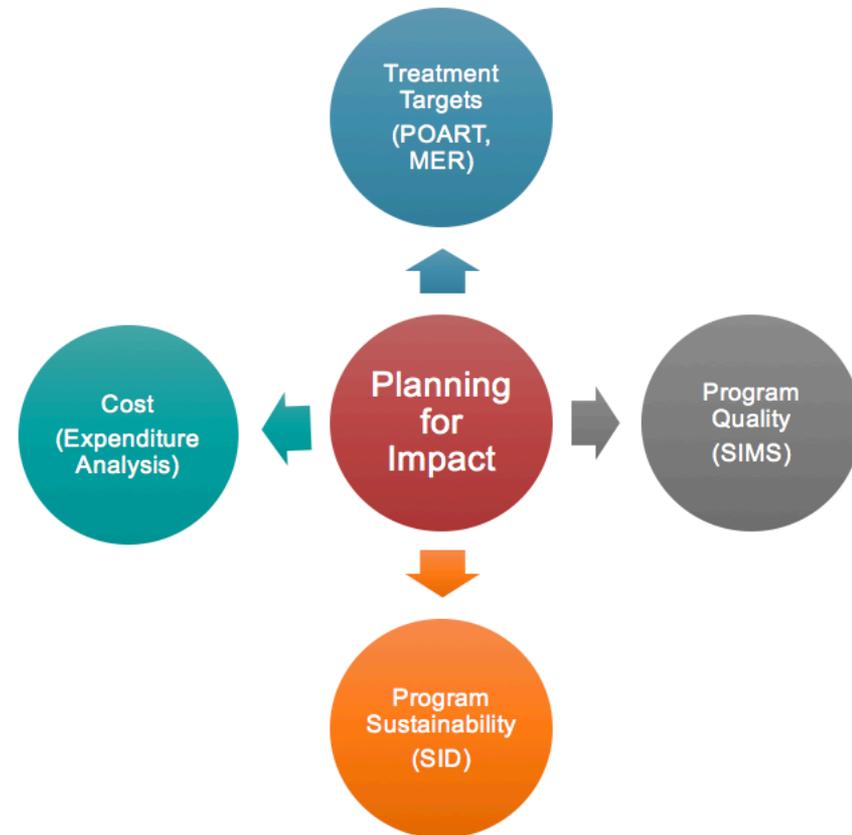
- New **age and sex disaggregations** allow PEPFAR to focus on the populations most at need
- Use of **site-level data** allows PEPFAR to focus on geographic areas with highest burden of HIV
- **Quarterly reporting** of site-level data and POART reviews makes PEPFAR very nimble and able to identify and respond to issues

PEPFAR Data Sources

PEPFAR uses a variety of data inputs in its program planning:

- POART (Program Oversight and Accountability Response Team)
- MER (Monitoring, Evaluation and Reporting)
- SIMS (Site Improvement Through Monitoring System)
- Expenditure Analysis
- SID (Sustainability Index Dashboard)

This gives us the most clear picture of the epidemic, as well as allows PEPFAR teams to respond in close to real time to issues in country.



Program Monitoring for Impact

Programming for impact requires monitoring for impact.



PEPFAR 3.0 has **site-level quarterly monitoring of the full spectrum of indicators**, from process to outcome to impact.

- Our programs and our partners are held to the highest standards
- We can identify and correct issues in underperforming programs in real time

Smart Data-driven Program Decisions

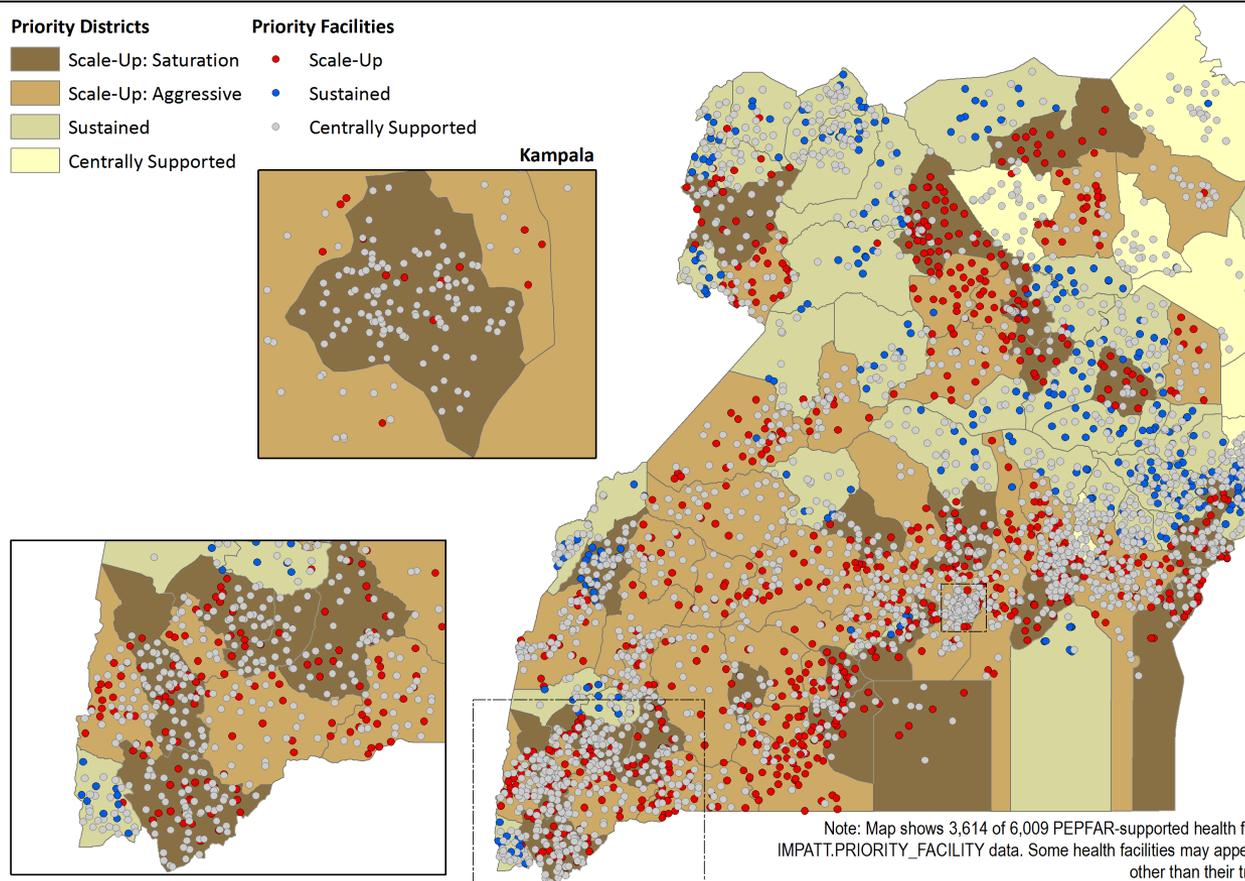
Uganda: Priority Districts and Facilities, FY16

Priority Districts

- Scale-Up: Saturation
- Scale-Up: Aggressive
- Sustained
- Centrally Supported

Priority Facilities

- Scale-Up
- Sustained
- Centrally Supported



Use of site level data for operational efficiency and program impact

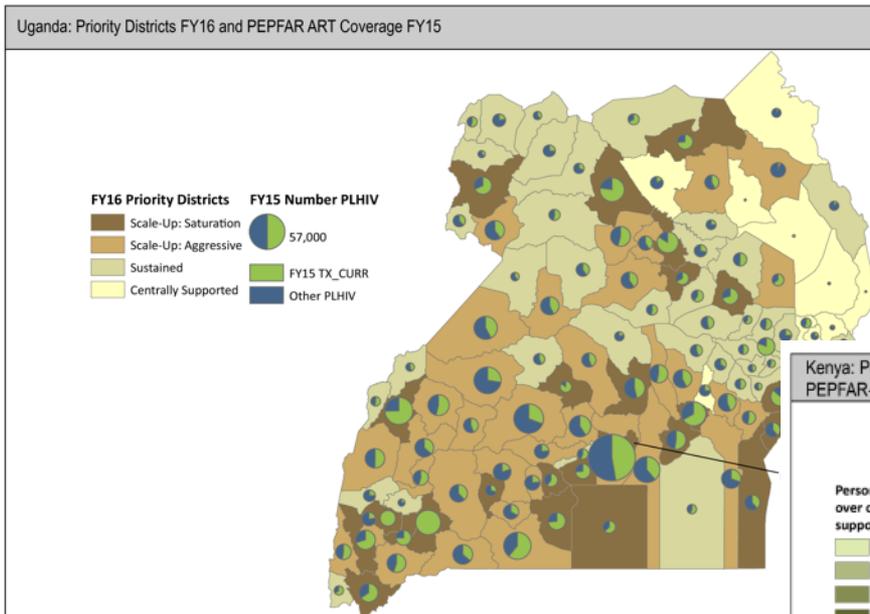
Names and boundary representation are not necessarily authoritative.

UNCLASSIFIED

Sources:

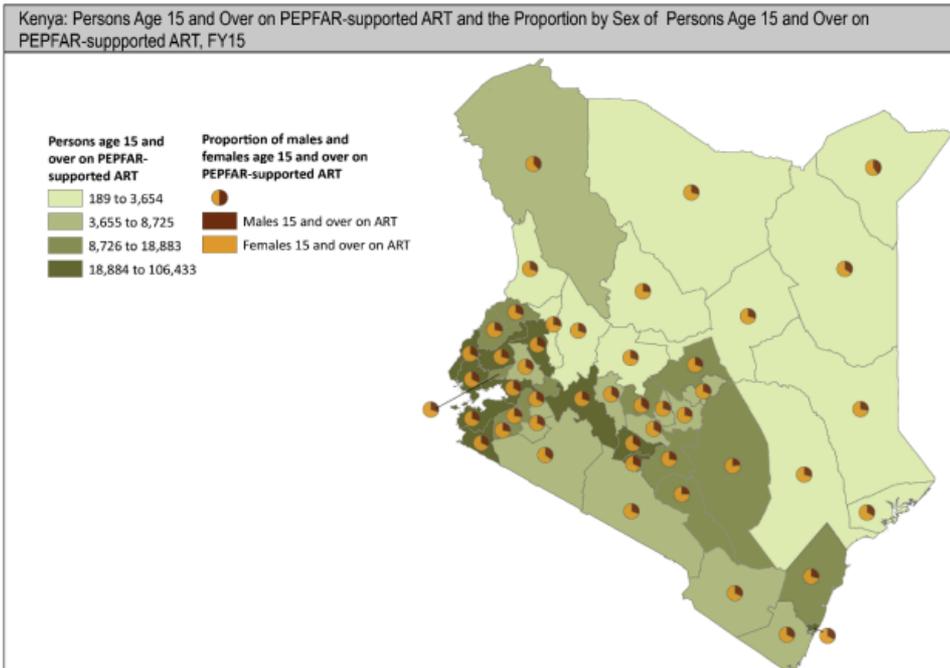
1. IMPATT.PRIORITY_SNU [Oct. 2015 - Sept. 2016], DATIM 2016.02.08
2. IMPATT.PRIORITY_FACILITY [Oct. 2015 - Sept. 2016], DATIM 2016.02.08

Program Monitoring in Real Time



Names and boundaries are not necessarily authoritative.
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Real-time program monitoring by population and geography for real-time course correction



Names and boundary representation are not necessarily authoritative.

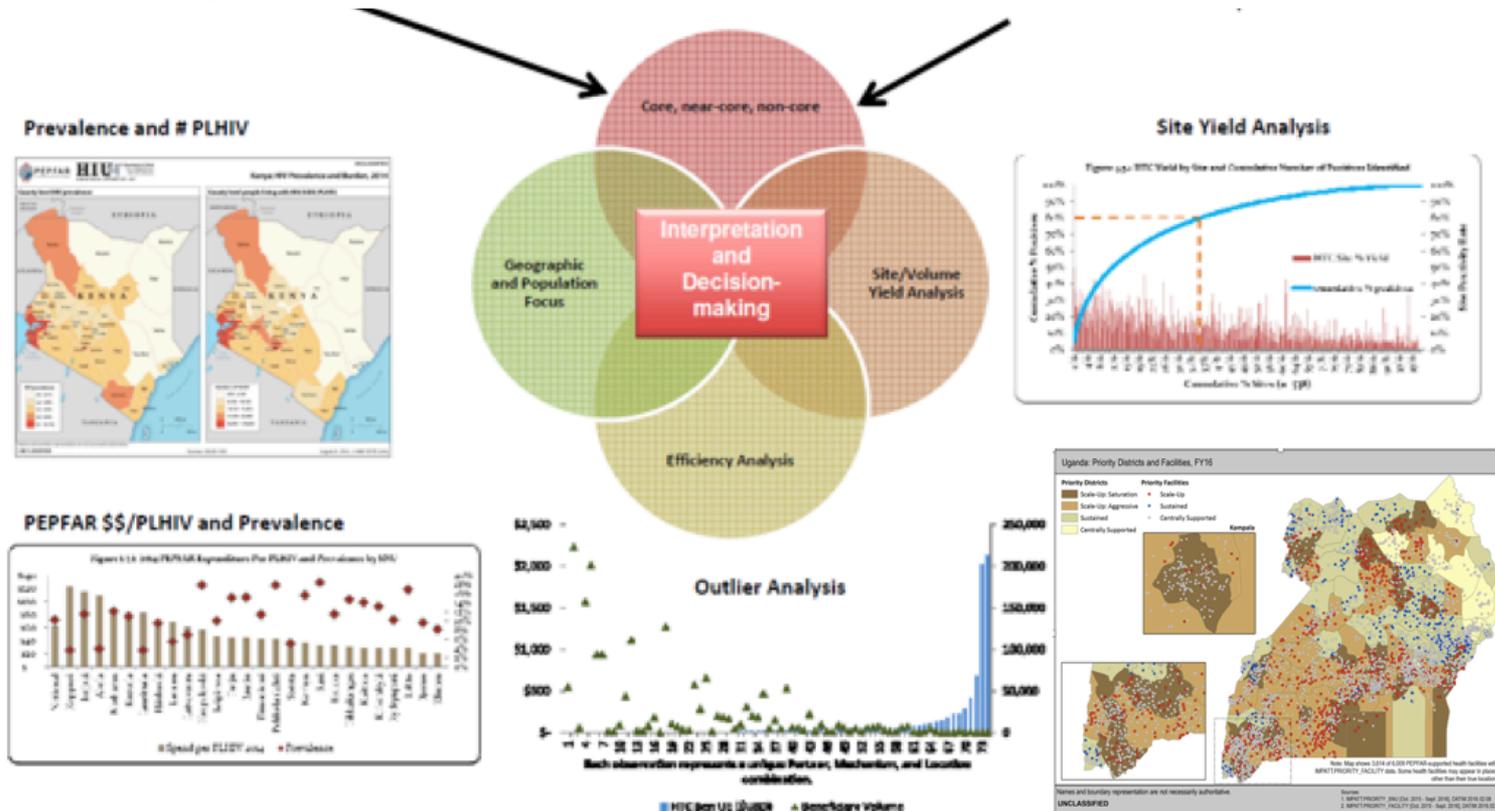
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Sources:
1. TX_CURR TX_CURR (N_Age/Sex), 15-19 Female, 20+ Female, 15-19 Male, 20+ Male [APR15], DATIM 2016 02.08

Triangulation of Data for Impact

Analysis of program results, epidemiologic data and efficiencies

National investment profile and critical gaps to reach sustained epidemic control



Interagency Collaborative for Program Improvement (ICPI)

ICPI is a unique collaboration that brings together program staff and analysts to identify key areas in the program through data analysis and visualization for immediate response and impact.

ICPI aims to improve the quality of PEPFAR-supported services, direct support and resources more effectively, assess outcomes, and ultimately increase the impact of every PEPFAR dollar spent.

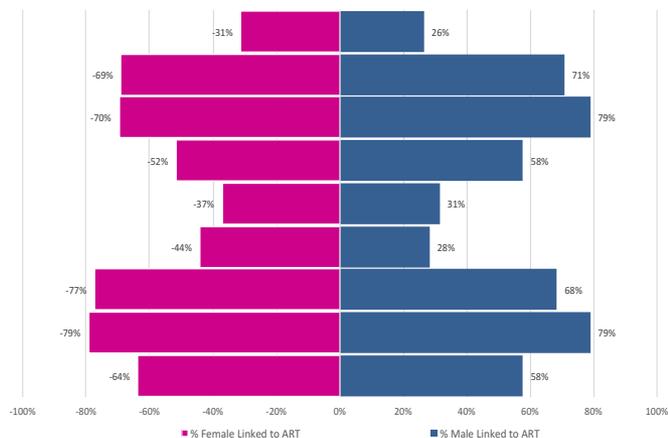


Quarterly Data Monitoring for Program Impact

- Routine collection and ongoing, focused review of data helps to inform programmatic course corrections or to identify and address implementation issues early on for the greatest impact.
- Reporting data on a quarterly basis allows the data to be used as a timely change agent in the programming process.



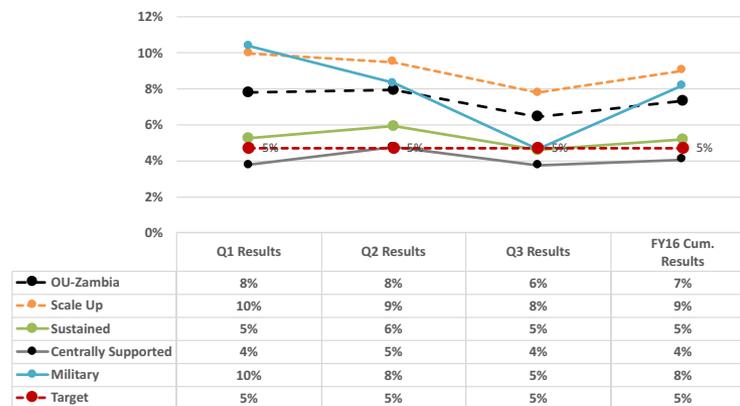
Percentage of Positives Linked to Treatment, by Age and Sex
- Cumulative FY16



Source: DATIM HTC_POS by Age/Sex
Panorama TX_NEW by Age/Sex



HTC Yield by OU and SNU Prioritization
- Cumulative FY16



Source: Panorama

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Summary

What's Next?

Together we can use data to strengthen the quality of care provided to patients living with HIV/AIDS and to better inform health providers and programs to reach those most vulnerable to acquiring HIV-infection with life-saving services.

There are four key areas that PEPFAR believes will bring the greatest impact:

- Shifting prevention to a greater focus on adolescents and young adults (under age 25) in sub-Saharan Africa
- Implementing a strategic mix of HIV testing modes to improve coverage, yield, and efficiency of testing services
- Retaining clients on treatment and care to achieve viral suppression
- Ensuring access to quality and sustainable HIV delivery systems

Our work is far from done. This week:



Over 2,000 children died
from HIV

Over 19,200 adults died
from HIV

Over 2,800 babies were infected with
HIV

Over 37,000 adults were infected
with HIV, of which more than 7,500
were young women



Thank You!

PEPFAR Dashboards
Using Data for Decision Making



PEPFAR

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