Office of the United States Global AIDS Coordinator

CONGRESSIONAL BUDGET JUSTIFICATION SUPPLEMENT

Fiscal Year 2014

Congressional Budget Justification
Supplement

PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR)

Fiscal Year 2014

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United States Department of State

Washington, D.C. 20520

Statement from the U.S. Global AIDS Coordinator

Dear Members of Congress,

I am pleased to share with you the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Supplement to the Fiscal Year (FY) 2014 Congressional Budget Justification (CBJ) for Foreign Operations. This document is intended to provide you with a deeper understanding of the work of PEPFAR and the Office of the U.S. Global AIDS Coordinator. PEPFAR is the U.S. contribution to the shared global responsibility to save lives through support for effective, country-led responses to the AIDS crisis.

The PEPFAR Supplement provides further justification for the HIV/AIDS programs to be funded with the FY 2014 request. The Office of the U.S. Global AIDS Coordinator intends to begin implementing these programs upon availability of FY 2014 funding.

The FY 2014 budget expands upon President Obama's commitment to the goal of an AIDS-free generation. This budget will build upon the historic goal of supporting 6 million on treatment by World AIDS Day 2013 and move the world closer to a tipping point in the fight against AIDS. The FY 2014 budget will also continue support for scale-up of treatment interventions in high-burden countries along with other evidence based prevention and care activities while simultaneously increasing the capacity of countries to sustain and support these efforts over time.

With your support, I look forward to continued work in partnership with countries to save lives through smart investments that maximize the impact of each dollar we provide.

Sincerely,

Eric P. Goosby, M.D.
Ambassador at Large and U.S. Global AIDS Coordinator
The President's Emergency Plan for AIDS Relief

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List of Acronyms

AB – Abstinence and Be Faithful
ABC – Abstain, Be faithful, and, as appropriate, correct and consistent use of Condoms
AF – African Affairs (U.S. State Department Bureau)
AIDS – Acquired Immune Deficiency Syndrome
ANC – Antenatal Care
APR – Annual Program Results
APS – Annual Program Statement
ART – Antiretroviral treatment
ARV – Antiretroviral (Drug)
BCC – Behavior Change Communication
CBJ – Congressional Budget Justification
CBO – Community-Based Organization
CCM – Country Coordinating Mechanism
CDC – Centers for Disease Control and Prevention (part of HHS)
CHW – Community Health Workers
CN – Congressional Notification
CO – Country Ownership
COC – Continuum of Care
CODB – Costs of Doing the USG's PEPFAR Business
COP – Country Operational Plan
COPRS – Country Operational Plan and Reporting System
CSH – Child Survival & Health (USAID funding account)
CSW – Commercial Sex Work or Worker
DFID – Department for International Development (UK)
DOD – U.S. Department of Defense
DOL – U.S. Department of Labor
DOS – U.S. Department of State
EID – Early Infant Diagnosis
EA – Expenditure Analysis
EAP – East Asian and Pacific Affairs (U.S. State Department Bureau)
EHSP – Essential Health Services Package
EUR – European and Eurasian Affairs (U.S. State Department Bureau)
F – Office of the Director of Foreign Assistance
FP – Family Planning
FBO – Faith-Based Organization
FDA – Food and Drug Administration (part of HHS)
FN – Food and Nutrition
FSW – Female Sex Workers
FSN – Foreign Service National
FTE – Full-Time Equivalent
FY – Fiscal Year
GAP – Global AIDS Program (CDC)
GBV – Gender-Based Violence
GHAI – Global HIV/AIDS Initiative (funding account; replaced by GHCS)
GHCS – Global Health Child Survival funds (funding account; replaced by GHP)
GHP – Global Health Programs (funding account)
GHI – Global Health Initative

GF – Global Fund to Fight AIDS, Tuberculosis and Malaria
G2G – Government-to-Government
HAART – Highly Active Antiretroviral treatment
HBC – Home-Based Care
HCT – HIV Counseling and Testing
HCW – Health Care Workers
HHS – U.S. Department of Health and Human Services
HIV – Human Immunodeficiency Virus
HMIS – Health Management Information System
HQ – Headquarters
HRSA – Health Resources and Services Administration (part of HHS)
HRH – Human Resources for Health
HSS – Health Systems Strengthening
ICASS – International Cooperative Administrative Support Services
ID – Identification
IDP – Internally-Displaced Person
IDU – Injecting Drug User
INR – Intelligence and Research (U.S. State Department Bureau)
IPT – Isoniazid Preventive Therapy
IRM – Information Resources Management
KPCF – Key Populations Challenge Fund
LCI – Local Capacity Initiative
LES – Locally Employed Staff
MAT – Medication Assisted Treatment
M&E – Monitoring and Evaluation
M&O – Management and Operations
MCA – Millennium Challenge Account
MCH – Maternal and Child Health
MDR-TB – Multidrug-Resistant Tuberculosis
MFI – Microfinance Institution
MOA – Memorandum of Agreement
MOH – Ministry of Health
MOU – Memorandum of Understanding
MSM – Men Who Have Sex with Men
MSW – Male Sex Workers
N/A – Not Applicable
NEA – Near Eastern Affairs (U.S. State Department Bureau)
NGO – Non-Governmental Organization
NPI – New Partners Initiative
NIH – National Institutes of Health (part of HHS)
OGAC – Office of the U.S. Global AIDS Coordinator (part of U.S. Department of State)
OGHA – Office of Global Health Affairs (part of HHS)
OI – Opportunistic Infection
OMB – Office of Management and Budget
OS – Office of the Secretary (part of HHS)
OP – Other Prevention
OVC – Orphans and Vulnerable Children
PAHO – Pan American Health Organization
PC – Peace Corps
PEP – Post-Exposure Prophylaxis

PEPFAR – President's Emergency Plan for AIDS Relief
PITC – Provider-Initiated Testing and Counseling
PLHIV – People Living with HIV/AIDS
PM – Political-Military Affairs (State Department Bureau)
PMTCT – Prevention of Mother-to-Child HIV Transmission
PPP – Public-Private Partnership
PR – Principal Recipient
PSC – Personal Services Contract
PWID – People Who Inject Drugs
PwP – Prevention with Positives
QA – Quality Assurance
ROP – Regional Operational Plan
S/APR – Semi-Annual Program Results
SAMHSA – Substance Abuse and Mental Health Services Administration (part of HHS)
SCMS – Partnership for Supply Chain Management
SI – Strategic Information
STI – Sexually-Transmitted Infection
TA – Technical Assistance
TB – Tuberculosis
TWG – Technical Working Group
UNAIDS – Joint United Nations Program on HIV/AIDS
UNICEF – United Nations Children's Fund
USAID – U.S. Agency for International Development
USDA – U.S. Department of Agriculture
USDH – U.S. Direct Hire
USG – United States government
VCT – Voluntary Counseling and Testing
VMMC – Voluntary Medical Male Circumcision
WFP – World Food Program
WHA – Western Hemisphere Affairs (U.S. State Department Bureau)
WHO – World Health Organization
XDR-TB – Extensively Drug-Resistant Tuberculosis

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SECTION I: PEPFAR BUDGET OVERVIEW

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PEPFAR Budget Overview

Under President Obama's Fiscal Year (FY) 2014 budget request, the United States will continue to lead the global effort to implement scientifically proven interventions that save lives and work toward creating an AIDS-free generation, as outlined in the *PEPFAR Blueprint*. The request provides the resources needed for PEPFAR to meet its goals through its bilateral programs. In light of the shared responsibility needed to respond to global AIDS, it also supports U.S. efforts to increase commitments of partner countries and strengthen the Global Fund.

PEPFAR Priorities and Goals

In FY 2014, PEPFAR will continue to increase its efficiency and maximize its impact by driving down the cost of commodities; expanding expenditure analysis and rigorous monitoring of impact; utilizing the highest yield interventions and targeting specific populations and risk behaviors; pushing services to the lowest appropriate level of delivery and service provider; and better coordinating with other donors, particularly the Global Fund, to avoid duplication, leverage our collective buying power, and maximize our combined impact.

On World AIDS Day 2012, the Administration launched its *PEPFAR Blueprint for Creating an AIDS-free Generation.* The *Blueprint* outlines PEPFAR's contribution to achieving an AIDS-free generation. It reflects lessons learned from nearly ten years of experience with AIDS-related programs, and PEPFAR's ongoing commitment to support countries in building sustainable health systems that can deliver for the long term. The *Blueprint* also makes clear that achieving an AIDS-free generation is a shared responsibility, requiring the commitment and leadership of partner countries, and reinforced with support from donors and others partners.

On World AIDS Day 2011, President Obama announced ambitious new targets for PEPFAR's prevention efforts, including directly supporting six million people on antiretroviral treatment (ART) by the end of 2013. PEPFAR is on track to meet the President's treatment target. PEPFAR is also working to achieve the President's goals for prevention of mother-to-child transmission (PMTCT), voluntary medical male circumcision (VMMC), and condoms. The FY 2014 request supports PEPFAR's ongoing efforts to expand coverage for these high-impact, targeted interventions, which, in turn, will reduce HIV incidence and AIDS-related mortality.

Key Accomplishments

Through strategic investments, PEPFAR has made great strides in the fight against HIV/AIDS around the world. As of September 30, 2012, PEPFAR directly supported antiretroviral treatment (ART) for more than 5.1 million people—a three-fold increase in only four years. During FY 2012 alone, PEPFAR provided antiretroviral (ARV) drugs to prevent mother-to-child transmission of HIV, providing drugs to nearly 750,000 pregnant women living with HIV. Thanks to this effort, approximately 230,000 infants were born without HIV. During this same period, PEPFAR also directly supported more than 15 million people with care and support, including more than 6 million orphans and vulnerable children (OVC). In FY 2014, PEPFAR will continue to support countries to expand access to these critical prevention, treatment, and care services.

PMTCT: In FY 2014, PEPFAR will continue to devote significant financing to PMTCT, not only saving children from infection but keeping women alive and preventing orphaning of other children. Implementation of Option B+, an innovative and simplified new "test-and-treat" approach to PMTCT, is helping to both overcome some barriers to PMTCT scale up and expand access to treatment for pregnant women. For example, with support primarily from PEPFAR and the Global Fund, Malawi has led the world in implementing the Option B+ antiretroviral regimen to prevent new HIV infections among children and keep their mothers alive. In the last year alone, the number of pregnant breastfeeding women with HIV in Malawi who started antiretroviral treatment increased by more than seven-fold, and the number of infant infections averted increased by more than four-fold in the country.

VMMC: In FY 2014, PEPFAR will maintain its intensive focus on expanding access to VMMC, with a focus on 14 African countries where this intervention can have the greatest impact on the epidemic. PEPFAR is proactively exploring innovative technological approaches around clinical technique, including the use of non-surgical medical devices for circumcision, that allow VMMC to be performed safely outside of conventional clinical settings. In FY 2014, further VMMC progress will be realized through a variety of efficiency gains and programmatic improvements, including more efficient clinical techniques, mobile and outreach services, short-term campaigns, improved commodities supply chain management, and more effective demand creation efforts based upon marketing and advertising strategies.

ART: PEPFAR has also realized greater efficiencies within its treatment portfolio, specifically in South Africa. South Africa has been a leader in efforts to decentralize provision of ART. ART was historically provided at district hospitals, and many people had to travel long distances to access lifesaving medication. With PEPFAR support, locally-led decentralization efforts have moved those services from the district level to local health centers. Effective decentralization of these critical services requires task-shifting of the provision of ART from doctors to nurses, which is a more efficient and cost-effective way to scale up treatment while maintaining quality of care. In FY 2014, PEPFAR will work to realize similar results in other countries.

Pediatric ART: In recent years, PEPFAR has helped to expand significant access to ART for children living with HIV. This progress has occurred alongside sizable declines in mother-to-child transmission of HIV, reducing the number of children born who newly require ART each year. Yet, despite these gains, global ART coverage for children under 15 years remains disproportionally low at 34%. HIV develops very rapidly among infants and children, and without treatment, half of infected children will die of AIDS-related causes before they are two.

In FY 2014, in order to help meet these challenges, PEPFAR will focus on four core priorities for expanding infant, pediatric, and adolescent treatment: 1) improved case finding of children and adolescents exposed to or infected with HIV; 2) expanded provider initiated testing and counseling for children and adolescents; 3) treatment of all identified children under 5 years of age and adolescents; and 4) retaining children and adolescents in life-long care and treatment. These efforts will be further aided by the decentralization of ART for pregnant and breastfeeding women that is occurring as countries transition to Option B and B+, which provides a prime opportunity to deliver pediatric care and treatment services in a family-centered, "one-stop-shop" model and to reduce pediatric morbidity and mortality.

Country Ownership: Over time, PEPFAR has moved from an emergency focus to an emphasis on sustainability. A key to a sustained response is country ownership, with partner countries

growing the capacity and commitment to lead, manage, monitor, and increasingly to finance their AIDS responses. PEPFAR has worked to promote country ownership by establishing 22 Partnership Framework (PFs) agreements with national governments, which outline clear and accountable activities and targets for both PEPFAR and the partner country to accelerate progress toward supporting a sustainable, partner country-led response to AIDS and an AIDS-free generation. This includes increasing national AIDS funding, based on each partner country's level of economic resources. In particular, middle-income countries have begun to increase their investments, a hopeful sign for the sustainability of the global response.

Through this fundamental shift from aid to co-investment, PEPFAR is supporting a purposeful evolution from a PEPFAR-led and funded program, to an integrated program led by partner countries. This has been delivered by targeting efforts along four dimensions: political ownership, institutional and community ownership, technical capabilities, and mutual accountability, including finance. Success in each dimension has advanced the transfer of the program's management, implementation, and ownership to several partner countries.

- South Africa: In August 2012, the U.S. and South African governments signed a Partnership Framework Implementation Plan (PFIP), which outlines how the transition to country ownership will occur over the next five years. Through the PFIP, the U.S. and South Africa are working together to gradually transition PEPFAR's investments from support of direct clinical care and treatment services to support for system strengthening, prevention, OVC, and health services innovation. This transition to South African government funding and operation of care and treatment services will be aligned with a reduction of PEPFAR's annual budget from US $484 million in 2012 to US $250 million in 2017 and an increase of the SAG's annual budget from US $1.2 billion in 2012 to US $1.9 billion in 2017.

- Namibia: From 2011-2012, the US government transitioned over $8 million in support for 54 medical officers from the PEPFAR program to the government of Namibia. In coordination with an increase in Namibian financing for the HIV/AIDS response, in FY 2014 PEPFAR Namibia will no longer have to purchase condoms, rapid test kits, and nutritional food supplementation. Since FY 2012, PEPFAR no longer purchases ARV drugs for Namibia, as the government has taken on this financial responsibility. PEPFAR now focuses on technical cooperation activities to human resources and infrastructure to support a high-impact, high-quality Namibian HIV/AIDS response.

- Zambia: PEPFAR used the signing of a PEPFAR PF and PFIP as an opportunity to leverage greater investment in HIV/AIDS from the Zambian government. The U.S. Mission team offered to make available $30 million if the Zambian government provided matching funds. The result was greater innovation and new programming as line Ministries competed for these funds. Ultimately, this led to a doubling of the Zambian ARV budget from 2011-2012 ($5 million to $10 million) and an additional increase in 2012-2013 (from $10 million to $25 million).

Data for Decision Making: In FY 2014, the PEPFAR Expenditure Analysis (EA) Initiative will be part of routine annual PEPFAR reporting. The data collection captures program expenditures in PEPFAR-supported countries and is the only routine monitoring process in the global health world that directly links expenditures to results. For example, EA shows the dollars spent by PEPFAR per person receiving testing and counseling, or person on treatment for one year. The first tranche of data was collected for nine countries in 2012. With the addition of 11 more high

investment countries in 2013, the PEPFAR EA will capture 95% of country program expenditures. The remaining countries will begin annual reporting in 2014. From 2013 onwards, all grants, cooperative agreements, and contracts using funds appropriated under PEPFAR will have standard language mandating this reporting.

PEPFAR country teams are using EA data to inform partner management, program planning, and for calculating budgets to ensure they are sufficient to meet program targets. Comparisons of the average unit expenditure per result to individual partner unit expenditures per result help program managers identify outliers and find efficiencies to ensure each dollar has maximum impact. Program level data are also being shared with partner governments to not only align donor funds and improve national level planning, but also to leverage financial support.

- Mozambique: PEPFAR is rigorously applying financial data to its program planning. For example, in the area of VMMC, analysis of the breakdown of program expenditures on recurrent (e.g., personnel, commodities), investment (e.g. clinic renovations), and program management costs ensured that funds were distributed correctly into service provision and technical assistance partners consistent with the average PEPFAR unit expenditure per circumcision. This method ensures efficient use of funds now, and allows for robust monitoring as the program matures.

- Vietnam: PEPFAR is working to classify and quantify its activities in technical assistance and health system strengthening for partner government programs. EA data is providing a framework to track these expenditures and ensuring these investments will enable key Vietnamese institutions to take over increasing responsibility for their own programs on a technical and eventually financial basis. These examples of direct application of fiscal and economic data to program planning represent a new paradigm of accountability in global health programming and exemplify a new emphasis on efficiencies which is allowing PEPFAR to accomplish increasingly ambitious goals.

Private Sector Engagement: PEPFAR has long supported and promoted the critical role that private sector engagement and public-private partnerships play in strengthening and extending the principle of shared responsibility to achieve an AIDS-free generation. Since 2006, PEPFAR has supported more than 170 public-private partnerships, investing $162 million and leveraging more than $229 million from the private sector. In addition to having skills like marketing and distribution networks that complement PEPFAR's technical focus, many of PEPFAR's private sector partners have specific technical expertise in areas such as laboratory capacity and information technology. PEPFAR has worked to link their capabilities with areas of program emphasis to leverage not just dollars, but results that can be sustained in the long term.

- For example, PEPFAR has partnered with the George W. Bush Institute, Susan G. Komen for the Cure, UNAIDS, and multiple private-sector partners on the Pink Ribbon Red Ribbon (PRRR). Launched in September 2011, the PRRR aims to expand the availability of vital cervical cancer screening and treatment—especially for high-risk HIV-positive women—and also promote breast cancer education. PEPFAR’s contribution to the partnership totals $30 million over five years, and this has leveraged $55 million in additional commitments from other founding partners. The PRRR is initially being rolled out in three countries: Zambia, Botswana, and Tanzania.

Key Populations: In FY 2014, PEPFAR will ensure countries are targeting funds for technical assistance to key populations. Reaching key populations at highest risk for HIV is a priority for

smart investments outlined in the *Blueprint*. In 2012, PEPFAR announced a number of initiatives aimed at key populations: 1) the Key Populations Challenge Fund, a $20 million dollar investment designed to stimulate a greater programmatic response to key populations and provide opportunities for PEPFAR programs to leverage current resources and stimulus funds to build local ownership of and commitment to programs for key populations; 2) an additional $15 million investment in implementation science for key populations, allowing PEPFAR to build the science needed to implement effective evidence-based interventions for populations at highest risk; and 3) a $2 million contribution to the Robert Carr Civil Society Networks Fund, which supports capacity building for global, regional, and national networks.

Impact on Broader Health Systems: PEPFAR's focused investments are enabling access to basic health care, often where little or none existed before. Each dollar invested in PEPFAR has an immediate benefit for persons living with or affected by HIV, and a secondary benefit to the entire health system and the broader populations its serves. In countries with substantial PEPFAR investments, there have been reductions in maternal, child, and TB-related mortality, increased use of antenatal care and, wider availability of safe blood, to name just a few. Since 2009, there has been a dramatic doubling of progress in reducing new HIV infections among children and TB-related mortality among people living with HIV—a rate of improvement that previously took four and six years respectively to attain. PEPFAR's investments in safe blood systems have resulted in sustainable, country-led programs that now provide safe blood for women in labor and those who have suffered auto accidents. Immunization rates have improved in PEPFAR-supported regions compared with non-PEPFAR-supported regions, improving child survival.

As a cornerstone of the Administration's Global Health Initiative (GHI), PEPFAR will continue to advance the seven GHI principles to ensure impact and sustainability. Key actions will continue to advance work on gender-based violence, promote smart integration with the President's Malaria Initiative, maternal and child health, TB and family planning, expand partnerships with multilateral organizations, especially the Global Fund, and increase country ownership. The PEPFAR platform will be an ongoing leveraging point for other partners and will promote ongoing health system strengthening—all contributing to the durability and sustainability of health programs in our partner countries.

Global Fund

The United States has welcomed the Global Fund's accomplishments in restructuring its management and core operations, introducing more rigorous fiduciary controls systems, implementing a new strategic funding model, and collaborating more intensively with U.S. bilateral health assistance programs in implementing countries. In leading the Global Fund's reform agenda, the U.S. government has helped the Fund to strengthen its promise as an efficient, long-term channel for funding evidence-based, high-impact interventions. In FY 2014, the United States will encourage other partners to join us in meeting our shared responsibility to politically and financially support the Global Fund.

The Global Fund is a smart investment that allows the U.S. government to save lives and improve health outcomes in multiple ways. The U.S. investment in the Fund contributes significantly to the success of U.S. HIV, TB, and malaria bilateral programs, which are complementary to and deeply interdependent with Global Fund-financed programs in many countries. The U.S. government's contribution to the Global Fund helps us achieve bilateral program results, reach more people with quality services, leverage contributions from other

donors, expand the geographic reach of our investment, and promote a shared responsibility among donors and partner governments for financing countries' responses to the three diseases.

PEPFAR and Global Fund financed programs are, to a greater extent than ever before, complementary and deeply intertwined in countries where both are present. Improved program coordination, decreased costs, and greater efficiencies between Global Fund and U.S. investments are helping to increase the coverage of essential HIV services and save more lives. In FY 2014, the U.S. contribution to the Global Fund will provide critical financial resources for the full launch of the Global Fund's new funding model. The model promotes more strategic investments, aligns the Global Fund with national strategic planning, and expedites the process from concept note to disbursement. Implementation of the new funding model will require a significant shift in how countries develop their investment cases and how technical partners and donors, including the U.S. government, engage in this process at country level. Engagement by U.S. government teams in this process will ultimately benefit our planning and advance our shared interests in jointly achieving an AIDS-free generation.

Investing through the Global Fund also allows the U.S. government to leverage increased health returns for scarce dollars; every dollar the U.S. Government invests in the Global Fund leverages more than two dollars from other donors. Given the scale of unmet need, it is essential that donors, both those that have already committed to the Global Fund and emerging donors, continue to support the international response in a significant way. The U.S. government will strive to strengthen public and private sector support leading up to the Global Fund's Fourth Replenishment Conference taking place in late 2013, in order to ensure the Fund has the financial commitments that will be essential for successful implementation of the new funding model in 2014-2016.

Conclusion

The Administration's FY 2014 budget request will allow for continued progress toward achieving an AIDS-free generation. The U.S. will continue its efforts to increase both donor and recipient countries' political and financial commitment to the effort, build country capacity to lead and manage a national response, and institutionalize the inclusion of diverse stakeholders in funding and policy decisions.

FY 2014 Budget Request Summary

The FY 2014 request moves PEPFAR – and the world – closer to an AIDS-free generation, and brings to bear the investments necessary to change the curve of the epidemic. The FY 2014 budget ensures that we are able to maintain the historic gains already made and that the momentum continues to swing upward.

The FY 2014 budget sustains and builds upon the gains made in FY 2013. PEPFAR is building upon the historic achievement of supporting 6 million on treatment by not only continuing to keep the treatment program on the same path, but by also prioritizing high-impact investments in areas of historic unmet need that will, in combination with the gains already made, change the trajectory of the epidemic.

A main focus of the program in FY 2014 will be concentrating resources where they will have the greatest programmatic impact, and in countries which already have a track record of success. Examples include ensuring countries are targeting funds for direct service delivery and technical assistance to key populations at high risk and continuing to invest in countries with significant unmet need in areas such as treatment, VMMC, and PMTCT.

In addition, FY 2014 will continue to see a focus in other priority areas such as gender programming and health systems strengthening (HSS). PEPFAR, one of the largest worldwide investors in gender-based violence-related programming and other approaches to support women and girls, will continue to invest in gender initiatives to pilot specific approaches, build an evidence base for investments, and support PEPFAR teams as they expand upon the funding built directly into their country programs. The investments made centrally have already and will continue to have an impact on gender-related programming at the country level. Similarly, investments in health systems strengthening – capacity-building in the public and private health sectors to support physical infrastructure, healthcare delivery systems, and workforce development -- continue to be key priorities in FY 2014. HSS is critical to achieving both PEPFAR's goals and to broader, long-term development goals. The investments made in HSS, both centrally and at the country level, ensure that not only is there sufficient infrastructure and systems in place to achieve an AIDS-free generation, but to benefit the population in many ways for years to come.

Country/Regional Operational Plan Budget Shifts

The FY 2014 request includes notional shifts to Country Operational Plan (COP) program budgets due to planned country transitions and realignment to ensure that funding is being utilized by those countries with greatest need.

Included in these shifts are increases to specific country and regional budgets. Funding allocations have increased in countries with unmet needs and smaller programs to date, such as Burundi and Cameroon, and in countries where the PMTCT and treatment programs are being accelerated, including Uganda and Zimbabwe. PEPFAR will also be increasing budgets for Ethiopia, Kenya and Mozambique, bringing them back to historical levels after decreases in FY 2013.

PEPFAR's FY 2014 budget also reflects planned transitions and a continued commitment to country ownership and shared responsibility with partner governments. Countries with planned transitions, including Vietnam, Haiti and Guyana will receive less PEPFAR funding in FY 2014. Vietnam is transitioning its service delivery portfolio to the Ministry of Health (MOH), and the PEPFAR program will now focus on providing technical assistance. This transition will be a significant step toward long-term sustainability of HIV treatment programs in Vietnam. In 2012 the U.S.–Haiti Health Partnership Framework (2012-2017) was developed and signed. The Partnership Framework also marked a redoubled commitment by the U.S. government to support the Government of Haiti in coordinating, overseeing and eventually absorbing health sector activities now so often provided through development partners. In the short term, the Government of Haiti is taking an increased role in U.S. government procurement processes, serving as technical advisors in the development of projects, while managing steadily increasing resources through direct government-to-government bilateral agreements. As the MOH's capacity improves, the U.S. government's expressed intent over the five years of the Partnership Framework is to transfer these PEPFAR mechanisms to MOH as a cornerstone of health programming and assistance. In Guyana, the HIV prevalence rate has progressively decreased among the general population over the last six years. As PEPFAR transitions from an emergency response to promoting sustainable country programs, support is shifting from direct assistance for services to a limited technical assistance collaborative model.

PEPFAR has also realigned some of its country programs to better target the HIV response. China, Laos, and Thailand previously reflected in bilateral lines will be included in the Asia Regional Program (ARP) line in FY 2014 to facilitate greater economies of scale and more efficient programming of funds.

SECTION II: PEPFAR FUNDING FOR INTERNATIONAL PARTNERS

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Global Fund to Fight AIDS, Tuberculosis and Malaria

International Partner	Fiscal Year				
	FY 2009	FY 2010	FY 2011	FY 2012	FY 2014 request
Global Fund	**$ 1,000,000,000**	**$ 1,050,000,000**	**$ 1,045,800,000**	**$ 1,300,000,000**	**$ 1,650,000,000**
GHP-State	$ 600,000,000	$ 750,000,000	$ 748,500,000	$ 1,300,000,000	$ 1,650,000,000
GHP-USAID	$ 100,000,000	$ -	$ -	$ -	$ -
HHS/NIH	$ 300,000,000	$ 300,000,000	$ 297,300,000	$ -	$ -

Table explanation: Includes FY 2009 – FY 2012 funding as enacted by Congress and contributed to the Global Fund from all appropriations, and as requested in FY 2014. Note: FY 2011 includes across-the-board and agency rescissions.

The U.S. government's contribution to and engagement with the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) are central elements of its strategy for achieving success in the fight against HIV/AIDS, Tuberculosis (TB), and Malaria. The Global Fund is a unique model that relies on partnerships among:

- Governments;
- Civil society - including community and faith-based organizations;
- International organizations;
- Bilateral and multilateral donors;
- The private sector; and
- Affected communities in the fight against AIDS, TB, and Malaria.

As of December 2012, Global Fund-supported programs in 151 countries were saving an estimated 100,000 lives every month. To date, its resources have provided support for HIV/AIDS treatment for 4.2 million people, PMTCT services for 1.7 million pregnant women, detection and treatment of 9.7 million TB cases, and the distribution of 310 million bed nets to protect families from malaria.

The United States' FY 2014 budget request of $1,650,000,000 comes during the critical period leading up to the Global Fund's Fourth Replenishment Conference later this year, at which time donors will be making pledges for the 2014-2016 period. As always, U.S. government political and financial support for the Global Fund remains tied to successful implementation of key reforms already underway, resulting in greater impact on the ground. By law, the U.S. cannot provide more than 33% of total Global Fund resources, and while we are currently short of that limit, we are strengthening our leverage in the upcoming replenishment by insisting that every dollar we contribute from 2014-2016 be matched two to one by other donors. The U.S. government will strive to strengthen public and private sector support for the Global Fund, in order to ensure the Fund has the financial commitments that will be essential for successful implementation of the new funding model in 2014-2016.

Through its investment in the Global Fund, the U.S. government dramatically increases its geographic reach and health impact and contributes directly and significantly to the success of PEPFAR's bilateral programs, which are complementary to and deeply interdependent with Global Fund-financed programs in many countries. These investments catalyze broad-based international investment in the global response to HIV/AIDS, TB, and malaria and increase both donor and recipient countries' political and financial commitment to the effort.

The FY 2014 request will provide critical financial resources for the continuation of high-impact programs and for the full launch of the Global Fund's new funding modality in 2014. In November 2012, with strong endorsement and input from the U.S. government, the Global Fund Board adopted a new funding model, which demonstrated the Fund's significant shift from being a passive grant maker to an active, strategic investor. The model is more adaptable to country planning and priorities and focused on countries with high disease impact. Grant applicants will develop investment cases and receive indicative funding ranges over a three-year period to ensure more predictable funding levels. Already, resources are being targeted to immediate funding needs, such as countries identified as being historically underfunded, countries at risk of interruption of Global Fund-financed services, and countries ready to achieve the greatest impact with additional resources. Implementation of the new funding model will require a significant shift in how countries develop their investment cases and how technical partners and donors, including the U.S. government, engage in this process at the country level. Engagement by U.S. government teams in this process will ultimately benefit our planning and advance our shared interests in jointly achieving an AIDS-free generation.

As we move toward a sustainable AIDS response, PEPFAR, the Global Fund, UNAIDS, and partner countries are working more closely together — leading to an overall decrease in costs, while saving more lives. Global Fund financing will enable high-impact countries to increase the number of patients receiving AIDS or TB treatment due to efficiency gains in the past three funding rounds and in other areas. Overall, more people – not fewer – will receive access to these services in the coming two years. However, donor support remains critical to signal confidence in the Fund and to reassure implementing countries that the Fund is a reliable source of support.

PEPFAR is working to make our programs more efficient and impactful, and accelerating these gains through increased collaboration with governments, the Global Fund, and other partners to align programs and target investments. In some countries, PEPFAR and the Global Fund each cover different geographic regions in the delivery of treatment and related services (e.g. Democratic Republic of Congo), while in others the two work together by supporting different treatment regimens (e.g. Tanzania).

PEPFAR DRC and the Global Fund are working collaboratively to strategically leverage resources in health zones of high HIV/AIDS burden to increase treatment and PMTCT coverage. PEPFAR's focal provinces are Oriental, Kinshasa and Katanga while Global Fund support is currently being redistributed within the country to complement PEPFAR's activities and strengthen linkages and referrals. In health zones where PEPFAR is supporting a continuum of response but drugs are not yet available, referral networks are being strengthened so that positive patients identified at PEPFAR supported sites can be referred to Global Fund sites were ART is available. PEPFAR and the Global fund are also jointly supporting the improvement of data collection and training of health care workers to increase the quality of reliable data to inform programming.

Tanzania's national HIV/AIDS response uses the PEPFAR supported platform of technical assistance and treatment services in combination with Global Fund financing, which provides essential commodities, such as anti-retroviral drugs (ARVs) and rapid test kits (RTKs). The Global Fund will soon start voluntary pooled procurement (VPP) of these core commodities to assure timely arrival in country. PEPFAR funds in the current Tanzania COP are programmed to fill-in forecasted gaps in commodities, while the Global Fund grant transitions to the VPP system.

The U.S. government will ensure that bilateral and Global Fund resources are invested in a fully coordinated and complementary manner to achieve better health outcomes within the framework of national strategic plans developed by partner countries. U.S. government health programs are institutionalizing joint planning and implementation in countries where both organizations are making investments. USAID, HHS/CDC, and other U.S. government implementing agencies are working closely with the Global Fund to exchange information, best practices, and knowledge in order to better define their respective roles in addressing the epidemics in the countries where both are working. Increasing program coordination, decreasing costs, and creating efficiencies between Global Fund and U.S. investments will help to increase coverage and save more lives. To simplify country systems, PEPFAR is also working with the Global Fund to harmonize monitoring, evaluation, expenditure analysis, and reporting practices, creating a local framework for better decision-making by countries and their bilateral and multilateral partners.

Joint United Nations Program on HIV/AIDS (UNAIDS)

International Partner	Fiscal Year				
	FY 2009	FY 2010	FY 2011	FY 2012	FY 2014 request
UNAIDS	**$ 40,000,000**	**$ 43,000,000**	**$ 42,914,000**	**$ 45,000,000**	**$ 45,000,000**
GHP-State	$ 40,000,000	$ 43,000,000	$ 42,914,000	$ 45,000,000	$ 45,000,000

Table explanation: Includes FY 2009 – FY 2012 funding as enacted by Congress and contributed to support the Joint United Nations Program on HIV/AIDS (UNAIDS) from all appropriations, and as requested in FY 2014. Note: FY 2011 includes across-the-board and agency rescissions.

The Joint United Nations Program on HIV/AIDS (UNAIDS) plays a vital role in the international response to fight HIV/AIDS by coordinating the UN system's response to the HIV/AIDS epidemic, catalyzing political and financial commitment to the fight against HIV/AIDS, and engaging civil society groups in the global response to the AIDS epidemic. UNAIDS is a unique and innovative partnership of eleven UN agencies that draws on the comparative advantages of each for coordinated and targeted action to specific challenges of the HIV/AIDS epidemic.

The United States' contribution to UNAIDS in FY 2014 is $45 million. This contribution will support an ongoing five-year Public International Organization (PIO) grant aimed at significantly increasing UNAIDS' effort to scale up the global response to HIV/AIDS with particular emphasis at the country level. This global response seeks to prevent the transmission of HIV/AIDS, provide care and support, reduce individual and community vulnerability to HIV/AIDS and mitigate the impact of the epidemic.

The U.S. government's investment in UNAIDS continues to support its core competencies in the HIV/AIDS response. The UNAIDS Secretariat coordinates the efforts of UN agencies to deliver as one with common strategies, goals, and objectives; mobilize political and financial resources; advocate for political and policy change; hold donors and other stakeholders accountable for results; and empower agents of change, including civil society, to make available strategic information for planning to ensure that resources are targeted where they deliver the greatest impact. UNAIDS also engages country leadership in support of country-owned responses that integrate with national health and development efforts.

In addition to this contribution, the United States plays an active role in the governance and oversight of UNAIDS through its participation as a Member State in UNAIDS Board meetings. In this forum, the U.S. government continues to promote evidence-based policies that ensure effective and efficient use of funds and resources to respond to the global HIV/AIDS epidemic. In 2011, the U.S. government strongly supported UNAIDS' establishment of the Unified Budget Results Accountability Framework (UBRAF) that provides an unprecedented level of transparency and accountability for the work of the UNAIDS program, clearly delineating the roles and responsibilities of the Secretariat and each UN co-sponsor in the achievement of goals set in the UNAIDS Strategy (2011-2015). The new UBRAF is loosely based on the PEPFAR COP, and includes a stronger focus on country level planning and coordination to support the UN to "Deliver as One." UN country teams report annually against the UBRAF, which is aggregated at regional and headquarters levels to provide information by region, country, co-sponsor, program area, and goal. The UNAIDS Board reviewed and evaluated the first cycle of the new UBRAF reporting in June 2013, to ensure UNAIDS is effectively implementing their

UNAIDS Strategy.

The U.S. government will continue to work alongside UNAIDS. In FY 2014, efforts will be made to ensure strong coordination at the country level, including a special focus on operationalizing the principles of the investment framework, an important tool that puts informed country ownership and decision making at the forefront of the HIV response. Through this tool, UNAIDS will support countries to further optimize and rationalize the resource allocations of national programs and target their national investments to high-impact programmatic activities to achieve maximum cost-effectiveness and impact.

The U.S. government continues to use its leverage as a donor and member of the Global Fund and UNAIDS governing bodies to ensure the complementarities of both organizations and the momentum and impact of the international response. More broadly, PEPFAR will continue to expand multilateral engagement with the goal of strengthening these institutions and leveraging the work of multilateral partners to maximize the impact of country programs.

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SECTION III: PEPFAR BUDGET FY 2009-2014

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Table 1: PEPFAR FY 2014 Request

$ in Thousands	FY 2014 Request	
State, Region, Operating Unit	**GHP-State**	**GHP-USAID**
Africa	**3,205,656**	**87,910**
Angola	10,938	4,400
Botswana	49,711	-
Burundi	14,899	3,500
Cameroon	23,107	1,500
Cote d'Ivoire	121,390	-
Democratic Republic of the Congo	38,332	9,200
Djibouti	1,800	-
Ethiopia	190,336	-
Ghana	4,042	5,500
Kenya	382,141	-
Lesotho	19,158	6,400
Liberia	800	2,700
Malawi	56,248	15,500
Mali	1,349	3,000
Mozambique	249,180	-
Namibia	60,675	-
Nigeria	441,225	-
Rwanda	74,202	-
Senegal	1,535	3,000
Sierra Leone	500	-
South Africa	414,636	-
South Sudan	13,904	2,010
Swaziland	35,065	6,900
Tanzania	330,038	-
Uganda	306,195	-
Zambia	292,175	-
Zimbabwe	69,675	16,500
USAID East Africa Regional	800	2,800
USAID Southern Africa Regional	1,600	2,000
USAID West Africa Regional	-	3,000
East Asia and Pacific	**73,117**	**25,250**
Burma	8,245	1,000
Cambodia	4,588	9,000
China	2,398	-
Indonesia	250	7,750
Papua New Guinea	2,280	2,500
Vietnam	53,173	-
Asia Regional Program	2,183	5,000
Europe and Eurasia	**21,204**	**2,500**
Ukraine	21,204	2,500
South and Central Asia	**18,290**	**19,000**
India	8,386	15,000
Central Asia Regional	9,904	1,000
Nepal	-	3,000
Western Hemisphere	**162,802**	**21,091**
Brazil	1,078	-
Dominican Republic	6,894	5,750
Guyana	5,945	-
Haiti	122,896	-
Caribbean Regional	14,108	6,950
Central America Regional	11,881	8,391
S/GAC Additional Funding	**2,188,931**	**-**
S/GAC, Additional Funding for Country Programs	227,057	-
S/GAC, International Partnerships	1,695,000	-
S/GAC, Oversight/Management	186,874	-
S/GAC, Technical Support/Strategic Information/Evaluation	80,000	-

Table explanation: Includes FY 2014 GHP-State and GHP-USAID requests for all PEPFAR countries and for headquarters HIV/AIDS programs.

Table 2: PEPFAR FY 2013 Estimate

	GHP-State	GHP-USAID
TOTAL ACCOUNT	**5,439,829,325**	**332,945,350**
Bilateral	**3,827,992,542**	**332,945,350**
Country Funding	$ 3,506,556,904	$ 159,751,000
Headquarters Funding	$ 321,435,638	$ 173,194,350
Additional Funding for Country Programs	$ 58,550,336	$ -
Technical Oversight and Management/Global Health Core	$ 182,885,302	$ 83,703,297
Technical Support/Strategic Information/Evaluation	$ 80,000,000	
Commodity Fund	$ -	$ 19,350,317
IAVI	$ -	$ 27,319,774
Microbicides	$ -	$ 42,820,962
International Partnerships	**$ 1,611,836,783**	
Global Fund	$ 1,569,044,656	$ -
UNAIDS	$ 42,792,127	$ -

Table explanation: GHP-State and GHP-USAID estimates are for PEPFAR and represent the FY 2013 Full Year Continuing Resolution inclusive of across-the-board rescissions and sequester. FY 2013 653(a) funding levels are "To Be Determined" pending final approval of the Office of the Director of Foreign Assistance (F).

Table 3: FY 2014 Request for PEPFAR Operational Plan Countries (GHP-State and GHP-USAID accounts only)

	FY 2014 Request	
State, Region, Operating Unit	**GHP-State**	**GHP-USAID**
Africa	**3,197,272,000**	**71,410,000**
Angola	10,938,000	4,400,000
Botswana	49,711,000	-
Burundi	14,899,000	3,500,000
Cameroon	23,107,000	1,500,000
Cote d'Ivoire	121,390,000	-
Democratic Republic of the Congo	38,332,000	9,200,000
Ethiopia	190,336,000	-
Ghana	4,042,000	5,500,000
Kenya	382,141,000	-
Lesotho	19,158,000	6,400,000
Malawi	56,248,000	15,500,000
Mozambique	249,180,000	-
Namibia	60,675,000	-
Nigeria	441,225,000	-
Rwanda	74,202,000	
South Africa	414,636,000	-
South Sudan	13,904,000	2,010,000
Swaziland	35,065,000	6,900,000
Tanzania	330,038,000	-
Uganda	306,195,000	-
Zambia	292,175,000	-
Zimbabwe	69,675,000	16,500,000
East Asia and Pacific	**70,934,000**	**20,250,000**
Asia Regional Program	4,581,000	5,000,000
Burma	8,245,000	1,000,000
Cambodia	4,588,000	9,000,000
Indonesia	250,000	7,750,000
Papua New Guinea	2,280,000	2,500,000
Vietnam	53,173,000	-
Europe and Eurasia	**21,204,000**	**2,500,000**
Ukraine	21,204,000	2,500,000
South and Central Asia	**18,290,000**	**16,000,000**
India	8,386,000	15,000,000
Central Asia Regional	9,904,000	1,000,000
Western Hemisphere	**161,724,000**	**21,091,000**
Dominican Republic	6,894,000	5,750,000
Guyana	5,945,000	-
Haiti	122,896,000	-
Carribean Regional	14,108,000	6,950,000
Central America Regional	11,881,000	8,391,000

Table explanation: Includes FY 2014 GHP-State and GHP-USAID requests for PEPFAR Operational Plan countries.
Note: Other PEPFAR funding sources are not requested by individual country.

Table 4: FY 2009 – FY 2012 Approved Funding in PEPFAR Operational Plans by Country (all accounts)

Approved Funding, $ in Millions	Fiscal Year			
State Region, Operating Unit	FY 2009	FY 2010	FY 2011	FY 2012
Africa	**$3,793.1**	**$3,730.2**	**$3,875.4**	**$ 3,223.9**
Angola	$ 17.0	$ 17.7	$ 17.7	$ 17.7
Botswana	$ 95.1	$ 87.0	$ 84.4	$ 75.9
Burundi	NA	NA	$ 18.5	$ 8.5
Cameroon	NA	NA	$ 24.3	$ 14.3
Cote d'Ivoire	$ 124.8	$ 119.1	$ 105.2	$ 130.2
Democratic Republic of Congo	$ 33.0	$ 31.3	$ 51.3	$ 25.4
Ethiopia	$ 346.0	$ 291.3	$ 293.0	$ 185.1
Ghana	$ 17.5	$ 13.0	$ 15.0	$ 15.0
Kenya	$ 565.0	$ 548.1	$ 517.3	$ 260.0
Lesotho	$ 28.3	$ 29.2	$ 34.2	$ 16.8
Malawi	$ 45.7	$ 55.3	$ 65.0	$ 70.0
Mozambique	$ 252.9	$ 269.1	$ 268.8	$ 231.1
Namibia	$ 107.9	$ 102.6	$ 102.6	$ 90.3
Nigeria	$ 442.3	$ 459.2	$ 488.6	$ 478.6
Rwanda	$ 147.6	$ 131.4	$ 115.4	$ 105.4
South Africa	$ 561.3	$ 560.4	$ 549.1	$ 523.7
Sudan	$ 8.8	$ 9.5	$ 14.5	$ 14.5
Swaziland	$ 32.4	$ 37.5	$ 60.8	$ 32.5
Tanzania	$ 361.2	$ 358.0	$ 357.2	$ 289.6
Uganda	$ 287.1	$ 286.3	$ 323.4	$ 298.4
Zambia	$ 271.1	$ 276.7	$ 306.7	$ 249.7
Zimbabwe	$ 48.0	$ 47.5	$ 62.5	$ 91.2
East Asia and Pacific	**$ 132.7**	**$ 144.8**	**$ 129.8**	**$ 102.1**
Cambodia	$ 18.0	$ 18.5	$ 18.5	$ 15.0
China	$ 10.3	$ 10.0	$ 8.0	$ 6.0
Indonesia	$ 9.0	$ 13.0	$ 13.0	$ 5.8
Thailand	$ 5.5	$ 5.5	$ 5.5	$ 5.5
Vietnam	$ 89.9	$ 97.8	$ 84.8	$ 69.8
Europe and Eurasia	**$ 16.2**	**$ 18.0**	**$ 27.2**	**$ 11.6**
Russia	$ 8.0	$ 6.0	$ 5.0	$ -
Ukraine	$ 8.2	$ 12.0	$ 22.2	$ 11.6
South and Central Asia	**$ 30.5**	**$ 48.8**	**$ 48.8**	**$ 33.2**
Central Asia Regional	NA	$ 15.8	$ 15.8	$ 5.2
India	$ 30.5	$ 33.0	$ 33.0	$ 28.0
Western Hemisphere	**$ 187.3**	**$ 233.7**	**$ 224.8**	**$ 207.7**
Caribbean Regional	$ 19.0	$ 23.3	$ 23.3	$ 22.2
Central America Regional	NA	$ 12.6	$ 12.6	$ 21.6
Dominican Republic	$ 17.3	$ 15.5	$ 15.5	$ 8.5
Guyana	$ 20.5	$ 18.2	$ 14.9	$ 11.9
Haiti	$ 130.5	$ 164.1	$ 158.5	$ 143.5
Grand Total	**$4,159.7**	**$4,175.6**	**$4,306.0**	**$ 3,578.5**

Table explanation: Includes all sources of approved funding supporting activities in PEPFAR Operational Plans for FY 2009 through FY 2012. Note: Central Asia Regional and Central America Regional did not complete PEPFAR Operational Plans until FY 2010 and Burundi and Cameroon prepared their first PEPFAR Operational Plans in FY 2011. FY 2012 levels reflect Global AIDS Coordinator's approved changes from the 653(a) allocations.

Table 5: FY 2009 – FY 2012 Approved Funding in PEPFAR Operational Plans by Funding Source

	FY 2009					FY 2010					FY 2011					FY 2012				
State Region, Operating Unit	GAP	GHP-USAID	GHP-State	Central GHP-State	Total All Funding Sources	GAP	GHP-USAID	GHP-State	Central GHP-State	Total All Funding Sources	GAP	GHP-USAID	GHP-State	Central GHP-State	Total All Funding Sources	GAP	GHP-USAID	GHP-State	Central GHP-State	Total All Funding Sources
Africa	**$ 71,439,000**	**$ 66,410,000**	**$ 3,457,001,414**	**$ 198,202,534**	**$ 3,793,052,948**	**$ 69,889,000**	**$ 66,410,000**	**$ 3,489,929,279**	**$ 104,019,359**	**$ 3,730,247,638**	**$ 70,979,000**	**$ 71,410,000**	**$ 3,635,638,196**	**$ 97,337,164**	**$ 3,875,364,360**	**$ 70,979,000**	**$ 71,410,000**	**$ 2,984,217,934**	**$ 97,337,164**	**$ 3,223,944,098**
Angola	$ 1,548,000	$ 4,400,000	$ 11,052,000	$ -	$ 17,000,000	$ 3,000,000	$ 4,400,000	$ 10,300,000		$ 17,700,000	$ 3,000,000	$ 4,400,000	$ 10,300,000		$ 17,700,000	$ 3,000,000	$ 4,400,000	$ 10,300,000	-	$ 17,700,000
Botswana	$ 7,547,000		$ 81,915,460	$ 5,662,698	$ 95,125,158	$ 7,147,000	$ -	$ 76,442,747	$ 3,430,411	$ 87,020,158	$ 7,147,000	$ -	$ 74,442,747	$ 2,786,962	$ 84,376,709	$ 7,147,000	-	$ 66,000,000	$ 2,786,962	$ 75,933,962
Burundi	NA					NA					$ -	$ 3,500,000	$ 15,000,000		$ 18,500,000	-	$ 3,500,000	$ 5,000,000	-	$ 8,500,000
Cameroon	NA					NA					$ 1,500,000	$ 1,500,000	$ 21,250,000		$ 24,250,000	$ 1,500,000	$ 1,500,000	$ 11,250,000	-	$ 14,250,000
Cote d' Ivoire	$ 5,253,000		$ 107,135,644	$ 12,443,768	$ 124,832,412	$ 5,153,000	$ -	$ 106,655,051	$ 7,319,108	$ 119,127,159	$ 5,153,000	$ -	$ 93,305,051	$ 6,722,257	$ 105,180,308	$ 5,153,000	-	$ 118,305,051	$ 6,722,257	$ 130,180,308
Democratic Republic of the Congo	$ 2,415,000	$ 9,200,000	$ 21,413,595	$ -	$ 33,028,595	$ 2,415,000	$ 9,200,000	$ 19,635,000		$ 31,250,000	$ 2,415,000	$ 9,200,000	$ 39,635,000		$ 51,250,000	$ 2,415,000	$ 9,200,000	$ 13,769,690	-	$ 25,384,690
Ethiopia	$ 5,800,000		$ 333,686,520	$ 6,494,588	$ 345,981,108	$ 4,273,000	$ -	$ 286,699,149	$ 350,000	$ 291,322,149	$ 3,863,000	$ -	$ 289,089,388	$ -	$ 292,952,388	$ 3,863,000	-	$ 181,239,987	-	$ 185,102,987
Ghana	$ 500,000	$ 5,500,000	$ 11,500,000	$ -	$ 17,500,000	$ 500,000	$ 5,500,000	$ 7,000,000		$ 13,000,000	$ 500,000	$ 5,500,000	$ 9,000,000		$ 15,000,000	$ 500,000	$ 5,500,000	$ 9,000,000	-	$ 15,000,000
Kenya	$ 8,121,000		$ 531,850,152	$ 24,984,441	$ 564,955,593	$ 8,121,000	$ -	$ 528,760,495	$ 11,237,946	$ 548,119,441	$ 8,121,000	$ -	$ 498,760,495	$ 10,405,680	$ 517,287,175	$ 8,121,000	-	$ 241,512,003	$ 10,405,680	$ 260,038,683
Lesotho	$ 1,150,000	$ 6,400,000	$ 20,760,000	$ -	$ 28,310,000	$ 1,150,000	$ 6,400,000	$ 21,650,000		$ 29,200,000	$ 1,150,000	$ 6,400,000	$ 26,650,000		$ 34,200,000	$ 1,150,000	$ 6,400,000	$ 9,235,000	-	$ 16,785,000
Malawi	$ 3,052,000	$ 15,500,000	$ 27,148,000	$ -	$ 45,700,000	$ 3,052,000	$ 15,500,000	$ 36,448,000	$ 275,000	$ 55,275,000	$ 3,052,000	$ 15,500,000	$ 46,448,000	$ -	$ 65,000,000	$ 3,052,000	$ 15,500,000	$ 51,448,000	-	$ 70,000,000
Mozambique	$ 2,337,000		$ 239,804,289	$ 10,737,022	$ 252,878,311	$ 2,337,000	$ -	$ 261,952,597	$ 4,800,000	$ 269,089,597	$ 2,337,000	$ -	$ 261,952,597	$ 4,500,000	$ 268,789,597	$ 2,337,000	$ -	$ 224,238,909	$ 4,500,000	$ 231,075,909
Namibia	$ 1,500,000		$ 103,370,613	$ 2,935,181	$ 107,805,794	$ 1,500,000	$ -	$ 100,809,181	$ 300,000	$ 102,609,181	$ 1,500,000	$ -	$ 101,122,181		$ 102,622,181	$ 1,500,000	-	$ 88,809,181	-	$ 90,309,181
Nigeria	$ 3,056,000		$ 418,807,628	$ 20,423,425	$ 442,287,053	$ 3,056,000	$ -	$ 441,227,282	$ 14,885,999	$ 459,169,281	$ 3,056,000	$ -	$ 471,227,282	$ 14,330,999	$ 488,614,281	$ 3,056,000	$ -	$ 461,227,282	$ 14,330,999	$ 478,614,281
Rwanda	$ 1,135,000		$ 133,921,948	$ 12,590,365	$ 147,647,313	$ 1,135,000	$ -	$ 124,072,239	$ 6,240,074	$ 131,447,313	$ 1,135,000	$ -	$ 109,072,239	$ 5,221,139	$ 115,428,378	$ 1,135,000	$ -	$ 99,072,239	$ 5,221,139	$ 105,428,378
South Africa	$ 4,818,000		$ 533,182,001	$ 23,313,145	$ 561,313,146	$ 4,043,000	$ -	$ 545,968,500	$ 10,394,261	$ 560,405,761	$ 4,043,000	$ -	$ 535,318,500	$ 9,729,351	$ 549,090,851	$ 4,043,000	$ -	$ 509,968,500	$ 9,729,351	$ 523,740,851
South Sudan	$ 500,000	$ 2,010,000	$ 6,327,000	$ -	$ 8,837,000	$ 500,000	$ 2,010,000	$ 7,036,000		$ 9,546,000	$ 500,000	$ 2,010,000	$ 12,036,000		$ 14,546,000	$ 500,000	$ 2,010,000	$ 12,036,000	-	$ 14,546,000
Swaziland	$ 1,200,000	$ 6,900,000	$ 24,350,000	$ -	$ 32,450,000	$ 1,200,000	$ 6,900,000	$ 29,444,322		$ 37,544,322	$ 1,200,000	$ 6,900,000	$ 52,700,000		$ 60,800,000	$ 1,200,000	$ 6,900,000	$ 24,424,819	-	$ 32,524,819
Tanzania	$ 3,883,000		$ 329,920,916	$ 27,362,427	$ 361,166,343	$ 3,683,000	$ -	$ 336,254,410	$ 18,031,863	$ 357,969,273	$ 3,683,000	$ -	$ 336,254,410	$ 17,256,079	$ 357,193,489	$ 3,683,000	-	$ 268,616,142	$ 17,256,079	$ 289,555,221
Uganda	$ 8,040,000		$ 258,800,402	$ 20,273,332	$ 287,113,734	$ 8,040,000	$ -	$ 271,583,697	$ 6,634,675	$ 286,258,372	$ 8,040,000	$ -	$ 309,083,697	$ 6,264,675	$ 323,388,372	$ 8,040,000	-	$ 284,083,697	$ 6,264,675	$ 298,388,372
Zambia	$ 2,914,000		$ 237,225,246	$ 30,982,142	$ 271,121,388	$ 2,914,000	$ -	$ 253,660,609	$ 20,120,022	$ 276,694,631	$ 2,914,000	$ -	$ 283,660,609	$ 20,120,022	$ 306,694,631	$ 2,914,000	$ -	$ 226,660,609	$ 20,120,022	$ 249,694,631
Zimbabwe	$ 6,670,000	$ 16,500,000	$ 24,830,000	$ -	$ 48,000,000	$ 6,670,000	$ 16,500,000	$ 24,330,000		$ 47,500,000	$ 6,670,000	$ 16,500,000	$ 39,330,000		$ 62,500,000	$ 6,670,000	$ 16,500,000	$ 68,020,825	-	$ 91,190,825
East Asia and Pacific	**$ 12,855,000**	**$ 25,250,000**	**$ 94,556,168**	**$ -**	**$ 132,661,168**	**$ 12,855,000**	**$ 25,250,000**	**$ 106,728,168**	**$ -**	**$ 144,833,168**	**$ 12,855,000**	**$ 21,250,000**	**$ 95,728,168**	**$ -**	**$ 129,833,168**	**$ 12,855,000**	**$ 15,750,000**	**$ 73,478,168**	**$ -**	**$ 102,083,168**
Cambodia	$ 3,000,000	$ 12,500,000	$ 2,500,000	$ -	$ 18,000,000	$ 3,000,000	$ 12,500,000	$ 3,000,000	$ -	$ 18,500,000	$ 3,000,000	$ 12,500,000	$ 3,000,000		$ 18,500,000	$ 3,000,000	$ 9,000,000	$ 3,000,000	$ -	$ 15,000,000
China	$ 3,000,000	$ 4,000,000	$ 3,308,000	$ -	$ 10,308,000	$ 3,000,000	$ 4,000,000	$ 3,000,000	$ -	$ 10,000,000	$ 3,000,000	$ -	$ 5,000,000		$ 8,000,000	$ 3,000,000	-	$ 3,000,000	$ -	$ 6,000,000
Indonesia		$ 7,750,000	$ 1,250,000	$ -	$ 9,000,000	$ -	$ 7,750,000	$ 5,250,000	$ -	$ 13,000,000	$ -	$ 7,750,000	$ 5,250,000		$ 13,000,000	-	$ 5,750,000	$ -	$ -	$ 5,750,000
Thailand	$ 4,000,000	$ 1,000,000	$ 500,000	$ -	$ 5,500,000	$ 4,000,000	$ 1,000,000	$ 500,000	$ -	$ 5,500,000	$ 4,000,000	$ 1,000,000	$ 500,000		$ 5,500,000	$ 4,000,000	$ 1,000,000	$ 500,000	$ -	$ 5,500,000
Vietnam	$ 2,855,000		$ 86,998,168	$ -	$ 89,853,168	$ 2,855,000	$ -	$ 94,978,168	$ -	$ 97,833,168	$ 2,855,000	$ -	$ 81,978,168		$ 84,833,168	$ 2,855,000	-	$ 66,978,168	$ -	$ 69,833,168
Europe and Eurasia	**$ 500,000**	**$ 5,000,000**	**$ 10,678,000**	**$ -**	**$ 16,178,000**	**$ 500,000**	**$ 5,000,000**	**$ 12,528,000**	**$ -**	**$ 18,028,000**	**$ 500,000**	**$ 5,000,000**	**$ 21,678,000**	**$ -**	**$ 27,178,000**	**$ 300,000**	**$ 2,500,000**	**$ 8,753,000**	**$ -**	**$ 11,553,000**
Russia	$ 500,000	$ 2,500,000	$ 5,000,000	$ -	$ 8,000,000	$ 500,000	$ 2,500,000	$ 3,000,000	$ -	$ 6,000,000	$ 200,000	$ 2,500,000	$ 2,300,000	$ -	$ 5,000,000	$ -	$ -	$ -	$ -	
Ukraine		$ 2,500,000	$ 5,678,000		$ 8,178,000	$ -	$ 2,500,000	$ 9,528,000	$ -	$ 12,028,000	$ 300,000	$ 2,500,000	$ 19,378,000		$ 22,178,000	$ 300,000	$ 2,500,000	$ 8,753,000	$ -	$ 11,553,000
South and Central Asia	**$ 3,000,000**	**$ 21,000,000**	**$ 6,450,000**	**$ -**	**$ 30,450,000**	**$ 3,150,000**	**$ 22,000,000**	**$ 23,664,000**	**$ -**	**$ 48,814,000**	**$ 3,560,000**	**$ 22,000,000**	**$ 23,254,000**	**$ -**	**$ 48,814,000**	**$ 3,560,000**	**$ 19,000,000**	**$ 10,602,415**	**$ -**	
Central Asia Regional	NA					$ 150,000	$ 1,000,000	$ 14,664,000	$ -	$ 15,814,000	$ 560,000	$ 1,000,000	$ 14,254,000		$ 15,814,000	$ 560,000	$ 1,000,000	$ 3,602,415	$ -	$ 5,162,415
India	$ 3,000,000	$ 21,000,000	$ 6,450,000	$ -	$ 30,450,000	$ 3,000,000	$ 21,000,000	$ 9,000,000	$ -	$ 33,000,000	$ 3,000,000	$ 21,000,000	$ 9,000,000		$ 33,000,000	$ 3,000,000	$ 18,000,000	$ 7,000,000	$ -	$ 28,000,000
Western Hemisphere	**$ 2,500,000**	**$ 5,750,000**	**$ 169,231,000**	**$ 9,834,588**	**$ 187,315,588**	**$ 6,225,000**	**$ 18,091,000**	**$ 208,036,534**	**$ 1,309,039**	**$ 233,661,573**	**$ 6,225,000**	**$ 18,091,000**	**$ 200,036,534**	**$ 459,039**	**$ 224,811,573**	**$ 6,225,000**	**$ 20,109,200**	**$ 180,936,734**	**$ 459,039**	**$ 207,729,973**
Caribbean Regional			$ 19,000,000		$ 19,000,000	$ 1,500,000	$ 6,950,000	$ 14,850,000	$ -	$ 23,300,000	$ 1,500,000	$ 6,950,000	$ 14,850,000		$ 23,300,000	$ 1,500,000	$ 6,950,000	$ 13,741,400	$ -	$ 22,191,400
Central America Regional	NA					$ 1,025,000	$ 5,391,000	$ 6,171,000	$ -	$ 12,587,000	$ 1,025,000	$ 5,391,000	$ 6,171,000		$ 12,587,000	$ 1,025,000	$ 8,391,000	$ 12,198,000	$ -	$ 21,614,000
Dominican Republic	$ 500,000	$ 5,750,000	$ 11,000,000	$ -	$ 17,250,000	$ 500,000	$ 5,750,000	$ 9,250,000	$ -	$ 15,500,000	$ 500,000	$ 5,750,000	$ 9,250,000		$ 15,500,000	$ 500,000	$ 4,768,200	$ 3,231,800	$ -	$ 8,500,000
Guyana	$ 1,000,000		$ 17,758,500	$ 1,773,075	$ 20,531,575	$ 1,200,000	$ -	$ 16,525,215	$ 456,360	$ 18,181,575	$ 1,200,000	$ -	$ 13,525,215	$ 156,360	$ 14,881,575	$ 1,200,000	$ -	$ 10,525,215	$ 156,360	$ 11,881,575
Haiti	$ 1,000,000		$ 121,472,500	$ 8,061,513	$ 130,534,013	$ 2,000,000	$ -	$ 161,240,319	$ 852,679	$ 164,092,998	$ 2,000,000	$ -	$ 156,240,319	$ 302,679	$ 158,542,998	$ 2,000,000	-	$ 141,240,319	$ 302,679	$ 143,542,998
Grand Total	**$ 90,294,000**	**$ 123,410,000**	**$ 3,737,916,582**	**$ 208,037,122**	**$ 4,159,657,704**	**$ 92,619,000**	**$ 136,751,000**	**$ 3,840,885,981**	**$ 105,328,398**	**$ 4,175,584,379**	**$ 94,119,000**	**$ 137,751,000**	**$ 3,976,334,898**	**$ 97,796,203**	**$ 4,306,001,101**	**$ 93,919,000**	**$ 128,769,200**	**$ 3,257,988,251**	**$ 97,796,203**	**$ 3,578,472,654**

Table explanation: Includes all approved funding supporting activities found in PEPFAR Operational Plans, by country and funding source. This table includes funding from all funding sources. Note: Central Asia Regional and Central America Regional did not complete PEPFAR Operational Plans until FY 2010 and Burundi and Cameroon prepared their first PEPFAR Operational Plans in FY 2011.

Table 6: FY 2009 – FY 2012 Approved Funding in PEPFAR Operational Plans, by Country and Implementing Agency

	FY 2009							FY 2010							FY 2011							FY 2012						
Sum of Approved Funding in Millions	Implementing Agency						TOTAL	Implementing Agency						TOTAL	Implementing Agency						TOTAL	Implementing Agency						TOTAL
State Region, Operating Unit	DoD	DoL	HHS	Peace Corps	State	USAID		DoD	DOL	HHS	Peace Corps	State	USAID		DoD	DOL	HHS	Peace Corps	State	USAID		DoD	DOL	HHS	Peace Corps	State	USAID	
Africa	**$107.6**	**$0.7**	**$1,528.4**	**$19.8**	**$51.7**	**$2,084.8**	**$ 3,793.1**	**$105.0**	**$0.7**	**$1,492.1**	**$10.3**	**$61.3**	**$2,060.9**	**$3,730.2**	**$134.2**	**$0.2**	**$1,575.0**	**$14.2**	**$59.0**	**$2,092.7**	**$3,875.4**	**$ 84.0**	**$ 0.2**	**$ 1,535.5**	**$25.3**	**$ 48.7**	**$ 1,534.7**	**$ 3,223.9**
Angola	$ 0.8		$ 6.2			$ 10.0	$ 17.0	$ 1.3		$ 6.9			$ 9.5	$ 17.7	$ 2.0	$-	$ 5.8	$ -	$ -	$ 9.9	$ 17.7	$ 1.5	$ -	$ 6.1	$ -	$ -	$ 10.1	$ 17.7
Botswana	$ 3.1	$0.5	$ 70.3	$ 1.5	$ 1.5	$ 18.3	$ 95.1	$ 2.6	$0.4	$ 60.8	$ 1.6	$ 4.0	$ 17.7	$ 87.0	$ 2.7	$-	$ 61.3	$ 1.7	$ 2.8	$ 15.9	$ 84.4	$ 2.2	$ -	$ 54.0	$ 2.0	$ 1.6	$ 16.1	$ 75.9
Burundi	NA							NA							$ 0.2	$-	$ -	$ -	$ 0.1	$ 18.2	$ 18.5	$ 0.3	$ -	$ -	$ -	$ 0.1	$ 8.1	$ 8.5
Cameroon	NA							NA							$ -	$-	$ 16.9	$ 1.1	$ 1.3	$ 5.0	$ 24.3	$ 5.0	$ -	$ 8.3	$ 1.0	$ 1.0	$ 3.5	$ 14.3
Cote d'Ivoire	$ 0.4		$ 69.1		$ 0.0	$ 55.3	$ 124.8	$ 0.2		$ 66.5		$ 0.2	$ 52.2	$ 119.1	$ 0.2	$-	$ 55.8	$ -	$ -	$ 49.2	$ 105.2	$ 0.3	$ -	$ 66.7	$ -	$ -	$ 63.2	$ 130.2
Democratic Republic of Congo	$ 1.3		$ 10.0		$ 0.7	$ 21.1	$ 33.0	$ 1.4		$ 11.0		$ 0.4	$ 18.5	$ 31.3	$ 1.3	$-	$ 21.2	$ -	$ 0.4	$ 28.3	$ 51.3	$ -	$ -	$ 9.6	$ -	$ 0.6	$ 15.2	$ 25.4
Ethiopia	$ 2.7		$ 117.8	$ 2.5	$13.9	$ 209.1	$ 346.0	$ 1.9		$ 112.0		$15.3	$ 162.1	$ 291.3	$ 2.3	$-	$ 103.4	$ 1.0	$13.0	$ 173.2	$ 293.0	$ 0.6	$ -	$ 100.6	$ 2.2	$ 18.1	$ 63.6	$ 185.1
Ghana	$ 0.2		$ 2.7	$ 0.2	$ 0.1	$ 14.4	$ 17.5	$ 0.4		$ 2.9	$ 0.2	$ 0.2	$ 9.4	$ 13.0	$ 0.5	$-	$ 3.4	$ 0.3	$ 0.2	$ 10.6	$ 15.0	$ 0.3	$ -	$ 3.4	$ 0.3	$ 0.2	$ 10.8	$ 15.0
Kenya	$ 24.7		$ 177.2	$ 0.3	$ 9.6	$ 353.1	$ 565.0	$ 23.5		$ 166.2		$ 9.7	$ 348.7	$ 548.1	$ 23.7	$-	$ 166.1	$ 1.5	$ 0.6	$ 325.3	$ 517.3	$ 10.0	$ -	$ 200.4	$ 1.6	$ 1.3	$ 46.7	$ 260.0
Lesotho	$ 0.7		$ 8.5	$ 0.3	$ 0.7	$ 18.1	$ 28.3	$ 0.9		$ 9.6	$ 0.4	$ 0.8	$ 17.5	$ 29.2	$ 0.7	$-	$ 13.4	$ 0.4	$ 0.4	$ 19.4	$ 34.2	$ -	$ -	$ 7.3	$ 0.6	$ 0.4	$ 8.5	$ 16.8
Malawi	$ 1.2		$ 15.7	$ 0.5	$ 0.3	$ 28.1	$ 45.7	$ 0.3		$ 21.8	$ -	$ 0.3	$ 32.9	$ 55.3	$ 2.0	$-	$ 25.7	$ 0.7	$ 0.8	$ 35.8	$ 65.0	$ 0.1	$ -	$ 30.9	$ 1.7	$ 0.2	$ 37.1	$ 70.0
Mozambique	$ 4.4		$ 106.6	$ 1.4	$ 3.1	$ 137.5	$ 252.9	$ 3.2		$ 110.0	$ 1.1	$ 9.4	$ 145.5	$ 269.1	$ 5.9	$-	$ 116.9	$ 0.8	$ 2.7	$ 142.4	$ 268.8	$ -	$ -	$ 110.8	$ 1.8	$ 2.0	$ 116.5	$ 231.1
Namibia	$ 3.4		$ 52.9	$ 2.3	$ 1.7	$ 47.6	$ 107.8	$ 2.7		$ 52.0	$ 2.0	$ 0.6	$ 45.4	$ 102.6	$ 2.5	$-	$ 51.5	$ 1.7	$ 1.6	$ 45.3	$ 102.6	$ 2.4	$ -	$ 47.2	$ 1.5	$ 0.8	$ 38.4	$ 90.3
Nigeria	$ 11.0		$ 203.3		$ 0.6	$ 227.4	$ 442.3	$ 11.9		$ 192.3		$ 0.8	$ 254.1	$ 459.2	$ 20.2	$-	$ 225.1	$ -	$ 0.4	$ 242.9	$ 488.6	$ 14.9	$ -	$ 216.5	$ -	$ 0.5	$ 246.7	$ 478.6
Rwanda	$ 4.5		$ 49.0	$ 2.5	$ 0.4	$ 91.2	$ 147.6	$ 4.0		$ 40.7	$ 0.8	$ 0.4	$ 85.5	$ 131.4	$ 3.6	$-	$ 40.0	$ 0.9	$ 0.3	$ 70.6	$ 115.4	$ 3.3	$ -	$ 52.1	$ 1.6	$ 0.3	$ 48.2	$ 105.4
South Africa	$ 2.1		$ 244.3	$ 0.9	$ 2.2	$ 311.8	$ 561.3	$ 1.0		$ 241.5	$ 0.9	$ 2.2	$ 314.8	$ 560.4	$ 1.0	$-	$ 230.1	$ 1.0	$ 2.9	$ 314.0	$ 549.1	$ 2.7	$ -	$ 214.7	$ 2.4	$ 5.3	$ 298.7	$ 523.7
Sudan			$ 3.7			$ 5.1	$ 8.8			$ 4.2			$ 5.3	$ 9.5	$ 0.9	$-	$ 6.7	$ -	$ -	$ 6.9	$ 14.5	$ 1.4	$ -	$ 6.1	$ -	$ -	$ 7.1	$ 14.5
Swaziland	$ 4.1	$0.2	$ 8.8	$ 0.1	$ 0.9	$ 18.3	$ 32.5	$ 0.6	$0.3	$ 15.3	$ 0.2	$ 0.6	$ 20.7	$ 37.5	$ 0.6	$0.2	$ 20.0	$ 0.2	$17.8	$ 22.0	$ 60.8	$ -	$ 0.2	$ 17.2	$ 0.8	$ 0.7	$ 13.6	$ 32.5
Tanzania	$ 29.0		$ 134.4	$ 1.0	$10.5	$ 186.3	$ 361.2	$ 32.9		$ 136.7	$ 1.0	$10.7	$ 176.7	$ 358.0	$ 38.8	$-	$ 142.5	$ 1.0	$ 7.7	$ 167.2	$ 357.2	$ 14.5	$ -	$ 122.9	$ 2.0	$ 3.9	$ 146.3	$ 289.6
Uganda	$ 5.4		$ 134.2	$ 3.0	$ 2.6	$ 141.9	$ 287.1	$ 6.2		$ 126.7	$ 0.3	$ 3.6	$ 149.4	$ 286.3	$ 7.1	$-	$ 148.0	$ 1.4	$ 3.7	$ 163.3	$ 323.4	$ 10.7	$ -	$ 161.1	$ 2.2	$ 3.5	$ 120.8	$ 298.4
Zambia	$ 8.6		$ 101.4	$ 3.4	$ 2.9	$ 154.8	$ 271.1	$ 10.1	$ -	$ 101.8	$ 1.9	$ 2.0	$ 160.9	$ 276.7	$ 18.0	$-	$ 104.5	$ 0.7	$ 1.9	$ 181.6	$ 306.7	$ 13.9	$ -	$ 78.2	$ 3.7	$ 2.0	$ 151.8	$ 249.7
Zimbabwe			$ 12.5		$ 0.1	$ 35.4	$ 48.0			$ 13.4		$ 0.2	$ 33.9	$ 47.5	$ -	$-	$ 16.4	$ -	$ 0.3	$ 45.8	$ 62.5	$ -	$ -	$ 21.5	$ -	$ 6.3	$ 63.5	$ 91.2
East Asia and Pacific	**$ 1.5**	**$ -**	**$ 54.7**	**$ -**	**$ 2.5**	**$ 74.0**	**$ 132.7**	**$ 4.2**	**$ -**	**$ 54.3**	**$ -**	**$ 0.2**	**$ 86.2**	**$ 144.8**	**$ 3.9**	**$-**	**$ 47.6**	**$ -**	**$ -**	**$ 78.3**	**$ 129.8**	**$ -**	**$ -**	**$ 43.0**	**$0.04**	**$ 0.2**	**$ 58.8**	**$ 102.1**
Cambodia			$ 4.0			$ 14.1	$ 18.0			$ 4.5			$ 14.1	$ 18.5	$ -	$-	$ 4.5	$ -	$ -	$ 14.1	$ 18.5	$ -	$ -	$ 4.5	$ -	$ -	$ 10.6	$ 15.0
China			$ 4.4			$ 5.9	$ 10.3			$ 4.5			$ 5.5	$ 10.0	$ -	$-	$ 4.0	$ -	$ -	$ 4.0	$ 8.0	$ -	$ -	$ 4.3	$ -	$ -	$ 1.7	$ 6.0
Indonesia	$ 0.3					$ 8.8	$ 9.0	$ 0.3	$ -	$ -	$ -	$ -	$ 12.8	$ 13.0	$ 0.3	$-	$ -	$ -	$ -	$ 12.8	$ 13.0	$ -	$ -	$ -	$ -	$ -	$ 5.8	$ 5.8
Thailand	$ -		$ 4.3	$ -		$ 1.3	$ 5.5			$ 4.2			$ 1.3	$ 5.5	$ -	$-	$ 4.2	$ -	$ -	$ 1.3	$ 5.5	$ -	$ -	$ 4.2	$0.04	$ -	$ 1.2	$ 5.5
Vietnam	$ 1.3		$ 42.1		$ 2.5	$ 44.1	$ 89.9	$ 3.9		$ 41.1		$ 0.2	$ 52.6	$ 97.8	$ 3.7	$-	$ 35.0	$ -	$ -	$ 46.2	$ 84.8	$ -	$ -	$ 30.0	$ -	$ 0.2	$ 39.6	$ 69.8
Europe and Eurasia	**$ 0.3**	**$ -**	**$ 1.7**	**$ 0.2**	**$ -**	**$ 14.0**	**$ 16.2**	**$ -**	**$ -**	**$ 4.5**	**$ 0.3**	**$ -**	**$ 13.2**	**$ 18.0**	**$ 0.2**	**$-**	**$ 7.8**	**$ 0.3**	**$ -**	**$ 18.8**	**$ 27.2**	**$ -**	**$ -**	**$ 4.6**	**$ 0.4**	**$ -**	**$ 6.6**	**$ 11.6**
Russia			$ 1.3			$ 6.7	$ 8.0			$ 0.5			$ 5.5	$ 6.0	$ -	$-	$ 0.8	$ -	$ -	$ 4.2	$ 5.0	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Ukraine	$ 0.3		$ 0.4	$ 0.2		$ 7.3	$ 8.2	$ -		$ 4.0	$ 0.3		$ 7.7	$ 12.0	$ 0.2	$-	$ 7.0	$ 0.3	$ -	$ 14.6	$ 22.2	$ -	$ -	$ 4.6	$ 0.4		$ 6.6	$ 11.6
South and Central Asia	**$ 0.6**	**$0.2**	**$ 7.0**	**$ -**	**$ -**	**$ 22.6**	**$ 30.5**	**$ 0.6**	**$0.3**	**$ 15.6**	**$ 0.1**	**$ -**	**$ 32.2**	**$ 48.8**	**$ 0.1**	**$-**	**$ 16.4**	**$ 0.3**	**$ -**	**$ 32.2**	**$ 48.8**	**$ -**	**$ 0.2**	**$ 9.1**	**$ 0.1**	**$ -**	**$ 23.8**	**$ 33.2**
Central Asia Regional	NA									$ 6.9	$ 0.1	$ -	$ 8.8	$ 15.8	$ -	$-	$ 7.8	$ 0.3	$ -	$ 7.8	$ 15.8	$ -	$ -	1.6	$ 0.1	$ -	$ 3.4	$ 5.2
India	$ 0.6	$0.2	$ 7.0			$ 22.6	$ 30.5	$ 0.6	$0.3	$ 8.7			$ 23.4	$ 33.0	$ 0.1	$-	$ 8.6	$ -	$ -	$ 24.4	$ 33.0	$ -	$ 0.2	$ 7.5	$ -	$ -	$ 20.4	$ 28.0
Western Hemisphere	**$ 3.0**	**$0.2**	**$ 105.4**	**$ 1.2**	**$ 0.3**	**$ 77.2**	**$ 187.3**	**$ 3.6**	**$0.2**	**$ 100.0**	**$ 1.8**	**$15.8**	**$ 112.3**	**$ 233.7**	**$ 4.0**	**$0.2**	**$ 123.3**	**$ 1.8**	**$ 0.2**	**$ 95.3**	**$ 224.8**	**$ 0.8**	**$ 0.2**	**$ 112.9**	**$ 2.2**	**$ 0.6**	**$ 91.1**	**$ 207.7**
Caribbean Regional	$ 1.3		$ 12.0	$ 0.2	$ 0.2	$ 5.2	$ 19.0	$ 1.6		$ 11.1	$ 0.7	$ 0.7	$ 9.2	$ 23.3	$ 2.0	$-	$ 10.3	$ 0.5	$ 0.1	$ 10.4	$ 23.3	$ 0.3	$ -	$ 11.0	$ 0.5	$ 0.2	$ 10.3	$ 22.2
Central America Regional	NA							$ 0.7		$ 3.9	$ 0.1		$ 7.8	$ 12.6	$ 0.9	$-	$ 3.4	$ 0.1	$ -	$ 8.1	$ 12.6	$ 0.5	$ -	$ 4.5	$ 0.3	$ 0.2	$ 16.1	$ 21.6
Dominican Republic	$ 1.3		$ 5.9	$ 0.9		$ 9.2	$ 17.3	$ 1.0		$ 5.9	$ 0.9		$ 7.7	$ 15.5	$ 1.0	$-	$ 5.9	$ 1.0	$ -	$ 7.6	$ 15.5	$ -	$ -	$ 2.5	$ 1.3	$ -	$ 4.8	$ 8.5
Guyana	$ 0.3	$0.2	$ 8.4	$ 0.1	$ 0.1	$ 11.4	$ 20.5	$ 0.3	$0.2	$ 7.2	$ 0.1	$ 0.1	$ 10.4	$ 18.2	$ 0.2	$0.2	$ 6.9	$ 0.1	$ 0.1	$ 7.5	$ 14.9	$ -	$ 0.2	$ 5.9	$ 0.1	$ 0.2	$ 5.5	$ 11.9
Haiti			$ 79.1			$ 51.4	$ 130.5	$ -	$ -	$ 71.8	$ -	$15.1	$ 77.2	$ 164.1	$ -	$-	$ 96.7	$ -	$ 0.1	$ 61.8	$ 158.5	$ -	$ -	$ 89.1	$ -	$ -	$ 54.5	$ 143.5
Grand Total	**$112.9**	**$1.1**	**$1,697.3**	**$21.2**	**$54.5**	**$2,272.6**	**$ 4,159.7**	**$113.4**	**$1.2**	**$1,666.4**	**$12.7**	**$77.3**	**$2,304.7**	**$4,175.6**	**$142.4**	**$0.4**	**$1,770.0**	**$16.6**	**$59.3**	**$2,317.3**	**$4,306.0**	**$ 84.7**	**$ 0.5**	**$ 1,705.1**	**$28.0**	**$ 49.5**	**$ 1,715.0**	**$ 3,578.5**

Table explanation: Includes all approved funding supporting activities in PEPFAR countries and regions that prepare PEPFAR operational plans. The table displays funding by region, country, and by agency of implementation. Note: Central Asia Regional and Central America Regional did not complete PEPFAR Operational Plans until FY 2010 and Burundi and Cameroon prepared their first PEPFAR Operational Plans in FY 2011.

Table 7: FY 2009 – FY 2012 Headquarters Operational Plan Approved GHP-State Funding, Technical Oversight and Management, and FY 2014 Request

	GHP-State				
	FY 2009	FY 2010	FY 2011	FY 2012	FY 2014 Request
S/GAC, Oversight/Management	**$ 127,407,692**	**$ 145,838,332**	**$ 172,153,634**	**$ 174,096,000**	**$ 186,874,000**
Other Agency Costs	$ 113,407,692	$ 131,838,332	$ 158,181,634	$ 159,846,000	$ 172,374,000
OGAC Administrative Costs	$ 14,000,000	$ 14,000,000	$ 13,972,000	$ 14,250,000	$ 14,500,000

Table explanation: Presents a summary of all approved Technical Oversight and Management funds from the GHP-State account programmed through the Headquarters Operational Plan (HOP) from FY 2009 – FY 2012, and FY 2014 estimate. FY 2013 653a funding levels for the Technical Oversight and Management are "To Be Determined" pending final approval of the Office of the Director of Foreign Assistance (F).

Table 8: FY 2009 – FY 2012 PEPFAR Funding for International Partners, and FY 2014 request

International Partner	Fiscal Year				
	FY 2009	FY 2010	FY 2011	FY 2012	FY 2014 request
Global Fund	**$ 1,000,000,000**	**$ 1,050,000,000**	**$ 1,045,800,000**	**$ 1,300,000,000**	**$ 1,650,000,000**
GHP-State	$ 600,000,000	$ 750,000,000	$ 748,500,000	$ 1,300,000,000	$ 1,650,000,000
GHP-USAID	$ 100,000,000	$ -	$ -	$ -	$ -
HHS/NIH	$ 300,000,000	$ 300,000,000	$ 297,300,000	$ -	$ -
UNAIDS	**$ 40,000,000**	**$ 43,000,000**	**$ 42,914,000**	**$ 45,000,000**	**$ 45,000,000**
GHP-State	$ 40,000,000	$ 43,000,000	$ 42,914,000	$ 45,000,000	$ 45,000,000

Table explanation: Includes FY 2009 – FY 2012 funding as enacted by Congress and contributed to the Global Fund and to support the Joint United Nations Program on HIV/AIDS (UNAIDS) from all appropriations, and as requested in FY 2014.
Note: FY 2011 includes across-the-board and agency rescissions.

Global Fund and UNAIDS contributions appropriated in the FY 2014 appropriations bill will immediately (subject to statutory withholding requirements) be made available to support Global Fund and UNAIDS activities identified in the Congressional Budget Justification.

SECTION IV: COUNTRY OPERATIONAL PLAN EXECUTIVE SUMMARIES

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Angola

Country Context

Angola has a generalized HIV/AIDS epidemic with a national HIV prevalence of 2.1 percent for adults between the ages of 15-49 and approximately 230,000 people living with HIV. Those primarily impacted by the epidemic are women, youth, and key populations including female sex workers (FSW), truckers and other clients of FSW, and men who have sex with men (MSM). PEPFAR funded biological surveillance studies (BSS) are currently underway that will help estimate the HIV prevalence and behavioral patterns among prisoners, diamond miners, and long-distance truck drivers—groups thought to be most at risk in Angola. The prevalence rate along the border with Namibia is also high (7 to 9 percent). The main driver of the epidemic among the general population is considered to be heterosexual intercourse, and it is assumed that early sexual debut and concurrent sexual partnerships are common.

The five year Partnership Framework (PF) signed in 2009 between the U.S. government and the Republic of Angola drives the PEPFAR mission's technical assistance program and FY 2014 priorities. FY 2014 activities build on prior PEPFAR investments in HIV prevention, health systems strengthening, and strategic information. Some new activities will address recent requests for technical assistance made by the Government of Angola's Ministry of Health and The National Institute for the Fight Against AIDS (INLS). In accordance with Angola's Global Health Initiative strategy and PF, PEPFAR Angola's FY 2014 activities will continue to provide technical assistance as components such as human resources for health training and supervision of laboratory services, blood safety program, and key behavior change communication activities are increasingly moved to the national government and civil society. In response to recent discussions with stakeholders, PEPFAR has placed renewed focus on activities and technical assistance relating to prevention of mother to child transmission (PMTCT), supply chain support, and HIV surveillance in key populations.

Below is a chart of PEPFAR Angola's budget representing its major program areas.

Fiscal Year	Angola Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 6,280,000	37%	$ 400,000	2%	$ -	0%	$ 10,320,000	61%	$ 17,000,000
2010	$ 7,550,000	43%	$ 150,000	1%	$ -	0%	$ 10,000,000	56%	$ 17,700,000
2011	$ 8,035,000	45%	$ -	0%	$ -	0%	$ 9,665,000	55%	$ 17,700,000
2012	$ 6,788,740	38%	$ -	0%	$ -	0%	$ 10,911,260	62%	$ 17,700,000
Total 2009-2012	**$ 21,865,000**	**42%**	**$ 550,000**	**1%**	**$ -**	**0%**	**$ 29,985,000**	**57%**	**$ 52,400,000**
2014 (est)	**$ 6,058,312**	**35%**	**$ -**	**0%**	**$ -**	**0%**	**$ 11,270,337**	**65%**	**$ 17,328,649**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Angola	$ 525,000	$ 1,380,000	$ 3,335,000	$ -	$ -	$ -	$ -	$ 1,040,000	**$ 6,280,000**
2010	Angola	$ 700,000	$ 1,825,000	$ 3,675,000	$ 700,000	$ -	$ -	$ -	$ 650,000	**$ 7,550,000**
2011	Angola	$ 500,000	$ 850,000	$ 5,135,000	$ 700,000	$ -	$ -	$ -	$ 850,000	**$ 8,035,000**
2012	Angola	$ 500,000	$ 504,870	$ 4,633,870	$ 500,000	$ -	$ -	$ -	$ 650,000	**$ 6,788,740**
	Totals FY09-FY12	**$ 2,225,000**	**$ 4,559,870**	**$ 16,778,870**	**$ 1,900,000**	**$ -**	**$ -**	**$ -**	**$ 3,190,000**	**$ 28,653,740**
2014 (est)	Angola									**$ 6,058,312**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In the area of prevention, the PEPFAR Angola program focuses on preventing the sexual transmission of HIV, primarily through social marketing campaigns and condom distribution, supporting the scale-up of HIV counseling and testing, and addressing drivers of the HIV epidemic including gender inequality and key populations. In FY 2014, the PEPFAR team's prevention activities will also include an expansion in support of PMTCT.

- Condoms: FY 2014 comprehensive sexual prevention activities include social marketing messaging, linkages to other U.S. government-funded prevention programs such as voluntary counseling and testing, family planning and sexually transmitted infection (STI) management, and condom distribution to vulnerable groups, such as commercial sex workers, clients of sex workers, truckers, and men who have sex with men. Female

condoms are made available through clinical settings and the prevention activities with the military also include condom distribution too.

- Key populations: Programs for key populations will strive to increase access to key population-friendly health care services that either provide or link with voluntary counseling and testing (VCT), STI services, condoms, family planning/reproductive health, and access to HIV care and antiretroviral ARV drug services. Within the military, the focus will be on training and supervising peer educator HIV/AIDS activists and linking VCT and ARV treatment services. Interventions will target identified key population groups, including young women between the ages of 15 and 24, men at high risk between the ages of 30 and 34, female sex workers and their clients, men who have sex with men, and migrant populations, including transportation workers. In FY 2014, PEPFAR will lay the groundwork with a community survey in a new HIV/TB cross-border initiative in Cunene and border cities in hopes of launching a sustainable program that might include preventing infection, reducing the rates of infection through counseling and testing activities, reducing HIV/AIDS stigma through education, preventing HIV/TB co-infection that includes surveillance and quality laboratory testing, and referral of those infected with HIV and TB to the identified primary care facilities.

- Gender: Previous year activities helped strengthen governance and leadership systems to support implementation of a recently passed law against gender-based violence (GBV) within Angola law enforcement, legal system and related ministries such as the Ministry of Family and Women's Affairs. FY 2014 activities will continue to strengthen linkages with other PEPFAR prevention activities to improve how the government and civil society address gender issues, specific to the GBV legislation.

- Counseling and Testing: The expansion of HIV counseling and testing continues to be a Government of the Republic of Angola and INLS priority. FY 2014 counseling and testing activities will continue to provide support to the military and civilians. PEPFAR will support service expansion among key populations in facility and community-based settings along the transport corridor and other identified high-risk areas. U.S. government partners will contribute to the provision of HIV counseling and testing (HCT) across the range of community settings and mobilization to support HCT as well as activities linking HCT users to appropriate follow-on services such as linking them to options for treatment, care and support. Beginning in FY 2014, INLS has agreed to facilitate training for PEPFAR supported partner outreach workers to conduct testing in high-risk zones; thus, the U.S. government will do direct testing to help the national government reach its HCT goals.

- PMTCT: PEPFAR Angola has made small investments over several years working through implementing partners who provide technical assistance and not direct service delivery. The U.S. government's priority in PMTCT is to provide support to the national government-led expansion to 100 percent coverage of PMTCT at antenatal care (ANC) clinics in both Luanda and Huambo provinces. PEPFAR partners provide supervision and monitoring at these sites, assist with improved processes for following mother-infant pairs, and in-service training for health workers. FY 2014 activities will continue to support the INLS's efforts in decentralizing the roll-out of elimination of mother to child

transition by assisting in the training of nurses and doctors in improved HIV diagnosis and shift to Option B+ treatment.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Angola	$ 790,000	$ 3,685,000	$ 2,590,000	$ 3,255,000	**$ 10,320,000**
2010	Angola	$ 460,000	$ 1,655,000	$ 3,050,000	$ 4,835,000	**$ 10,000,000**
2011	Angola	$ 540,000	$ 500,000	$ 3,700,000	$ 4,925,000	**$ 9,665,000**
2012	Angola	$ 1,159,747	$ 1,256,457	$ 4,405,638	$ 4,089,418	**$ 10,911,260**
	Totals FY09-FY12	**$ 2,949,747**	**$ 7,096,457**	**$ 13,745,638**	**$ 17,104,418**	**$ 40,896,260**
2014 (est)	Angola					**$ 11,270,337**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In the area of systems strengthening, PEPFAR's overarching objective in FY 2014 is to improve human and institutional capacity within the MOH and non-governmental organizations (NGOs) so that they can effectively respond to the HIV epidemic. In support of this objective, the U.S. government will continue its collaboration with the Provincial Health Directorates in health systems strengthening, strategic information, and building a competent health workforce.

- Health Systems Strengthening: The health systems strengthening priorities for FY 2014 are: strengthening the supply chain, ensuring national blood safety, and ensuring a functional National Reference Laboratory. In FY 2014, PEPFAR Angola will intensify support and capacity building activities in the area of forecasting, quantification of ARVs, and coordinating at all levels of the supply chain—national, provincial, and health facility.

- Laboratory Strengthening: PEPFAR activities will continue to support labs with the World Health Organization (WHO) accreditation and strengthening their HIV testing capabilities. The PEPFAR team will ensure blood centers are operating under the same regulations and guidelines. In addition, PEPFAR will work with the Provincial Health Directorates to establish a policy for community health workers to provide follow up HIV care and support, and formulate a strategy to reinforce the referral system.

- Strategic Information: Strategic information priorities for FY 2014 surveillance activities include: continuing previous year efforts in training health care workers in behavioral surveillance methods; survey implementation and data collection; data analysis and dissemination; and results reporting to inform INLS policy and a strategic science based HIV response to key populations. Areas of focus include key populations, truck drivers, and prisoners. With regards to the military, PEPFAR will continue to work through their

partner to collect data about HIV prevalence and risk behaviors among Angolan military personnel in four locations throughout the country with the goal of gaining much-needed information to guide prevention efforts. In FY 2014, a PEPFAR partner, in conjunction with the Angolan Military, will conduct a follow up BSS survey to assess knowledge, attitude, and practice, with linkages to HIV testing. This study will gauge male circumcision, alcohol use and gender norms within the military.

- Human Resources for Health: In FY 2014, a cadre of trainers trained with previous U.S. government support will provide ongoing education and supervision for both health care workers and community health workers. PEPFAR will continue to use FY 2014 resources to build the capacity of a competent health workforce through pre-service education in epidemiology and laboratory management including trainers, assessors, lab mentors and 88 technicians. PEPFAR will also support training for blood service staff at the provincial level as well as medical personnel in areas of quality management of blood donors, materials handling, and testing for transmittable infections. In addition, PEPFAR will work with the Provincial Health Directorates to coordinate health care worker in-service training, and develop a policy and plan for HCT and ART task shifting to nurses and auxiliaries.

Country Engagement

Containing and reducing the relatively low-level prevalence of HIV/AIDS remains a priority for the national government. Promising opportunities from the rapidly-growing Angolan economy, combined with a recent decade of peace have resulted in movement in and out of Angola steadily increasing.

In terms of health policy, there will continue to be a significant shift towards decentralization in FY 2014, including a focus on human resources for health. The Angola government is moving to revitalize health services (especially primary health care) and increase the number of primary care providers. Due to a critical lack of physicians in the country and a lack of functioning medical schools, the government has increasingly recognized the importance of non-physicians in the health system. In response, the Ministry of Health (MOH) has taken important steps to allow certified nurses to provide ARV treatments to patients. The INLS has initiated campaigns to reduce maternal mortality linked with HIV and has made a commitment to prioritize the elimination of new HIV infections among children.

PEPFAR represents 17 percent of the funding budgeted by the MOH. The U.S. government team continues to play an influential role in the shaping of the national policy. The U.S. government team maintains ongoing dialogues with Angolan counterparts throughout the year. Informal discussions also involve key partners and other stakeholders in the community. The INLS has shown initiative in AIDS activities, but also looks to in-country partners such as the Joint United Nations Program on HIV/AIDS (UNAIDS), Global Fund and the PEPFAR team for guidance on the most recent trends in HIV activities so they can be applied in the Angolan context.

Botswana

Country Context

Botswana, a sparsely populated country with an estimated 21 million people, has one of the highest HIV prevalence rates in the world. The Botswana AIDS Impact Survey III (BAIS III) showed that the national HIV prevalence was 17.1 percent in 2004 and 17.6 percent in 2008 for persons above 18 months of age. In 2011, there were an estimated 350,000 Botswana (Batswana) living with HIV, with nearly 19,000 new infections. The HIV infection rate for persons with TB is 64 percent. An estimated 40 percent of deaths among persons living with HIV are due to TB.

The health partnership with Botswana has resulted in a clear record of success. HIV-associated mortality has been reduced by more than half since treatment became available, and the rate of new infections has declined. Botswana's blood safety, HIV treatment, and PMTCT programs are models for their coverage and quality of services. The percent of donated blood that is positive for HIV declined from 7.5 percent in 2003 to 1.0 percent in 2010. The rate of mother to child HIV transmission in Botswana has declined to less than 4 percent. As of October 2012, 200,511 patients were receiving antiretroviral treatment (ART) in Botswana. This represents 98.4 percent of those eligible using a CD4 standard of less than 350. PEPFAR Botswana's work will build upon past successes while filling critical gaps identified in the Partnership Framework, signed in 2010. FY 2014 activities represent the continuation of prior efforts focused on preventing new infections and caring for those affected by HIV.

Below is a chart of PEPFAR Botswana's budget representing its major program areas.

Fiscal Year	Botswana Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 33,543,986	35%	$ 18,719,643	20%	$ 16,686,196	18%	$ 26,175,333	28%	$ 95,125,158
2010	$ 26,989,599	31%	$ 14,577,235	17%	$ 12,280,742	14%	$ 33,172,582	38%	$ 87,020,158
2011	$ 27,265,561	32%	$ 15,799,059	19%	$ 9,073,641	11%	$ 32,238,448	38%	$ 84,376,709
2012	$ 23,615,377	31%	$ 14,289,718	19%	$ 6,331,168	8%	$ 31,697,699	42%	$ 75,933,962
Total 2009-2012	**$ 111,414,523**	**33%**	**$ 63,385,655**	**19%**	**$ 44,371,747**	**13%**	**$ 123,284,062**	**36%**	**$ 342,455,987**
2014 (est)	**$ 17,951,839**	**32%**	**$ 9,915,761**	**18%**	**$ 1,761,543**	**3%**	**$ 26,834,138**	**48%**	**$ 56,463,281**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Botswana	$ 4,707,985	$ 7,577,471	$ 6,262,455	$ 1,745,593	$ 1,191,042	$ -	$ 4,115,798	$ 7,943,642	**$ 33,543,986**
2010	Botswana	$ 3,380,700	$ 4,829,000	$ 6,301,250	$ 300,100	$ 643,449	$ -	$ 4,075,000	$ 7,460,100	**$ 26,989,599**
2011	Botswana	$ 3,420,048	$ 1,854,883	$ 5,782,537	$ 1,353,024	$ 700,000	$ -	$ 7,150,000	$ 7,005,069	**$ 27,265,561**
2012	Botswana	$ 3,154,603	$ 826,202	$ 3,813,884	$ 575,290	$ 362,790	$ -	$ 8,854,878	$ 6,027,730	**$ 23,615,377**
	Totals FY09-FY12	**$ 14,663,336**	**$ 15,087,556**	**$ 22,160,126**	**$ 3,974,007**	**$ 2,897,281**	**$ -**	**$24,195,676**	**$ 28,436,541**	**$ 111,414,523**
2014 (est)	Botswana									**$ 17,951,839**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Two of PEPFAR Botswana's key HIV prevention accomplishments in recent years include significant reduction of HIV transmission among newborns from HIV positive mothers and reduced medical transmission from unsafe injections and blood transfusions. The key priorities in FY 2014 include substantially increasing gender based violence (GBV) related programming, and transitioning the financing of the ARV components for the prevention of mother-to-child (PMTCT) program to full country ownership with ongoing technical assistance and monitoring provided by PEPFAR. PEPFAR Botswana is also seeking broader coverage of HIV Counseling and Testing (HCT), with greater emphasis on identifying and linking discordant couples to appropriate treatment and prevention services. These priorities are in close alignment with those of the Government of Botswana priorities outlined in the 2010 Partnership Framework, the National HIV Strategic Framework II (2010-2016), and the National Operational Plan (2011-2016).

Women in Botswana who experience GBV are 50 percent more likely to be infected with HIV than women in non-violent relationships. In the past, PEPFAR Botswana provided limited support to the Government of Burundi and civil society organizations to increase awareness of GBV issues. However, the August 2012 release of the Botswana Gender-based Violence Indicators Study revealed that GBV's scale and extent within Botswana were much greater than previously known. For example, over two-thirds of women in Botswana reported that they had been victims of GBV and 44 percent of men admitted to committing GBV. The study strongly underscores that GBV is a key driver of the country's HIV epidemic and an important area to strengthen. In response to the 2012 study, the PEPFAR team will substantially increase their FY 2014 GBV-related programming by integrating GBV into existing projects and developing new ones that will have a major impact preventing and mitigating GBV in Botswana.

Starting in FY 2014, PEPFAR Botswana will provide short term assistance to the MOH/HIV Counseling and Testing Unit as the provider-initiated counseling and testing, or the routine HCT program is transitioning from partner supported to government owned and managed. In

FY 2014 PEPFAR's Voluntary Counseling and Testing partner will expand its activities beyond service delivery and activities will place greater emphasis on identifying and linking discordant couples to appropriate treatment and prevention services.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Botswana	$ 8,292,500	$ 6,902,072	$ 1,491,624	**$ 16,686,196**
2010	Botswana	$ 7,367,000	$ 4,413,742	$ 500,000	**$ 12,280,742**
2011	Botswana	$ 5,816,395	$ 2,507,246	$ 750,000	**$ 9,073,641**
2012	Botswana	$ 4,550,588	$ 1,555,290	$ 225,290	**$ 6,331,168**
	Totals FY09-FY12	**$ 26,026,483**	**$ 15,378,350**	**$ 2,966,914**	**$ 44,371,747**
2014 (est)	Botswana				**$ 1,761,543**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, PEPFAR assistance in Botswana will continue to focus on strengthening the national HIV program through effective coordination and joint planning with the Government of Burundi and other implementing partners. Despite the exemplary response Botswana has pioneered, there have been significant challenges and the U.S. government will continue to assist the Government of Botswana to focus on human resources and infrastructure. The procurement and logistics of drugs, including ARVs and related commodity supplies remain a challenge. Since FY 2008, Supply Chain Management Systems (SCMS) began to work with Central Medical Stores , the Drug Registration Unit, and other relevant Government of Botswana organizations to improve the quality of these services.

The longer term plan is for PEPFAR Botswana to move to a technical assistance model with a limited budget to support external partners. This is a reflection of the strength of the Government of Botswana's HIV response. "Masa," a Setswana word meaning "a new dawn," was the name given to the program to signify the hope that ARVs offer to people living with HIV and AIDS. As of October 2012 the Masa treatment program now covers 200,511 patients who are receiving antiretroviral treatment (ART). This represents 98.4 percent of those eligible using a CD4 cell count standard of <350. PEPFAR direct funding for treatment is scheduled to decline in the next couple of years as the Government of Burundi takes on the financial responsibility of purchasing ARVs. PEPFAR would then focus treatment activities on providing technical assistance to the Government of Botswana.

The high TB/HIV co-infection rates in Botswana are such that TB is the leading cause of death among persons with HIV, accounting for approximately 40 percent of mortality. Currently integration of services for co-infection is of importance for both the national HIV and TB

programs. PEPFAR support will assist the Government of Botswana to implement isoniazid preventive therapy (IPT) (first-line medication in prevention and treatment of tuberculosis), infection control, intensified case finding, integration with HIV services, and monitoring and evaluation activities.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Botswana	$ 4,936,715	$ 1,060,900	$ 5,452,214	$ 7,269,814	**$ 18,719,643**
2010	Botswana	$ 4,531,350	$ 1,210,000	$ 3,614,325	$ 5,221,560	**$ 14,577,235**
2011	Botswana	$ 4,529,350	$ 460,000	$ 5,230,000	$ 5,579,709	**$ 15,799,059**
2012	Botswana	$ 3,707,111	$ 584,190	$ 5,472,073	$ 4,526,344	**$ 14,289,718**
	Totals FY09-FY12	**$ 17,704,526**	**$ 3,315,090**	**$ 19,768,612**	**$ 22,597,427**	**$ 63,385,655**
2014 (est)	Botswana					**$ 9,915,761**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

TB/HIV activities are jointly supported by African Comprehensive HIV/AIDS Partnerships (ACHAP), the World Health Organization (WHO), and the Global Fund (GF). The FY 2014 priority areas for care are TB include:

- Development of action plans for the "three I's" (Intensified Case Finding, Infection Control, and IPT) and early initiation of ART in HIV positive TB patients.
- Efforts to revamp the National Advisory Committee on TB/HIV to improve its role of policy oversight on TB/HIV prevention, treatment, care, and support.

For orphans and vulnerable children (OVC), the program's key priorities for FY 2014 include:

- Improving civil society organizations' capacity to work with OVC to provide good quality services especially in the areas of psychosocial support and integrated early childhood development;
- Increasing access of OVC and their families to livelihood opportunities;
- Supporting the Government of Botswana to implement guidelines and policies that address the needs of vulnerable children; and
- Strengthening of coordination, monitoring, and evaluation structures.

Through PEPFAR support, the national OVC program is currently working on developing a database to strengthen coordination efforts. The database will centralize data for OVC in one

place and will achieve efficiencies. The current electronic system captures orphans only. Vulnerable children are captured using a manual system.

Results of the IPT study in Botswana, which was partially supported by PEPFAR, influenced WHO recommendations for IPT in persons with HIV. Botswana was one of first countries to pilot the PRRR campaign using the PEPFAR platform to serve HIV+ women with screening for cervical cancer. Results of this pilot program which use the "See and Treat" approach for cervical cancer were presented at an international scientific meeting and have helped to persuade the Government of Botswana to approve this approach for use in Botswana.

Governance & Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Botswana	$ 5,854,615	$ 5,271,858	$ 9,049,764	$ 5,999,096	**$ 26,175,333**
2010	Botswana	$ 4,955,998	$ 4,171,000	$ 9,342,553	$ 14,703,031	**$ 33,172,582**
2011	Botswana	$ 5,079,709	$ 4,912,630	$ 8,884,078	$ 13,362,031	**$ 32,238,448**
2012	Botswana	$ 3,820,041	$ 5,990,857	$ 11,050,402	$ 10,836,399	**$ 31,697,699**
	Totals FY09-FY12	**$ 19,710,363**	**$ 20,346,345**	**$ 38,326,797**	**$ 44,900,557**	**$ 123,284,062**
2014 (est)	Botswana					**$ 26,843,138**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Botswana had one of the most developed public health systems in Africa with impressive successes in health indices until the early 1990s when HIV/AIDS became the most significant social and public health problem. The country has led an impressive response, but at a cost to the overall health system. The HIV epidemic has severely stressed the health system's foundation, negatively impacting it resources, non-HIV conditions and diseases, and quality of health care.

Previous PEPFAR funding was used for the development of the MOH's Integrated Health Service Plan: A strategy for Changing the Health Sector for a Healthy Botswana 2010-2020 (IHSP) which delineated services at each delivery level. The plan covered the six WHO health system building blocks and lays out the roadmap for a more equitable, effective, and efficient health sector to deliver quality health services.

In FY 2014, PEPFAR Botswana is focusing on supporting the country's transition to a post-emergency HIV response. Over the next four years, PEPFAR will support the implementation of critical health reforms included in the Integrated Health Service Plan 2010–2020, including:

- Institutional review and reorganization of health care delivery by strengthened District Health Management Teams (DHMT);

- Improving strategic planning, implementation, and monitoring of services;
- Implementing quality management structures and accreditation processes;
- Reviewing health financing and cost effectiveness; and
- Strengthening supply chain management systems for drugs and other medical commodities. The goal is fully functional DHMTs with authority and skills to manage all resources (human, financial, and other) and deliver quality services.

Country Engagement

PEPFAR Botswana is committed to a thoughtful and appropriate transitioning of responsibility for the HIV/AIDS service delivery programs to the Government of Burundi and moving towards greater country ownership. This approach is consistent with the PEPFAR "Blueprint for Creating an AIDS-free Generation." In this context, PEPFAR Botswana has embarked on a process to gradually transfer oversight and financial ownership of the Botswana treatment, PMTCT, blood safety and injection safety programs to the Government of Botswana in FY 2014. Ongoing technical assistance and monitoring will be supported by the PEPFAR team.

The goals and objectives outlined in the Botswana Partnership Framework (PF) are linked to Government of Botswana plans outlined in the National Development Plan 10 (NDP 10) and the Second National Strategic Framework for HIV and AIDS, 2009-2016. Many of the PEPFAR-supported objectives in these documents contain baselines, indicators, and targets, which were included in the National Operational Plan for HIV/AIDS. In addition to regular exchanges with senior Government of Botswana officials, including an extensive consultative process, PEPFAR has funded a position within the Ministry of Health (MOH) Office of Strategic Management to help its senior management address constraints.

Burundi

Country Context

Burundi faces a low-prevalence generalized HIV/AIDS epidemic, which continues to be a growing public health threat. National health information systems are weak and provide little reliable recent data on HIV/AIDS.

The 2010 Demographic and Health Survey (DHS) demonstrated that the HIV prevalence rate among adults between the ages of 15-49 years was 1.4 percent. The data suggested that women are almost twice as likely to be infected as men with a ratio of 1.7 to 1. While the rate of mother-to-child transmission (MTCT) has improved dramatically during the last decade, it remains high at 28 percent. In 2010, coverage of maternal anti-retroviral medicines was 37 percent in non-PEPFAR supported sites, and there were 2000 new infections in babies as a result of MTCT.

Although Burundi may be considered a low-prevalence generalized epidemic, there are specific key populations which demonstrate significantly higher prevalence rates. For example, a 2011 bio-behavioral survey showed that the HIV prevalence in female sex workers (FSW) is approximately 20 percent, with rural areas being adversely affected. Among men having sex with men (MSM) the rate was 2.4 and 3 percent within the male prisoner population.

The overarching goal of the PEPFAR program in Burundi for FY 2014 is to strengthen the capacity of the Burundian government, civil society, and the private sector to plan, deliver, monitor, and evaluate high-quality, sustainable HIV/AIDS prevention, care, and treatment services.

Since 2002, Burundi has developed three national HIV strategic plans (NSPs) with the objective of defining clear priorities to coordinate the interventions of various donors. The most recent NSP 2012-2016 was prepared with the technical assistance from PEPFAR and sets realistic targets for prevention, treatment, care and support. All U.S. government HIV/AIDS assistance is aligned with the national strategic plans.

PEPFAR Burundi will continue to work toward the elimination of MTCT. The Government of Burundi , represented by the Second Vice-President and the U.S. Ambassador to Burundi, launched the Global Plan towards the Elimination of New HIV Infections in Children and Keeping their Mothers Alive program. To accelerate the attainment of the goal, the Minister of Health established a PMTCT task force in charge of accelerating progress and results.

The PEPFAR Burundi program will also focus on improving service delivery and strengthening the health system in 2014. The PEPFAR Burundi program will continue to focus on reinforcing the combination of structural, biomedical, and behavioral interventions targeting FSW, MSM, mobile populations, truck drivers, and other important key populations. In addition, Burundi will take advantage of the results of the study on mapping and size estimation of MSM and FSW that will be implemented in 2013 to better program prevention activities to reduce new infections and increase access to care and treatment for those who need services.

In 2014, PEPFAR will continue to partner with the Global Fund (GF) to provide treatment in Burundi. PEPFAR's assistance will include targeted technical assistance to the various levels of the health system; from training and supervision of the health providers to the provision of home-based care and support services. More importantly, PEPFAR will work closely with the Government of Burundi and the GF to ensure that lifelong treatment needs generated from the PMTCT platform is assured over time.

Below is a table of PEPFAR Burundi's budget representing its major program areas.

Fiscal Year	Burundi Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
2010	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
2011	$ 13,596,759	73%	$ 1,429,171	8%	$ 825,707	4%	$ 2,648,363	14%	$ 18,500,000
2012	$ 3,624,800	43%	$ 1,517,785	18%	$ 910,944	11%	$ 2,446,471	29%	$ 8,500,000
Total 2009-2012	**$ 17,221,559**	**64%**	**$ 2,946,956**	**11%**	**$ 1,736,651**	**6%**	**$ 5,094,834**	**19%**	**$ 27,000,000**
2014 (est)	**$ 8,347,497**	**45%**	**$ 1,612,019**	**9%**	**$ 2,097,770**	**11%**	**$ 6,341,715**	**34%**	**$ 18,399,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Burundi did not complete a Country Operational Plan until FY 2011.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Burundi	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2010	Burundi	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2011	Burundi	$ 10,749,571	$ 875,000	$ 1,160,000	$ -	$ -	$ -	$ -	$ 812,188	**$ 13,596,759**
2012	Burundi	$ 816,375	$ 725,544	$ 1,186,956	$ -	$ -	$ -	$ -	$ 895,925	**$ 3,624,800**
	Totals FY09-FY12	**$ 11,565,946**	**$ 1,600,544**	**$ 2,346,956**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 1,708,113**	**$ 17,221,559**
2014 (est)	Burundi									**$ 8,347,497**

* Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Burundi did not complete a Country Operational Plan until FY 2011.

Based on increasing consensus, there is not one single set of behaviors or services that can effectively influence a long-term population-wide reduction in HIV incidence. The U.S.

government's response to HIV prevention in 2014 will be to continue to improve upon a combination prevention framework for key populations and the general population.

In FY 2014, PEPFAR Burundi will continue to scale-up PMTCT services in an additional four provinces reaching eight provinces that represent over 50% of the population of Burundi., PMTCT activities include sensitization for HIV counseling and testing (HCT), PMTCT trainings, prevention messaging integrated with family planning (FP), HCT during antenatal care (ANC), and antiretroviral treatment (ART) for HIV-positive mothers and infants.

Additional interventions will include linkages to nutrition and malaria care, and ongoing HIV prevention for HIV-negative mothers. Interventions such as referrals and access to care and treatment, FP, ART and breastfeeding guidance will provide prevention of transmission from mother-to-child for HIV-positive pregnant women and provide care and treatment as necessary for their children and families.

In FY 2014, PEPFAR Burundi will also scale up prevention interventions targeting key populations through the current and expanded PEPFAR programs, which will include the following activities:

- Community-based outreach activities through peer educators, discussion/support groups providing targeted information, education and communication (IEC) materials in order to increase their knowledge on HIV/AIDS, awareness on using condoms and uptake of voluntary testing and counseling (HCT) services and STI treatment at primary health care clinics where these services are available. PEPFAR is working with health clinic staff to ensure continued reductions in stigma and discrimination towards key populations;
- Condoms and condom-compatible lubricants will be readily available at hotspots identified in urban centers through trained peer educators;
- FSW and MSM benefiting from community-based outreach will be referred to health facilities for HIV counseling and testing. PEPFAR also supports the strengthening of a "case-finding" approach that emphasizes mobile testing to bridge the gap between clients and services;
- An active referral and follow-up system to health care and ART will be defined and implemented in order to increase access to treatment and care for FSW and MSM (pre-ART, ART, TB/HIV screening and treatment). This will be done through training of outreach workers, building MSM's trust in local HIV prevention and care programs, and facilitating linkages and referrals to friendly HIV prevention and care programs;
- FP services will be offered to FSW of childbearing age (family planning products purchased by the United Nations Population Fund);
- Advocacy activities aiming to set up an enabling environment (non-discriminatory and responsive) for access to prevention, treatment, and care for FSW and MSM will be conducted and will be focused on health care providers, justice officers, and community leaders. This will be achieved through advocacy trainings and campaigns aiming to raise awareness of the issue of access to HIV/AIDS services and reducing stigma and discrimination;
- Managerial and programmatic capacity for the civil society organizations will be reinforced to allow for better management of the activities targeting FSW and MSM.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Burundi	$ -	$ -	$ -	**$ -**
2010	Burundi	$ -	$ -	$ -	**$ -**
2011	Burundi	$ 50,000	$ 445,707	$ 330,000	**$ 825,707**
2012	Burundi	$ 50,000	$ 500,688	$ 360,256	**$ 910,944**
	Totals FY09-FY11	**$ 100,000**	**$ 946,395**	**$ 690,256**	**$ 1,736,651**
2014 (est)	Burundi				**$ 2,097,770**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Burundi did not complete a Country Operational Plan until FY 2011.

In FY 2014, the PEPFAR Burundi program will continue to support multiple aspects of pediatric and adult treatment with the exception of procurement of ARVs. The PEPFAR program will continue to work closely with the GF, the major ARV procurer in Burundi, to maximize resources in support of HIV positive persons. Treatment support will include training of the health providers in adult and pediatric treatment and care and support. The U.S. government will assist in providing laboratory equipment for hematology and biochemistry for biological follow-up of people living with HIV/AIDS. It will also supply CD4 count machines and all the reagents used in the biological follow-up of people under ART. All the laboratory technical assistance and capacity building activities will be carried out in strict compliance with standards and procedures established by the Minister of Public Health and Fight Against AIDS.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Burundi	$ -	$ -	$ -	$ -	**$ -**
2010	Burundi	$ -	$ -	$ -	$ -	**$ -**
2011	Burundi	$ 843,171	$ -	$ -	$ 586,000	**$ 1,429,171**
2012	Burundi	$ 901,529	$ -	$ -	$ 616,256	**$ 1,517,785**
	Totals FY09-FY12	**$ 1,744,700**	**$ -**	**$ -**	**$ 1,202,256**	**$ 2,946,956**
2014 (est)	Burundi					**$ 1,612,019**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Burundi did not complete a Country Operational Plan until FY 2011.

In FY 2014, care will focus on an integrated approach to services including HIV/TB co-infection. In FY 2014, the PEPFAR program will continue to complement the Global Fund's TB work by ensuring systematic TB screening among HIV positive people and in reinforcing the cross-referral system between HIV/AIDS and TB settings wherever indicated. HIV/TB co-infection rate in Burundi exceeds 20 percent and TB is the common opportunistic infection (OI) among people living with HIV/AIDS (PLHIV). The PEPFAR program will continue to focus on integrated service delivery by leveraging the ANC platform for PMTCT, FP, malaria in pregnancy, and emergency obstetric and neonatal care; and integrating health services into other health and non-health resources and programs (e.g., income generation, water and sanitation, and food and nutrition).

For OVC in FY 2014, the PEPFAR Burundi program will continue to provide a family-centered care approach using home-based care providers to identify and provide care and support for OVC. The U.S. government will continue to collaborate with other programs and donors, such as Food for Peace, the United National High Commission on Refugees (UNHCR), and United Nations Children's Fund (UNICEF), to increase coverage and strengthen support for OVC activities, including in the policy areas of legal support, and domestic violence reduction and mitigation (including trafficking).

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Burundi	$ -	$ -	$ -	$ -	**$ -**
2010	Burundi	$ -	$ -	$ -	$ -	**$ -**
2011	Burundi	$ -	$ 500,000	$ 1,050,000	$ 1,098,363	**$ 2,648,363**
2012	Burundi	$ -	$ 537,008	$ 1,128,700	$ 780,763	**$ 2,446,471**
	Totals FY09-FY12	**$ -**	**$ 1,037,008**	**$ 2,178,700**	**$ 1,879,126**	**$ 5,094,834**
2014 (est)	Burundi					**$ 6,341,715**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Burundi did not complete a Country Operational Plan until FY 2011.

In 2014, the U.S. government will support Burundi in addressing supply chain design, performance, and planning in order to adequately support the provision of HIV services. Additionally to maintain quality HIV services, PEPFAR support will include training new healthcare workers and technical assistance in curriculum design and development.

Country Engagement

The U.S. government assistance in HIV/AIDS is aligned with the national strategic plan and regular consultations with the government of Burundi are frequently held. With technical assistance provided by PEPFAR and other donors in early 2011, the National AIDS Commission (NAC) conducted a review of the national strategic plan to fight AIDS (2007-2011) which resulted in a new Strategic plan for 2012-2016. The latter inspired the new Health Development Plan 2011-2015 prepared by the MOHA and its partners. The National Health Development Plan itself draws from the National Poverty Reduction Strategy Paper and the Vision 2025 for Burundi. In October 2011, the second Vice-President, the Minister of Public Health and Fight Against AIDS, and the U.S. Ambassador to Burundi launched the Global Plan toward Elimination of HIV in Children and Keeping their Mothers Alive. To concretize the plan, a technical PMTCT working group that meets monthly was appointed by the Minister.

In 2014, the U.S. government will continue to capitalize on the Government of Burundi's high level of ownership and commitment to fighting HIV/AIDS to build an effective, mutually accountable partnership aimed at a country-led response. This paradigm aligns with the Global Health Initiative (GHI), which places an emphasis on effective, efficient, and country-led platforms for the sustainable delivery of essential services and public health programs.

Specifically, the continuing strategy in 2014 enables the U.S. government to support the Government of Burundi in implementing the Burundi HIV/AIDS NSP, National Health Development Plan, and Poverty Reduction Strategy by:

- Improving access to high-quality HIV/AIDS prevention and care services;
- Decentralizing HIV/AIDS services especially PMTCT services;
- Building the capacity of civil society organizations to provide direct HIV/AIDS services;
- Improving the performance of the national health system.

Burundi is still far from being able to allocate sufficient internal resources to cover gaps in HIV services. MOHA has advocated for increased HIV/AIDS funding of $10 million from the national budget in addition to $3 million already budgeted. When the World Bank ended their five year project with the National AIDS Council in 2011, the staff salaries were picked up by the Government of Burundi. At the request of the Government of Burundi, the U.S. government is funding an organizational management specialist group to restructure and build the capacity and human resources of the department of HIV/AIDS at the MOHA to better manage and coordinate their division. In 2014 PEPFAR will assist the Government of Burundi to roll-out the recommendations. The GF is a key player in the health sector and provides a significant share of funding to combat HIV/AIDS, TB, and malaria in Burundi. The U.S. government is currently a voting member on the Global Fund Country Coordinating Mechanism (CCM) and is the coordinator of the technical committee of the CCM in charge of the development of proposals. In 2014, the PEPFAR program will be working closely with the GF to make sure that necessary synergies are established and efforts to avoid duplication are successful. The PEPFAR Burundi team will continue to work closely with the East Africa Regional Global Fund Liaison based in Nairobi to provide support to GF activities in Burundi.

Cameroon

Country Context

Cameroon is a lower-middle income country with a population of 20 million people, representing over 275 ethnic groups. Cameroon's epidemiological profile is dominated by communicable diseases such as malaria and HIV (prevalence of 4.3 percent). Maternal mortality is estimated at 782 per 100,000 live births, while the under-five mortality rate is estimated at 122 per 1,000 live births. Funding for health is approximately 5 percent of the 2013 National budget. In 2010, private spending (out of pocket) accounted for 70.4 percent of total health. According to a World Bank report in 2012, government funds covered 16.4 percent of total expenditures on health. The significant financial burden on households to finance health care consequently affects access to and use of health services in Cameroon.

Despite the recent reported decrease in the HIV/AIDS prevalence to 4.3 percent, Cameroon remains on the list of countries with the highest overall HIV prevalence in West and Central Africa. Similar drops in prevalence have been observed in pockets of hyper-endemicity, including the military (6 percent) and pregnant women (7. 3 percent). Prevalence remains relatively high among long-distance truck drivers (16.2 percent); men who have sex with men (MSM) (38 percent); and female commercial sex workers (CSW) (36 percent). There is also a marked disparity in HIV rates between women and men: women remain most affected by the pandemic with 5.6 percent prevalence against 2.9 percent for men. The Government of the Republic of Cameroon estimated that there were approximately 500,000 people living with HIV (PLHIV) in 2012, among which 233,966 were eligible for antiretroviral treatment (ART). At the end of December 2012, the government placed 121,000 people living with HIV/AIDS (PLHIV) on ART, representing 52 percent coverage.

In 2012, the U.S. government mission in Cameroon submitted its first Global Health Initiative (GHI) Strategy, which seeks to improve the health of Cameroonians by reducing the incidence of HIV and other communicable diseases, to decrease child and maternal mortality rates, and to strengthen health systems in Cameroon. PEPFAR Cameroon's interventions fit well into the GHI principles and allow PEPFAR Cameroon to plan and implement activities in support of key priorities.

PEPFAR activities in FY 2014 will continue to contribute to Cameroon's progress towards the GHI Strategy results, including improved quality of and accessibility to health services, adoption of health-friendly behaviors, and improved coordination and institutional strengthening. PEPFAR will leverage other existing programs, including the Centers for Disease Control and Prevention's (CDC) Central African Field Epidemiology and Laboratory Training Program (FELTP) and the USAID Emerging Pandemic Threats (EPT) and Neglected Tropical Disease Control (NTD) programs.

In FY 2014, PEPFAR Cameroon plans to strengthen its prevention and care programs while working with the Government of the Republic of Cameroon and the Global Fund to expand treatment services. PEPFAR activities for FY 2014 include:

- Support to the Government of the Republic of Cameroon to implement and scale up PMTCT in four of Cameroon's ten regions (Center, Littoral, Northwest, and Southwest);
- Increased prevention programming for key populations, military populations, long-distance truck drivers, and young women aged 15-24. This includes community outreach through peer educators recruited from within targeted populations, HIV Counseling and Testing (HCT) at health facilities and through mobile clinics;
- Care and support to children affected by HIV/AIDS;
- Ensuring a safe and reliable blood supply system; and
- Health Systems Strengthening (HSS) with particular focus on governance, laboratory quality management systems, strategic information, human resources for health, and pharmaceutical management systems.

Below is a chart of PEPFAR Cameroon's budget representing its major program areas.

Fiscal Year	Cameroon Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
2010	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
2011	$ 15,649,433	65%	$ 1,409,012	6%	$ 11,491	< 1%	$ 7,180,064	30%	$ 24,250,000
2012	$ 6,089,111	43%	$ 1,107,751	8%	$ -	< 1%	$ 7,053,138	49%	$ 14,250,000
Total 2009-2012	**$ 21,738,544**	**56%**	**$ 2,516,763**	**7%**	**$ 11,491**	**< 1%**	**$ 14,233,202**	**37%**	**$ 38,500,000**
2014 (est)	**$ 14,131,067**	**55%**	**$ 2,380,098**	**9%**	**$ 139,263**	**1%**	**$ 8,884,572**	**35%**	**$ 25,535,000**

*Totals include planned funding for all accounts.
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*** Cameroon did not complete a Country Operational Plan until FY 2011.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Cameroon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2010	Cameroon	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2011	Cameroon	$ 14,002,109	$ 190,440	$ 545,945	$ 757,000	$ -	$ -	$ -	$ 153,939	**$ 15,649,433**
2012	Cameroon	$ 3,574,366		$ 1,322,356	$ 754,500				$ 437,889	**$ 6,089,111**
	Totals FY09-FY12	**$ 14,002,109**	**$ 190,440**	**$ 545,945**	**$ 757,000**	**$ -**	**$ -**	**$ -**	**$ 153,939**	**$ 15,649,433**
2014 (est)	Cameroon									$ 14,131,067

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Cameroon did not complete a Country Operational Plan until FY 2011.

In FY 2014, PEPFAR will focus both prevention and treatment efforts on the transition to Option B+ (lifelong treatment of all pregnant women) in response to the recent interagency task team's PMTCT recommendations and the government's declaration to shift to Option B+.

HIV-prevention interventions constitute a critical component of PEPFAR Cameroon's program with a special focus on HIV prevention in populations identified as key drivers of the pandemic according to the HIV/AIDS National Strategic Plan (NSP) 2011-2015. Key interventions in FY 2014 will include community outreach through peer educators recruited from within target populations, HCT at health facilities and through mobile clinics, psychosocial support, condom and lubricants distribution, and economic strengthening activities.

Providing key populations with improved access to HIV prevention and treatment services remains a critical priority for PEPFAR Cameroon. PEPFAR has implemented a prevention program targeted at this group with an array of entry points. To ensure adequate data availability for programming, PEPFAR has embarked on a robust implementation science agenda with the aim of understanding the epidemic profile of key populations through data triangulation (comparing against national estimates); mapping of HIV prevention services; and improved population estimates for MSM and CSW in Cameroon. PEPFAR plans to use the findings of these studies to scale up comprehensive prevention, care, and treatment services for hard-to-reach groups through wider geographic coverage and improving linkages to treatment for PLHIV.

In FY 2014, PEPFAR will also continue to support the creation of a national blood transfusion program, including five national blood transfusion centers to ensure blood is screened for HIV. Community-based activities that link pregnant women to facilities with access to safe blood will directly contribute to improvements in maternal mortality (hemorrhages currently account for 40 percent of maternal mortality). PEPFAR will strive to increase the supply of blood that is safe by using standardized procedures that include donor-screening protocols, a self-assessment questionnaire, and new national policies and guidelines for blood safety.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Cameroon	$ -	$ -	$ -	**$ -**
2010	Cameroon	$ -	$ -	$ -	**$ -**
2011	Cameroon	$ -	$ 11,491	$ -	**$ 11,491**
2012	Cameroon	$ -	$ -	$ -	**$ -**
	Totals FY09-FY12	**$ -**	**$ 11,491**	**$ -**	**$ 11,491**
2014 (est)	Cameroon				**$ 139,263**

*Totals include planned funding for all accounts.
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*** Cameroon did not complete a Country Operational Plan until FY 2011.

The trajectory for 2014 is for PEPFAR Cameroon to work with the Government of the Republic of Cameroon and the Global Fund to expand into treatment. These plans are in line with Government of the Republic of Cameroon's HIV/AIDS NSP 2011-2015, the GHI Strategy, and the PEPFAR Blueprint. In FY 2014, PEPFAR Cameroon will continue supporting interventions to scale up high-quality PMTCT activities through a strategic regional approach in support of the government's push for virtual elimination of mother-to-child transmission by 2015.

Specifically, PEPFAR Cameroon supports integration of PMTCT into maternal, neonatal and child (MNCH) services, including the development of a national MNCH training curriculum and the roll out of training on PMTCT integration. PEPFAR Cameroon will provide technical support to the government's move towards Option B+ through development of a plan to be based on a national task shifting document; development of a national training plan for nurses to implement Option B+; and evaluation of an Option B+ strategy. In doing so, PEPFAR will contribute to updating a national Option B+ curriculum; roll out a national training plan; and progressively scale up Option B+.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Cameroon	$ -	$ -	$ -	$ -	**$ -**
2010	Cameroon	$ -	$ -	$ -	$ -	**$ -**
2011	Cameroon	$ 271,846	$ 607,166	$ -	$ 530,000	**$ 1,409,012**
2012	Cameroon	$ 255,248	$ 418,000		$ 434,503	**$ 1,107,751**
	Totals FY09-FY12	**$ 527,094**	**$ 1,025,166**	**$ -**	**$ 964,503**	**$ 2,516,763**
2014 (est)	Cameroon					**$ 2,380,098**

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*** Cameroon did not complete a Country Operational Plan until FY 2011

In FY 2014, PEPFAR's support to Orphans and Vulnerable Children (OVC) will provide support to Cameroon government and to local organizations to expand access to a range of quality services for OVC and their caregivers to optimize the continuum of prevention, care and treatment. Key services will include home visits, social protection, child protection, psychosocial support, health and nutrition provision, and the economic empowerment of their families. PEPFAR efforts collectively will achieve approximately 30 percent OVC coverage. As the U.S. government in Cameroon moves toward meeting its OVC programmatic requirements, PEPFAR's support to children affected by AIDS will include a combination of structural and service delivery interventions focused on supporting the Government of the Republic of Cameroon to meet its targets of extending coverage to 55 percent of OVC and their families in 2011-2015. In close collaboration with UNICEF, PEPFAR will continue to provide technical assistance to the Government of the Republic of Cameroon on OVC systems strengthening, including implementation of a sound monitoring and evaluation system. The U.S. government will also build the capacity of local Community-Based Organizations (CBO) to provide comprehensive care and support services to OVC in line with PEPFAR's new OVC programming guidance.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Cameroon	$ -	$ -	$ -	$ -	**$ -**
2010	Cameroon	$ -	$ -	$ -	$ -	**$ -**
2011	Cameroon	$ 1,970,671	$ 672,176	$ 1,658,029	$ 2,879,188	**$ 7,180,064**
2012	Cameroon	$ 2,214,933	$ 734,044	$ 898,865	$ 3,205,296	**$ 7,053,138**
	Totals FY09-FY12	**$ 4,185,604**	**$ 1,406,220**	**$ 2,556,894**	**$ 6,084,484**	**$ 14,233,202**
2014 (est)	Cameroon					**$ 8,884,572**

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*** Cameroon did not complete a Country Operational Plan until FY 2011

In FY 2014, PEPFAR aims to strengthen those functions of the health system that must work better for PEPFAR Cameroon's interventions to succeed. Planned activities in the cross-cutting areas of supply chain management, laboratory systems strengthening, strategic information, and training in leadership and good governance, are designed to produce strategic, targeted, and sustainable improvements in Cameroon's health system. PEPFAR Cameroon will support a cascade of training activities to district and community levels in order to support the government's decentralization goals.

PEPFAR Cameroon will employ a range of methods to support health systems strengthening, including:

- Staff placement within the Ministry of Public Health for on-site technical assistance;
- Review of curricula to support pre-service trainings for health personnel;
- Support creation of a National Public Health Laboratory and continue to improve the quality of laboratory services within public health facilities and military hospitals;
- Development of a national Health Management Information System beginning with PMTCT and eventually expanding to the other program areas; and
- Working with stakeholders to improve health commodities procurement and supply chain management systems and to ensure availability and access to essential medicines and services.

PEPFAR will also focus on improving country ownership and accountability, including supporting local advocacy efforts for increased public health spending. Health diplomacy efforts with be aligned with accountability in the health care sector together with growing diplomatic engagement to address corruption, promote governance, and improve public financial management.

Country Engagement

To improve country ownership and engagement in Cameroon, PEPFAR's long-term goals are to foster political ownership and the capacity to plan, oversee, and monitor HIV/AIDS programs and national response. PEPFAR Cameroon will advocate for increased public spending on health. Specifically, the Government of the Republic of Cameroon should increase show progress in increasing health sector spending to 15 percent of the national budget in order to meet its commitment within the framework of the Abuja Declaration on HIV/AIDS, Tuberculosis, and other related Infectious Diseases and the Millennium Development Goals. PEPFAR will support the government to continually increase mutual accountability, including financial management of health resources. PEPFAR Cameroon will support this by providing support for broader efforts to improve public financial management; providing technical assistance through inter-agency grant delivery mechanisms; and seeking to maximize on carryover benefits from Global Fund-related technical assistance. PEPFAR Cameroon will also provide assistance to civil society structures that constructively monitor public health spending and delivery. Furthermore PEPFAR Cameroon will support the government to improve capacity, human resources, and institutional strengths of the health system based on an assessment of areas where capacity is needed. PEPFAR Cameroon has made efforts to expand the quantity and skills of health care workers. This includes assisting the Ministry of Public Health to improve its curriculum for midwifery training and providing technical assistance on the management and distribution of pharmaceuticals to pharmaceutical managers and community dispensers.

Côte d'Ivoire

Country Context

Côte d'Ivoire is returning to stability after more than 10 years of civil unrest that divided the country, impoverished the population, decimated health and social services, and culminated in a six-month political and military standoff that brought the country to a virtual halt. PEPFAR Côte d'Ivoire is working with the Government of Côte d'Ivoire to finalize the 2012 Demographic and Health Survey (DHS) report, and to conduct data verification and secondary analyses. Preliminary analyses comparing national AIDS Indicator Survey (AIS) findings from 2005 with DHS 2012 data indicate that the HIV/AIDS epidemic in Côte d'Ivoire has changed in gender, age, and geographic distribution. HIV prevalence among adults decreased from 4.7 percent in 2005 to 3.7 percent in 2012, placing Côte d'Ivoire on par with Nigeria as West Africa's highest-prevalence countries. HIV prevalence among females declined from 6.4 percent to 4.6 percent, still much higher prevalence than among males, which remained almost unchanged at 2.7 percent. Prevalence dropped dramatically among women ages 30-34 (from 14.9 percent to 6.8 percent) and increased significantly among older men (from 5.9 percent to 7.8 percent among men ages 40-49, reaching 9.0 percent among men ages 50-59).

Adult prevalence remains lower among more educated women and marginally higher among adults in the highest wealth quintile. Geographically, HIV prevalence remains highest (5.1 percent) in Abidjan and high (4.3 percent) in the Southwest, but other higher-prevalence zones have shifted to the Center-North (4. 4 percent) and the West (3.6 percent), where civil and ethnic conflict resulted in displaced populations, disrupted social networks, and increased rates of gender-based violence (GBV), including rape (Human Rights Watch, 2011).

From other available data, the epidemic appears to be driven by early sexual debut, multiple and concurrent sexual partnerships, transactional and inter-generational sex, weak knowledge about HIV, and low condom use. Key populations include sex workers and men who have sex with men (MSM); data from a recent study of MSM in Abidjan (SHARM 2012) indicate an HIV prevalence of 18 percent. Gender inequality and gender-based violence (GBV) heighten HIV risk across all socio-economic and cultural backgrounds.

In FY 2014, the PEPFAR program in Côte d'Ivoire will focus on treatment and prevention of mother-to-child transmission (PMTCT), health systems strengthening, and directing the prevention program towards key populations. The top priorities for FY 2014 include assuring that the retention rate for patients on anti-retroviral treatment (ART) in the treatment and PMTCT programs remains at 80 percent over a twelve-month period. PEPFAR Côte d'Ivoire will also continue to improve the supply chain management system and tracking of anti-retrovirals (ARVs), align the prevention portfolio with the new DHS data, and improve the quality of key care and support services for adults and children including tuberculosis (TB) diagnosis and care, nutritional support, economic strengthening for people living with HIV/AIDS (PLHIV), orphans and vulnerable children (OVC), and their families (especially women and girls), and positive health, dignity, and prevention (PHDP) activities, including HIV/TB

prevention, testing and care, WASH (water, sanitation, and hygiene), and adherence/risk reduction activities for PLHIV and their partners.

Below is a table of PEPFAR Côte d'Ivoire's budget representing its major program areas.

Fiscal Year	Cote d'Ivoire Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 32,835,012	26%	$ 21,973,368	18%	$ 35,310,809	28%	$ 34,713,223	28%	$ 124,832,412
2010	$ 32,563,000	27%	$ 23,536,088	20%	$ 36,295,257	30%	$ 26,732,814	22%	$ 119,127,159
2011	$ 25,398,000	24%	$ 23,715,308	23%	$ 41,812,000	40%	$ 14,255,000	14%	$ 105,180,308
2012	$ 29,345,521	23%	$ 21,915,001	17%	$ 47,911,014	37%	$ 31,008,772	24%	$ 130,180,308
Total 2009-2012	**$ 120,141,533**	**25%**	**$ 91,139,765**	**19%**	**$ 161,329,080**	**34%**	**$ 106,709,809**	**22%**	**$ 479,320,187**
2014 (est)	**$ 29,531,099**	**23%**	**$ 26,874,050**	**21%**	**$ 45,150,994**	**36%**	**$ 24,870,857**	**20%**	**$ 126,427,000**

*Totals include planned funding for all accounts.
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Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Cote d'Ivoire	$ 6,590,000	$ 6,384,683	$ 6,372,000	$ 4,550,000	$ 2,096,851	$ -	$ -	$ 6,841,478	**$ 32,835,012**
2010	Cote d'Ivoire	$ 7,081,000	$ 5,810,000	$ 6,575,000	$ 3,750,000	$ 1,473,000	$ -	$ -	$ 7,874,000	**$ 32,563,000**
2011	Cote d'Ivoire	$ 7,417,000	$ 3,696,000	$ 5,195,000	$ 2,325,000	$ 400,000	$ -	$ -	$ 6,365,000	**$ 25,398,000**
2012	Cote d'Ivoire	$ 8,103,574	$ 3,508,199	$ 7,363,015	$ 2,893,875	$ 515,529	$ -	$ -	$ 6,961,329	**$ 29,345,521**
	Totals FY09-FY12	**$ 29,191,574**	**$ 19,398,882**	**$ 25,505,015**	**$ 13,518,875**	**$ 4,485,380**	**$ -**	**$ -**	**$ 28,041,807**	**$ 120,141,533**
2014 (est)	Cote d'Ivoire									**$ 29,531,099**

*Totals include planned funding for all accounts.
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In FY 2014, PEPFAR Côte d'Ivoire's program will include prevention activities focused on:

- PMTCT;
- Prevention of sexual transmission;
- Availability of condoms and uptake;
- Integration of PHDP services into routine clinic and home-based HIV/AIDS care;
- Prevention of medical transmission through blood and injection safety, and medical waste management activities, including expanding access to blood and blood products, supporting safe blood collection, screening, and use in collaboration with the National

Blood Transfusion Service (NTBS), training and behavior change communication (BCC) for health workers on injection safety, decentralized provision of post-exposure prophylaxis (PEP); and
- HIV counseling and testing.

PEPFAR Côte d'Ivoire will move forward to realign the sexual prevention portfolio with new DHS and other evaluation data, consolidating activities in high prevalence areas for greater impact. The number of implementing partners will be reduced to improve efficiency and allow for improved oversight. Given limited resources, realignment will focus on concentrating a combination of prevention strategies in a few key geographic areas selected for prevention interventions, and coordinating with Global Fund (GF)-supported prevention activities to ensure coverage. Strong focus will be placed on improving access and use of testing, counseling, treatment, and PHDP services for key populations, with a particular focus on ensuring effective mobilization strategies are being used to reach these often hidden populations. Blood safety interventions will continue to expand equitable access to blood and blood products at the decentralized level. These safety interventions will support five new blood collection sites in the field while developing a strategy to mobilize blood donors on a national scale.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Cote d'Ivoire	$ 17,516,677	$ 15,594,132	$ 2,200,000	**$ 35,310,809**
2010	Cote d'Ivoire	$ 17,010,000	$ 17,102,257	$ 2,183,000	**$ 36,295,257**
2011	Cote d'Ivoire	$ 25,625,000	$ 13,678,000	$ 2,509,000	**$ 41,812,000**
2012	Cote d'Ivoire	$ 31,099,585	$ 14,260,225	$ 2,551,204	**$ 47,911,014**
	Totals FY09-FY12	**$ 91,251,262**	**$ 60,634,614**	**$ 9,443,204**	**$ 161,329,080**
2014 (est)	Cote d'Ivoire				**$ 45,150,994**

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Treatment and PMTCT priorities for FY 2014 include strengthening community mobilization to increase uptake of PMTCT and maternal health services for HIV+ women, and strengthening linkages between PMTCT and family planning (FP) services. The program in FY 2014 will continue to support the effective implementation of new ART and PMTCT guidelines (Option B) at all supported sites and pilot Option B+, with support from the United Nations Children's Fund (UNICEF). The program will increase decentralized capacity for early infant diagnosis (EID) and treatment of pediatric HIV/AIDS. Other treatment activities include improving access to laboratory services to determine ART eligibility, monitoring of treatment for HIV-infected

pregnant women and their babies by implementing point-of-care CD4 technologies, and exploring a pilot for support for HIV/AIDS services in private for-profit clinics.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Cote d'Ivoire	$ 6,450,000	$ 1,470,000	$ 4,000,000	$ 10,053,368	**$ 21,973,368**
2010	Cote d'Ivoire	$ 9,448,000	$ 1,873,000	$ 3,350,000	$ 8,865,088	**$ 23,536,088**
2011	Cote d'Ivoire	$ 9,297,800	$ 2,328,200	$ 3,000,000	$ 9,089,308	**$ 23,715,308**
2012	Cote d'Ivoire	$ 6,351,823	$ 1,920,764	$ 3,662,090	$ 9,980,324	**$ 21,915,001**
	Totals FY09-FY12	**$ 31,547,623**	**$ 7,591,964**	**$ 14,012,090**	**$ 37,988,088**	**$ 91,139,765**
2014 (est)	Cote d'Ivoire					**$ 26,874,050**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, the U.S. government and the Government of Côte d'Ivoire will continue to work towards improving the quality and reach of care and support services for People Living with HIV (PLHIV) and their families. Both clinical and community-based partners will focus on improved tracking of PLHIV as a key element of PEPFAR Côte d'Ivoire's strategy to reduce loss to follow-up before ART initiation. Clinical partners will ensure that PHDP services are integrated into routine care at all sites, as well as the systematic provision of co-trimoxazole (CTX) and the scale-up of nutrition support (with Food by Prescription activities as feasible). Clinical partners will also ensure that water purification products are available and used by all patients in need, based on data from situation analyses. Community partners will ensure that community-based PHDP and nutrition services are integrated into a basic package of home-based care for HIV.

In FY 2014, PEPFAR Côte d'Ivoire will strengthen linkages between pediatric HIV/AIDS programs (and participating health care facilities) and services OVC, including ensuring retention in pediatric HIV care and treatment programs. PEPFAR Côte d'Ivoire will continue to streamline its OVC programs and focus on bolstering economic strengthening. PEPFAR Côte d'Ivoire's OVC program will include strengthening the national system, including attention to monitoring and evaluation of OVC care and support activities to guide targeting of support based on need and impact.

In FY 2014, to improve TB/HIV co-infection outcomes, PEPFAR Côte d'Ivoire will work with the World Health Organization (WHO) to ensure that national guidelines require all TB/HIV patients be put on ART regardless of CD4 cell count, and that the clinical TB symptom screening tool for HIV-positive adults and children is being utilized. PEPFAR Côte d'Ivoire will continue to work with the Government of Côte d'Ivoire and the GF to track and treat detected multidrug-resistant tuberculosis (MDR-TB) cases, which have increased dramatically after new diagnostic

equipment was installed in 2012 by PEPFAR at the Pasteur Institute. PEPFAR Côte d'Ivoire will work with the government to ensure a national committee is put in place to ensure the revision of testing algorithms and the installation of GenXpert to improve TB diagnosis and access of patients to TB testing.

To improve CTX outcomes, clinical partners will ensure CTX is available for all eligible HIV patients, and improve the prescription and documentation of CTX usage. A new supply chain partner will also focus on tracking CTX and holding sites accountable for CTX reporting.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Cote d'Ivoire	$ 10,028,000	$ 7,198,000	$ 10,125,500	$ 7,361,723	**$ 34,713,223**
2010	Cote d'Ivoire	$ 2,653,000	$ 4,260,100	$ 6,390,000	$ 13,429,714	**$ 26,732,814**
2011	Cote d'Ivoire	$ 2,185,000	$ 3,330,000	$ 1,160,000	$ 7,580,000	**$ 14,255,000**
2012	Cote d'Ivoire	$ 4,705,533	$ 4,781,215	$ 16,059,556	$ 5,462,468	**$ 31,008,772**
	Totals FY09-FY12	**$ 19,571,533**	**$ 19,569,315**	**$ 33,735,056**	**$ 33,833,905**	**$ 106,709,809**
2014 (est)	Cote d'Ivoire					**$ 24,870,857**

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In FY 2014, PEPFAR Côte d'Ivoire will provide technical assistance for the development and implementation of decentralized health development plans in twelve regions. These twelve regions will be selected by a national technical working group (TWG) on health decentralization. In two of these regions, PEPFAR Côte d'Ivoire will deliver a robust package of technical, logistical, and material support to regional and district health teams to aid in the implementation of the health development plans and to evaluate the impact of this support on HIV service quality (including 12-month patient retention rates) and other indicators like service utilization rates, commodity stock-out rates, and average facility wait times.

PEPFAR Côte d'Ivoire will provide continuing technical and material support to the Ministry of Health and AIDS (MSLS) for policy application and development (including task-shifting for HIV services) and inter-ministerial advocacy for increased and equitable public financing of health. PEPFAR Côte d'Ivoire will work with MSLS, private providers, and insurers to expand HIV services to a number of private and nonprofit health facilities in and around Abidjan, with a focus on improving oversight of and reporting by these facilities.

PEPFAR Côte d'Ivoire will continue to build the capacity of the Public Health Pharmacy (PSP) to increase skills in forecasting, warehousing, distribution, and tracking of commodities to eventually transition procurement responsibility. A focus in FY 2014 will be to strengthen decentralized commodities management. PEPFAR Côte d'Ivoire will continue to support a

logistics management information system for health commodities country-wide. This logistics management system supports PEPFAR and GF commodities tracking, and government capacity for commodities management, not only of ARVs but also lab reagents, CTX, rapid test kits, blood/blood products, and other health commodities. PEPFAR Côte d'Ivoire will continue performance-based payments to PSP under its new legal framework, as a contribution to operating costs and in order to roll out a more decentralized drug distribution process through trained and supervised community health workers.

PEPFAR strategic information efforts will assist in building government and NGO capacity to regularly collect, compile, analyze, and use data for evidence-based decision making. PEPFAR Côte d'Ivoire will contribute to an effective national strategic information (SI) system by supporting the Government of Côte d'Ivoire with routine monitoring and evaluation (M&E) activities and data collection, conducting surveys and surveillance, and developing health management information systems.

Country Engagement

Country engagement will continue to fulfill the PF shared objectives and respective contributions to support the Government of Côte d'Ivoire, civil society, and the private sector to:

- Reduce new HIV infections;
- Increase access to quality care and treatment and improve the quality of life for PLHIV;
- Reduce the impact of HIV/AIDS on public and private sectors, communities, and families; and
- Ensure the strengthening of governance, financing, and health systems necessary for an optimal national response.

PEPFAR support will continue to help in achieving universal coverage by 2015, and eventually an "AIDS-free generation" in Côte d'Ivoire. The PEPFAR team will continue to work with the Government of Côte d'Ivoire on plans to transition the following to the government:

- Responsibility for supporting 10 percent of ART sites;
- Responsibility for data managers, community counselors, and other PEPFAR-supported human resources; and
- Responsibility for the blood safety program, incinerator management, laboratory maintenance contracts, and routine laboratory services for HIV/AIDS.

PEPFAR Côte d'Ivoire promotes all major coordination efforts, including HIV/AIDS TWGs, and participates in regular donor coordination meetings with the United Nations (UN), European Union (EU), and French Development Agency (AFD). PEPFAR Côte d'Ivoire is a voting member of the Country Coordinating Mechanism (CCM) and has been instrumental in moving HIV GF grants forward.

PEPFAR Côte d'Ivoire has worked to ensure coverage and support the national response on an interim basis as feasible in response to limited GF contributions and implementation delays

during the last two years. As a result, PEPFAR Côte d'Ivoire has advocated that Phase Two of the Round Nine grant focus largely on procurement of essential commodities, freeing more PEPFAR funds for site support.

Democratic Republic of the Congo

Country Context

The Democratic Republic of Congo (DRC) has one of the lowest gross national incomes (GNI) per capita in the world ($160), with an estimated 80 percent of the total population of 68 million living below the poverty line. The United Nations Development Index ranks the DRC the least developed country in the world (177/177). The population size, poverty scale, and decades of conflict have resulted in the lack of cohesive and functional health systems. DRC, in its post-conflict reconstruction phase, faces several challenges that hinder its ability to provide quality health services. In 2012, the government disbursed $119 million of the budgeted health resources, which is only 22 percent of the total that was legislatively authorized. According to the National Health Accounts, data showed that $13 per capita was spent on health, of which 43 percent was paid by individual households and 15 percent by the government. Existing health facilities have high operating costs, logistical constraints, and weak supervision and oversight. Poor infrastructure, including inadequate roads and the lack of electricity and water at many health facilities, further complicates access to healthcare. Additionally, political instability and a rapid rate of population growth limit the Government of The Democratic Republic of the Congo's ability to provide basic services.

Although data quality has been a challenge, UNAIDS (2009) estimates that HIV prevalence ranges from 1.2 percent to 1.6 percent in the general adult population. The DRC has a mixed HIV epidemic marked by variation across different regions and populations. High-risk groups indicate prevalence ranging from 4.3 percent in Mbandaka (Equateur province) to 14.6 percent in Mbuji-Mayi (Kasai Orientale Province) among commercial sex workers, and 0.7 percent in Bukavu (Sud Kivu province) to 5. 1 percent in Lubumbashi (Katanga Province) among miners. HIV prevalence among tuberculosis (TB) patients presenting in specialized tuberculosis (TB) clinics was 16 percent in 2009. Recent data from over 200,000 pregnant women attending 521 clinics supported by PEPFAR indicated a prevalence rate of 1.3 percent. The 2013 demographic health survey is currently in process and new population-based data, including HIV prevalence, should be available in 2014.

In an effort to maximize available resources and increase impact, the PEPFAR DRC program will significantly shift activities in FY 2014 towards an HIV continuum of response (CoR) to ensure that there are strong linkages in the delivery of HIV prevention, care, and treatment services that are accessed by HIV infected and affected individuals. This pivot will be achieved through the adoption of a PEPFAR DRC Health Zone Model where PEPFAR will focus efforts in select health zones in three high prevalence/population provinces in Kinshasa, Katanga, and Orientale, to increase coverage and a comprehensive package of services prior to expanding activities in other provinces. Through this model, PEPFAR DRC will primarily focus efforts on:

- Expanding the care and treatment program for HIV positive mothers and their families identified through expanded prevention of mother-to-child transmission (PMTCT) programming;

- Improving treatment outcomes through the procurement of antiretroviral drugs (ARVs) and establishing strong linkages to treatment, care, and retention in coordination with the Global Fund;
- Enhancing coordination with the Global Fund to reduce duplication of services, particularly as it relates to improving treatment outcomes and strengthening health systems;
- Estimating the size of key populations and defining services available to these target population; and
- Strengthening care services for orphans and vulnerable children (OVC).

Below is a table of PEPFAR DRC's budget representing its major program areas.

Fiscal Year	Democratic Republic of the Congo Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 9,978,480	30%	$ 10,052,721	30%	$ 996,951	3%	$ 12,000,443	36%	$ 33,028,595
2010	$ 10,969,469	35%	$ 8,095,505	26%	$ 2,405,547	8%	$ 9,779,479	31%	$ 31,250,000
2011	$ 29,411,121	57%	$ 9,971,771	19%	$ 1,053,000	2%	$ 10,814,108	21%	$ 51,250,000
2012	$ 9,865,726	39%	$ 7,768,288	31%	$ 1,161,852	5%	$ 6,588,824	26%	$ 25,384,690
Total 2009-2012	**$ 60,224,796**	**43%**	**$ 35,888,285**	**25%**	**$ 5,617,350**	**4%**	**$ 39,182,854**	**28%**	**$ 140,913,285**
2014 (est)	**$ 18,852,123**	**39%**	**$ 13,975,265**	**29%**	**$ 4,189,911**	**9%**	**$ 11,796,702**	**24%**	**$ 48,814,001**

*Totals include planned funding for all accounts.
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Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	DRC	$ 1,783,504	$ 1,950,381	$ 3,692,881	$ 325,000	$ 19,115	$ -	$ -	$ 2,207,599	**$ 9,978,480**
2010	DRC	$ 2,909,957	$ 1,790,461	$ 3,329,701	$ 1,050,000	$ -	$ -	$ -	$ 1,889,350	**$ 10,969,469**
2011	DRC	$ 18,297,657	$ 2,643,999	$ 4,256,301	$ 1,000,000	$ 250,000	$ -	$ -	$ 2,963,164	**$ 29,411,121**
2012	DRC	$ 2,376,666	$ 1,146,256	$ 1,859,498	$ 872,285	$ 200,000	$ -	$ -	$ 3,411,021	**$ 9,865,726**
	Totals FY09-FY12	**$ 25,367,784**	**$ 7,531,097**	**$ 13,138,381**	**$ 3,247,285**	**$ 469,115**	**$ -**	**$ -**	**$ 10,471,134**	**$ 60,224,796**
2014 (est)	DRC									**$ 18,852,123**

*Totals include planned funding for all accounts.
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PMTCT remains a key priority of the PEPFAR DRC program. In 2014 the U.S. government will continue efforts to ensure pregnant women know their HIV status and that infected pregnant women receive efficacious PMTCT regimens. PEPFAR DRC will continue to procure male and female condoms and make them available to pregnant women and the general population through PMTCT and other HIV service facilities including those serving the military in all the targeted areas.

Other bio-medical prevention programming will continue in FY 2014, focusing on increasing access to safe blood, ensuring that all blood transfusions are being tested for HIV and that there is proper disposal of medical waste. Likewise, the U.S. government will provide technical assistance to support the Ministry of Health (MOH) in policy and infrastructure development, blood collection, testing, quality management, transfusion and blood utilization, training, and monitoring and evaluation.

In FY 2014, PEPFAR DRC will shift from generalized HIV counseling and testing (HCT) in low prevalence non-priority provinces to provider initiated testing and counseling (PITC) delivered through PMTCT and other HIV service facilities, including those serving military populations. HCT will only be implemented where there are strong linkages to dependable care and treatment services. Resources will be redirected from low prevalence sites to priority provinces to support this transition and ensure quality of services. Moreover, general abstinence/be faithful (HVAB) prevention interventions will be reduced from six percent of the budget to two percent to support combination prevention activities.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	DRC	$ -	$ 869,060	$ 127,891	**$ 996,951**
2010	DRC	$ -	$ 1,736,896	$ 668,651	**$ 2,405,547**
2011	DRC	$ -	$ 684,000	$ 369,000	**$ 1,053,000**
2012	DRC	$ 19,116	$ 553,285	$ 589,451	**$ 1,161,852**
	Totals FY09-FY12	**$ 19,116**	**$ 3,843,241**	**$ 1,754,993**	**$ 5,617,350**
2014 (est)	DRC				**$ 4,189,911**

*Totals include planned funding for all accounts.
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In the DRC, only an estimated 10% of individuals eligible for ART are receiving treatment and only 5% of eligible women have access to PMTCT services. In part, this is largely a result of multiple factors including low funding for HIV/AIDS and weaknesses in the health system including unreliable lab services, weak consistent supply chain systems leading to stock-outs, insufficiently trained staff, stigma and discrimination. In an effort to improve treatment outcomes, the PEPFAR DRC program will begin procuring and providing ARVs for targeted populations (focused on pregnant women and their families) in PEPFAR supported HZs in FY 2014. While the program initially intended to procure ARVs for 18 months and then transition patients to the Global Fund as part of PMTCT acceleration efforts, in 2014, PEPFAR DRC will support lifelong treatment for pregnant mothers and their families and will also support an Option B+ pilot in Katanga in collaboration with UNICEF. In 2014, the PEPFAR DRC program will support an inventory and mapping exercise to determine which sites within targeted HZs require technical assistance and training to scale-up treatment off of the PMTCT platform. Upon completion of this exercise, PEPFAR DRC will develop a strategy to ensure that PEPFAR supported sites provide a comprehensive package of services including point-of-care (POC) CD4 count technology, early infant diagnosis (EID), co-trimoxazole (CTX), and TB screening.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	DRC	$ 2,181,582	$ 566,450	$ 1,299,291	$ 6,005,398	**$ 10,052,721**
2010	DRC	$ 1,912,171	$ 837,238	$ 2,629,744	$ 2,716,352	**$ 8,095,505**
2011	DRC	$ 3,918,473	$ 801,000	$ 2,562,118	$ 2,690,180	**$ 9,971,771**
2012	DRC	$ 2,891,635	$ 709,072	$ 1,226,887	$ 2,940,694	**$ 7,768,288**
	Totals FY09-FY12	**$ 10,903,861**	**$ 2,913,760**	**$ 7,718,040**	**$ 14,352,624**	**$ 35,888,285**
2014 (est)	DRC					**$ 13,975,265**

*Totals include planned funding for all accounts.
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In FY 2014, PEPFAR DRC will continue to provide basic care and support to people living with HIV (PLHIV) based on a continuum of HIV care and support services package with linkages between health facilities and communities within targeted HZs in the three priority provinces. Some of these interventions include services such as HCT, laboratory support, TB screening and treatment, opportunistic infection (OI) prevention and management (including CTX prophylaxis), and food and nutrition assistance. Additionally, PEPFAR DRC will continue to provide pediatric and adult care and support services including psychosocial support focused on support groups which provide opportunities for individuals to meet and discuss coping mechanisms with trained community outreach workers, and community-based care programs that provide linkages to youth friendly HCT services.

To minimize bottlenecks in 2014, the DRC team has developed an OVC strategy aligned with the DRC government's priorities and the new PEPFAR OVC guidance. The strategy calls for adoption of a facility- and community-based approach to the identification, assessment, and delivery of services to OVC. The objectives are to:

- Strengthen families' capacity to provide for the basic needs of children in their care;
- Increase equitable access to basic services for vulnerable children;
- Improve the DRC government's capacity and systems to improve and sustain the national OVC response; and
- Exchange information and rigorous evidence for a more coordinated, effective, and efficient responses.

At the facility level a full clinical package of services is being developed with significant attention placed on creating linkages with the community, identifying OVC through PMTCT services, PITC, and referring OVC to social services. At the community level, PEPFAR DRC will continue to provide wraparound services which include nutritional support, income generating activities and support groups.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	DRC	$ 509,128	$ 5,823,868	$ 1,785,068	$ 3,882,379	**$ 12,000,443**
2010	DRC	$ 1,380,013	$ 1,729,543	$ 1,841,635	$ 4,828,288	**$ 9,779,479**
2011	DRC	$ 1,161,000	$ 1,561,509	$ 2,477,157	$ 5,614,442	**$ 10,814,108**
2012	DRC	$ 1,519,654	$ 810,731	$ 1,532,878	$ 2,725,561	**$ 6,588,824**
	Totals FY09-FY12	**$ 4,569,795**	**$ 9,925,651**	**$ 7,636,738**	**$ 17,050,670**	**$ 39,182,854**
2014 (est)	DRC					**$ 11,796,702**

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The U.S. government remains committed to building leadership and fostering country ownership as outlined in the Partnership Framework (PF). PEPFAR DRC will continue investing in country-led plans and health systems while increasing impact and efficiency through the implementation of evidence-based interventions. Governance and system inputs funded directly through PEPFAR include human resources for health; laboratory strengthening and pharmaceutical management; improvement of strategic information, including monitoring and evaluation; and promoting research and innovation.

In an effort to build capacity of national systems, the PEPFAR DRC program will focus health systems strengthening (HSS) efforts on supply chain management, laboratory operations, strategic information, development of public health capacity and systems strengthening at the provincial and HZ level. Specific systems activities include the expansion of an additional early infant diagnosis (EID) lab, lab accreditation, support to the National AIDS Control Program (NACP) to develop a national health information system, data quality assurance, and support for the standardization of patient registers. Drug procurement, distribution and management systems are weak and lack accountability, with multiple parallel systems in place and frequent stock-outs occur. In FY 2014, PEPFAR DRC will assist the GDRC in establishing a supply chain management technical working group which will be tasked with developing a roadmap to evaluate gaps and weaknesses and support strengthening efforts of the supply chain system.

Country Engagement

The U.S. Government's role in the national HIV/AIDS response is directly aligned with the Ministry of Health's National Health Development Plan for 2011-2015 which covers major causes of mortality and morbidity in the country. The main goals of both GHI, including PEPFAR, and the NHDP is moving toward sustainable health systems and health care services, by making the HZ network the key implementation unit and increasing program efficiencies, effectiveness, and mutual accountability. PEPFAR contributes to achieving about 85 percent of the targets set by the government and actively participates in quarterly meetings of the elimination of mother-to-child transmission Technical Working Group, convened by the Ministry of Health (MOH). In FY 2014, PEPFAR DRC will support the MOH in its mid-term review of its HIV National Strategic Plan which is slated to end at the end of FY 2014. Through this review, PEPFAR DRC will work with the MOH, Global Fund, UNAIDS and other donors to evaluate progress to date, gaps and areas for increased support and technical assistance. PEPFAR DRC will also work with the Democratic Republic of Congo government to reallocate and rationalize HIV commodities from sites of low prevalence and yield to facilities of higher prevalence to maximize public health impact of treatment efforts.

Ethiopia

Country Context

Ethiopia is the second most populous country in Sub-Saharan Africa, with a population of 82 million. Despite impressive economic growth, Ethiopia remains a low-income country with a real per capita income of US $351 and 39 percent of the population living below the international poverty line of $1.25/day. According to the UN Human Development Index (2012), Ethiopia ranks 174 out of 187 countries on both the overall index and the per capita Gross National Income (GNI). It is also one of the least urbanized countries with 82 percent of the population living in rural areas.

The HIV/AIDS situation in Ethiopia continues to be characterized by a mixed epidemic with significant heterogeneity across geographic areas, urban vs. rural, and population groups. The 2011 Ethiopia Demographic and Health Survey (EDHS) estimated the national HIV prevalence at 1.5 percent, compared to 2.4 percent according to the previously accepted Single Point Estimate. A comparison with 2005 EDHS data suggests stable low HIV prevalence of 0.6 percent in rural areas, but substantial declines from 7.7 percent to 4.2 percent in urban areas. Routine biannual antenatal surveillance tracking HIV prevalence confirms sustained declines in HIV prevalence in both urban and peri-urban areas up through the most recent estimate published for 2009. There are contrasts in prevalence across regions (ranging from 6.5 percent in Gambella and 5.2 percent in Addis Ababa to 0.9 percent in Southern Nations, Nationalities and Peoples Region), residence types (4.2 percent urban versus 0.6 percent rural) and gender (1.9 percent for women vs. 1.0 percent for men). Prevalence in the 15-24 year age range has also significantly declined from 12.4 percent in 2001 to 2.6 percent in 2009.

In FY 2014, PEPFAR Ethiopia will continue programs and activities in support of the Government of Ethiopia's Health Sector Development Plan Four (HSDP IV) and Second Multi-sectoral Strategic Plan (SPMII), which have been incorporated in the Global Health Initiative (GHI) Strategy. Ethiopia's GHI Strategic framework includes three pillars and combines all U.S. government assets for improving access to health care services, increasing demand for services, and strengthening the health systems, all of which will increase utilization of quality health services, decrease maternal, neonatal, and child mortality, and reduce incidence of communicable diseases.

FY 2014 also includes support for the transition of the clinical care and treatment program to the Ethiopian government and increased government-to-government funding with a reduction in the number of international implementing partners. These changes will lead to a more targeted evidence-based program and will continue the momentum to transition activities to the Ethiopian government, civil society, and the private sector.

Below is a table of PEPFAR Ethiopia's budget representing its major program areas.

Fiscal Year	Ethiopia Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 86,080,829	25%	$ 70,914,774	20%	$ 108,206,088	31%	$ 80,779,417	23%	$ 345,981,108
2010	$ 80,653,379	28%	$ 66,372,860	23%	$ 64,985,841	22%	$ 79,310,069	27%	$ 291,322,149
2011	$ 88,770,440	30%	$ 66,334,995	23%	$ 66,901,633	23%	$ 70,945,320	24%	$ 292,952,388
2012	$ 43,066,085	23%	$ 29,109,596	16%	$ 53,467,805	29%	$ 59,459,501	32%	$ 185,102,987
Total 2009-2012	**$ 298,570,733**	**27%**	**$ 232,732,225**	**21%**	**$ 293,561,367**	**26%**	**$ 290,494,307**	**26%**	**$1,115,358,632**
2014 (est)	**$ 56,119,866**	**29%**	**$ 44,390,861**	**23%**	**$ 43,318,030**	**22%**	**$ 50,284,243**	**26%**	**$ 194,113,000**

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Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Ethiopia	$19,686,735	$ 9,465,291	$ 34,766,924	$ 4,968,200	$ 3,466,777	$ -	$ 435,750	$ 13,291,152	**$ 86,080,829**
2010	Ethiopia	$21,349,650	$ 8,367,902	$ 34,708,865	$ 1,400,000	$ 2,603,902	$ -	$ 748,294	$ 11,474,766	**$ 80,653,379**
2011	Ethiopia	$27,134,076	$ 7,712,610	$ 35,618,999	$ 1,672,100	$ 7,145,552	$ -	$ 506,500	$ 8,980,603	**$ 88,770,440**
2012	Ethiopia	$11,207,302	$ 2,602,944	$ 14,563,254	$ 3,352,448	$ 4,791,922	$ 14,226	$ 850,201	$ 5,683,788	**$ 43,066,085**
	Totals FY09-FY12	**$79,377,763**	**$ 28,148,747**	**$ 119,658,042**	**$ 11,392,748**	**$ 18,008,153**	**$ 14,226**	**$ 2,540,745**	**$ 39,430,309**	**$ 298,570,733**
2014 (est)	Ethiopia									**$ 56,119,866**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The foundation of the prevention portfolio is evidence-based combination sexual prevention activities, involving more than one method of HIV prevention, in line with the complex epidemiology of the HIV/AIDS epidemic in Ethiopia. There will be an increased focus on Amhara, Addis Ababa, Oromia, and SNNPR, which account for most new infections. The prevention program will increase the Ethiopian government's capacity to lead national HIV prevention efforts, and strengthen prevention efforts in large-scale workplaces. A network of confidential sexually transmitted infections (STI) clinics for key populations and other vulnerable groups will also be improved to enhance delivery of biomedical prevention interventions, including targeted treatment as prevention.

A hallmark of FY 2014 will be accelerated work on prevention of mother-to-child transmission of HIV (PMTCT). PEPFAR Ethiopia will support the Ethiopian government's Accelerated Plan towards the elimination of mother-to-child transmission, including the rollout of the B+ option and ongoing advocacy to focus PMTCT efforts in urban areas, market towns, and other hotspots where prevalence is higher. Although the Ethiopian government is taking the lead in community

mobilization through the "Health Development Army," PEPFAR Ethiopia will continue to support efforts to increase demand for antenatal care (ANC) and PMTCT services and promote better integration of services at facilities, including leveraging bilateral resources.

A major focus for PMTCT in FY 2014 will be continuous quality improvement to decrease fall-off along the PMTCT cascade, including better tracking of mother-infant pairs post-delivery, strengthening of early infant diagnosis (EID), and ensuring that family planning services are available in facilities providing antiretroviral treatment (ART). In order to better capture the impact of these concerted efforts, PEPFAR Ethiopia will work with the Ministry of Health (MOH) to better measure PMTCT indicators within the Health Management Information System (HMIS) and respond to bottlenecks that are identified.

PEPFAR Ethiopia will provide continued and more targeted support for counseling and testing to maximize coverage and improve quality assurance for testing of key populations. Selected prevention efforts addressing general population and school and university-based programs are gradually transitioning to the Ethiopian government. These include focused prevention for university students practicing high risk behaviors and efforts to address in-school young people by leveraging resources. PEPFAR Ethiopia will develop strategic partnerships with other U.S. government offices and provide direct funding support to local universities, the Ministry of Education (MOE), and the Ethiopian government in the production of behavior change communication materials.

In line with the Ethiopia GHI strategy and significant country need, there is continued investment in improving the safe blood supply and supporting a national blood transfusion service. In response to the epidemiology, male circumcision activities are focused in Gambela region and within the uniformed services.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Ethiopia	$ 25,132,215	$ 75,504,276	$ 7,569,597	**$ 108,206,088**
2010	Ethiopia	$ -	$ 59,012,177	$ 5,973,664	**$ 64,985,841**
2011	Ethiopia	$ 3,774,817	$ 58,033,358	$ 5,093,458	**$ 66,901,633**
2012	Ethiopia	$ 14,789	$ 49,305,932	$ 4,147,084	**$ 53,467,805**
	Totals FY09-FY12	**$ 28,921,821**	**$ 241,855,743**	**$ 22,783,803**	**$ 293,561,367**
2014 (est)	Ethiopia				**$ 43,318,030**

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In FY 2014, PEPFAR Ethiopia will support provision of quality ART in areas with the highest prevalence. PEPFAR Ethiopia will continue to work in partnership with Regional Health Bureaus (RHBs) and support hospitals to provide outreach mentoring to health centers within their catchment areas. Local partners also will be engaged in building the capacity of RHBs.

Laboratory infrastructure accreditation will remain essential at the national, regional, and facility levels. PEPFAR funding will support the integration of a national quality-controlled network of tiered lab services. This will include direct support to Ethiopian laboratories at the national and regional level. PEPFAR Ethiopia will include expansion of: programs focused on quality assurance (conducted by the laboratories themselves as well as external monitoring and evaluation); enhanced PMTCT programming; and increased ART-as-prevention in clinics targeting commercial sex workers (CSW).

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Ethiopia	$ 24,826,529	$ 3,081,122	$ 8,944,854	$ 34,062,269	**$ 70,914,774**
2010	Ethiopia	$ 24,370,729	$ 2,846,108	$ 8,525,545	$ 30,630,478	**$ 66,372,860**
2011	Ethiopia	$ 29,578,899	$ 2,714,826	$ 7,240,871	$ 26,800,399	**$ 66,334,995**
2012	Ethiopia	$ 12,079,062	$ 1,552,625	$ 5,323,093	$ 10,154,816	**$ 29,109,596**
	Totals FY09-FY12	**$ 90,855,219**	**$ 10,194,681**	**$ 30,034,363**	**$ 101,647,962**	**$ 232,732,225**
2014 (est)	Ethiopia					**$ 44,390,861**

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In FY 2014, PEPFAR Ethiopia will focus on strengthening the entire continuum of care, which will include: a family centered approach with efforts to increase couple counseling; maintaining patients in pre-ART through utilization of case managers at facilities and linkages with community support programs; screening for opportunistic infections and tuberculosis (TB); routinely providing co-trimoxazole prophylaxis; nutritional support both as therapeutic feeding for patients with a body mass index (BMI) under 18.5 and supplementary feeding to those who are eligible; and the basic preventive package (water guard, de-worming, condoms, insecticide-treated nets) when required. High loss-to-follow-up among pre-ART patients will be addressed by focusing on effective retention models and networks at the facility and community level.

Care funding will also strengthen TB programming to increase the proportion of HIV/TB patients started on ART including: aggressive pursuit of implementing the three "I's"; strengthened support for Directly Observed Therapy-Short course for patients with TB/HIV co-infection; ongoing support for improved laboratory diagnosis; support for multidrug-resistant tuberculosis (MDR-TB) in MDR-TB wards; improved diagnosis, care, and technical assistance to promote quality treatment; and improved alignment of bilateral and PEPFAR-funded TB programs.

Pediatric care and support programs will include strengthening EID, task shifting, and greater retention in care and orphans and vulnerable children (OVC) programs. PEPFAR Ethiopia will issue new OVC guidelines and improve access to key services including education, shelter, and psychosocial support.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Ethiopia	$ 27,907,714	$ 17,853,500	$ 17,022,710	$ 17,995,493	**$ 80,779,417**
2010	Ethiopia	$ 9,994,772	$ 16,449,756	$ 23,774,676	$ 29,090,865	**$ 79,310,069**
2011	Ethiopia	$ 11,062,100	$ 16,597,218	$ 28,948,444	$ 14,337,558	**$ 70,945,320**
2012	Ethiopia	$ 7,759,245	$ 14,206,485	$ 28,285,472	$ 9,208,299	**$ 59,459,501**
	Totals FY09-FY12	**$ 56,723,831**	**$ 65,106,959**	**$ 98,031,302**	**$ 70,632,215**	**$ 290,494,307**
2014 (est)	Ethiopia					**$ 50,284,243**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR Ethiopia will directly provide key technical and managerial support both at the federal Ministry of Health (MOH) and RHB levels. Leadership and training will be prioritized for improved coordination and management in RHBs and the federal HIV/AIDS Prevention and Control Office (HAPCO). This will include strengthening local professional associations and improved service standardization at the Food, Medicine and Health Care Administration and Control Authority of Ethiopia (FMHACA).

Health workforce development will continue to be a major focus in FY 2014. Human resources for health programs will include: pre-service and postgraduate training of key health cadres; direct funding to local universities; and the development of in-service training centers resulting in gradual transition of demand-driven training to in-country, primarily government, partners. U.S. government support for pre-service training will be complemented by the centrally funded Medical Education Partnership Initiative, e-learning opportunities, and support for FMHACA to develop legal and regulatory frameworks for licensing and certification of health professionals and accreditation of facilities.

PEPFAR Ethiopia will also be supporting supply chain and logistics and health finance. Support will be provided to the National Pharmaceutical Logistics Master Plan in order to better leverage PEPFAR, bilateral, and other donor funding to support the entire logistics cycle. Additional equipment such as provision of vehicles, cold rooms, and other essential equipment will be provided.

Country Engagement

FY 2014 will build upon a series of key Ethiopian government strategic plans spanning the next five years. This foundation will provide a strong platform for the U.S. government program. There is strong country ownership of programs with open dialogue around how PEPFAR contributes to Ethiopia's strategic directions.

PEPFAR Ethiopia will meet regularly with its main government interlocutor, HAPCO, with the goal of exchanging information, measuring progress, and working towards improved harmonization with the Global Fund (GF). The PEPFAR team plays an active role in HAPCO's biannual national program reviews.

In FY 2014, there will be increased collaboration between PEPFAR Ethiopia and the GF, including monthly joint Supply Chain meetings to review procurements and stock, and reduce duplication of inputs from GF and PEPFAR.

The U.S. government continues to advocate for more targeted programming that better takes into account the epidemiological profile of the HIV epidemic. There is clear Ethiopian government commitment to addressing HIV/AIDS and strengthening the health sector, but somewhat weaker Ethiopian government support for the roles of civil society and the private sector. Barriers under the new Civil Society Law limit active engagement by non-governmental organizations in advocacy roles, but they are able to provide service delivery.

Ghana

Country Context

The HIV prevalence rate in Ghana peaked in 1998 at 2.4 percent, and appears to have stabilized at about 1.5 percent in 2012. Sexual transmission accounts for over 80 percent of new infections. As of 2003, the HIV prevalence rate was highest among 35-39 year-old women (4.1 percent) and 40-44 year-old men (4.7 percent). Youth in Ghana are relatively less affected by HIV/AIDS than adults, perhaps due in part to low levels of cross-generational sex and few concurrent sexual relationships among girls. A 2009 Modes of Transmission in West Africa study concluded that approximately 50 percent of new infections occur within the general population through casual or low-risk heterosexual sex, and the other 50 percent are related to key populations, which would characterize the epidemic as 'mixed', rather than concentrated.

There is general agreement within the country that the HIV infection rate in the general population is low and slowly declining. However, the HIV rate is five to 20 times higher in key populations, especially men who have sex with men (MSM) and female sex workers (FSW) and their partners. Prevalence among FSW varies geographically and by type of sex worker, ranging from 4.1 percent in Upper West Region to 16 percent in Greater Accra. In a 2012 national study, 18 percent of MSM were found to be HIV-infected. In Accra, as many as 34 percent of MSM are infected, a significant increase from the 26 percent found in a 2006 study.

The overarching goals of the PEPFAR Ghana program are to reduce the number of new infections by focusing on:

- Prevention activities for key populations;
- Positive health, dignity, and prevention programs for people living with HIV (PLHIV); and
- Strengthening national systems to carry out the nation's prevention, treatment, and care programs.

Below is a chart of PEPFAR Ghana's budget representing its major program areas.

Fiscal Year	Ghana Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 9,617,558	55%	$ 1,511,500	9%	$ 1,000,000	6%	$ 5,370,942	31%	$ 17,500,000
2010	$ 3,638,400	35%	$ 1,169,200	11%	$ 650,000	6%	$ 4,901,627	47%	$ 10,359,227
2011	$ 6,760,200	45%	$ 1,945,000	13%	$ 752,824	5%	$ 5,541,976	37%	$ 15,000,000
2012	$ 7,425,395	50%	$ 1,594,132	11%	$ -	0%	$ 5,980,473	40%	$ 15,000,000
Total 2009-2012	**$ 27,441,553**	**47%**	**$ 6,219,832**	**11%**	**$ 2,402,824**	**4%**	**$ 21,795,018**	**38%**	**$ 57,859,227**
2014 (est)	**$ 4,939,337**	**50%**	**$ 1,123,520**	**11%**	**$ -**	**0%**	**$ 3,812,143**	**39%**	**$ 9,875,000**

* Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Ghana	$ -	$ 600,000	$ 7,617,558	$ -	$ -	$ -	$ -	$ 1,400,000	**$ 9,617,558**
2010	Ghana	$ 389,200	$ 260,000	$ 390,000	$ 130,000	$ -	$ 390,000	$ 260,000	$ 1,819,200	**$ 3,638,400**
2011	Ghana	$ 900,000	$ 640,000	$ 4,430,200	$ 200,000	$ -	$ -	$ -	$ 590,000	**$ 6,760,200**
2012	Ghana	$ 646,632	$ -	$ 6,048,763	$ 200,000	$ -	$ -		$ 530,000	**$ 7,425,395**
	Totals FY09-FY12	**$ 1,935,832**	**$ 1,500,000**	**$ 18,486,521**	**$ 530,000**	**$ -**	**$ 390,000**	**$ 260,000**	**$ 4,339,200**	**$ 27,441,553**
2014 (est)	Ghana									**$ 4,939,337**

* Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

HIV transmission from high risk populations, specifically FSW and MSMs, to the general population is of specific concern in Ghana. By focusing on prevention for key populations and other at-risk populations, the PEPFAR Ghana team expects incidence to continue to decline among both the general population and among key populations.

The PEPFAR Ghana team's approach of supporting the implementation of combination prevention activities, a suite of mutually reinforcing interventions to address the risks of transmission and acquisition including biomedical, behavioral, and structural and may include prevention of mother-to-child transmission (PMTCT), voluntary medical male circumcision (VMMC), HIV counseling and testing (HCT), condom promotion and distribution, comprehensive programs for key populations, blood safety, positive health, dignity and prevention, infection prevention and control and linkages to care and treatment, is the most cost-

effective way to reduce the number of new infections. The Ghana Government, with financial support from the Global Fund, focuses on preventing mother to child transmission (PMTCT) services and other general population interventions including testing and treatment.

The country team's approach in FY 2014 will continue to rely heavily on informal social networks, peer education, linkages to health services, and innovative electronic communications. Peer educators will cluster in and around the drop-in centers, some staffed with government health workers. Key populations-friendly clinics will link key populations members to HIV-related services, including: PMTCT, tuberculosis (TB) treatment, and anti-retroviral therapy (ART) at public clinics.

In FY 2014, a number of program elements will be scaled up when proven successful. These include:

- Special programs that provide for the needs of young sex workers;
- A program for risk reduction among people who inject drugs (PWID) that will be piloted in two major cities in the country.
- Programs for male sex workers and their clients including those meeting in brothels; and
- A program to encourage HIV counseling and testing among MSM using rapid social networking.

PEPFAR Ghana will fund the Ghana AIDS Commission to develop NGO funding systems whereby parallel funding with the Global Fund finance will be harmonized.

The PEPFAR Program focus is on key populations and other vulnerable populations and Prevention with Positives (PwP). PwP programs also link PLHIV with treatment and care programs, including TB treatment, improving adherence to treatment programs, tracing drop-outs and readmitting them into treatment and reducing risk behaviors. The Ambassador's Self-Help Fund will provide four or five small grants supporting prevention for vulnerable groups. PEPFAR Ghana will continue supporting integration of HIV prevention into the Ghana Armed Forces (GAF) peer education program, and expand the "Know your Status Campaign" to all the seven GAF garrisons. HIV/AIDS training for Peacekeepers will be continued, and the Prevention with Positives program will be intensified in all the garrisons for the military, their family members, and civilian staff.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Ghana	$ -	$ 700,000	$ 300,000	**$ 1,000,000**
2010	Ghana	$ -	$ 390,000	$ 260,000	**$ 650,000**
2011	Ghana	$ -	$ 452,824	$ 300,000	**$ 752,824**
2012	Ghana	$ -	$ -	$ -	**$ -**
	Totals FY09-FY12	**$ -**	**$ 1,542,824**	**$ 860,000**	**$ 2,402,824**
2014 (est)	Ghana				**$ -**

* Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The PEPFAR Ghana program will not directly be involved in providing ART in FY 2014.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Ghana	$ 485,000	$ 194,000	$ 450,000	$ 382,500	**$ 1,511,500**
2010	Ghana	$ 389,200	$ 260,000	$ 390,000	$ 130,000	**$ 1,169,200**
2011	Ghana	$ 585,000	$ 300,000	$ 550,000	$ 510,000	**$ 1,945,000**
2012	Ghana	$ 856,632	$ 100,000	$ 250,000	$ 387,500	**$ 1,594,132**
	Totals FY09-FY12	**$ 2,315,832**	**$ 854,000**	**$ 1,640,000**	**$ 1,410,000**	**$ 6,219,832**
2014 (est)	Ghana					**$ 1,123,520**

* Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The positive health, dignity, and prevention program for PLHIV program will continue to work through monthly meetings of over 300 PLHIV groups nationwide rather than through clinical facilities. It will provide a full spectrum of services using an updated positive living tool kit. Health workers will participate in monthly meetings providing screenings and referrals for essential health services. Newly available mobile TB diagnostic units will visit each group once a year. Peer counselors in clinical HIV settings will continue to support their peers, accompany newly diagnosed PLHIV to clinical settings, and trace patients lost to follow-up. The

Department of Defense will also build GAF's capacity to conduct quality HIV and AIDS programming and help provide accreditation for the "37 Military Hospital Laboratory."

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Ghana	$ 35,000	$ 2,192,000	$ 1,684,542	$ 1,459,400	**$ 5,370,942**
2010	Ghana	$ 823,413	$ 990,000	$ 1,057,508	$ 2,030,706	**$ 4,901,627**
2011	Ghana	$ 1,289,413	$ 1,236,150	$ 1,087,508	$ 1,928,905	**$ 5,541,976**
2012	Ghana	$ 1,379,286	$ 1,864,286	$ 1,671,836	$ 1,065,065	**$ 5,980,473**
	Totals FY09-FY12	**$ 3,527,112**	**$ 6,282,436**	**$ 5,501,394**	**$ 6,484,076**	**$ 21,795,018**
2014 (est)	Ghana					**$ 3,812,143**

* Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR Ghana has prioritized health systems strengthening increasingly in its partnership with the Government of Ghana. A high priority is supporting the Ghana Health Service and the Ghana Ministry of Health to address the logistical challenges presented by the growing amount of commodities required as the number of PMTCT and ART sites increase, and to provide pre-service training for different cadres of health staff. PEPFAR Ghana is working with government to improve the quality of laboratories, enhancing health information management systems, increasing monitoring and evaluation capacity of the Ghana AIDS Commission and other bodies in country, and providing technical leadership for MSM and PWID surveys and surveillance and evaluation.

Country Engagement

PEPFAR Ghana has worked closely with the Government of Ghana on the national HIV strategy. It has supported the process for creating a policy framework using existing data for key populations. As a result, the Government of Ghana has developed a National Strategic Plan for key populations. PEPFAR Ghana also has piloted a key populations program that has become the national program.

With Partnership Framework funds, substantial investments were made in building the capacity of the Government of Ghana. PEPFAR Ghana will intensify its dialogue with the Government of Ghana on moving financing and coordination of the NGO prevention program for key populations and PLHIV towards the government, by using government to government funding mechanisms and joint coordination and monitoring.

The Government of Ghana's contributions to finance the HIV/AIDS response have significantly increased in 2012 and recent Global Fund grants are focused increasingly on prevention. Substantial funds are now available for the Government of Ghana to support the initial PEPFAR Ghana investment in key populations programs. To continue this trend, PEPFAR Ghana will support strengthening of the Global Fund Country Coordinating Mechanism in its new functions under the Global Fund New Funding Mechanism that will start piloting in 2013. The ultimate goal of increased country engagement is for PEPFAR to provide targeted assistance to the Government of Ghana as they address the national HIV epidemic.

Kenya

Country Context

HIV prevalence in Kenya varies considerably by geographical region, age, sex, location and socio-economic status. In 2008, HIV prevalence in Nyanza was estimated at 13. 9 percent, the highest in the country compared to only 0.9 percent in North Eastern province (KDHS). Significant differences also exist in HIV prevalence by age and gender. In 2011, 91,000 adults and 12,894 children were newly infected with HIV (Kenya AIDS Epidemic Survey 2011). The majority of new infections occur among persons in marital or cohabiting relationships (44.1 percent), casual heterosexual sex (20.3 percent), and key populations. Despite the lack of national level data, prevalence among key populations continues to be higher compared to the general population and accounts for more than a third of new infections.

Host country policies and guidelines that govern programming around key populations have been developed with active involvement of the United States government. There is strong Government of Kenya leadership in sensitizing law enforcement and health providers to provide a supportive environment for the right to health care by all populations. Structural interventions still require more focused linkages to ensure that there is a standardized understanding to guarantee services for key populations.

The PEPFAR Team is in discussion with the Government of Kenya on the current and future implications of the new constitution on the health and HIV sector as it relates to the national role of the Ministry of Health (MOH) and devolution of authority to the counties. Important issues with regard to the transition period and the devolved systems include: sufficiency of county health resources; keeping health as a priority in county governments; potential for interruption of services; county readiness to assume new functions and responsibilities; accountability and management of international agreements and commitments; and the changes donors will have to make to sustain programs at the county level.

PEPFAR Kenya key priorities in FY 2014 include treatment scale-up, supporting B+ for prevention of mother-to-child transmission (PMTCT), strengthened collaboration with the Global Fund and Kenyan government, and a strengthened supply chain management system. In FY 2014 the PEPFAR team and Kenyan government will review the Partnership Framework (PF) and work on a road map for sustainability planning and increased country ownership.

Below is a table of PEPFAR Kenya's budget representing its major program areas.

Kenya Program Planned Area Totals and Percentages								
PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
$ 159,575,761	28%	$ 118,515,077	21%	$ 194,393,690	34%	$ 92,471,065	16%	$ 564,955,593
$ 151,999,111	28%	$ 113,194,154	21%	$ 190,984,440	35%	$ 91,941,736	17%	$ 548,119,441
$ 149,725,654	29%	$ 111,424,380	22%	$ 172,649,013	33%	$ 83,488,128	16%	$ 517,287,175
$ 89,747,085	35%	$ 60,206,328	23%	$ 59,123,573	23%	$ 50,961,697	20%	$ 260,038,683
$ 551,047,611	**29%**	**$ 403,339,939**	**21%**	**$ 617,150,716**	**33%**	**$ 318,862,626**	**17%**	**$1,890,400,892**
$ 144,716,012	**37%**	**$ 68,669,497**	**18%**	**$ 110,730,236**	**29%**	**$ 64,065,255**	**17%**	**$ 388,181,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Kenya	$ 32,785,264	$ 36,437,693	$ 28,900,280	$ 7,657,846	$ 3,153,309	$ 500,000	$14,417,374	$ 35,723,995	**$ 159,575,761**
2010	Kenya	$ 31,251,792	$ 30,945,503	$ 30,945,503	$ 7,312,284	$ 3,861,156	$ 932,500	$13,080,380	$ 33,669,993	**$ 151,999,111**
2011	Kenya	$ 30,137,709	$ 30,896,051	$ 30,896,835	$ 6,675,912	$ 3,855,176	$ 931,385	$13,214,323	$ 33,118,263	**$ 149,725,654**
2012	Kenya	$ 22,611,505	$ 5,039,986	$ 19,989,821	$ 4,384,533	$ 2,940,363	$ 1,029,375	$ 9,972,400	$ 23,779,102	**$ 89,747,085**
	Totals FY09-FY12	**$ 116,786,270**	**$ 103,319,233**	**$ 110,732,439**	**$ 26,030,575**	**$ 13,810,004**	**$ 3,393,260**	**$50,684,477**	**$ 126,291,353**	**$ 551,047,611**
2014 (est)	Kenya									**$ 144,716,012**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, PEPFAR Kenya will work to stem new infections by expanding coverage to target populations to maximize impact. Kenya's prevention program intends to reach people living with HIV (PLHIV), discordant couples, key populations with increased vulnerability, and youth.

PEPFAR Kenya will prioritize HIV counseling and testing (HCT) for couples who lack knowledge of their HIV status, key populations and men in rural areas. HCT in health facilities, a low-cost model, will be scaled-up significantly, and home-based testing and counseling and outreach services will be provided in regions of high HIV prevalence and with poor access to services. Ultra-rapid test kits will increase the number of people being tested over the same amount of time. Strategies for strengthening referrals such as use of a community strategy will ensure HIV infected individuals and their families have access to care and support services.

In FY 2014, PEPFAR Kenya will also continue to support voluntary male medical circumcision (VMMC). VMMC services will be available in MOH facilities, as well as in faith-based organization health centers. Support includes renovations of operating rooms, procurement of VMMC surgical equipment and supplies, and capacity building of MOH facility staff. Eligible men will be referred to VMMC sites, while linkages to care and treatment services will be available to all HIV infected individuals. PEPFAR Kenya will continue employing targeted approaches through media and those who have undergone male circumcision to raise awareness.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Kenya	$ 83,500,000	$ 96,879,363	$ 14,014,327	**$ 194,393,690**
2010	Kenya	$ 84,750,000	$ 93,234,440	$ 13,000,000	**$ 190,984,440**
2011	Kenya	$ 70,768,240	$ 89,200,373	$ 12,680,400	**$ 172,649,013**
2012	Kenya	$ 40,860	$ 54,228,104	$ 4,854,609	**$ 59,123,573**
	Totals FY09-FY12	**$ 239,059,100**	**$ 333,542,280**	**$ 44,549,336**	**$ 617,150,716**
2014 (est)	Kenya				**$ 110,730,236**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, PEPFAR Kenya plans to increase new patient enrollment on care and treatment, sustain scale-up, and adopt new strategies to increase the number of patients on antiretroviral treatment (ART). Emphasis will also be put on identifying and linking children to care and ART, continuing improvement of quality of care, working with MOH to harmonize quality assessment tools, adoption of routine viral load monitoring, and increasing access of ART to key populations.

PEPFAR will continue to support efforts to roll out Option B+ for pregnant women. The program will support effective partnerships with the government, community, the private sector and other partners in leveraging resources to support maternal and neonatal child health services towards elimination of mother-to-child transmission.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Kenya	$ 43,264,401	$ 3,664,663	$ 20,145,509	$ 51,440,504	**$ 118,515,077**
2010	Kenya	$ 42,000,000	$ 3,750,000	$ 18,519,154	$ 48,925,000	**$ 113,194,154**
2011	Kenya	$ 41,333,684	$ 3,745,508	$ 17,500,000	$ 48,845,188	**$ 111,424,380**
2012	Kenya	$ 21,058,825	$ 6,861,300	$ 10,643,419	$ 21,642,784	**$ 60,206,328**
	Totals FY09-FY12	**$ 147,656,910**	**$ 18,021,471**	**$ 66,808,082**	**$ 170,853,476**	**$ 403,339,939**
2014 (est)	Kenya					**$ 68,669,497**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR Kenya has made tremendous progress in the provision of HIV care and support services. In FY 2014, PEPFAR will continue the provision of a minimum package of care and ART services that every provider should offer to every HIV+ patient. This minimum package includes confirmation of HIV status, ART eligibility assessment, immediate ART provision for those eligible, laboratory monitoring, co-trimoxazole prophylaxis, psychosocial counseling, adherence counseling, nutritional assessment/supplementation, prevention counseling, and opportunistic infection (OI) management.

PEPFAR Kenya will increase support to orphans and vulnerable children (OVC) in Kenya with emphasis on improved quality of care. Other innovations to be implemented in FY 2014 include strengthening the social protection framework, availing scholarships for older OVC to attend rural vocational training centers, continuing scale-up of HCT services in OVC programs and establishing an environment conducive to the sensitivities of testing children. The U.S. government will further explore public-private partnership opportunities to support the development of age-appropriate pediatric formulations, including fixed dose combinations of ARV and TB drugs particularly for OVC infants and young children at the highest risk of dying without treatment.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Kenya	$ 33,191,940	$ 21,436,149	$ 13,912,976	$ 23,930,000	**$ 92,471,065**
2010	Kenya	$ 27,828,666	$ 18,529,569	$ 15,341,013	$ 30,242,488	**$ 91,941,736**
2011	Kenya	$ 21,728,665	$ 19,208,068	$ 13,572,800	$ 28,978,595	**$ 83,488,128**
2012	Kenya	$ 7,395,081	$ 18,896,356	$ 5,710,972	$ 18,959,288	**$ 50,961,697**
	Totals FY09-FY12	**$ 90,144,352**	**$ 78,070,142**	**$ 48,537,761**	**$ 102,110,371**	**$ 318,862,626**
2014 (est)	Kenya					**$ 64,065,255**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, PEPFAR Kenya will begin transferring health service delivery to county governments within Kenya. PEPFAR Kenya will continue to work with the Kenyan government to strengthen governance structures, and provide better access to training at the county level.

The PEPFAR program will also assist the new Health Ministry, which is changing with the newly elected President and new Constitution, to finalize key policies and guidelines stemming from the new Constitution thus ensuring a smooth transition to a devolved health sector.

In FY 2014, PEPFAR Kenya will continue supporting pre-service training in Kenyan counties to increase production of key staff cadres, improve financial access to those students from rural areas, and expand the capacity of training institutions.

In FY 2014 the U.S. government will continue working to transition health workers hired under PEPFAR-funded programs to the Kenyan government's payroll. The U.S. government will support innovative private health financing mechanisms that target increased coverage for the poor and those lacking access to care; and conduct technical analyses such as the cost of an outpatient primary health care benefit package under the National Hospital Insurance Fund; and to inform national health financing policy, conduct a household health expenditure and utilization survey to generate information on the health seeking behavior of clients and household spending on health. New activities in FY 2014 will also address supply chain needs so counties can procure medical products.

The U.S. government will work to leverage funding from other multilateral organizations supporting health financing, including the German Agency for International Cooperation, the World Bank, U.K.'s Department for International Development, the Danish International Development Agency and Japan International Cooperation Agency to maximize the impact of PEPFAR-funded activities. PEPFAR Kenya will also work closely with UNAIDS and the Global Fund to coordinate advocacy, policy, and programming efforts, including engagement on

the National Oversight Committee, and providing policy support to the National AIDS Control Committee.

The U.S. government will continue working closely with the Kenyan government, other development partners and all PEPFAR implementing partners to strengthen strategic information systems and structures through surveys and surveillance, health information systems, and monitoring and evaluation. The majority of the earmarked strategic information (SI) activities will have a national focus cutting across all targeted populations in HIV programming.

Country Engagement

PEPFAR activities are planned and coordinated within the context of Kenya's National AIDS Strategic Plan, the Partnership Framework and the Partnership Framework Implementation Plan. The U.S. government will continue to facilitate joint review meetings with the Kenyan government and other development partners to ensure continued commitment towards achieving these goals.

The Global Fund continues to play an important role in support of HIV treatment in Kenya. Global Fund financing supports ARV drugs and other ART-related commodities in addition to health systems strengthening. PEPFAR and the Global Fund as donors work together with the Kenyan government to identify gaps in the HIV care and treatment program to ensure coverage.

The private sector will also be on the frontline of national sustainable financing for HIV/AIDS. The Kenya Private Sector HIV/AIDS Business Council will continue to work closely with key corporate CEOs and hold regular meetings with the Kenyan government. The private sector is also represented at the HIV/AIDS Inter-Agency Coordinating Committee at the National AIDS Control Council, and the Kenya Coordination Mechanism of the Global Fund. The sector also reaches out to the general public with various responses and partners with communities all over the country. The U.S. government continues to leverage and harness private sector partnership through its Public-Private Partnership efforts. Two of these innovative initiatives have included: the Partnership for an HIV-free Generation and the Phones for Health Project supporting the implementation of mobile health information systems.

Lesotho

Country Context

The mountainous Kingdom of Lesotho, located in the eastern part of Southern Africa, covers an area of 30,350 square kilometers and has a population of 1,876,633 million. The majority of the population, around 77 percent, lives in rural and difficult to access areas. Less than 20 percent of the population has salaried employment and 77 percent of households in Lesotho depend on subsistence agricultural as their main source of food. Employment in Lesotho is limited, and 43 percent of the population lives on less than $1.25 per day. The Lesotho workforce depends on migration to the Republic of South Africa for work opportunities such as mining, agriculture, construction, and domestic work.

Lesotho's health indicators are poor. Maternal mortality has increased to 1,155 deaths per 100,000 live births, and population growth declined to 0.08 percent. The HIV epidemic, with the world's third highest HIV prevalence, is a major factor in this decline. Since 2005, there has been no significant change in Lesotho's national adult HIV prevalence. Of those infected with HIV, over half are women, and 41,000 are children. At least 2 percent of people who need treatment are not accessing it. In 2011, there were 26,000 new HIV infections and 14,000 people died from AIDS. The prevalence of TB in Lesotho is among the highest in the world, and 80 percent of patients identified with TB are co-infected with HIV.

Based on the principles of country ownership, the response of PEPFAR Lesotho has been guided by the National Strategic Plan, launched on December 1, 2011. The national priorities going forward for the multi-sectoral response to the HIV epidemic are:

- To accelerate and intensify HIV prevention in order to reduce new annual HIV infections by 50 percent;
- To scale up universal access to comprehensive and quality-assured care, treatment, and support;
- To strengthen coping mechanisms for vulnerable individuals, groups, and households; and
- To improve the efficiency and effectiveness of coordination of the national multi-sectoral HIV and AIDS response.

Below is a chart of PEPFAR Lesotho's budget representing its major program areas.

Fiscal Year	Lesotho Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 9,440,000	33%	$ 7,337,500	26%	$ 1,085,000	4%	$ 10,447,500	37%	$ 28,310,000
2010	$ 7,843,084	27%	$ 6,430,500	22%	$ 1,365,000	5%	$ 13,561,416	46%	$ 29,200,000
2011	$ 13,610,000	40%	$ 7,595,000	22%	$ 1,275,000	4%	$ 11,720,000	34%	$ 34,200,000
2012	$ 7,707,426	46%	$ 5,027,655	30%	$ 61,714	0%	$ 3,988,205	24%	$ 16,785,000
Total 2009-2012	**$ 38,600,510**	**36%**	**$ 26,390,655**	**24%**	**$ 3,786,714**	**3%**	**$ 39,717,121**	**37%**	**$ 108,495,000**
2014 (est)	**$ 12,639,079**	**48%**	**$ 5,781,928**	**22%**	**$ 1,931,791**	**7%**	**$ 6,255,202**	**24%**	**$ 26,608,000**

* Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Lesotho	$ 2,835,000	$ 1,450,000	$ 1,305,000	$ 200,000	$ -	$ -	$ 1,000,000	$ 2,650,000	**$ 9,440,000**
2010	Lesotho	$ 705,000	$ 2,149,042	$ 2,399,042	$ 1,200,000	$ -	$ -	$ 200,000	$ 1,190,000	**$ 7,843,084**
2011	Lesotho	$ 6,810,000	$ 1,600,000	$ 1,720,000	$ 1,100,000	$ -	$ -	$ -	$ 2,380,000	**$ 13,610,000**
2012	Lesotho	$ 74,706	$ 32,481	$ 36,346	$ 35,652	$ 11,857	$ -	$ 5,024,849	$ 2,491,535	**$ 7,707,426**
	Totals FY09-FY12	**$10,424,706**	**$ 5,231,523**	**$ 5,460,388**	**$ 2,535,652**	**$ 11,857**	**$ -**	**$ 6,224,849**	**$ 8,711,535**	**$ 38,600,510**
2014 (est)	Lesotho									**$ 12,639,079**

* Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Lesotho's PEPFAR prevention portfolio supports the Government of Lesotho's priorities and emphasizes HIV counseling and testing (HCT), male circumcision, and prevention of mother-to-child transmission (PMTCT).

The government launched a national behavior change and risk reduction program with a strong community-based HCT element, though this national program needs stronger linkages to care. PEPFAR will scale-up new activities to promote provider-initiated HIV counseling and testing (PITC) at clinics and will increase efforts to reach adult men ages 25 to 35 in urban areas through workplace and door-to-door outreach. In an attempt to increase the identification of people who are HIV-infected, PEPFAR will change targeting for HCT activities. Existing community-based HCT (CBHCT) programs targeting men in transport corridors are currently identifying only

8 percent HIV-infected within the context of a national male prevalence of roughly 18 percent. In order to increase the number of HIV-infected persons identified within the CBHCT program, shifts will be made to better target higher-risk men.

The Ministry of Health (MOH) launched its Voluntary Medical Male Circumcision (VMMC) program in February 2012 and performed 10,000 circumcisions in the first twelve months of operations. PEPFAR Lesotho is rapidly scaling up VMMC services to all 10 districts of Lesotho in collaboration with the MOH's vision of integrated, facility-based services. The MOH is implementing its plan to scale up VMMC services and as of May 2013, Lesotho will adopt Option B+ for HIV positive pregnant women.

PEPFAR Lesotho will continue to support the national PMTCT program. The transition to Option B+ (lifelong treatment for pregnant women) comes with a whole cascade of activities to strengthen the national, district, and local health systems in quality improvement, strategic information, surveillance, PITC, improved (evidence based and measurable) community-based approaches, and human resources for health. Building on the current PMTCT acceleration plan, in FY 2014 PEPFAR will closely monitor HIV positive mother-infant pairs to ensure HIV-free survival of HIV exposed infants.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Lesotho	$ -	$ 633,000	$ 452,000	**$ 1,085,000**
2010	Lesotho	$ -	$ 715,000	$ 650,000	**$ 1,365,000**
2011	Lesotho	$ -	$ 675,000	$ 600,000	**$ 1,275,000**
2012	Lesotho	$ -	$ 29,233	$ 32,481	**$ 61,714**
	Totals FY09-FY12	**$ -**	**$ 2,052,233**	**$ 1,734,481**	**$ 3,786,714**
2014 (est)	Lesotho				**$ 1,931,791**

* Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The Lesotho treatment program focuses on providing technical assistance and capacity building support to strengthening ART and health systems. The overall goals and priorities of PEPFAR's treatment program are to:

- Support the scale-up of PMTCT Option B+;
- Increase antiretroviral treatment (ART) uptake and retention;
- Support the health decentralization process;
- Strengthen supply chain management systems; and

- Improve the technical and organizational capacity of nursing educational institutions and nurses.

The Government of Lesotho buys all antiretroviral drugs (ARV) drugs while PEPFAR Lesotho supports a national, integrated systems approach and provides training of in-country clinicians, facility-level clinical capacity building, and guidance on policies and strategies to improve data collection, programmatic efficiency, and quality of care. PEPFAR Lesotho also supports the national program to quantify ART and related commodity needs and purchase accordingly. To strengthen treatment services and health systems, PEPFAR Lesotho provides technical assistance to build leadership skills for program management.

Adult and pediatric treatment budget allocations will increase in FY 2014 as the U.S. government supports the move to Option B+ and national coverage for treatment services increases. In adult treatment, PEPFAR Lesotho will scale up district and facility level quality improvement of services. Also, capacity building at these levels for treatment will be strengthened with the secondment of five additional nurse clinicians to ART clinics in 5 more district hospitals. Trainings and rotations for HIV resistance diagnosis and management will be established at a high-volume Maseru site while central support for early diagnosis of HIV resistance will be provided. As a complement to the prevention activities that follow mother-infant pairs, PEPFAR Lesotho's pediatric treatment program will support four additional pediatric HIV management satellite centers of excellence.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Lesotho	$ 1,315,500	$ 622,000	$ 2,175,000	$ 3,225,000	**$ 7,337,500**
2010	Lesotho	$ 1,432,500	$ 975,000	$ 2,365,000	$ 1,658,000	**$ 6,430,500**
2011	Lesotho	$ 1,900,000	$ 1,000,000	$ 3,000,000	$ 1,695,000	**$ 7,595,000**
2012	Lesotho	$ 219,706	$ 45,473	$ 3,312,003	$ 1,450,473	**$ 5,027,655**
	Totals FY09-FY12	**$ 4,867,706**	**$ 2,642,473**	**$ 10,852,003**	**$ 8,028,473**	**$ 26,390,655**
2014 (est)	Lesotho					**$ 5,781,928**

* Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Care and support activities in Lesotho include provision of basic health care and support for adults and children, delivery of integrated TB/HIV services, and orphans and vulnerable children (OVC) programs. PEPFAR interventions in Lesotho will result in a marked increase in access to a full range of well-coordinated essential services focused on OVC and their families. These interventions will be provided in a manner consistent with the local context and meeting international standards for quality.

Support for the clinical response to the combined TB and HIV epidemics is a significant part of the PEPFAR program in Lesotho. The TB/HIV response will continue to support TB diagnostics, care, and treatment of TB/HIV in the military, textile factories, and in public and private clinics. Together with the MOH, PEPFAR activities will support the national strategy for the TB response, including monitoring and evaluation.

In prior years, the PEPFAR Lesotho program supported counseling for sero-discordant couples, counseling on sero-conversion in pregnancy, counseling on safer sex negotiation skills, and male partner testing and counseling. However, these services have not been expressly provided in one package at all health facilities. In FY 2014, PEPFAR Lesotho will increase efforts to provide these services as an integrated package, and will work with MOH and implementing partners to develop a strategy for positive health, dignity, and prevention (PHDP) and improve the quality of services provided.

Malnutrition is a key health issue in Lesotho, and PEPFAR Lesotho integrates nutrition into all hospitals in Lesotho, with nutrition assessment, counseling, and support (NACS) services for all mothers and their children. The NACS program builds on the PMTCT platform and a Government of Lesotho-led program for food support. PEPFAR Lesotho also contributes to the national nutrition technical working group with technical expertise and capacity building.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Lesotho	$ 1,995,000	$ 2,420,000	$ 4,437,075	$ 1,595,425	**$ 10,447,500**
2010	Lesotho	$ 1,255,000	$ 1,155,000	$ 5,171,914	$ 5,979,502	**$ 13,561,416**
2011	Lesotho	$ 1,885,000	$ 1,265,000	$ 4,400,000	$ 4,170,000	**$ 11,720,000**
2012	Lesotho	$ 432,403	$ 458,234	$ 1,203,617	$ 1,893,951	**$ 3,988,205**
	Totals FY09-FY12	**$ 5,567,403**	**$ 5,298,234**	**$ 15,212,606**	**$ 13,638,878**	**$ 39,717,121**
2014 (est)	Lesotho					**$ 6,255,202**

* Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Defined as a human resources in health (HRH) crisis country by the WHO, Lesotho has distinct challenges which place it at a disadvantage even as compared to other African countries. The lack of HRH for health is a critical limitation to the functioning of Lesotho's health system. As a result, there is a high level of misdistribution of the health workforce within the country, with urban areas absorbing much of the labor pool.

The MOH takes these challenges seriously and has taken steps to address them. The MOH has developed several sector policies and strategies, including a Human Resource Development Strategic Plan (2005-2025). Since the plan's development, the MOH, with the support of various partners, has been implementing components of this strategy. An area that has received particular attention includes pre-service training, with an emphasis on increasing the cadre of nurses. Lesotho is also preparing to open its first School of Medicine in partnership with the University of Zimbabwe, where PEPFAR Lesotho is leveraging support from the Medical Education Partnership Initiative.

The programs will intensify efforts to enhance the implementation capacity of the HRH Directorate and will finalize implementation plans for strengthening the recruitment and retention systems. Revamped technical assistance will improve progress in the refinement and roll-out of the human resource information system (HRIS) as part of the structures for a decentralized workforce. The Council for Higher Education will be supported to further take up their authority for oversight of health training institutions. Finally, to support the sustainability of technical assistance to the MOH for strengthening HRH, programs will implement some program activities through local organizations. This selection of activities is expected to maximize the impact of the efforts made in prior years and create a firm foundation for the MOH to continue strengthening its human resource for health systems in subsequent years.

Another key issue for strengthening the health system is the weak supply chain, which has an unreliable supply of essential medicines. The weak information management capacity within the ART program has resulted in the Global Fund (GF) setting a condition precedent which the Principal Recipient (PR) has to address to qualify for further disbursement of Round 8, Phase 2 funds. The GF has requested that the PR put in place a robust, functional management information system for the ART program. This has been evidenced by over-stocking of some ARVs and stock-outs of rapid HIV test kits and laboratory reagents in the recent past. To complement the GF request, PEPFAR Lesotho will focus on improving pharmaceutical management by strengthening the central pharmaceutical directorate and building capacity at facilities to enable them to improve commodity management and patient care. Particular focus will be placed on building information management capacity among healthcare workers, both at the central level as well as the districts and facilities. The program activities are based not only on the need to strengthen systems, but also on the immediate needs identified locally, including the need to satisfy the GF's condition precedent for further Round 8 disbursements.

Country Engagement

Lesotho is one of PEPFAR's long-term strategy countries and falls in GF as a Band 1 country with low income and high disease burden. The Government of Lesotho has allocated 14 percent of its budget to health, and the MOH's HIV program has $38 million of public funding. PEPFAR Lesotho's technical assistance partnership with the Government of Lesotho has resulted in policy development and shifts that were outlined in the PF. The Government of Lesotho sets the vision for the U.S. government investments in HIV, and in the broader development partner community, is the leader in joint planning and execution of the HIV response.

Based on the commitment, financial and otherwise, of the Government of Lesotho, the PEPFAR Lesotho team anticipates that the country will take increasing responsibility for strategic development of the HIV response. Working with all actors, through a timely and transparent process, the development partners and government will define priorities, strategies and targets that are evidence based and allocate funding accordingly. As this is realized, the Government of Lesotho will be enabled to take more financial planning decisions in guiding the PEPFAR support. In turn, the PEPFAR Lesotho program will be able to focus increasingly on discreet programmatic technical assistance projects to improve the quality, effectiveness, and efficiency of the national response. Specifically, the U.S. government will support the Government of Lesotho's efforts to hire more nurses, redesign and simplify the supply chain, and bring key HIV policies like Option B+ and VMMC to scale.

Malawi

Country Context

The HIV epidemic in Malawi is mature and generalized. HIV prevalence among 15-49 year olds has declined from 11.8 percent in 2004 to 10.6 percent in 2010 per the Malawian Demographic and Health Survey (MDHS).

In this country of nearly 16 million people, AIDS is the leading cause of death, with an estimated 44,000 deaths in 2011, and is a major contributing factor to Malawi's low life expectancy of 54 years. Modeling of 2010 antenatal clinic data and the 2010 MDHS data shows just fewer than one million of Malawians living with HIV, 19 percent are children under 15 and 47 percent are adult women. Despite having a severe health worker shortage and a very resource limited environment, Malawi has been able to maintain leadership in sub-Saharan Africa while making gains in fighting the HIV epidemic. By the end of 2012, the Malawian Ministry of Health's (MOH) HIV treatment program had 391,338 patients alive and on antiretroviral treatment (ART), which is an increase of 32 percent from 2011.

Malawi has made tremendous progress in expanding both the scale and quality of its national response to HIV/AIDS in recent years, leveraging Global Fund (GF) resources, PEPFAR, and other donor investments to bolster the health system in the near-term while making long-term systems strengthening investments. PEPFAR provides critical support for Malawi's national HIV treatment program. While the GF funds the antiretroviral drugs (ARV), PEPFAR supports critical inputs in service delivery, program management and performance, prevention of new infections, and health systems strengthening. In 2011, Malawi's national HIV response transitioned to an integrated model, incorporating HIV treatment, prevention of mother-to-child transmission (PMTCT), and primary care in a unified service delivery approach. Option B+ has provided a platform to aggressively scale-up ART access under a programmatically-sustainable approach.

Below is a table of PEPFAR Malawi's budget representing its major program areas.

Fiscal Year	Malawi Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 15,464,110	34%	$ 10,004,348	22%	$ 1,401,387	3%	$ 18,830,155	41%	$ 45,700,000
2010	$ 27,225,331	49%	$ 7,468,369	14%	$ 2,101,777	4%	$ 18,479,523	33%	$ 55,275,000
2011	$ 30,005,717	46%	$ 9,531,278	15%	$ 2,414,816	4%	$ 23,048,189	35%	$ 65,000,000
2012	$ 34,033,995	49%	$ 8,097,992	12%	$ 7,711,039	11%	$ 20,156,974	29%	$ 70,000,000
Total 2009-2012	**$ 106,729,153**	**45%**	**$ 35,101,987**	**15%**	**$ 13,629,019**	**6%**	**$ 80,514,841**	**34%**	**$ 235,975,000**
2014 (est)	**$ 28,690,572**	**39%**	**$ 10,687,952**	**15%**	**$ 10,735,682**	**15%**	**$ 23,145,795**	**32%**	**$ 73,260,000**

* Totals include planned funding for all accounts.
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Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Malawi	$ 1,223,650	$ 5,871,022	$ 3,901,821	$ 150,000	$ 108,460	$ -	$ 2,062,380	$ 2,146,777	**$ 15,464,110**
2010	Malawi	$ 12,036,294	$ 5,040,260	$ 3,753,481	$ 1,140,000	$ 275,000	$ -	$ 1,513,168	$ 3,467,128	**$ 27,225,331**
2011	Malawi	$ 12,443,104	$ 4,507,850	$ 3,602,620	$ 1,240,000	$ 100,000	$ -	$ 4,252,770	$ 3,859,373	**$ 30,005,717**
2012	Malawi	$ 11,588,925	$ 3,407,898	$ 2,877,986	$ 1,173,909	$ 100,000	$ -	$ 11,135,792	$ 3,749,485	**$ 34,033,995**
	Totals FY09-FY12	**$ 37,291,973**	**$ 18,827,030**	**$ 14,135,908**	**$ 3,703,909**	**$ 583,460**	**$ -**	**$ 18,964,110**	**$ 13,222,763**	**$ 106,729,153**
2014 (est)	Malawi									**$ 28,690,572**

* Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR Malawi's comprehensive prevention program began with a focus on risk reduction, which was done by strengthening communities to identify and address HIV risk. It includes strong components for people living with HIV/AIDS (PLHIV), and involves working with local and traditional leadership. The PEPFAR team continues its multi-faceted approach to reducing new infections in Malawi by focusing on improving the quality of all HIV counseling and testing (HCT) services, strengthening the Option B+ program, scaling up voluntary medical male circumcision (VMMC), targeting high risk and vulnerable groups through community interventions, increasing condom access and utilization, and linking HIV-infected individuals to facility-based services.

Historically, PEPFAR has been the main funder of HIV prevention activities in Malawi, although the GF has funded condom procurement and programs for young people. With emphasis on task-shifting to non-physician care providers, PEPFAR Malawi has provided financial and technical support for rapid scale up of Option B+, whereby all HIV positive pregnant women are offered ART for life regardless of CD4 cell count or clinical stage. National rollout of Option B+ has achieved impressive results, with 87 percent of known HIV infected pregnant women initiating lifelong ART and the likelihood of substantially decreasing prevention of mother-to-child transmission (PMTCT) and maternal deaths. Scaling up VMMC is a U.S. government priority in Malawi. Malawi has overcome several political hurdles surrounding this intervention, and the Government of Malawi, religious leaders, and civil society have all officially endorsed VMMC for HIV prevention. Traditional local structures and community-based organizations are being bolstered to establish linkages and referrals, track mother-infant pairs, and provide adherence support.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Malawi	$ 250,000	$ 1,151,387	$ -	**$ 1,401,387**
2010	Malawi	$ 138,000	$ 939,082	$ 1,024,695	**$ 2,101,777**
2011	Malawi	$ -	$ 1,666,541	$ 748,275	**$ 2,414,816**
2012	Malawi	$ -	$ 5,672,562	$ 2,038,477	**$ 7,711,039**
	Totals FY09-FY12	**$ 388,000**	**$ 9,429,572**	**$ 3,811,447**	**$ 13,629,019**
2014 (est)	Malawi				**$ 10,735,682**

* Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Treatment priorities include the scale up of a high quality comprehensive HIV service delivery package for adults and children using a family centered approach for pre-ART and ART. As the national treatment program continues to expand, PEPFAR Malawi will continue to focus on ensuring high quality service delivery by addressing each of the individual clinical or social interventions of the comprehensive package, as well as the different systems elements with a focus on human resources, commodity security, information systems, laboratory and infrastructure and patient flow. There will be ongoing support to the national clinical mentoring program. TB-HIV interventions will be expanded to include intensified case finding, Isoniazid preventive therapy and infection control.

Malawi has a streamlined public-health approach to ART and has had remarkable success in scaling-up ART nationally. In 2011, Malawi's national HIV response transitioned to an integrated model, incorporating ART, HIV care, TB care, and PMTCT into primary health clinics. The changes include a new approach to PMTCT ("Option B+"). Option B+ has greatly

increased mothers' access to ART and allowed Malawi to move much more rapidly toward elimination of mother-to-child transmission. The GF funds core elements of the ART program, including ARV and other commodities. U.S. government programs are designed to complement the GF elements and will support the provision of ART, treatment for opportunistic infections, access to family planning services, and viral load and CD4 monitoring. Technical assistance will be provided to district health management teams and zonal health support offices to strengthen HIV service delivery, program management, and quality improvement approaches at site level. PEPFAR Malawi will support the revision of the ART- PMTCT guidelines and refresher trainings for ART and PMTCT service providers to enable a full transition to a Tenofovir-based regimen.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Malawi	$ 2,294,902	$ -	$ 1,978,193	$ 5,731,253	**$ 10,004,348**
2010	Malawi	$ 2,278,481	$ 591,957	$ 817,081	$ 3,780,850	**$ 7,468,369**
2011	Malawi	$ 2,515,892	$ 674,126	$ 1,738,336	$ 4,602,924	**$ 9,531,278**
2012	Malawi	$ 1,701,767	$ 438,103	$ 1,524,012	$ 4,434,110	**$ 8,097,992**
	Totals FY09-FY12	**$ 8,791,042**	**$ 1,704,186**	**$ 6,057,622**	**$ 18,549,137**	**$ 35,101,987**
2014 (est)	Malawi					**$ 10,687,952**

* Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The PEPFAR Malawi HIV care program supports care to both adults and children living with HIV. Programs provide pre-ART management for people living with HIV/AIDS (PLHIV), support access to TB/HIV services, and address the nutrition and care needs of orphans and vulnerable children (OVC).

The PEPFAR care program will continue to strengthen the national referral, feedback, and patient tracking systems. PEPFAR funds support a minimum package of services including co-trimoxazole preventive therapy, counseling and referral to family planning, TB screening, sexually transmitted infection screening, health education, and nutrition counseling. PEPFAR Malawi's OVC portfolio will continue at both the national level to strengthen systems, and at the community level to support families and provide services to vulnerable populations. The HIV/AIDS clinical care program will optimize the identification of HIV infected children, enrollment in care and timely initiation on ART, and scale-up youth-friendly services for adolescents.

PEPFAR Malawi will continue to support demand creation, adherence counseling, improved retention in care, referral systems, patient tracking and follow-up of Mother Infant Pairs at

facility and community levels. Partners will collaborate with national networks for PLHIV to increase PLHIV support groups' efficacy. A key program shift will be implementing a concerted approach in addressing the needs of adolescent PLHIV to support progress towards an AIDS-Free Generation, including prevention, HCT, care and treatment, and adherence retention.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Malawi	$ 1,170,000	$ 2,186,796	$ 11,453,798	$ 4,019,561	**$ 18,830,155**
2010	Malawi	$ 3,378,767	$ 2,739,004	$ 5,866,190	$ 6,495,562	**$ 18,479,523**
2011	Malawi	$ 3,359,075	$ 3,037,252	$ 8,679,934	$ 7,971,928	**$ 23,048,189**
2012	Malawi	$ 2,561,469	$ 3,063,231	$ 7,502,847	$ 7,029,427	**$ 20,156,974**
	Totals FY09-FY12	**$ 10,469,311**	**$ 11,026,283**	**$ 33,502,769**	**$ 25,516,478**	**$ 80,514,841**
2014 (est)	Malawi					**$ 23,145,795**

* Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Malawi's national HIV response has a high level of country ownership, a very carefully coordinated health sector through the MOH and the National AIDS Commission (NAC), and a willingness to use evidence to boldly introduce and evaluate innovative new policies and service delivery programs.

The PEPFAR Malawi health systems strengthening (HSS) portfolio balances support for delivery of HIV health services with implementation of crosscutting approaches in order to improve Malawi's health system. This includes strengthening supply chain for health commodities, health financing, leadership and governance activities, as well as support for human resources for health (HRH) strengthening, laboratory services and strategic information (SI).

PEPFAR Malawi will improve and strengthen national level supervision and clinical mentoring systems; monitor national policies that affect HIV/AIDS programs; and develop and/or revise key national level strategies and guidelines to implement HCT, Option B+, VMMC, HIV/TB, community care and HIV prevention programs. PEPFAR Malawi will scale up pilot initiatives on referral and patient tracking systems, specimen transportation systems and performance-based financing through existing partners. PEPFAR Malawi will support construction and renovations at high volume sites in selected districts.

Country Engagement

The Government of Malawi supports a public health system which incorporates much of the HIV response. Like many countries, Malawi also has a NAC that coordinates a multi-sectoral response to the epidemic. Sixty percent of all health and HIV/AIDS services are delivered through the public health infrastructure by government employees, and the other 40 percent is delivered through health facilities and training institutions of the Christian Health Association of Malawi (CHAM), a faith-based umbrella organization. However, over 90 percent of the national HIV response is funded by donors. Increasing the financial ownership of Malawi's government to reduce Malawi's donor dependence in the health sector is an issue of growing importance.

Malawi was the first country to sign a Partnership Framework (PF) with the U.S. government and is in the final year of its PF implementation plan. PEPFAR Malawi interacts with NAC and the MOH HIV Department on a daily basis, and maintains very strong, close, and interdependent relationships with key staff in both institutions.

The recent political transition in Malawi has brought renewed optimism among its citizens and the Banda Administration has moved decisively to restore confidence among donors. A new Joint Financing Agreement for health and agreement with the Government of Malawi on auditing and financial oversight requirements will pave the way for renewed budget support from European donors. The development of a National Health Financing Strategy by the MOH, with PEPFAR support, is an opportunity to chart a new course for the country.

Mozambique

Country Context

Mozambique is a rural country of approximately 23 million people where the impact of HIV and other major preventable diseases (e.g. malaria, tuberculosis, and waterborne diseases) contribute to Mozambique's life expectancy of 51 years. It has a low United Nations Human Development Index ranking of 168 out of 177 countries.

Mozambique faces a severe generalized HIV epidemic that has adversely affected growth and development in the country, and has taxed a fragile health system. The prevalence of HIV among Mozambican adults aged 15-49 is 11.5 percent (2009 national survey), with prevalence among women higher than men (13.1 percent vs. 9.2 percent). Young women (aged 15-24 years), particularly in Sofala and Gaza provinces, are disproportionately affected at rates five and six times higher in comparison to men. Prevalence among children aged 0-11 years is 1.4 percent. An estimated 1.4 million Mozambicans are living with HIV, with an additional 821,000 orphaned children directly affected by the epidemic. Key drivers of Mozambique's HIV epidemic are risky sexual behaviors, low rates of male circumcision, low and inconsistent condom use, mobility and migration, and sex work.

Eighty-two percent of Mozambicans live on less than two dollars per day. With limited health infrastructure, more than half of all Mozambicans walk over one hour to reach the nearest health facility. Health facilities face frequent commodity stock outs and a general dearth of basic amenities: 55 percent lack electricity and 41 percent lack running water. Likewise, human resources for health (HRH) are severely constrained in Mozambique. With only five doctors and 24 nurses per 100,000 population, and 429 social workers in the country, Mozambique faces some of the most critical HRH shortages in the world. There is an inadequate number of trained and competent health care workers in all cadres, including an uneven geographic distribution of health providers, which are often poorly trained and have limited supervision. The Government of Mozambique's capability to oversee its policies and regulations and to coordinate all health actors is weak, resulting in poor overall supervision and coordination. Information systems and monitoring and evaluation efforts are generally unable to provide timely and accurate health system data.

In FY 2014, the PEPFAR program will focus efforts to contribute to the global priorities set forth in the AIDS Free Generation (AFG) policy by supporting the Mozambique government's national "HIV/AIDS Acceleration Plan 2013-2015" (Acceleration Plan) to increase the percentage of eligible adults and children with advanced HIV infection who receive antiretroviral treatment (ART) to 80 percent; increase the percentage of HIV-positive pregnant women who receive antiretrovirals (ARVs) to 90 percent; and increase the percentage of adult males circumcised in Mozambique to 80 percent by 2015. The Acceleration Plan, developed in close partnership with the PEPFAR Mozambique team, prioritizes high-impact interventions and geographic areas, and focuses on a continuum of response which addresses key populations.

Below is a table of PEPFAR Mozambique's budget representing its major program areas.

Fiscal Year	Mozambique Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 68,430,075	27%	$ 37,051,615	15%	$ 58,225,814	23%	$ 89,170,807	35%	$ 252,878,311
2010	$ 91,454,076	34%	$ 39,992,336	15%	$ 54,828,985	20%	$ 82,814,200	31%	$ 269,089,597
2011	$ 86,127,878	32%	$ 44,017,526	16%	$ 56,720,000	21%	$ 81,924,193	30%	$ 268,789,597
2012	$ 60,652,109	26%	$ 33,518,680	15%	$ 78,899,565	34%	$ 58,005,555	25%	$ 231,075,909
Total 2009-2012	**$ 306,664,138**	**30%**	**$ 154,580,157**	**15%**	**$ 248,674,364**	**24%**	**$ 311,914,755**	**31%**	**$1,021,833,414**
2014 (est)	**$ 65,061,920**	**26%**	**$ 51,858,975**	**20%**	**$ 81,382,376**	**32%**	**$ 55,989,729**	**22%**	**$ 254,293,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Mozambique	$ 21,610,179	$ 14,085,078	$ 14,961,457	$ 2,370,000	$ 2,848,780	$ -	$ 3,000,000	$ 9,554,581	**$ 68,430,075**
2010	Mozambique	$ 40,759,401	$ 16,477,474	$ 14,991,473	$ 2,194,589	$ 3,014,078	$ -	$ 3,491,765	$ 10,525,296	**$ 91,454,076**
2011	Mozambique	$ 31,609,878	$ 14,221,927	$ 14,388,073	$ 2,194,000	$ 3,014,000	$ 800,000	$ 8,400,000	$ 11,500,000	**$ 86,127,878**
2012	Mozambique	$ 24,110,187	$ 2,983,479	$ 7,325,478	$ 1,525,833	$ 2,193,085	$ 222,874	$ 9,891,509	$ 12,399,664	**$ 60,652,109**
	Totals FY09-FY12	**$ 118,089,645**	**$ 47,767,958**	**$ 51,666,481**	**$ 8,284,422**	**$ 11,069,943**	**$ 1,022,874**	**$24,783,274**	**$ 43,979,541**	**$ 306,664,138**
2014 (est)	Mozambique									**$ 65,061,920**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, a key prevention priority of PEPFAR Mozambique will be to support the Ministry of Health (MOH) in improving and sustaining maternal health by scaling-up PMTCT Option B+ (lifelong treatment of all pregnant women). In a phased approach, PEPFAR Mozambique will:

- Support the MOH with immediate initiation of lifelong ART for couples;
- Leverage other donor funds to increase provision of family planning together with ART services;
- Prioritize high impact prevention activities for voluntary medical male circumcision (VMMC) and key populations;
- Provide support for improvement of data collection; and
- Expand quality improvement (QI) activities.

The new MOH national VMMC strategy aims to achieve 80 percent coverage in target provinces by 2017 and with support from the U.S. government. As VMMC is scaled up, so will efforts to increase male use of treatment and care services. Mozambique's FY 2014 programming for key populations (commercial sex workers (CSW), men who have sex with men (MSM), miners, and truckers) will focus on expanding outreach, counseling and testing activities, and linking those individuals identified as positive into treatment and care. Resources will be used to advance universal treatment for most-at-risk MSM and CSW populations. Efforts will be made to coordinate activities with principal recipients of the GF which is also focusing on key populations. Resources for abstinence and be faithful programs, blood safety, and general HIV counseling and testing will be significantly reduced to support MOH priorities in PMTCT and VMMC.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Mozambique	$ 13,541,522	$ 37,198,256	$ 7,486,036	**$ 58,225,814**
2010	Mozambique	$ 10,000,000	$ 36,348,983	$ 8,480,002	**$ 54,828,985**
2011	Mozambique	$ 9,920,000	$ 38,320,000	$ 8,480,000	**$ 56,720,000**
2012	Mozambique	$ 43,004,667	$ 27,218,145	$ 8,676,753	**$ 78,899,565**
	Totals FY09-FY12	**$ 76,466,189**	**$ 139,085,384**	**$ 33,122,791**	**$ 248,674,364**
2014 (est)	Mozambique				**$ 81,382,376**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, the U.S. government team in Mozambique will direct a significant amount of the overall budget to support care and treatment activities. For treatment services, PEPFAR will support National Acceleration Plan activities which include:

- Task shifting from clinics to nurses and lower cadres;
- Site expansion with a focus on 24 high-impact districts defined by the MOH based on HIV disease epidemiology and burden;
- Expansion of early infant diagnosis and universal pediatric ART to age five;
- Treatment for individuals with TB/HIV co-infection; and
- Engaging gender advisors who will develop action plans to ensure that more men access HIV services.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Mozambique	$ 14,686,673	$ 939,237	$ 3,668,470	$ 17,757,235	**$ 37,051,615**
2010	Mozambique	$ 16,537,003	$ 1,995,295	$ 3,975,589	$ 17,484,449	**$ 39,992,336**
2011	Mozambique	$ 17,290,000	$ 1,990,900	$ 6,070,000	$ 18,666,626	**$ 44,017,526**
2012	Mozambique	$ 12,055,464	$ 1,872,900	$ 6,800,167	$ 12,790,149	**$ 33,518,680**
	Totals FY09-FY12	**$ 60,569,140**	**$ 6,798,332**	**$ 20,514,226**	**$ 66,698,459**	**$ 154,580,157**
2014 (est)	Mozambique					**$ 51,858,975**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

FY 2014 represents a shift in prioritization of the care portfolio, with counseling and testing, care, PMTCT, and treatment targets directly linked in a cascade to ensure a continuum of response. Key strategies employed to ensure PLHIV are retained in care services and receive timely initiation into HIV treatment include provision of a basic pre-ART package of services, formalized linkages between the facility and communities and shifts away from traditional palliative care. Strengthening linkages between facilities and communities fundamental to the continuum of response continues to be a priority to increase demand, expand access, and increase of uptake of services.

In line with Goal 5 of the Partnership Framework (PF), the U.S. government and Mozambique government are collaborating in FY 2014 to create a more effective system for ensuring that both adults and children living with HIV have access to HIV testing, timely initiation of ART and prophylaxis to prevent opportunistic infections including tuberculosis (TB), and screening and treatment of sexually transmitted infections. Care and support activities in Mozambique include provision of basic health care and primary health care for HIV+ adults and children, delivery of integrated TB/HIV services, and extensive orphan and vulnerable children (OVC) programs. To increase demand, expand access, and increase use of services, PEPFAR will continue supporting the Mozambique government by providing support to the MOH's cadre of community health workers (CHWs) who serve as primary interlocutors between MOH facilities and the

community. By standardizing the roles of official and unofficial CHWs in all PEPFAR-supported health facilities, CHWs will be better placed to support bidirectional referral systems for positive prevention, nutritional counseling and OVC services.

Moreover, Mozambique is currently in the final drafting stages of a new National Plan of Action for Children, the overarching document to guide OVC programming for Mozambique.
In FY 2014, special emphasis will be placed on integrating community activist (*activista*) activities, improving linkages with clinical services, increasing HIV testing of families of OVC, increasing economic strengthening activities and strengthening the National AIDS Council (NAC), and systems support to the Ministry of Women and Social Action. Addressing the needs of adolescent girls will continue to be a focus of OVC programming. As early marriage is a serious issue in Mozambique, programs will strive to keep more girls in primary school as well as ensure their successful transition into secondary school. Efforts will continue to address their vulnerabilities to HIV as well as gender-based violence (GBV) in collaboration with activities under the GBV Initiative.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Mozambique	$ 11,230,166	$ 6,694,673	$ 54,865,050	$ 16,380,918	**$ 89,170,807**
2010	Mozambique	$ 10,924,314	$ 4,390,589	$ 42,443,018	$ 25,056,279	**$ 82,814,200**
2011	Mozambique	$ 9,200,000	$ 7,246,000	$ 39,390,000	$ 26,088,193	**$ 81,924,193**
2012	Mozambique	$ 9,362,258	$ 7,221,664	$ 24,186,693	$ 17,234,940	**$ 58,005,555**
	Totals FY09-FY12	**$ 40,716,738**	**$ 25,552,926**	**$ 160,884,761**	**$ 84,760,330**	**$ 311,914,755**
2014(est)	Mozambique					**$ 55,989,729**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In the Partnership Framework Implementation Plan (PFIP), the PEPFAR team outlined a sustainability and transition strategy which included efforts to strengthen Mozambican institutions and increase direct funding to local institutions (Mozambique government and civil society). In FY 2014, all agreements with local institutions will be coupled with intensive capacity building at organizational and individual levels to strengthen systems needed as directed management of U.S. government funding transitions from large international organizations to local organizations. In FY 2014, direct funding to local NGOs is expected to increase to $21.6 million of program resources to ensure sustainability and strengthen capacity. The U.S. government HRH portfolio will increase attention to recruitment, deployment, and retention for essential health worker cadres critical to reaching rural populations, as well as training and deploying nonclinical cadres such as health administrators, managers, and supply chain logisticians. Additionally, the U.S. government will focus on building citizen capacity to

demand better and more accountable services and engage in decentralization of Mozambique government health sector functions and management processes to the provinces and districts. In 2013 and 2014, PEPFAR will increase support to decentralized planning, management, and implementation to better ensure health priorities and resources at local levels respond to local needs, and contribute to greater transparency and accountability in the planning and budgeting process.

Commodity security and a strong supply chain system are critical to the achievement of the AFG targets in the National Acceleration Plan, as well as, the PF and GHI strategy. PEPFAR Mozambique will increase funding for HIV commodities until Global Fund and other financing can be secured to enable the MOH to scale-up activities, increase the interval between patient drug pick-ups, and improve patient care and retention. Recent experience has demonstrated that without adequate (one year) buffer stock, providers dispense out medicines in smaller quantities, requiring patients to return more frequently to collect drugs. This, in turn, increases the burden on both the facility and the patient, overwhelming facilities and undermining patient retention. Ensuring procured medicines reach patients via the national supply chain system continues to be a top priority in 2014. In addition, PEPFAR prioritizes technical assistance to the national, provincial, and district levels with a focus on support for data systems for improved quantification and improved local distribution.

The Mozambique government has a well-developed donor coordination system that encourages country ownership and enables the U.S. government to invest in country-led plans. Donors supporting the HIV sector in Mozambique include the United Kingdom, Ireland, Denmark, Canada, the European Union, World Bank, UN agencies, Brazil, the Clinton Foundation, and the GF. Coordination of support to the HIV response is facilitated by the HIV Partners Forum which engages the NAC in policy dialogue and programmatic issues, and through the Health Partners Group which engages the MOH in broader health and HIV issues through policy dialogue. The Mozambique government/donor forum has a technical working group structure in which U.S. government staff actively participates. In addition to these structures, the U.S. government meets regularly with key officials of individual Ministries (Health, Defense, Women and Social Action) and monthly with the National Directors of the MOH to ensure that U.S. government assistance complements and supports the Mozambique government's plans for prevention, care, treatment, and health systems strengthening. The U.S. government is a member of the GF Country Coordination Mechanism (CCM).

Country Engagement

Mozambique government leadership has been actively confronting challenges in the health sector and HIV response. This past year, the Mozambique government developed a focused, evidence-based national acceleration plan for the HIV response which the Mozambique government is both leading and driving. In 2012, the Mozambique government allocated U.S. $420 million to the health sector – including U.S. $320 million to the Ministry of Health (MOH) and US $6 million to the Mozambique's National AIDS Council (NAC). This funding, plus external resources, or donor support, represents 7.2 percent of the total Mozambique government budget for 2012. Relative to the Mozambique government and other donors, including the GF, U.S. government health funding represented 42 percent (US $340 million) of total health budget funds.

The Mozambique government is leading and coordinating a five-year health sector strategy development process which aims to improve the clarity and focus of health activities within specific provinces with the intention of harmonizing activities and targets across health programs in order to ensure measurable and coordinated outcomes. The Mozambique government has fulfilled its PF commitment to create a national VMMC strategy and is currently conducting several costing studies to enable them to better plan and use resources to achieve their ambitious targets and recruit additional resources.

In FY 2013, the MOH began to absorb previously donor funded employees (non-U.S. government funded) into its permanent staff, paying their wages with internal funds. In 2014, the U.S. government will continue to support the Mozambique government in evidence-based decision making and will continue to advocate for more investments in its own health sector so that U.S. government efforts are part of a sustainable plan for strengthening the overall public health sector. The PEPFAR team will continue to foster and strengthen institutional capacity and capabilities of staff within the MOH, the National AIDS Council (NAC), the Ministry of Women and Social Action, and the Ministry of Defense. In 2014, the U.S. government will continue to support significant technical assistance (TA) to the Mozambique government and local institutions to improve their capabilities, support the Mozambique government Acceleration Plan at central and provincial levels, and support the MOH to successfully implement Global Fund resources.

Namibia

Country Context

The HIV epidemic in Namibia is generalized, with HIV prevalence among 15-49 year old adults estimated at 13.3 percent. Approximately 173,000 Namibian adults and children are living with HIV, around 6,310 Namibians die annually of AIDS-related causes, and an estimated 15 new infections occur daily. HIV prevalence is highest among women aged 30–34 years (29.6 percent) and 35-39 years (29.7 percent). In the last three rounds of sentinel surveillance, prevalence in these age groups increased. However, the same surveillance reports identified a decline in prevalence among 15–19 and 20–24 year old women, indicative of a maturing epidemic. The 2012 antenatal clinic (ANC) survey reported HIV prevalence among pregnant women attending ANCs at 18.2 percent, a decline from the peak prevalence estimate of pregnant women engaged in ANC of 22 percent reported in 2002. Approximately 250,000 Namibian children age 18 years or younger are considered to be orphans and/or vulnerable children (OVC), with some 28 percent of these (69,000) orphaned by AIDS. The primary drivers of Namibia's HIV epidemic include multiple and concurrent partnerships, inconsistent condom use, low HIV risk perceptions, low levels of male circumcision, alcohol misuse, intergenerational and transactional sex, the mobility of populations, and emerging pockets of key population groups.

In FY 2014, PEPFAR Namibia is prioritizing activities that reflect the program's transition and access to health care objectives from the Global Health Initiative (GHI) strategy. PEPFAR Namibia's transition goal is to ensure that Namibia has the body of country-specific data, technical capacity, human resources, and coordinating mechanisms required to manage its HIV/AIDS response. FY 2014 activities will continue the shift away from direct service delivery and inputs toward greater collaborative technical assistance initiated by the September 2010 Partnership Framework. Most notably, in FY 2014, PEPFAR Namibia will no longer purchase condoms, rapid test kits, and nutritional food supplementation. PEPFAR Namibia stopped purchasing antiretroviral (ARV) drugs in FY 2012. The technical capacity of human resources and infrastructure to support a high impact, high quality HIV/AIDS response remains a significant focus for PEPFAR Namibia programming.

Below is a table of PEPFAR Namibia's budget representing its major program areas.

Fiscal Year	Namibia Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 35,318,172	33%	$ 24,057,525	22%	$ 22,631,333	21%	$ 25,798,764	24%	$ 107,805,794
2010	$ 28,078,622	27%	$ 20,224,732	20%	$ 22,454,164	22%	$ 31,851,663	31%	$ 102,609,181
2011	$ 27,134,909	26%	$ 20,120,852	20%	$ 19,681,885	19%	$ 35,684,535	35%	$ 102,622,181
2012	$ 28,439,255	31%	$ 19,118,569	21%	$ 15,777,071	17%	$ 26,974,286	30%	$ 90,309,181
Total 2009-2012	**$ 118,970,958**	**29%**	**$ 83,521,678**	**21%**	**$ 80,544,453**	**20%**	**$ 120,309,248**	**30%**	**$ 403,346,337**
2014 (est)	**$ 16,143,009**	**26%**	**$ 11,445,896**	**18%**	**$ 8,609,969**	**14%**	**$ 26,924,125**	**43%**	**$ 63,123,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Namibia	$ 4,697,882	$ 9,275,576	$ 6,562,085	$ 2,000,000	$ 600,000	$ -	$ 1,665,060	$ 10,517,569	**$ 35,318,172**
2010	Namibia	$ 3,936,478	$ 7,989,917	$ 5,486,548	$ 1,000,000	$ 900,000	$ -	$ 1,887,798	$ 6,877,881	**$ 28,078,622**
2011	Namibia	$ 3,754,124	$ 5,546,422	$ 6,273,284	$ 857,458	$ 550,000	$ -	$ 2,628,350	$ 7,525,271	**$ 27,134,909**
2012	Namibia	$ 5,225,202	$ 964,606	$ 8,258,300	$ 660,220	$ 325,000	$ -	$ 5,747,740	$ 7,258,187	**$ 28,439,255**
	Totals FY09-FY12	**$ 17,613,686**	**$ 23,776,521**	**$ 26,580,217**	**$ 4,517,678**	**$ 2,375,000**	**$ -**	**$11,928,948**	**$ 32,178,908**	**$ 118,970,958**
2014 (est)	Namibia									**$ 16,143,009**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

There are considerable achievements in the area of prevention, as defined by the goals and priorities in the Namibian government's National Strategic Framework 2010/11 - 2015/2016. These include high coverage of the prevention of mother-to-child transmission (PMTCT) program and HIV counseling and testing (HCT).

PEPFAR FY 2014 funding will support:

- Combination prevention (with a special focus on other sexual prevention activities);
- Namibia's National Elimination of Mother-to-Child Transmission (eMTCT) plan;
- HIV counseling and testing (HCT); and
- Voluntary Medical Male Circumcision (VMMC) for public health impact, specifically working with the government to develop and implement an improved strategy in targeted regions.

PEPFAR budgets and activities for injection and blood safety programs continue to decrease as the Namibian government and civil society take on more of the responsibilities for these program areas. Currently, prevention activities in Namibia remain highly dependent on external resources from PEPFAR and the Global Fund.

In support of the national goal of eliminating mother-to-child transmission by 2015, PEPFAR priorities will emphasize the accessibility of ARV drugs and strong integration of PMTCT with HIV prevention programming. In FY 2014, PMTCT activities will reflect the transition from PEPFAR supported recurrent operational costs, including healthcare worker salaries and supplies to a focus on technical assistance to support evaluations, service integration, and community level strengthening of linkages and referrals. Lastly, PEPFAR Namibia and the Global Fund will support Namibia's introduction of Option B+ (lifelong treatment for pregnant women) for preventing mother-to-child transmission.

Other FY 2014 priorities are in sexual prevention and HCT. In sexual prevention, PEPFAR will focus on programming targeted for youth and key populations and on integrating HIV prevention programming at the clinic and community level, through healthcare worker in-service training and the Health Extension Program. Targeted programs for key populations are also a focus of the Global Fund HIV Rolling Continuation Channel (RCC) Phase II renewal proposal. In counseling and testing, PEPFAR will support the development and scale-up of the Namibian national mixed-model counseling and testing strategies, including support for "Door 2 Door" testing, outreach, mobile testing, and other innovative approaches to increase uptake.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Namibia	$ 1,215,324	$ 18,318,500	$ 3,097,509	**$ 22,631,333**
2010	Namibia	$ 1,879,596	$ 17,431,372	$ 3,143,196	**$ 22,454,164**
2011	Namibia	$ 939,798	$ 15,787,179	$ 2,954,908	**$ 19,681,885**
2012	Namibia	$ -	$ 12,953,290	$ 2,823,781	**$ 15,777,071**
	Totals FY09-FY12	**$ 4,034,718**	**$ 64,490,341**	**$ 12,019,394**	**$ 80,544,453**
2014 (est)	Namibia				**$ 8,609,969**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Namibia continues to make remarkable progress toward the goal of providing universal access to high quality comprehensive HIV treatment services, and recently achieved one of the highest levels of treatment coverage in sub-Saharan Africa, with an estimated 76 percent of eligible Namibians (CD4 cell count < 350) on ART in 2011. In FY 2014, PEPFAR Namibia will support the national treatment program, prioritizing quality assurance, adherence, and links with community care and support.

PEPFAR Namibia continues to work closely with the Namibian government on human resources absorption, and anticipates that all clinical and pharmaceutical staff will complete transition from PEPFAR support during calendar year 2013. Additionally, monitoring and evaluation officers and program management staff are scheduled to complete transition from PEPFAR support during calendar year 2014. PEPFAR will provide technical assistance for staff during this transition in areas such as pharmaceutical management pre-service training.

In tuberculosis (TB), PEPFAR will continue to provide technical assistance to strengthen programming and TB/HIV integration. As part of this work, PEPFAR will work with both the Namibian government and various civil society organizations to coordinate TB/HIV programs at all levels and to ensure quality throughout the continuum of care. At the clinic level PEPFAR will support technical assistance to increase TB screening efforts for people living with HIV, and at the Ministry of Health and Social Services (MOHSS) level, activities will support an increase in capacity for case detection and control.

In FY 2014, PEPFAR Namibia will also support the reduction of the unit cost of treatment by maximizing efficiencies. For example, PEPFAR will support strategic integration by providing costing and workload scenario models to one-stop TB/HIV services, HIV and primary healthcare service delivery, out-patient departments, and integration with antenatal care for PMTCT. PEPFAR will also promote cost effectiveness and sustainability of bio-clinical monitoring for treatment through the implementation and evaluation of point-of-care testing for CD4 counts.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Namibia	$ 7,982,340	$ 2,845,454	$ 3,657,504	$ 9,572,227	**$ 24,057,525**
2010	Namibia	$ 6,356,384	$ 2,658,958	$ 3,087,488	$ 8,121,902	**$ 20,224,732**
2011	Namibia	$ 6,232,041	$ 3,305,665	$ 3,083,546	$ 7,499,600	**$ 20,120,852**
2012	Namibia	$ 5,493,871	$ 2,411,108	$ 4,092,244	$ 7,121,346	**$ 19,118,569**
	Totals FY09-FY12	**$ 26,064,636**	**$ 11,221,185**	**$ 13,920,782**	**$ 32,315,075**	**$ 83,521,678**
2014 (est)	Namibia					**$ 11,445,896**

*Totals include planned funding for all accounts.
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Approaches and priorities in the PEPFAR Namibia FY 2014 care and support portfolio reflect Namibia's maturing epidemic, and appropriately have a family-centered approach. With over 250,000 adults and children provided with care in the past two years, Namibia has high coverage with quality clinical and community-based HIV care services. In FY 2014, programs will focus on strengthening systems and protection for OVC are priorities. Another priority for mitigating vulnerability of children to HIV, violence, and poverty is strengthening of the social sector workforce.

Other PEPFAR Namibia care and support program priorities to be implemented during FY 2014 include:

- Support for integrating TB/HIV and maternal child health (MCH) services with a family-centered approach;
- Enhancing bidirectional referrals and linkages to care including social protection, nutrition, and economic strengthening;
- Improving partnerships between domestic institutions, civil society organizations, and community structures to mitigate child vulnerability;
- Addressing HIV care needs in the Health Extension Program;
- Conducting program evaluations to advance program approaches or fill knowledge gaps;
- Strengthening community-based mother infant follow up systems for early infant diagnosis and infant feeding and growth monitoring; and
- Supporting the MOHSS policy development and piloting of alternative cervical cancer screening approaches.

PEPFAR collaborates actively with other donors in Namibia to harmonize these priorities with other care efforts, leverage combined expertise, and establish joint strategies for engagement with the Namibian government. PEPFAR, in collaboration with the Global Fund, supports more than 90 percent of the community-level home-based care program implemented by non-governmental organizations and civil society.

Governance & Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Namibia	$ 2,311,413	$ 5,868,234	$ 8,642,507	$ 8,976,610	**$ 25,798,764**
2010	Namibia	$ 1,414,655	$ 3,520,720	$ 10,075,183	$ 16,841,105	**$ 31,851,663**
2011	Namibia	$ 1,212,562	$ 5,571,912	$ 11,495,192	$ 17,404,869	**$ 35,684,535**
2012	Namibia	$ 2,629,862	$ 7,816,593	$ 8,769,685	$ 7,758,146	**$ 26,974,286**
	Totals FY09-FY12	**$ 7,568,492**	**$ 22,777,459**	**$ 38,982,567**	**$ 50,980,730**	**$ 120,309,248**
2014 (est)	Namibia					**$ 26,924,125**

*Totals include planned funding for all accounts.
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With FY 2014 funding, PEPFAR Namibia will continue to increase emphasis in strategic information and health systems strengthening, including laboratory support. PEPFAR Namibia will prioritize strategic information activities that focus on eliminating critical gaps in Namibia's ability to conduct core monitoring and evaluation, surveys and surveillance, health management information systems, and operational research activities. Critical to the strengthening of core monitoring and evaluation activities in Namibia, is the support for in-country capacity to ensure the sustainability of these approaches. This includes support to the MOHSS, the National Statistics Agency, line ministries, and select civil society organizations.

In FY 2014, PEPFAR Namibia will continue to strengthen partnerships with civil society and the private sector, particularly domestic stakeholders that can contribute to the sustainability of the HIV response. To address financial sustainability, PEPFAR will support the Namibian government in developing informed budget submissions related to the HIV/AIDS response, supporting national funding mechanisms that have the potential for financing civil society services, and working with NGO partners to develop innovative resource mobilization plans.

Country Engagement

Responding to and taking responsibility for the HIV epidemic is a national priority for Namibia's government. Domestic funding for health has increased since 2001 when Namibia signed the Abuja Declaration committing to allocate 15 percent of total Namibian government spending to health. By 2008/9, the Namibian government nearly reached this goal, allocating 14.3 percent of its annual budget to health. The 2010/11-2015/16 National Strategic Framework (NSF) is the five-year plan for addressing HIV/AIDS, building on work in four prior plans, and is linked to national development strategies and international commitments. The NSF commits the Namibian government to increasing its financial contribution to the HIV/AIDS response to 70 percent by 2015 (a 20 percent increase from 2010/11).

In FY 2014, PEPFAR Namibia will continue to work closely with Namibian government stakeholders, the Global Fund, and Namibian civil society organizations to develop a joint three-year work plan in the focus areas of the Global Fund RCC Phase II proposal. This exercise will serve as the basis for the establishment of a comprehensive three year HIV/AIDS programmatic plan, inclusive of details related to the transition of PEPFAR Namibia support in defined program areas. This level of full transparency will help to provide the solid foundation upon which Namibia can make future programming decisions and gain full ownership of the HIV/AIDS response.

Nigeria

Country Context

The Federal Republic of Nigeria consists of six geo-political zones that include 36 states and the Federal Capital Territory (FCT), which, in turn, contain 774 local government areas (LGAs). The country has 2.98 million HIV-positive individuals and constitutes the second greatest burden of HIV/AIDS care and treatment worldwide. Adding to this burden are the estimated 2.18 million children orphaned by HIV/AIDS. Nigeria also has one of the highest tuberculosis (TB) burdens in the world (311/100,000 population), ranking fifth among the 22 high TB burden countries, and the largest TB burden in Africa. Generalized HIV prevalence among 15-49 year olds is about 3.6 percent, but significantly higher rates exist among key populations, including commercial sex workers (30.2-37.4 percent), people who inject drugs (5.6 percent), and men who have sex with men (13.5 percent). Heterosexual transmission accounts for up to 95 percent of HIV infections. Women account for close to 60 percent of all adults living with HIV.

HIV prevalence varies widely across states as well as rural and urban areas. The variability in prevalence by states was demonstrated in a 2010 antenatal care (ANC) prevalence survey, with prevalence ranging from a low of one percent in Kebbi State to 12.7 percent in Benue state. The drivers of the HIV epidemic include low-risk perception, multiple concurrent partners, informal transactional and inter-generational sex, lack of effective services for sexually-transmitted infections (STIs), and poor quality of health services. Gender inequalities, poverty, and HIV/AIDS-related stigma and discrimination also contribute to the continuing spread of the infection. Risky behaviors continue and are targets for key prevention interventions.

The U.S. government programmatic approach for FY 2014 will continue to shift as a result of its commitment to implementing the Global Health Initiative (GHI) Strategy and the Partnership Framework Implementation Plan (PFIP). Priorities of the GHI and PFIP strategies include: improved human resources for health, greater focus on women and children, delivery of highest-impact service interventions, particularly at the primary health care (PHC) level, and strengthened leadership, management, governance, and accountability for program ownership and sustainability. The U.S. government will provide technical assistance to the Government of Nigeria by shifting its focus to state and local levels of government to improve capacity in planning, management, and leadership of HIV/AIDS and TB programs.

The U.S. Department of Defense Walter Reed Program (DOD WRP-N), USAID, and Centers for Disease Control and Prevention (CDC) implement the PEPFAR program in Nigeria. In FY 2014, the DOD WRP-N will continue to strengthen its partnership with the Nigerian Ministry of Defense Emergency Plan Implementation Committee (NMOD – EPIC) to promote country ownership and sustainability for the USDOD-NMOD HIV Program. USAID and CDC will continue to work with their implementing partners (IPs) in close collaboration with the Nigerian government at all levels across the full array of HIV/AIDS service delivery areas.

All U.S. government agencies will work towards fulfilling the 2015 partnership framework (PF) and PFIP goals in FY 2014:

- Repositioning the prevention of new HIV infections as the major focus of the national HIV/AIDS response through the implementation of evidence-based behavior change communication and HIV prevention interventions;
- Assuring that at least 50 percent of people living with HIV (PLHIV) have access to quality care and support services;
- Increasing access to antiretroviral treatment (ART) for PLHIV from 32 percent to 80 percent;
- Increasing Nigerian government (federal, state, and local) financing of the national HIV/AIDS response from 7 percent to 50 percent; and
- Ensuring that at least 80 percent of HIV/AIDS programs have adequate numbers of approximately skilled and gender-responsive professional and community health workers.

Below is a table of PEPFAR Nigeria's budget representing its major program areas.

Fiscal Year	Nigeria Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 66,321,853	15%	$ 90,712,770	21%	$ 194,136,582	44%	$ 91,115,848	21%	$ 442,287,053
2010	$ 76,551,080	17%	$ 100,154,685	22%	$ 170,062,584	37%	$ 112,400,935	24%	$ 459,169,283
2011	$ 81,808,867	17%	$ 99,227,503	20%	$ 152,755,036	31%	$ 154,822,875	32%	$ 488,614,281
2012	$ 106,283,958	22%	$ 93,663,611	20%	$ 141,391,043	30%	$ 137,275,669	29%	$ 478,614,281
Total 2009-2012	**$ 330,965,758**	**18%**	**$ 383,758,569**	**21%**	**$ 658,345,245**	**35%**	**$ 495,615,327**	**27%**	**$1,868,684,898**
2014 (est)	**$ 93,785,156**	**21%**	**$ 73,454,147**	**17%**	**$ 177,126,542**	**40%**	**$ 100,603,156**	**23%**	**$ 444,969,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Nigeria	$ 17,837,942	$ 18,173,234	$ 18,206,442	$ 6,230,923	$ 3,028,502	$ -	$ 40,000	$ 2,804,810	**$ 66,321,853**
2010	Nigeria	$ 29,301,532	$ 14,604,587	$ 20,749,479	$ 7,198,941	$ 3,215,091	$ -	$ -	$ 1,481,450	**$ 76,551,080**
2011	Nigeria	$ 31,579,984	$ 14,028,918	$ 20,560,241	$ 7,142,720	$ 2,460,039	$ -	$ -	$ 6,036,965	**$ 81,808,867**
2012	Nigeria	$ 36,169,199	$ 8,327,302	$ 23,603,493	$ 6,832,867	$ 2,431,146	$ -	$ -	$ 28,919,951	**$ 106,283,958**
	Totals FY09-FY12	**$ 114,888,657**	**$ 55,134,041**	**$ 83,119,655**	**$ 27,405,451**	**$ 11,134,778**	**$ -**	**$ 40,000**	**$ 39,243,176**	**$ 330,965,758**
2014 (est)	Nigeria									**$ 93,785,156**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The Nigerian government has committed to make the prevention of new infections the focus of the national HIV/AIDS response. Prevention activities include prevention of mother-to-child-transmission (PMTCT), prevention of sexual transmission, condoms/other prevention initiatives, positive health, dignity and prevention programs (PHDP), prevention of medical transmission (blood and injection safety), and HIV counseling and testing.

The U.S. government will continue to support partners to expand PMTCT activities to primary health care and secondary facilities. Prevention strategies also include integration of PMTCT services into maternal and neonatal child health service outlets and increasing private sector engagement for PMTCT services expansion. The U.S. government is leveraging resources for PMTCT commodities, which include laboratory test kits for HIV testing, reagents for Early Infant Diagnosis (EID), and antiretroviral (ARV) drugs for prophylaxis. There will be an increased emphasis on training and technical assistance to the Nigerian government, especially in the fields of quality assurance, quality control, and logistics management.

PEPFAR Nigeria continues to improve upon coordination with other donors working on PMTCT and other program elements, most notably the Global Fund, ensuring complementary efforts and avoiding duplication. Joint planning and site visits between the U.S. government and the Global Fund occurred during preparation of the 2013 Country Operational Plan (COP) and will continue in the 2014 COP. The U.S. government currently serves as the representative to Development Partners Group for HIV to the Global Fund Country Coordinating Mechanism and occupies the Chair of the Oversight Committee. Joint planning and procurement design occurred among the U.S. government, United Kingdom (UK) Department for International Development (DFID), UNICEF, and the World Bank for sexual transmission prevention and Orphans and Vulnerable Children (OVC) care and support efforts as well.

Only 14 percent of the adult population knows their HIV status. The National HIV/AIDS and Reproductive Health Survey of 2007 reports that while 34 percent of respondents perceived themselves to be at low risk, as high as 60 percent perceived themselves to be at no risk at all of

contracting HIV infection. During FY 2014, the U.S. government sexual prevention strategic focus includes the following:

- Prioritize combination prevention approach (biomedical, behavioral, and structural) in line with the National Prevention Plan's Minimum Prevention Package Initiative;
- Focus behavioral interventions focus on minimizing sexual risk and increasing protection in focus populations; and
- Seek behavioral interventions via mass media campaigns and community and social mobilization by partners. In 2014, the U.S. government will continue to focus more on key populations in geographic hot spots and less on general population interventions.

Blood transfusion services still remain a source of transmission for HIV and other pathogens despite the gains made by the National Blood Transfusion Service (NBTS) since 2007. In FY 2014, the U.S. government will continue supporting the dissemination and implementation of existing policy protocols as well as advocating, building service provider capacity, and providing technical assistance to encourage the adoption of universal precaution services.

Prevention activities will be integrated into all care and treatment activities, including HIV counseling and testing (HCT) services. Efforts to reduce new infections among high-risk and high-transmission communities will continue. Multiple HCT strategies (PITC, mobile HCT, couples HCT, and door-to-door HCT) will be employed to enable target populations to know their HIV status as a launch-pad into prevention, care, and treatment services. FY 2014 targets will extend to 6 million people.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Nigeria	$ 103,602,788	$ 79,810,493	$ 10,723,301	**$ 194,136,582**
2010	Nigeria	$ 80,610,573	$ 80,615,519	$ 8,836,492	**$ 170,062,584**
2011	Nigeria	$ 72,159,642	$ 72,328,642	$ 8,266,752	**$ 152,755,036**
2012	Nigeria	$ 69,151,271	$ 63,764,794	$ 8,474,978	**$ 141,391,043**
	Totals FY09-FY12	**$ 325,524,274**	**$ 296,519,448**	**$ 36,301,523**	**$ 658,345,245**
2014 (est)	Nigeria				**$ 177,126,542**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Treatment activities in FY 2014 include the provision of ARVs and services to eligible patients and laboratory support for the diagnosis and monitoring of HIV-positive patients identified through U.S. government activities and in-line with goals and strategies of the Nigerian government National Strategic Framework (NSF) and the PFIP. In FY 2014 the U.S. government will use a 'Test to Treat' strategy focusing on identifying positive persons eligible for treatment based on a CD4 cell count of 350 or less. Partners will be encouraged to use the PITC for all patients accessing health facilities. HIV-exposed children less than 18 months of age will be diagnosed for HIV infection and started on ARVs and provided with co-trimoxazole prophylaxis. Priority areas in the provision of care and support services will include scaling-up pediatric care and support services, early identification of HIV-infected children using PITC, integration into maternal and newborn child health (MNCH), and scaling-up PMTCT.

U.S. government partners will scale up ART services by focusing on: high burden states and states with high unmet need, early identification of HIV infected persons, linkages and retention in care, continued decentralization of ART services to the Primary Health Care (PHC) level, and expansion of the pool procurement mechanism to include selected laboratory commodities/reagents in addition to ARV drugs and rapid test kits. Partners will increase coverage and access to ART among HIV-infected children and reduce the number of deaths attributable to pediatric HIV/AIDS. Services will be integrated into the broader MNCH services as well as strengthen linkages between pediatric treatment, PMTCT, OVC, and adult treatment programs. To promote more cost efficient services, the U.S. government will support and encourage streamlining of trainings for health care workers at lower levels through an integrated training package.

Phased transition of first-line ARV procurement to the Nigerian government Ministry of Health (MOH) remains an important goal in the PFIP and FY 2014. To support this goal, the U.S. government and other donors will continue to build the capacity of MOH, support the Ministry's efforts to forecast, identify, and expand access to lower-cost drugs, and develop an ARV transition plan.

In FY 2014, the U.S. government will continue to pool all ARV procurements through the Partnership for Supply Chain Management (SCMS). This method, based on PEPFAR and Nigerian government forecasting, decreases duplication by individual partners and increases efficiency. The U.S. government supports logistics management activities, a key component of ARV delivery, through ongoing development of a Logistics Management Information System and an Inventory Control System. Key activities include a pilot unification of the multiple PEPFAR supply chain systems in a selected region. Lessons learned from this pilot will inform the planned merger of PEPFAR supply chain systems with the Nigerian government logistics system. This arrangement will bolster Nigerian government ownership and sustainability of logistics management operations.

Preventing and treating TB-HIV co-infections remains a priority due to the high TB burden. Nigeria has the fourth highest burden of TB in Africa. The TB prevalence in Nigeria (WHO 2011 report) is 199/ 100,000. A major focus for FY 2013 is the expansion and enhancement of TB-HIV sites at the state and local levels which will be continued under FY 2014. The U.S. government will contribute medical equipment, testing commodities, and training to support treatment and testing sites. In the TB Directly Observed Treatment Short-Course (TB DOTS) settings, the U.S. government will continue provider-initiated routine HIV testing. In FY 2014, the U.S. government will strengthen screening of TB disease among HIV positive patients through the scale up of GeneXpert system for molecular diagnosis of TB at peripheral laboratories, scale up of isoniazid preventive therapy to prevent TB in HIV positive persons and strengthen TB infection control in comprehensive HIV treatment sites with co-located TB DOTS treatment sites.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Nigeria	$ 37,289,099	$ 4,296,325	$ 10,569,102	$ 38,558,244	**$ 90,712,770**
2010	Nigeria	$ 41,389,794	$ 4,890,689	$ 9,795,201	$ 44,079,000	**$ 100,154,685**
2011	Nigeria	$ 37,963,758	$ 5,234,038	$ 11,878,943	$ 44,150,764	**$ 99,227,503**
2012	Nigeria	$ 37,137,475	$ 5,959,620	$ 11,559,438	$ 39,007,078	**$ 93,663,611**
	Totals FY09-FY12	**$ 153,780,126**	**$ 20,380,672**	**$ 43,802,684**	**$ 165,795,086**	**$ 383,758,569**
2014 (est)	Nigeria					**$ 73,454,147**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The U.S. and Nigerian governments will continue to work towards establishing a basic package of services for HIV-positive people and their families. Within FY 2014, care services will be provided to all HIV-positive patients identified in U.S. government programs. These include

basic care kits, management of opportunistic infection and sexually transmitted infections, laboratory follow-up, nutritional, psychosocial, and spiritual support, and referral to a care network. People living with HIV/AIDS will receive support services and access to psychosocial support. The U.S. government will promote access to community home-based care and strengthen networks of health care personnel and community health workers. The U.S. government will continue to support the harmonization of training materials and their use and increase focus on adherence counseling and pooled commodity procurements.

Children of HIV-infected adults currently in care will be linked to specialized OVC services. The U.S. government will continue to support the federal, state, and local government, and civil society to collaboratively provide, manage, and monitor integrated, comprehensive care to OVC and their families. The U.S. government will also continue to support the Ministry of Women Affairs and Social Development (MWASD) OVC Division to improve its capacity for better coordination of activities, initiatives, and advocacy to address the overwhelming needs of OVC and their caretakers. The OVC program will scale up household economic strengthening to empower families to respond to the needs of vulnerable children. Other strategies include promotion of community-initiated responses, child protection, early childhood development, HIV/sexually transmitted infections (STIs) prevention, and social workforce strengthening. It is anticipated that in 2014 the U.S. government will provide support to over 1.6 million OVC.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Nigeria	$ 41,706,290	$ 17,739,019	$ 11,991,301	$ 19,679,238	**$ 91,115,848**
2010	Nigeria	$ 40,191,356	$ 15,113,616	$ 18,392,982	$ 38,702,981	**$ 112,400,935**
2011	Nigeria	$ 39,957,633	$ 21,592,343	$ 55,650,161	$ 37,622,738	**$ 154,822,875**
2012	Nigeria	$ 40,303,452	$ 18,829,939	$ 51,439,895	$ 26,702,383	**$ 137,275,669**
	Totals FY09-FY12	**$ 162,158,731**	**$ 73,274,917**	**$ 137,474,339**	**$ 122,707,340**	**$ 495,615,327**
2014 (est)	Nigeria					**$ 100,603,156**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

U.S. government activities in systems strengthening will support all of the health systems building blocks including Human Resources for Health (HRH), Governance, Health Care Financing, Health Management Information Systems, Service Delivery, and Drugs and Supplies. Health Systems Strengthening is pursued as an approach to implementation in all program areas.

Nigeria is among countries identified as having an HRH crisis as densities of health care workers are considered too low in many places to deliver effective health services. There are shortages of critically needed health workforce. In addition, there is significant mal-distribution and poor planning, management, and retention of the available health workforce compounding the problem. Moreover, the quality of pre-service training is poor. The Nigerian government

recognized HRH as one of the pillars of its National Strategic Health Development Plan 2010-2015 (NSHDP). The U.S. government GHI Strategy and the PF have also identified HRH as a critical element of health programming in Nigeria. The U.S. government will improve the availability, distribution, and utilization of adequately skilled HRH. The U.S. government, through WRP, will support the Nigerian Ministry of Defense to provide capacity building for its personnel and the Ministry of Health in advanced HIV/AIDS care at its Clinical Training and Research Center at 44 Nigerian Army Reference Hospital Kaduna. This will be achieved through curriculum development, training, and clinical attachment for doctors, nurses, and pharmacists.

The U.S. government's engagement in Health Systems Governance will focus on providing technical assistance for the establishment and strengthening of local and state agencies for the control of AIDS (LACAs and SACAs) to coordinate sustainable and gender-sensitive, multi-sectoral HIV/AIDS responses. The U.S. government will also work to strengthen coordination mechanisms at all levels. With FY 2013 funds, the U.S. government implemented a lead IP strategy and will continue to consolidate and strengthen the system in FY 2014. The U.S. government will also strengthen civil society organizations at all levels by providing financial and technical support, management training, planning, and advocacy skills.

Healthcare financing is one of the eight priority areas in the Nigerian government NSHDP. The PF clearly stipulates that the Nigerian government increases its contribution to the national response from the current level of seven percent to 50 percent in 2015. The U.S. government's strategy in this regard includes: intensified policy dialogue and health diplomacy to increase Nigerian government allocations for health; building the capacity of NACA so that it can effectively mobilize adequate resources from the Nigerian government's internal sources; promoting and supporting performance based financing/budgeting; assisting the Nigerian government in exploring alternative financing options to sustainably fund HIV/AIDS programs; exploring ways to facilitate access to credit for private sector healthcare providers that provide HIV-related services; supporting activities to improve transparency and accountability in resource allocations and utilization in the public sector; supporting costing studies and assessments for program planning and implementation; supporting the implementation of health insurance schemes; and exploring public/private partnership opportunities to unleash private resources for HIV/AIDS programming.

The Health Management Information System (HMIS) will be strengthened for proper monitoring and evaluation of programs. The Nigerian government has adopted the District Health Information System (DHIS) database originally developed for U.S. government supported sites for reporting routine data from the health facilities through LGAs to the state and then to the national level. The U.S. government will assist the Nigerian government to scale-up the use of DHIS in all sites. The skills of local monitoring and evaluation officers will be built through providing in-service training.

Country Engagement

At the 2011 General Assembly High-Level Meeting on HIV/AIDS in New York, Nigerian President Goodluck Ebele Jonathan committed to achieving universal access to HIV prevention, treatment, care, and support. President Jonathan stated that the Nigerian government needs to commit to 50 percent of HIV/AIDS funding. Although this commitment is impressive, the challenge around country ownership and sustainability remains significant. Traditionally, organizational and technical capacity among government offices and staff has been low at the state and LGA levels. Insufficient staff, significant staff turnover, poorly defined and over-lapping job descriptions, and insufficient resources to carry out key functions (e.g. coordination, planning, monitoring, and reporting) are a few of the challenges facing state and LGA level offices. In addition, offices at the state and LGA levels have few mechanisms to collect data on their own performance and have limited opportunities to contribute to national HIV/AIDS priorities and work plans.

In support of greater country ownership and sustainability, activities set forth in FY 2014 will reflect the objectives outlined in the Nigerian government National Strategic Framework 2 and the Nigerian government NSHDP. FY 2014 activities will specifically follow the commitments agreed upon by the U.S. government, Nigerian government, and other PFIP stakeholders.

Numerous challenges and opportunities exist within the country ownership dimensions (for example: political ownership/stewardship, institutional and community ownership, capabilities, and accountabilities). While the Nigerian government has clearly articulated its priorities and plans, it remains dependent on technical and operational assistance from the U.S. government and other donors to improve organizational capacity to oversee stakeholder activities. Increased institutional ownership requires greater amounts of support to local entities (e.g. local and state governments and non-governmental and civil society organizations) to more effectively monitor, coordinate, and oversee programmatic efforts.

In addressing these numerous challenges, the U.S. government has identified opportunities to transition its service delivery and capacity building efforts to local entities. Substantial progress has occurred with several projects designed exclusively for local entities commencing implementation in the 2012 Country Operational Plan. The U.S. government has expertise in a wide variety of technical areas, including health systems strengthening and health care financing, to provide the Nigerian government and other organizations with state of the art technical guidance and assistance. Additionally, the U.S. government has commenced efforts to decentralize service delivery which will allow for a more manageable program at the local level. The U.S. government will accomplish this through targeted capacity building and direct engagement of state and local governments to leverage locally-available resources to achieve synergy and improve overall efficiency.

Rwanda

Country Context

Rwanda has made remarkable progress since the tragedy of the 1994 genocide, with growth in real per capita income averaging nearly five percent and accelerating to an average of over eight percent in the period 2006 – 2010 (National Institute of Statistics Rwanda, Statistical Yearbook 2011). However, Rwanda remains one of the world's poorest countries. Rwanda is ranked 166 out of 187 worldwide in the United Nations Development Program's (UNDP) Human Development Index (UNDP HDI 2011).

Rwanda is the most densely populated country in sub-Saharan Africa and faces a multitude of health and development challenges. An estimated 3 percent of the adult population is infected with HIV (3.7 percent of adult women and 2.2 percent of adult males). These levels have been stable since 2005. Out of a population of approximately 10.7 million, 170,000 Rwandan adults and 22,000 children are estimated to be living with HIV. The repercussions from the 1994 genocide, in which up to a million Rwandan citizens were killed, combined with HIV, have resulted in more than a million orphans and vulnerable children (OVC) and deaths of approximately 5,600 persons due to HIV-related illness each year.

According to epidemiologic models, Rwanda's epidemic is primarily driven by heterosexual contact (75 percent) and mother-to-child transmission (MTCT) (20 percent). Populations most at-risk for HIV in Rwanda include: discordant couples, out-of-school youth, commercial sex workers (CSW), their clients and partners, military and police personnel, long distance truck-drivers, and prisoners.

The HIV prevalence rate in Rwanda has remained relatively stable, with an overall decline since the late 1990s, partially due to improved HIV surveillance methodology. The Government of Rwanda is committed to fighting HIV and AIDS and takes a proactive role in HIV/AIDS prevention, care, and treatment (with national antiretroviral (ART) coverage at 85 percent of adults and 60 percent of children in need) for all its citizens. Key focus of the FY 2014 program includes continued support for the sustainable transition of activities to national ownership, initiating increased financial ownership of the program by the Rwandan government, and increased coordination with Global Fund (GF) support to the national HIV and AIDS program. Rwandan leadership has demonstrated the political will to achieve these goals. Further, FY 2014 activities will continue to support the Rwandan medical education system to support the long-term care of HIV positive individuals.

Strategic priorities for FY 2014 include:

- Maintaining gains in prevention of mother-to-child transmission (PMTCT) with an emphasis on scaling up pediatric care and treatment and expanding prevention, care, and treatment with key populations;

- Ensuring commodities are available through the Rwanda's national supply chain system; and
- Supporting OVC programs through civil society organizations (CSOs) and increasing coordination and collaboration with the GF.

Shifts in FY 2014 include decreased support to the HIV/TB program based on decreasing cases seen at facilities and a reduction in recurrent costs including Ministry of Health (MOH) staff salaries and individual performance based funding in addition to laboratory consumables and commodities not directly related to HIV and AIDS program demand.

Below is a table of PEPFAR Rwanda's budget representing its major program areas.

Fiscal Year	Rwanda Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 37,614,871	25%	$ 35,123,654	24%	$ 39,325,615	27%	$ 35,583,173	24%	$ 147,647,313
2010	$ 26,227,329	20%	$ 31,562,874	24%	$ 35,695,827	27%	$ 37,961,283	29%	$ 131,447,313
2011	$ 21,870,114	19%	$ 25,962,412	22%	$ 33,663,460	29%	$ 33,932,392	29%	$ 115,428,378
2012	$ 18,709,632	18%	$ 22,301,686	21%	$ 19,928,380	19%	$ 44,488,680	42%	$ 105,428,378
Total 2009-2012	**$ 104,421,946**	**21%**	**$ 114,950,626**	**23%**	**$ 128,613,282**	**26%**	**$ 151,965,528**	**30%**	**$ 499,951,382**
2014 (est)	**$ 12,211,225**	**16%**	**$ 12,866,090**	**17%**	**$ 19,976,022**	**26%**	**$ 32,651,663**	**42%**	**$ 77,705,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Rwanda	$ 9,082,966	$ 6,010,700	$ 6,629,000	$ 5,585,000	$ 1,530,672	$ -	$ 1,825,000	$ 6,951,533	**$ 37,614,871**
2010	Rwanda	$ 5,019,411	$ 3,517,897	$ 5,873,864	$ 3,267,001	$ 1,537,825	$ -	$ 1,361,250	$ 5,650,081	**$ 26,227,329**
2011	Rwanda	$ 4,376,455	$ 1,790,282	$ 4,541,361	$ 2,852,000	$ 1,439,067	$ -	$ 1,232,800	$ 5,638,149	**$ 21,870,114**
2012	Rwanda	$ 3,320,921	$ -	$ 5,459,188	$ 2,696,025	$ 346,025	$ -	$ 952,441	$ 5,935,032	**$ 18,709,632**
	Totals FY09-FY12	**$ 21,799,753**	**$ 11,318,879**	**$ 22,503,413**	**$ 14,400,026**	**$ 4,853,589**	**$ -**	**$ 5,371,491**	**$ 24,174,795**	**$ 104,421,946**
2014 (est)	Rwanda									**$ 12,211,225**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Although Rwanda will be on track to achieve its Millennium Development Goal (MDG) target for 2015 of stabilizing HIV prevalence at 3 percent, Rwanda's challenge is balancing interventions for its mixed epidemic. The U.S. government, therefore, supports combination prevention approaches where biomedical, behavioral, and structural interventions work synergistically to complement and reinforce one another.

In FY 2014, there will be an overall shift in prevention programming from a focus on the general population to an emphasis on key populations, including men who have sex with men (MSM), CSW and their clients, mobile populations, and youth. Reaching these populations with testing and counseling and sexual prevention activities will be a priority. PEPFAR Rwanda, in partnership with the MOH, will place a greater emphasis on targeted HIV prevention. Behavior change communication prevention messaging will be focused to target key populations and surrounding communities, and U.S. government support for mass campaigns for prevention will be discontinued. Social marketing activities and support for socially marketed condoms will be scaled down. In FY 2014, the U.S. government will scale-up support for the capacity building of local CSOs to implement and manage prevention programs.

The 2010 Rwanda Demographic and Health Survey estimates the HIV prevalence rate in women of reproductive age in Rwanda at 3.7 percent. The Government of Rwanda aims to reduce the HIV MTCT rate below 2 percent by 2015. In FY 2014, Rwanda's PMTCT program will provide a comprehensive package: counseling and testing for pregnant women; preventive antiretroviral (ARV) regimens to prevent MTCT (Option B+); counseling and support for safe infant feeding practices; safe labor and delivery practices; family planning counseling or referrals; as well as referrals for long-term ART for infected children and eligible mothers identified at antenatal care (ANC) or maternity. The Rwandan government and partners will work to improve uptake of PMTCT services, reaching women with ANC services through community outreach, sensitizing local authorities, and displaying strong leadership. Provision of optimal PMTCT services will be made possible through improved monitoring and evaluation and staff mentoring and integration of PMTCT activities into existing maternal and child health (MCH) programs. Systems will be reinforced for post-natal follow-up of HIV-positive mothers and HIV-exposed infants to ensure

women and children receiving care through PMTCT programs are linked to ongoing care and treatment services.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Rwanda	$ 10,860,593	$ 25,830,863	$ 2,634,159	**$ 39,325,615**
2010	Rwanda	$ 11,490,309	$ 21,913,758	$ 2,291,760	**$ 35,695,827**
2011	Rwanda	$ 13,463,272	$ 18,310,109	$ 1,890,079	**$ 33,663,460**
2012	Rwanda	$ 4,305,445	$ 13,243,010	$ 2,379,925	**$ 19,928,380**
	Totals FY09-FY12	**$ 40,119,619**	**$ 79,297,740**	**$ 9,195,923**	**$ 128,613,282**
2014 (est)	Rwanda				**$ 19,976,022**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, treatment will remain a priority and major focus for PEPFAR support to Rwanda. The Government of Rwanda is expanding treatment for all children under 5, has adopted PMTCT Option B+, and plans to treat all discordant couples regardless of CD4 count. PEPFAR will continue to support the Rwandan government's efforts to provide care and treatment to all HIV eligible patients in accordance with national guidelines. At the community level, PEPFAR Rwanda will ensure continuity of care and adherence support through case managers, community health workers (CHW), and peer support groups. Through community mobilization activities, home visits, community-based registers, referral slips, patient cards, and other tools, CHWs will facilitate transfer of information within and between facilities and communities to improve patient retention. CHWs will provide adherence counseling, patient education, and referrals for drug side-effect management.

While the proportion of children on ART continues to lag behind adult ART coverage, increased support for pediatric HIV care and treatment activities at all levels of the health care system will be a priority for the U.S. government and MOH in FY 2014. Strategies include reinforcing a family approach using an index of positive patients to identify all family members with particular emphasis on children. PEPFAR, the GF, and UNICEF are some of the major stakeholders working with the Government of Rwanda to develop and implement programs for HIV-affected and infected infants, children, and adolescents. PEPFAR Rwanda has supported the MOH in the revision and dissemination of the pediatric care and treatment guidelines based on the new World Health Organization (WHO) recommendations. The revised guideline to treat all children under 5 is expected to be fully implemented in 2014.

Some of the challenges facing the pediatric treatment program include lack of sufficient numbers of nurses trained in task shifting and with experience in pediatric HIV care and treatment service

provision; lack of fully implemented provider-initiated testing and counseling (PITC) for the pediatric population; and limited active pediatric HIV case-finding among families of persons enrolled in care and treatment or identified through voluntary counseling and testing (VCT). There is also a need to improve ART adherence especially for adolescents. In FY 2014, there will be a particular emphasis on the provision of psychosocial support to improve treatment adherence in children and adolescents. Moreover, PEPFAR Rwanda will increase procurement of pediatric formulations of ARV drugs to support the new guidelines.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Rwanda	$ 12,906,429	$ 2,841,480	$ 6,010,154	$ 13,365,591	**$ 35,123,654**
2010	Rwanda	$ 12,487,165	$ 2,215,873	$ 4,702,636	$ 12,157,200	**$ 31,562,874**
2011	Rwanda	$ 10,379,567	$ 2,893,746	$ 3,714,204	$ 8,974,895	**$ 25,962,412**
2012	Rwanda	$ 8,688,768	$ 1,880,995	$ 4,440,304	$ 7,291,619	**$ 22,301,686**
	Totals FY09-FY12	**$ 44,461,929**	**$ 9,832,094**	**$ 18,867,298**	**$ 41,789,305**	**$ 114,950,626**
2014 (est)	Rwanda					**$ 12,866,090**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, the U.S. government will continue to support a comprehensive package for adult and pediatric care at PEPFAR-supported sites. The support provided by the U.S. government is aimed at keeping people living with HIV (PLHIV) healthy and living in dignity, reducing transmission of HIV among PLHIV and assessing PLHIV for clinical treatment eligibility. Specifically, PEPFAR Rwanda will continue to support integrated service delivery in primary care services at health centers and hospitals in 22 of the 30 districts of Rwanda where the U.S. government is the lead donor for HIV services. PEPFAR Rwanda will also continue to support access to a broad range of basic care and support services both at facility and community levels. To date, the majority of prevention, care, and treatment services for PLHIV are provided in the health facility setting, with linkages to the community level for related support services. The promotion of a linkages model of service provision, utilizing facility-based staff, community volunteers, community health workers (CHWs) and existing health committees at the health facility level will also be continued by PEPFAR Rwanda. The model focuses on improving communication and coordination to guarantee a continuum of care for HIV-positive individuals and their families and to minimize loss to follow-up of patients, particularly in pre-ART services.

The FY 2014 PEPFAR Rwanda program will continue to build the capacity of the government and local non-governmental, faith-, and community-based organizations to ensure the smooth transition and sustainability of services by host institutions. PEPFAR Rwanda will continue to leverage family planning and MCH funds to support integration of services. Specifically the

U.S. government will continue to integrate reproductive health, family planning, MCH services, and HIV in supported sites and at the community level in supported districts, hence providing a continuum of care and a minimum package of care and support services.

In FY 2014, care and support for OVC will remain a priority, with a focus on continuing assistance to local CSOs to provide comprehensive assistance to OVC and their households. In Rwanda, PEPFAR, as the primary donor for OVC programs, is responding to Government of Rwanda goals and priorities to reach OVC with an integrated focus of service provision and psychosocial support. U.S. support includes providing direct support to OVC and their households to increase the socio-economic resilience of their families and assisting the Government of Rwanda to strengthen its district and sector-level support to OVC through their children's forums and orphan care committees. These interventions ensure the coordinated participation of children and local leaders in OVC activities and services. PEPFAR Rwanda will continue to provide support for OVC education and for the strengthening of referral systems, including linkages between community services, health facilities, and other supportive organizations that enable OVC to access a full spectrum of services. PEPFAR assistance related to supportive care (including school materials and supplies), social protection, and legal support will be scaled down. Provision of food commodities will be discontinued.

In FY 2014, while the overall budget for TB/HIV activities will be reduced to reflect a decrease in the number of TB cases reported at PEPFAR-supported facilities, TB/HIV continues to be a critical component of PEPFAR support to Rwanda. Almost all TB diagnostic and treatment centers in U.S.-supported districts provide ART, and all health facilities in Rwanda offer TB treatment. Directly-observed treatment, short-course is practiced countrywide at the health center and community levels. Key strategies for TB/HIV programming in FY 2014 will include systematic screening for TB among HIV-positive patients within HIV services and systematic screening for HIV among TB patients within TB clinics.

PEPFAR Rwanda will continue to procure basic care related commodities in coordination with the Rwandan government's Medical Procurement Division (MPD). The U.S. government will support the procurement of drugs for the prevention and treatment of opportunistic infections and will continue to promote coverage of key clinical interventions (e.g., co-trimoxazole, safe water products) which have been demonstrated to reduce morbidity and mortality among PLHIV.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Rwanda	$ 6,625,640	$ 9,172,876	$ 13,429,204	$ 6,355,453	**$ 35,583,173**
2010	Rwanda	$ 10,070,097	$ 6,575,622	$ 8,910,246	$ 12,405,318	**$ 37,961,283**
2011	Rwanda	$ 6,186,719	$ 5,378,564	$ 8,670,017	$ 13,697,092	**$ 33,932,392**
2012	Rwanda	$ 5,627,595	$ 3,700,302	$ 25,520,642	$ 9,640,141	**$ 44,488,680**
	Totals FY09-FY12	**$ 28,510,051**	**$ 24,827,364**	**$ 56,530,109**	**$ 42,098,004**	**$ 151,965,528**
2014 (est)	Rwanda					**$ 32,651,663**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, PEPFAR Rwanda will continue to support institutional and human capacity building in the Rwandan government from the central to the community level. The U.S. government employs three strategies to achieve its objective of increasing human and institutional capacity in Rwanda: 1) leverage established coordination structures; 2) develop and strengthen relationships with national partners; and 3) integrate capacity building across all health assistance. Using a systems approach, efforts will continue to focus on increasing efficient utilization and integration of the workforce at the district, sector, and community level, strengthening national management of service delivery, management of financial resources, leadership of human resources, as well as staff training and deployment.

In addition, the FY 2014 PEPFAR Rwanda program will continue to strengthen the capacity of the national HIV/ AIDS strategic information network to plan, collect, manage, and make use of integrated data from a variety of sources as outlined in the eHealth Enterprise Architecture. Assistance will continue to support the implementation of Rwanda's National e-Health Strategic Plan and National HIV/AIDS Monitoring and Evaluation Policy and Strategy.

In FY 2014, the U.S. government will collaborate with other donors and stakeholders to ensure effective and efficient training, deployment, and management of human resources for health (HRH) across Rwanda, using evidenced based decisions in program implementation. In pre-service education, the U.S. government will continue to provide support to key educational institutions in Rwanda to increase the country's capacity to provide pre- and post-graduate training in nursing, midwifery, medicine, public health management, field epidemiology, program management, and strategic information. In partnership with U.S. academic institutions, the Government of Rwanda will continue to strengthen the capacity of Rwandan health sciences institutions, as well as provincial and district hospitals, to produce a well-trained health workforce capable of responding to Rwanda's health needs. PEPFAR will work closely with the Rwanda government to monitor and evaluate the HRH program.

The FY 2014 PEPFAR laboratory strategy continues to build on a tiered national laboratory system for creating sustainable infrastructure to support care and treatment of PLHIV. FY 2014 support for the national laboratory policy and strategic plan will include: establishing national laboratory policies; integrating clinical diagnostic services; harmonizing and maintaining equipment; managing inventory and national forecasting of supplies, reagents and test kits; supporting quality assurance programs and human capacity development; and setting standards for and implementation of a Laboratory Information System.

In FY 2014, the U.S. government will support the MOH to ensure that essential health services are provided in a high quality and financially accessible manner to the entire Rwandan population. Particular emphasis will be placed on promoting an equitable, efficient and sustainable health financing framework based on results. Activities designed to strengthen the national community-based health insurance mechanism will continue, and U.S. assistance will support the development of robust national health financing mechanisms that increase the accessibility and affordability of high quality health services.

Country Engagement

The Government of Rwanda is deeply committed to implementing the principle of country ownership, despite a continued reliance on external funding. The Rwandan government is fully engaged with donor partners, non-governmental organizations, and international organizations and directs all programs within the country. From the beginning of PEPFAR, the U.S. government and the Government of Rwanda have worked closely on the coordination and implementation of HIV/AIDS programs, ensuring that the PEPFAR program is aligned with Government of Rwanda strategies, goals, and priorities. PEPFAR strategies are planned and coordinated under the leadership of the MOH. The MOH convenes members of the Rwandan government, U.S. government, other donors, civil society, and implementing partners to establish technical priorities and share information about the PEPFAR Country Operational Planning process, following which, PEPFAR and the Government of Rwanda jointly develop Country Operational Plans. In addition, in preparation for Rwanda's Vision 2020 and goal of decreasing reliance on foreign aid, the U.S. government and the Government of Rwanda have agreed to gradually shift financial responsibility for recurrent costs. In addition, the U.S. government will work with the Rwandan government (Ministries of Finance and Health) to develop a transition plan for the Government of Rwanda's increased financing for the national HIV/AIDS program, especially regarding recurrent costs covered by PEPFAR. Also in FY 2014, activities around clinical services and commodities will continue to focus increasingly on building capacity in order to better support and prepare for transition.

Other major bilateral and multilateral donors supporting HIV/AIDS in Rwanda include: the GF; United Nations agencies; the Great Lakes Initiative on HIV/AIDS; the Belgium Technical Cooperation; the European Union; the German Agency for International Cooperation; the Netherlands Embassy; the Luxembourg Agency for Development Coordination; the Swedish International Development Agency; and the United Kingdom Department for International Development. The U.S. government actively participates in donor harmonization on a number of levels, including the two main bodies that coordinate health activities undertaken by donors and civil society in Rwanda: the Health Sector Working Group, chaired by the MOH Permanent Secretary and co-chaired by the Belgian Embassy, of which the U.S. government is vice co-chair; and the Global Fund Country Coordinating Mechanism, chaired by the MOH Permanent Secretary and co-chaired by the WHO country representative. These bodies include substantial representation from the Rwandan government, donors, and international and local civil society organizations that support the health sector. In addition, the U.S. government co-chairs multiple technical working groups under a newly adopted national technical working group structure.

South Africa

Country Context

South Africa has a population of nearly 52 million and the largest HIV epidemic in the world, with approximately 5.7 million people living with HIV. The HIV epidemic in South Africa is characterized by significant geographic and population heterogeneity. Similar to other generalized, hyper-endemic HIV epidemics, the South African epidemic is largely driven by heterosexual transmission. HIV prevalence among the adult population (15-49 years) is estimated to be 16.6 percent, with an estimated HIV incidence of 1.4 percent in 2011, though prevalence and incidence vary significantly across geographic areas with 54 percent of people living with HIV (PLHIV) living in Gauteng and KwaZulu-Natal Provinces. Antenatal HIV prevalence has stabilized around 30 percent over the past four years with women and girls bearing approximately 60 percent of the overall HIV disease burden.

In conjunction with the HIV/AIDS epidemic, South Africa ranks third in the world in TB burden, with an incidence of 993 new infections per 100,000 people in 2011 (WHO estimate). While the TB cure rate increased to 73 percent in 2010 from 54 percent in 2000, this is still well below the global target of over 85 percent. The TB epidemic is compounded by high levels of multidrug-resistant tuberculosis (MDR-TB) with an estimated 5,000 confirmed MDR-TB cases among new pulmonary TB cases in 2011. High rates of co-infection (approximately 65 percent of TB patients are co-infected with HIV) lead to further expansion of the epidemics and complicate treatment and care of patients. South Africa's health system is heavily burdened by the HIV and TB epidemics which severely affect a wide range of population health outcomes including life expectancy, which is currently 54.9 years for men and 59.1 years for women

The U.S. government and the South African government entered a strong partnership on HIV with the completion of *The Partnership Framework in Support of South Africa's National HIV and AIDS and TB Response (2012/13 – 2016/17)* in December 2010. When the South African National AIDS Council (SANAC) launched the National Strategic Plan (NSP) for HIV, sexually transmitted infections (STIs), and TB (2012 – 2016) in December 2011, the U.S. government agreed to support the plan. The NSP and the Partnership Framework (PF) guide the PEPFAR South Africa program and annual country operational planning.

The PF Implementation Plan, signed in July 2012, is an agreement to shift financial and implementation responsibilities for clinical care and treatment services into the South African government public health system by 2017. In FY 2014, slight shifts in the strategic focus of the PEPFAR South Africa program will reflect this ongoing transition of clinical service delivery to the South African government. The South African government views clinical services as an inherent responsibility of the National Department of Health (NDOH). While the South African government works to absorb PEPFAR-support for clinical services and continues to increase the number of patients on treatment through the public health system, PEPFAR will support this expansion of services through increasing access, efficiency, and quality in patient outcomes.

Below is a table of PEPFAR South Africa's budget representing its major program areas.

Fiscal Year	South Africa Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 145,696,701	26%	$ 141,910,505	25%	$ 199,862,618	36%	$ 73,843,322	13%	$ 561,313,146
2010	$ 154,261,510	28%	$ 136,073,992	24%	$ 196,996,694	35%	$ 73,073,565	13%	$ 560,405,761
2011	$ 152,616,905	28%	$ 134,243,428	24%	$ 190,269,450	35%	$ 71,961,068	13%	$ 549,090,851
2012	$ 176,335,520	34%	$ 117,043,677	22%	$ 161,584,320	31%	$ 68,777,334	13%	$ 523,740,851
Total 2009-2012	**$ 628,910,636**	**29%**	**$ 529,271,602**	**24%**	**$ 748,713,082**	**34%**	**$ 287,655,289**	**13%**	**$2,194,550,609**
2014 (est)	**$ 122,802,547**	**29%**	**$ 112,433,218**	**27%**	**$ 126,441,867**	**30%**	**$ 60,498,368**	**14%**	**$ 422,176,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	South Africa	$ 36,526,675	$ 24,715,378	$ 33,419,249	$ 2,500,000	$ 664,910	$ -	$ 9,208,216	$ 38,662,273	**$ 145,696,701**
2010	South Africa	$ 51,555,902	$ 26,495,965	$ 27,745,164	$ 1,250,000	$ 664,910	$ -	$ 15,172,253	$ 31,377,316	**$ 154,261,510**
2011	South Africa	$ 49,872,350	$ 21,165,513	$ 31,369,480	$ 10,000	$ -	$ -	$ 19,322,253	$ 30,877,309	**$ 152,616,905**
2012	South Africa	$ 32,683,634	$ 19,482,256	$ 31,843,758	$ -	$ -	$ -	$ 76,772,471	$ 15,553,401	**$ 176,335,520**
	Totals FY09-FY12	**$ 170,638,561**	**$ 91,859,112**	**$ 124,377,651**	**$ 3,760,000**	**$ 1,329,820**	**$ -**	**$120,475,193**	**$ 116,470,299**	**$ 628,910,636**
2014 (est)	South Africa									**$ 122,802,547**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The primary objective of PEPFAR South Africa's overall prevention portfolio is to expand coverage of combination prevention interventions addressing the key drivers of HIV infection, reducing vulnerability to HIV and TB infection, and strengthening systems and capacity to implement programs in concentrated areas, as defined by a prevention strategic framework.

In FY 2014, the PEPFAR South Africa program will scale up HIV counseling and testing (HCT) through a combination of technical assistance and population-based HCT services including mobile HCT, couples testing, and home-based HCT. Interventions will also strengthen the quality of rapid HIV testing via implementation of a quality management system at all HIV rapid testing sites as well as linkages from HCT to prevention, care, and treatment services including provider-initiated HIV counseling and testing (PICT) in hospitals. These models of HCT have the potential to identify those not accessing health care facilities and target hard-to-reach

populations including key populations, farm workers, migrant and mobile populations, and sero-discordant couples.

The PEPFAR South Africa team will continue to support rapid scale up of neonatal and adult circumcision to meet the South African government goal of circumcising 1,000,000 men in 2014/15, with 4.3 million total circumcised by 2015/16. The PEPFAR voluntary medical male circumcision (VMMC) program has gradually expanded to include provinces that were not previously prioritized with uptake significantly increasing over the last year.

In FY 2014, PEPFAR South Africa will address gaps related to linkages and retention of women on prevention of mother-to-child transmission (PMTCT) to full antiretroviral therapy (ART). PMTCT will be supported across all 52 districts and facilities through an integrated mentoring and capacity building approach using PEPFAR's comprehensive partnerships. The FY 2014 program will increase focus on follow-up of mother-baby pairs post-delivery (after 6 weeks) and infant feeding to ensure durable PMTCT outcomes. PEPFAR South Africa will also provide ongoing assistance and on-site mentorship of nurse-initiated and management of ART (NIMART), the promotion of PICT, management and prevention of STIs and TB, and community outreach and referral to wellness, nutrition, and treatment programs.

Prevention services for HIV-positive persons include both behavioral and biomedical activities aimed at reducing morbidity and mortality and the risk of transmission to HIV-negative partner(s) and infants. HIV prevention messages and services are delivered as part of the routine care offered to HIV-positive persons.

The South African government and PEPFAR South Africa continue to prioritize condom promotion efforts and increasing the availability of male and female condoms where and when people need them. Particular attention will focus on the development of demand creation and distribution programs for female condoms and lubricant as appropriate for the sub-populations targeted. Programs will support the South African government to strengthen condom logistics and to address bottlenecks in acquisition and distribution. PEPFAR South Africa and the South African government will support strategies to provide alternative branding to the current choice-branded condoms.

PEPFAR South Africa is strengthening efforts to target key populations with the goal of reducing the number of new HIV infections in South Africa among sex workers (SW), persons who inject drugs (PWID), men who have sex with men (MSM), and their sex partners. In FY 2014, services will include treatment and prevention packages for SWs involving public-private partnership linkages. A new activity for FY 2014 supports prevention services in corrections facilities.

Since 2009, PEPFAR has been refocusing and consolidating its youth activities to be more strategic by targeting at risk youth and strengthening systems in a number of departments to implement evidence-based HIV prevention programs for at risk youth between 10-19 years. PEPFAR South Africa continues to support a number of school-based approaches targeting youth directly with curriculum and targeting the education sector more broadly with technical assistance at the policy level. In FY 2014, PEPFAR South Africa will launch a Families Matter initiative focused on youth.

The PEPFAR South Africa team now has a USAID Gender Advisor on staff to assist the U.S. government team with developing an overall strategy for gender activities within the PEPFAR portfolio. The U.S. government has successfully supported and transitioned government's rollout plan for Thuthuzela Care Centres, currently supports the South African government with nationwide public awareness campaigns which are culturally and community nuanced, and continues to support NGOs engaging in community prevention messaging targeted to men and boys.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	South Africa	$ 29,454,737	$ 147,095,716	$ 23,312,165	**$ 199,862,618**
2010	South Africa	$ 28,917,534	$ 144,366,995	$ 23,712,165	**$ 196,996,694**
2011	South Africa	$ 27,906,556	$ 141,044,277	$ 21,318,617	**$ 190,269,450**
2012	South Africa	$ 7,434,016	$ 133,340,115	$ 20,810,189	**$ 161,584,320**
	Totals FY09-FY12	**$ 93,712,843**	**$ 565,847,103**	**$ 89,153,136**	**$ 748,713,082**
2014 (est)	South Africa				**$ 126,441,867**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR South Africa's primary objective is to support further scale up of the national HIV treatment and care program, including pediatrics, TB/HIV, PMTCT, and care components, through partnerships covering all 52 districts and all public facilities offering HIV services nationally. While beginning to transition aspects of the care and treatment portfolio to the South African government, PEPFAR South Africa will bridge key gaps in direct service delivery and capacity building to ensure that this transition does not result in disruptions in patient care. In addition, PEPFAR South Africa will continue to support critical investments which the South African government is not yet prepared to absorb including: pediatric treatment services in community-level clinics; services for advanced clinical management of AIDS and TB/HIV; HIV and TB services in prison settings; services for vulnerable and at-risk populations such as commercial sex workers (CSW) and MSM; as well as services for other underserved groups such as adolescents, immigrants, and people living in informal settlements.

Adult treatment activities will focus on:

- Initiation of NIMART through multi-disciplinary mentoring teams focused on strengthening core components of clinical services in facilities and clinical program management in districts;
- Building effective quality improvement programs supporting HIV service delivery;

- Supporting effective linkages to adherence, retention, and community support;
- Addressing gap needs in advanced HIV case management through "centers of excellence" and "advanced clinical care" partnerships;
- Support for roll-out of HIV and TB treatment services in correctional facilities;
- Increasing access to treatment for key and vulnerable populations (e.g., immigrants, informal settlements, remote populations);
- A pilot for screening for Cryptococcus in HIV-infected patients with CD4 cell counts < 100 cells/ul;
- Screening for cervical cancer; and
- Strengthening supply chain management (SCM) to overcome challenges in public sector.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	South Africa	$ 45,369,612	$ 7,192,004	$ 37,290,231	$ 52,058,658	**$ 141,910,505**
2010	South Africa	$ 44,323,742	$ 7,192,004	$ 35,933,494	$ 48,624,752	**$ 136,073,992**
2011	South Africa	$ 41,944,114	$ 7,110,164	$ 37,424,589	$ 47,764,561	**$ 134,243,428**
2012	South Africa	$ 34,521,158	$ 6,201,947	$ 33,264,545	$ 43,056,027	**$ 117,043,677**
	Totals FY09-FY12	**$ 166,158,626**	**$ 27,696,119**	**$ 143,912,859**	**$ 191,503,998**	**$ 529,271,602**
2014 (est)	South Africa					**$ 112,433,218**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

HIV care is strengthened through PEPFAR support for primary health care (PHC) re-engineering, including community health worker training, mentoring and supervision, and strengthening referrals and linkages between communities and facilities. Other areas of program focus include:

- Integrating national AIDS councils (NACS) as a routine and integral part of HIV care and support;
- Supporting pre-ART programs and tracing early defaulters;
- Screening, diagnosis, and treatment of TB, STIs, opportunistic infections, and other HIV-related conditions;
- Implementing co-trimoxazole and isoniazid prophylaxis ;
- Developing positive health, dignity and prevention PHDP guidance, training materials, and implementation; and
- Evaluating programs related to PHC re-engineering, integrated access to care and treatment program (I-ACT)linkages, retention, and loss to follow-up.

In pediatric care and support, PEPFAR will continue to strengthen strategies for early infant diagnosis, intensified case finding of HIV-infected children and adolescents, and capacitating healthcare workers and facilities to better serve this population. Support for the development of child-specific NACS will also be a key focus, along with updating and rolling out new infant and young child feeding and counseling (IYCF) guidelines and supporting broader capacity support around breastfeeding.

PEPFAR supports NDOH priority districts based on high TB case load, poor treatment outcomes, high TB/HIV co-infection rates, multidrug-resistant and extensively drug-resistant tuberculosis (MDR/XDR-TB) prevalence, smear coverage, and smear conversion rates. TB/HIV funding is also integrated into the broader comprehensive treatment and care partnerships to ensure that program capacity building and outcomes are supported in districts and facilities across South Africa. Aligned with MDR-TB policy and PHC re-engineering, PEPFAR partners train health workers on improved reporting for better data quality and accelerated implementation of the key program areas for successful TB/HIV interventions. PEPFAR is also supporting task-shifting and funding the pilot and roll out of nurse-initiated management of MDR-TB through the NDOH.

The new orphans and vulnerable children (OVC) portfolio will focus particular attention on ensuring improved linkages and referrals for the provision of sexual and reproductive health and HIV information and prevention services for vulnerable adolescents. OVC programs will continue to address known HIV risk factors that are particularly prevalent in OVC populations, such as poverty and psychosocial distress. In addition to delivering HIV education and services, these programs will prioritize livelihood opportunities and psychosocial well-being — key factors in sexual decision making and indicators of overall well-being in their own right. Systems strengthening is the centerpiece of the OVC portfolio. The new Department of Social Development Government Capacity Building and Support award will provide technical assistance and capacity development within discrimination, stigmatization and denial (DSD) to strengthen its capacity to address the social and structural barriers that increase OVC vulnerability to HIV and AIDS.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	South Africa	$ 5,889,767	$ 17,860,099	$ 21,555,830	$ 28,537,626	**$ 73,843,322**
2010	South Africa	$ 6,465,036	$ 16,452,150	$ 18,615,239	$ 31,541,140	**$ 73,073,565**
2011	South Africa	$ 6,368,967	$ 15,132,854	$ 20,018,108	$ 30,441,139	**$ 71,961,068**
2012	South Africa	$ 5,951,504	$ 16,587,608	$ 28,545,515	$ 17,692,707	**$ 68,777,334**
	Totals FY09-FY12	**$ 24,675,274**	**$ 66,032,711**	**$ 88,734,692**	**$ 108,212,612**	**$ 287,655,289**
2014 (est)	South Africa					**$ 60,498,368**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Through consultative engagement with the South African government, the health systems and strengthening (HSS) portfolio has been developed to address key gaps including supply chain management, human resources for health, governance, training, policy development, and health finance. In SCM, activities include support for improved quantification and forecasting, support for pharmaceutical depot management and distribution, and assistance with tendering processes resulting in improved access to HIV-related pharmaceuticals. PEPFAR South Africa also supports the implementation of a South African government managed Human Resource Information System that tracks human resources training with the intention of improving staff retention through capacity development. PEPFAR South Africa supports multiple activities to improve evidence-based budgeting at national, provincial, and district levels. During the past year, PEPFAR South Africa conducted an analysis of internal U.S. government and external (South African government) budget cycles to identify key opportunities for joint planning. Future engagement is planned to facilitate PEPFAR input into the South African government's Medium-Term Expenditure Framework and mid-year South African government budget adjustment. PEPFAR South Africa is also using the results of the Expenditure Analysis to contribute to HIV resource allocation models to identify potential program and geographic areas that are not receiving sufficient resources. The HSS portfolio also supports operational research that identifies best practices for scale up including the cost effectiveness of task shifting and active TB/HIV case finding; acceptability, uptake, and cost of alternative scenarios for HIV treatment initiation; and the potential budgetary impact of changes to HIV treatment policy.

PEPFAR South Africa's key strategic information activities in FY 2014 will support a new phase of the Enhancing Strategic Information project, allowing the Partnership Information Management System to continue operating for an additional year. During this year, the PEPFAR team will evaluate options for improvement of the partner reporting system. PEPFAR South Africa will also explore options for another information management system that supports the South African government and civil society to improve data quality and date use for evidence-based management of HIV programs across national, provincial, district, and facility levels.

In FY 2014, PEPFAR South Africa will continue to support the new laboratory information system (Trakcare) which was developed with U.S. government support and is currently initiated under the leadership of the National Health Laboratory Services (NHLS). Plans are being developed to work with the NDOH and the NHLS to link health care facilities to this new information system and thereby improve timely access to test results. The pilot and initiation of innovative technologies (e.g., GeneXpert, Web Enabled Lab Result) are also supported for enhanced early detection of TB and timely treatment responses as well as improve access to laboratory results especially in rural healthcare facilities. The implementation of the GeneXpert has greatly reduced the TB turnaround time especially for MDR-TB.

Country Engagement

In July 2012, the Partnership Implementation Framework Plan (PFIP) was finalized and signed by the U.S. Ambassador and South African government Minister of Health. Following finalization of the PFIP, the bilateral Management Committee was constituted as well as four bilateral work streams which include participation from the U.S. government, South African government and other key stakeholders. The Management Committee has met several times to deepen joint planning between the South African government and U.S. government and the bilateral work streams have conducted reviews of the PEPFAR portfolio which were utilized to inform COP 2013 planning and decision-making.

The U.S. government has collaborated with the South African government to develop a consolidated Global Fund grant application and an interim application for the New Funding Model. These consolidated grants and the interim application complement the PEPFAR programmatic work and fill some of the funding gaps that are critical to obtaining the goals of the South African NSP for STIs, TB, and HIV.

On the service delivery front, the South African government has continued its expansion of HIV care and treatment. Successes include the launch of the Accelerated PMTCT Plan that has resulted in universal access to PMTCT services across the country and a decrease to 2.7 percent in early transmission; a rapid increase in access to ART with an estimated 1.7 million people on treatment in 2012 making it the world's largest ART program; improvement in the TB cure rate to 73 percent; and declining HIV incidence from 2.4 percent in 2001 to 1.5 percent in 2009 (UNAIDS 2011). The new NSP has once again set ambitious targets to be achieved by 2016/17 that include 30 million people tested for HIV and screened for TB, 80 percent of people in need receiving ART, and an over 85 percent TB cure rate for new smear positive cases. The South African government has increased spending for HIV from just under ZAR 5 billion ($576 million) in 2008 to around ZAR 11 billion ($1.25 billion) in 2012, with planned further growth in spending already included in South African government budget projections for the coming years.

South Sudan

Country Context

South Sudan has a generalized HIV epidemic with geographic areas of hyperendimicity. HIV prevalence rates are as high as 15.7 percent. States report HIV seroprevalence rates ranging from zero percent (Northern Bahr El-Ghazal) to 7.2 percent (Western Equatoria). Existing data suggest that military personnel are similar to the general population in terms of HIV risk in South Sudan. In 2012, an estimated 250,000 South Sudanese were infected with HIV, with 62,000 in need of anti-retroviral therapy (ART). HIV transmission in South Sudan is assumed to be driven by heterosexual practices, including multiple and concurrent sexual partnerships, as well as transactional and inter-generational sex. Presumed at-risk populations include: HIV discordant couples; commercial sex workers (CSWs), their clients and partners; long distance truckers; refugees; and members of the uniformed services. More than two million refugees have returned from neighboring countries where HIV infection rates are high.

In FY 2014, it is expected that the overall focus will be to improve the linkages between prevention, care, and treatment services.

FY 2014 priorities will include:

- Reducing the number of new infections by continuing to focus prevention efforts in geographic areas of higher prevalence and within key populations;
- Providing technical assistance to the Government of the Republic of South Sudan to increase antenatal care (ANC) clinic attendance and prevention of mother-to-child transmission (PMTCT) services;
- Strengthening surveillance, monitoring and evaluation (M&E), and laboratory systems;
- Supporting human resource capacity building; and
- Building national institutional capacity in governance, leadership, and policy.

PEPFAR South Sudan will work with the South Sudan government to increase the number of health facilities adapting and using provider-initiated testing and counseling (PITC) and to scale up quality PMTCT services.

Below is a table of PEPFAR South Sudan's budget representing its major program areas.

Fiscal Year	South Sudan Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 4,567,095	52%	$ 1,473,425	17%	$ -	0%	$ 2,796,480	32%	$ 8,837,000
2010	$ 5,258,090	55%	$ 1,449,900	15%	$ -	0%	$ 2,838,010	30%	$ 9,546,000
2011	$ 6,537,800	45%	$ 1,397,400	10%	$ -	0%	$ 6,610,800	45%	$ 14,546,000
2012	$ 5,835,756	40%	$ 1,788,523	12%	$ 3,570,203	25%	$ 3,351,518	23%	$ 14,546,000
Total 2009-2012	**$ 22,198,741**	**47%**	**$ 6,109,248**	**13%**	**$ 3,570,203**	**8%**	**$ 15,596,808**	**33%**	**$ 47,475,000**
2014 (est)	**$ 6,480,738**	**40%**	**$ 1,907,815**	**12%**	**$ 1,693,461**	**10%**	$ 6,233,985	**38%**	**$ 16,316,000**

*Totals include planned funding for all accounts.
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Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	South Sudan	$ 624,425	$ 1,010,000	$ 1,469,000	$ -	$ -	$ -	$ -	$ 1,463,670	**$ 4,567,095**
2010	South Sudan	$ 1,072,790	$ 1,087,800	$ 1,545,200	$ -	$ -	$ -	$ -	$ 1,552,300	**$ 5,258,090**
2011	South Sudan	$ 1,418,900	$ 816,800	$ 2,068,200	$ -	$ -	$ -	$ -	$ 2,233,900	**$ 6,537,800**
2012	South Sudan	$ 1,319,628	$ 418,436	$ 2,047,586	$ 377,891	$ -	$ -	$ -	$ 1,672,215	**$ 5,835,756**
	Totals FY09-FY12	**$ 4,435,743**	**$ 3,333,036**	**$ 7,129,986**	**$ 377,891**	**$ -**	**$ -**	**$ -**	**$ 6,922,085**	**$ 22,198,741**
2014 (est)	South Sudan									$ 6,480,738

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The priority areas in prevention include HIV counseling and testing (HCT), PMTCT, behavior change communication (BCC), and blood transfusion safety. In FY 2014, HCT sites will continue to serve as a key entry point for services within the continuum of care with an emphasis on implementing PITC to facilitate earlier identification of HIV-infected persons. HCT will also be provided through outreach services in high prevalence areas. Partners will continue to focus on improving HCT services to test partners and children of persons living with HIV (PLHIV) as well as improving the provision of basic care services, including: tuberculosis (TB) screening for positive individuals; condom promotion; providing co-trimoxazole prophylaxis; and effective linkages to treatment, care, and support in both clinic and community-based settings. PEPFAR South Sudan will focus on improving the quality of care at ANC and PMTCT sites. Partners will continue work with communities and the Ministry of Health (MOH) at state and county

levels to mobilize women to attend ANC as they continue to work towards 100 percent testing of all ANC attendees, at labor and delivery, and post-partum.

BCC addresses norms, attitudes, values, and behaviors that increase vulnerability to HIV such as multiple and casual sexual relations, cross-generational and transactional sex, the unequal status of women, and sexual coercion. BCC activities also provide full and accurate information about correct and consistent condom use. Over the past two years, PEPFAR South Sudan has been shifting the BCC program to target those more at risk for HIV. This focus will continue in FY 2014, with prevention efforts focused on key populations and other vulnerable groups through BCC strategies.

FY 2014 will be the first year PEPFAR South Sudan will provide technical assistance in blood transfusion safety. This activity complements the Global Fund support of constructing blood centers and procuring equipment. The plan is to have one of the three proposed regional blood transfusion centers open and functioning within the first year and the other two open and functioning by the end of FY 2014. In the longer term, support will also include setting up a voluntary blood donor program.

Since the end of the Global Fund Round 4 resources, there are no other donors in South Sudan for prevention services. The South Sudan government is in a fiscal crisis and has not allocated resources to HIV prevention programs, but continues to support the salaries and facilities where many of the services are located. It is expected that further gains in HCT will be found with the shift to PITC as well as more ownership at the health facility level for HCT.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	South Sudan	$ -	$ -	$ -	**$ -**
2010	South Sudan	$ -	$ -	$ -	**$ -**
2011	South Sudan	$ -	$ -	$ -	**$ -**
2012	South Sudan	$ -	$ 3,570,203		**$ 3,570,203**
	Totals FY09-FY12	**$ -**	**$ -**	**$ -**	**$ -**
2014 (est)	South Sudan				**$ 1,693,461**

*Totals include planned funding for all accounts.
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Technical assistance will continue through FY 2014 to strengthen the treatment system so that retention rates increase, clients receive care and treatment in accordance with guidelines, and patient load can increase without a decrease in quality of services. Technical assistance will include a facility level assessment of each of the 23 ART sites with an action plan to improve services, including retention and linkages. ART sites located in key areas (high population, high HIV prevalence) will be the first to receive technical assistance to address identified weakness in the action plan including in-service training/updates for clinicians. PEPFAR South Sudan will also provide commodities for treatment in FY 2014 as part of a two year gap program created by the Global Fund for newly eligible persons.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	South Sudan	$ 1,473,425	$ -	$ -	$ -	**$ 1,473,425**
2010	South Sudan	$ 1,449,900	$ -	$ -	$ -	**$ 1,449,900**
2011	South Sudan	$ 1,209,900	$ -	$ 187,500	$ -	**$ 1,397,400**
2012	South Sudan	$ 1,711,523	$ -	$ 77,000	$ -	**$ 1,788,523**
	Totals FY09-FY12	**$ 5,844,748**	**$ -**	**$ 264,500**	**$ -**	**$ 6,109,248**
2014 (est)	South Sudan					**$ 1,907,815**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Care activities in FY 2014 will continue to focus on health maintenance of PLHIV and their families, and retention of HIV-infected clients across the continuum of care from prevention to treatment.

Technical assistance will be increased as the number of persons testing positive in FY 2013 will have increased the demand for care. Activities will continue to be directed toward geographic areas with a high burden of HIV disease.

Key activities include:

- Exploring the use of nurses or clinical officers from HIV treatment sites to travel intermittently to smaller health care facilities within their catchment areas to expand HIV care services;
- Continuing to implement the basic care package of clinical staging for ART eligibility (including obtaining specimens for CD4 cell counts), including CTX provision, TB screening and referral, condom provision, linkages to PLHIV support groups, and treatment of opportunistic infections;
- Focusing on adherence counseling and support for ART to increase retention of all HIV positive persons, particularly pregnant women and their exposed infants;
- Improving integration of the prevention with positives (PwP) components into routine clinical care provided at HIV care and treatment clinics, antenatal clinics, and TB clinics with a focus on quality of care, and partner and family testing to identify discordant couples and others who may be infected;
- Continuing to work with community support groups of PLHIV to improve linkages to treatment as well as provide clinical, psychological, spiritual, social, and prevention services; and
- Capacity building of clinicians, data managers, and adherence counselors.

In FY 2014, PEPFAR South Sudan will continue to support the MOH to increase the number of ART sites with CD4 testing machines. This will build on work from the prior fiscal year, through which PEPFAR South Sudan provided training and mentorship on the use of point-of-care CD4 cell testing machines in key ART sites.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	South Sudan	$ 271,180	$ 766,900	$ 275,000	$ 1,483,400	**$ 2,796,480**
2010	South Sudan	$ 206,600	$ 486,680	$ 322,600	$ 1,822,130	**$ 2,838,010**
2011	South Sudan	$ 557,500	$ 2,560,700	$ 1,127,600	$ 2,365,000	**$ 6,610,800**
2012	South Sudan	$ 756,360	$ 1,107,936	$ 476,579	$ 1,010,643	**$ 3,351,518**
	Totals FY09-FY12	**$ 1,791,640**	**$ 4,922,216**	**$ 2,201,779**	**$ 6,681,173**	**$ 15,596,808**
2014 (est)	South Sudan					$ 6,233,985

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, PEPFAR South Sudan will continue to work in partnership with the MOH to strengthen its capacity in governance, leadership, and policy. At a system-wide level, PEPFAR South Sudan along with the MOH will coordinate the integration of HIV/AIDS services into existing health care services. This integration will ensure a continuum of response and support the national laboratory system. Strategic information capacity also will be improved to better define the epidemic with quality surveillance.

Given the lack of sufficient information on the HIV epidemic in South Sudan, PEPFAR South Sudan continues to place considerable importance on supporting the MOH to develop an evidence base from which to build its response. In FY 2014, there will be formative and bio-behavioral surveys of CSWs and long distance truck drivers. The program will continue activities to strengthen the system and the capacity of the MOH to generate, collect, analyze, and utilize HIV strategic information for policy, programming, and decision making. PEPFAR South Sudan will provide technical support for surveillance, M&E, data quality assessments, and indicator harmonization, and support to the MOH to develop a surveillance strategic plan and assist in the development and implementation of the HIV M&E strategy. Support for the HIV M&E capacity of the South Sudan government will also be provided, via placement of an M&E Advisor in the MOH to support standardizing data collection tools and processes, bringing together disparate data, and identifying and developing data collections to monitor and evaluate the epidemic and inform future HIV programming.

Country Engagement

The ultimate goal in country engagement is to build a partnership with the South Sudan government to provide HIV/AIDS programs and services that are needed by the South Sudanese people. The South Sudan PEPFAR team has engaged in a collaborative process with the Government of the Republic of South Sudan, UNAIDS, and other donors in providing technical assistance on the new South Sudan National Strategic Plan for HIV/AIDS for 2013-2017. PEPFAR South Sudan also worked with the South Sudan government to identify the need for a two year treatment bridge so that additional patients could receive ART while the country was receiving continuity of services funds from the Global Fund.

The South Sudan PEPFAR team has good technical level working relationships with its South Sudan government counterparts. Technical support for policy and guidelines have been provided by the South Sudan PEPFAR team and the government of South Sudan vets these documents and, once adopted, leads the implementation of the activities. The PEPFAR South Sudan program has developed a cadre of HIV counselors including trainers and the South Sudan government now uses these trainers.

Swaziland

Country Context

Swaziland is a landlocked kingdom at the epicenter of the global HIV/AIDS pandemic. It struggles to mitigate the world's highest prevalence rates of HIV and tuberculosis (TB). Economic growth and development are stagnated by HIV/AIDS and related health issues, which are an enormous drain on economies, the health system, and support networks critical to combating the epidemic. Over half of the population is under 20 and, by conservative estimates, nearly half of all children are orphaned or vulnerable. The PEPFAR-funded Swaziland HIV Incidence Measurement Survey (SHIMS), published in 2012, provides the most current and comprehensive data on the HIV/AIDS epidemic in Swaziland. SHIMS identifies the national HIV prevalence among adults 18-49 years of age as 31 percent, demonstrating stabilization in prevalence from the 2007 Demographic Health Survey. However, adult incidence remains high at 2.4 percent, indicating over 30 new HIV infections occurring each day. Women are disproportionately affected by HIV, with incidence among men at 1.7 percent compared to 3.1 percent among women. Additionally, a staggering 41 percent of pregnant women attending antenatal care (ANC) facilities are HIV positive. With support from PEPFAR, 85 percent of pregnant women access ANC services and treatment for the prevention of HIV for their unborn babies. The antiretroviral treatment (ART) program with PEPFAR support now reaches over 80 percent of the eligible population.

The Swaziland Partnership Framework (2009) outlines PEPFAR's programmatic goals, which include:

1. Decentralized and improved quality of care and HIV treatment services for adults and children, including HIV testing and TB/HIV;
2. A coordinated and comprehensive approach to sexual prevention of HIV, including improved social and behavior change communication interventions;
3. Rapid expansion of voluntary medical male circumcision (VMMC) to reach 10-49 year old males;
4. Impact mitigation focused on vulnerable children by improving the policy environment, strengthening national systems and supporting accelerated, improved service delivery through existing national and community initiatives and structures; and
5. Development of human and institutional capacity of government and civil society to manage an effective HIV response, particularly improving human resources for health.

In FY 2014 PEPFAR Swaziland will continue to be a fully engaged stakeholder in the process of revising and renewing the National Strategic Framework for HIV/AIDS (2008-2013). Based on the renewed National Strategic Framework, PEPFAR Swaziland and the Government of the Kingdom of Swaziland will work to redefine priority areas of support for a new partnership framework.

Below is a table of PEPFAR Swaziland's budget representing its major program areas.

Fiscal Year	Swaziland Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 9,880,426	30%	$ 5,383,778	17%	$ 6,795,000	21%	$ 10,390,796	32%	$ 32,450,000
2010	$ 18,910,201	50%	$ 5,279,779	14%	$ 4,818,000	13%	$ 8,536,342	23%	$ 37,544,322
2011	$ 15,693,000	26%	$ 10,465,090	17%	$ 6,510,810	11%	$ 28,131,100	46%	$ 60,800,000
2012	$ 9,267,910	28%	$ 10,153,544	31%	$ 5,641,348	17%	$ 7,462,017	23%	$ 32,524,819
Total 2009-2012	**$ 44,483,627**	**34%**	**$ 21,128,647**	**16%**	**$ 18,123,810**	**14%**	**$ 47,058,238**	**36%**	**$ 130,794,322**
2014 (est)	**$ 14,285,251**	**33%**	**$ 13,425,286**	**31%**	**$ 4,771,027**	**11%**	**$ 10,234,437**	**24%**	**$ 42,716,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Swaziland	$ 1,642,000	$ 1,617,221	$ 482,467	$ 50,000	$ -	$ -	$ 5,003,749	$ 1,084,989	**$ 9,880,426**
2010	Swaziland	$ 2,225,000	$ 1,452,500	$ 1,209,084	$ 1,125,000	$ -	$ -	$11,443,628	$ 1,454,989	**$ 18,910,201**
2011	Swaziland	$ 8,180,000	$ 1,290,000	$ 1,350,000	$ 350,000	$ -	$ -	$ 2,700,000	$ 1,823,000	**$ 15,693,000**
2012	Swaziland	$ 2,739,916	$ 1,039,150	$ 1,151,150	$ 340,000	$ -	$ -	$ 2,046,916	$ 1,950,778	**$ 9,267,910**
	Totals FY09-FY12	**$14,786,916**	**$ 5,398,871**	**$ 4,192,701**	**$ 1,865,000**	**$ -**	**$ -**	**$21,194,293**	**$ 6,313,756**	**$ 53,751,537**
2014 (est)	Swaziland									**$ 14,285,251**

*Totals include planned funding for all accounts.
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PEPFAR Swaziland adopted a mix of combination interventions (biomedical and behavioral) to combat the transmission of HIV. Armed with new comprehensive HIV/AIDS data from SHIMS, PEPFAR Swaziland utilizes best practices from regional scientific studies to inform the PEPFAR prevention portfolio.

In alignment with National Emergency Response Council on HIV/AIDS (NERCHA), the priorities of the PEPFAR prevention program for FY 2014 include:

1. Increased comprehensive knowledge of HIV and AIDS throughout the Swazi population;
2. Reduced numbers of concurrent partners among the sexually active population;

3. Increased reach, scope and coverage of prevention of mother-to-child transmission (PMTCT) services;
4. Increased circumcision of HIV negative males, with special attention to infants and males age 15-24 years; and
5. Integration of prevention programs targeting key populations.

In FY 2014, PEPFAR Swaziland will introduce new activity to strengthen community systems for PMTCT. Community stakeholders will be empowered to address socio-cultural and gender norms contributing to barriers in accessing HIV/AIDS services. PEPFAR Swaziland will collaborate with important partners supporting HIV prevention activities including the Global Fund, agencies of the United Nations, the Clinton Health Access Initiative (CHAI), the World Bank, and Médecins Sans Frontières **(**MSF).

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Swaziland	$ 4,170,000	$ 2,290,000	$ 335,000	**$ 6,795,000**
2010	Swaziland	$ 600,000	$ 3,583,000	$ 635,000	**$ 4,818,000**
2011	Swaziland	$ 750,000	$ 4,776,872	$ 983,938	**$ 6,510,810**
2012	Swaziland	$ 498,694	$ 4,263,622	$ 879,032	**$ 5,641,348**
	Totals FY09-FY11	**$ 6,018,694**	**$ 14,913,494**	**$ 2,832,970**	**$ 23,765,158**
2013 (est)	Swaziland				**$ 4,771,027**

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The primary programmatic treatment objectives of PEPFAR Swaziland are to establish sustainable mentorship systems for healthcare workers, thus to supporting the decentralization of service and increasing access to services in rural areas.

In FY 2014, PEPFAR will continue assistance to the Swaziland Ministry of Health (MOH) in developing and institutionalizing systems to support quality management. PEPFAR Swaziland and implementing partners established Regional Clinical Mentoring Teams (RCMT) in FY 2013. RCMTs provide on-site clinical mentoring, as well as leadership for decentralization of HIV and TB services. RCMT also promote task-shifting of antiretroviral treatment (ART) initiation from doctors to nurses. The integration of HIV within maternal and child health as well as primary care settings is an ongoing treatment programmatic focus. In addition to supporting antiretroviral (ARV) prophylaxis among HIV positive pregnant women, PEPFAR Swaziland also implements a support strategy to ensure these women subsequently enroll in HIV care and initiate ART when eligible. PEPFAR Swaziland will continue to support ARV prophylaxis among HIV positive pregnant women. To improve efficiency, PEPFAR Swaziland will support activities to improve data availability, inform forecasting, and improve procurement processes of

ARVs. PEPFAR Swaziland will continue to collaborate with the Global Fund in these areas, and also meet quarterly with CHAI, MSF, and the Swaziland MOH to monitor supplies and identify gaps in procurement.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Swaziland	$ 929,378	$ 340,000	$ 2,084,400	$ 2,030,000	**$ 5,383,778**
2010	Swaziland	$ 1,654,379	$ 690,000	$ 968,400	$ 1,967,000	**$ 5,279,779**
2011	Swaziland	$ 4,005,752	$ 953,938	$ 2,735,400	$ 2,770,000	**$ 10,465,090**
2012	Swaziland	$ 4,218,409	$ 850,032	$ 2,879,987	$ 2,205,116	**$ 10,153,544**
	Totals FY09-FY12	**$ 10,807,918**	**$ 2,833,970**	**$ 8,668,187**	**$ 8,972,116**	**$ 31,282,191**
2014 (est)	Swaziland					**$ 13,425,286**

*Totals include planned funding for all accounts.
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PEPFAR Swaziland's key priorities and major goals in care for FY 2014 include:

- Improving initiation of co-infected TB patients on ART within the first month (currently only 55 percent are initiated);
- Establishing a strong pre-ART system at every health facility offering HIV services in the country;
- Positive prevention messaging with emphasis on positive living, adherence, condom use, household TB screening, disclosure, and couples counseling; and
- Impact mitigation programs with a focus on comprehensive prevention messaging and care for in and out-of school youth.

PEPFAR Swaziland currently supports orphans and vulnerable children (OVC) impact mitigation by improving the policy environment, strengthening national systems, and supporting community-based service delivery. In FY 2014, PEPFAR Swaziland will begin to support evaluations of social assistance programs benefitting OVC. The current system is fragmented with limited coordination among programs. Accordingly, the evaluation will consider the functionality of programs and general sustainability. Ultimately, this evaluation will support the Swaziland Department of Social Welfare and other stakeholders to develop consensus and priorities for national social protection issues.

A standard operating procedure for linkage, retention and tracing of HIV patients (initiated by PEPFAR partners, but owned by the MOH) now governs the connections between the patients, their communities and the facilities they choose to attend. For example, people who test positive during community-based testing and VMMC outreach activities are followed-up with and

supported by Adherence and Psychosocial Officers to encourage care linkages. In some testing sites, an HIV positive expert client is on hand to help the newly diagnosed accept their status and encourage them to access care.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Swaziland	$ 2,625,000	$ 1,847,000	$ 3,894,200	$ 2,024,596	**$ 10,390,796**
2010	Swaziland	$ 900,000	$ 1,627,923	$ 2,457,027	$ 3,551,392	**$ 8,536,342**
2011	Swaziland	$ 950,000	$ 20,617,923	$ 2,680,000	$ 3,883,177	**$ 28,131,100**
2012	Swaziland	$ 1,354,396	$ 2,243,958	$ 1,518,433	$ 2,345,230	**$ 7,462,017**
	Totals FY09-FY12	**$ 5,829,396**	**$ 26,336,804**	**$ 10,549,660**	**$ 11,804,395**	**$ 54,520,255**
2014 (est)	Swaziland					**$ 10,234,437**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Strengthening national institutions will be a cross-cutting focus of all PEPFAR HIV investments. PEPFAR Sawziland in collaboration with the MOH developed a monitoring and evaluation framework for the health sector in 2008. In FY 2014, the PEPFAR Swaziland team and the MOH will work together to harmonize indicators to support the creation of a single system. Additionally, PEPFAR Swaziland will support program evaluations in the areas of linkage to care, ART program outcomes, costing, and PMTCT to enhance the culture of data use for program improvement.

Country Engagement

Despite being a lower-middle income country, Swaziland manages to finance over 40 percent of its HIV response. The Swaziland government absorbed financial responsibility for all ARV drug procurement in 2011, a great demonstration to the commitment of achieving an AIDS-free generation and embracing country ownership. In 2013, the MOH will receive an additional 3.2 percent of the 2013/14 Swazi National Budget. Spending on drugs has nearly tripled from 4 percent in the 2008/2009 national budget to the 2013/2014 national budget where ARV drugs and other medicines compromise 13 percent of total spending. Additionally, in FY 2014 PEPFAR Swaziland will begin to work with the Swaziland government to define a plan to absorb essential health positions currently funded by PEPFAR and other donors. This will require a significant dialogue with the MOH, the Ministry of Finance, civil society, and other donors.

The PEPFAR Swaziland team is also closely engaged with the Global Fund's Fund Portfolio Manager, Country Coordinating Mechanism (CCM), and Global Fund Principal Recipient to work toward the effective use of Global Fund resources, and ensure these resources compliment PEPFAR investments. The PEPFAR Swaziland team works closely with NERCHA and the MOH to address outstanding conditions on Global Fund grants, discuss long-term human resource management challenges, and improve CCM governance.

The PEPFAR team continuously engages with the Swaziland government to determine the most impactful and needed assistance from PEPFAR in Swaziland's HIV response.

Tanzania

Country Context

According to the 2011 UNAIDS Report on the Global AIDS Epidemic, adult HIV prevalence in the United Republic of Tanzania is estimated at 5.8 percent, with an estimated 1.6 million persons living with HIV (PLHIV) and 1.3 million orphans and vulnerable children (OVC). An estimated 84,000 AIDS related deaths occur in Tanzania each year. According to the 2007-08 Tanzania HIV/AIDS and Malaria Indicator Survey, the impact of the epidemic varies significantly by region, with the highest prevalence region (Iringa) estimated at 15.7 percent, and the lowest (Zanzibar) estimated at 0.6 percent, and with a significant difference in the prevalence between urban (9 percent) and rural (5 percent) areas. The data also reveal significant sex differentials in HIV prevalence, with male prevalence at 5 percent and female prevalence at 7 percent. Despite a generalized epidemic, key populations play a critical role in HIV transmission dynamics. Studies carried out in Dar es Salaam indicate that the HIV prevalence is 42 percent among people who inject drugs (PWID) (2007) and 31.4 percent among sex workers (SW) (2010), while unpublished data for men who have sex with men (MSM) in Dar es Salaam indicates prevalence over 30 percent (2012).

Since 2004, PEPFAR Tanzania has been working closely with the Tanzanian Government and other donors, including the Global Fund (GF), to respond to the HIV epidemic. The country grapples with weak health infrastructure, shortages of health and social workers, high levels of stigma, and cumbersome government procurement systems. PEPFAR Tanzania continues to support achievement of the six Partnership Framework (PF) goals: Service Delivery and Scale Up; Prevention; Leadership, Management, Accountability, and Governance; Sustainable and Secure Drug and Commodity Supply; Human Resources; and Evidence-based and Strategic Decision Making. Gender is a cross-cutting consideration in the PF, and PEPFAR Tanzania continues to recognize the importance of gender-differentiated strategies to achieve its goals. Implementation of the PF goals will closely correspond to the *PEPFAR Blueprint: Creating an AIDS-free Generation* by strategically prioritizing high-impact interventions, including adopting prevention of mother to child transmission (PMTCT) Option B+, scaling up both adult and pediatric treatment coverage under the 2010 World Health Organization (WHO) guidelines on antiretroviral therapy (ART), and increasing access to and uptake of voluntary medical male circumcision (VMMC), HIV counseling and testing (HCT), and condoms.

Below is table of PEPFAR Tanzania's budget representing its major program areas.

Fiscal Year	Tanzania Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 87,654,555	24%	$ 80,796,787	22%	$ 112,563,141	31%	$ 80,151,860	22%	$ 361,166,343
2010	$ 99,933,263	28%	$ 74,959,567	21%	$ 116,808,202	33%	$ 66,268,241	19%	$ 357,969,273
2011	$ 115,738,786	32%	$ 75,085,567	21%	$ 96,220,948	27%	$ 70,148,188	20%	$ 357,193,489
2012	$ 87,839,666	30%	$ 51,223,713	18%	$ 87,601,777	30%	$ 62,890,065	22%	$ 289,555,221
Total 2009-2012	**$ 391,166,270**	**29%**	**$ 282,065,634**	**21%**	**$ 413,194,068**	**30%**	**$ 279,458,354**	**20%**	**$ 1,365,884,326**
2014 (est)	**$ 108,351,891**	**32%**	**$ 65,474,231**	**19%**	**$ 113,332,184**	**34%**	**$ 50,612,694**	**15%**	**$ 337,771,000**

*Totals include planned funding for all accounts.
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Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Tanzania	$ 21,878,648	$ 18,673,605	$ 16,412,270	$ 6,622,182	$ 2,722,883	$ 1,644,936	$ 3,090,078	$ 16,609,953	**$ 87,654,555**
2010	Tanzania	$ 40,125,979	$ 15,287,493	$ 15,966,507	$ 5,477,104	$ 2,735,383	$ 2,239,450	$ 2,666,078	$ 15,435,269	**$ 99,933,263**
2011	Tanzania	$ 38,970,462	$ 20,301,360	$ 21,372,173	$ 5,327,104	$ 1,959,599	$ 3,950,000	$ 8,566,078	$ 15,292,010	**$ 115,738,786**
2012	Tanzania	$ 29,775,929	$ 4,376,214	$ 16,387,680	$ 4,899,806	$ 1,593,415	$ 2,776,788	$14,009,456	$ 14,020,378	**$ 87,839,666**
	Totals FY09-FY12	**$ 130,751,018**	**$ 58,638,672**	**$ 70,138,630**	**$ 22,326,196**	**$ 9,011,280**	**$ 10,611,174**	**$28,331,690**	**$ 61,357,610**	**$ 391,166,270**
2014 (est)	Tanzania									**$ 108,351,891**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR Tanzania continues to support high impact, evidence-based HIV prevention services and increase the adoption of protective social and gender norms and behaviors in an effort to reduce HIV incidence. In FY 2014, this combination approach, which includes behavioral, biomedical, and structural interventions, balances its focus between the general population, key populations, and other at-risk sub-population interventions. This strategy will enable the prevention portfolio to better create demand for other components of the HIV continuum of response and more effectively address the needs of program beneficiaries. PEPFAR Tanzania will strategically direct resources to prioritize targeted and evidence-based interventions for populations at greatest risk, including improving the availability and uptake of HIV services for key populations; linking PLHIV with community-based care and support interventions; and addressing stigma, discrimination, and legal barriers to ensure key populations' access to services. Additionally, PEPFAR Tanzania will focus on multiple and concurrent partnerships,

transactional and inter-generational sex, and developing an enabling environment to diminish vulnerability among adolescent and young girls, including gender-based violence prevention.

In an effort to support the goal of increasing the number of people on ART, the HCT portfolio will heighten its focus on provider-initiated testing and counseling (PITC) and adopt a high-yield approach to HCT by strategically working in regions with high HIV prevalence, key populations and other large at-risk sub-populations, and will focus on improving linkages and coordination with other program area activities. The VMMC program will continue to scale up services and implement innovative methods to attract older men to services. The blood safety program is focusing on strengthening and streamlining systems for blood collection, screening, and distribution, also with the vision of gradual transition to the Government of Tanzania.

The PMTCT strategy focuses on preparing mainland Tanzania for the rollout of Option B+. PEPFAR Tanzania is working closely with the Ministry of Health and Social Welfare (MOHSW) to strategize and implement the regional rollout of Option B+ by reviewing policies on monitoring and evaluation for ART and PMTCT integration, logistics, training, defining the minimum package of services, and organizing community roll-out. While preparing for Option B+, PEPFAR Tanzania will continue scaling up PMTCT services to facilities offering reproductive and child health services, with a goal of providing treatment to 95 percent of all HIV positive pregnant women identified. Couples counseling; gender-based violence prevention, detection and care; and positive health, dignity and prevention (PHDP) activities will be supported.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Tanzania	$ 24,279,322	$ 78,710,333	$ 9,573,486	**$ 112,563,141**
2010	Tanzania	$ 23,886,322	$ 82,383,961	$ 10,537,919	**$ 116,808,202**
2011	Tanzania	$ 4,636,322	$ 81,518,140	$ 10,066,486	**$ 96,220,948**
2012	Tanzania	$ 15,392,830	$ 63,644,482	$ 8,564,465	**$ 87,601,777**
	Totals FY09-FY12	**$ 68,194,796**	**$ 306,256,916**	**$ 38,742,356**	**$ 413,194,068**
2014 (est)	Tanzania				**$ 113,332,184**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR Tanzania partners implement a variety of treatment services including diagnosis, prevention and management of opportunistic infections, PITC, PMTCT, early infant diagnosis and pediatric care and treatment, cervical cancer screening and referrals, tuberculosis (TB) screening, and PHDP interventions. Moreover, PEPFAR Tanzania care and treatment partners support the integration of family planning services at care and treatment clinics (CTCs) and HIV care and treatment within reproductive and child health clinics. The adult ART strategy focuses on increased identification of people living with HIV (PLHIV), increased linkages along the prevention, care, and treatment continuum, timely ART initiation, maintenance of patients on ART with quality clinical services, and retention of patients in care and treatment. PEPFAR Tanzania has initiated collaboration among ART, HCT, and home-based care (HBC) partners to strengthen linkages to and retention of patients in care and treatment services. To accommodate the full adoption of the United Republic of Tanzania national ART guidelines, PEPFAR Tanzania is advocating for an increase in clinic days at facilities, comprehensive reviews of adult and pediatric pre-ART patient charts to determine ART eligibility, CD4 testing when indicated, and regimen simplification. PEPFAR Tanzania will continue to expand pediatric ART services in parallel with adult ART services and aims to expand pediatric ART services to 80 percent of all facilities offering PMTCT.

In FY 2014, PEPFAR Tanzania will continue to support the National TB Program and work toward stronger TB/HIV integration and collaboration with a focus on quality improvement and expanded coverage. Of particular interest, PEPFAR Tanzania will work with the Government of Tanzania to adopt the revised national HIV/TB guidelines and scale up the WHO "3 Is" HIV/TB key intervention in high burden CTCs in order to ensure intensive case finding through continued screening for TB among PLHIV and initiate all HIV/TB co-infected patients on ART. The MOHSW will also continue to receive PEPFAR support in laboratory management and accreditation, diagnostics, logistics and procurement, and pre-service training.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Tanzania	$ 39,757,173	$ 2,134,121	$ 8,017,799	$ 30,887,694	**$ 80,796,787**
2010	Tanzania	$ 35,948,202	$ 2,329,121	$ 7,855,150	$ 28,827,094	**$ 74,959,567**
2011	Tanzania	$ 35,842,802	$ 2,129,121	$ 8,355,150	$ 28,758,494	**$ 75,085,567**
2012	Tanzania	$ 18,735,494	$ 1,675,683	$ 6,286,035	$ 24,526,501	**$ 51,223,713**
	Totals FY09-FY12	**$ 130,283,671**	**$ 8,268,046**	**$ 30,514,134**	**$ 112,999,783**	**$ 282,065,634**
2014 (est)	Tanzania					**$ 65,474,231**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Despite increasing numbers of PLHIV on ART, there are still high rates of loss to follow up, with up to 26 percent of CTC clients no longer being reported in the system, as well as late enrollment, in some cases with very low CD4 cell counts, and delays in ART initiation due to lack of regular monitoring and late diagnosis. The goal of the community care service portfolio is to ensure improved access to quality community health and social services for PLHIV, people affected by HIV and other vulnerable populations. In the past, the community care package for PLHIV was primarily palliative care for bed-ridden patients. With more PLHIV receiving ART and living longer, the portfolio is currently undergoing critical strategic changes to address essential care and support services to better respond to the changing needs of PLHIV and households affected by AIDS. Strategic changes in the portfolio include assuring linkages in the continuum of care, from the point of diagnosis through enrollment, pre-ART care, and ART initiation.

In FY 2014, the HBC program will focus on scale-up in high prevalence areas, create efficiencies wherever possible, and leverage the clinical and HCT programs to support joint linkage and retention strategies. Standardizing the role of community health workers and updating Government of Tanzania national guidelines to better address discharging patients from HBC to self-care will be a major policy priority. The strategic focus of the orphans and vulnerable children (OVC) portfolio has shifted from an individual child to a family-based, care-centered approach, conforming to PEPFAR OVC guidance. Responding to recent program data which indicate that more than 50 percent of OVC are adolescents, the portfolio will also strengthen linkages of OVC into youth-friendly, sexual and reproductive health services. OVC programs will continue to integrate child protection strategies and respond to violence against children. National guidance for integration of community-focused support in HIV services at the community level has been developed and will be rolled out to ensure comprehensive, holistic health promotion in addition to prevention for PLHIV.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Tanzania	$ 12,725,000	$ 12,611,831	$ 41,396,661	$ 13,418,368	**$ 80,151,860**
2010	Tanzania	$ 7,969,000	$ 8,153,000	$ 27,200,827	$ 22,945,414	**$ 66,268,241**
2011	Tanzania	$ 8,312,523	$ 7,659,000	$ 28,832,109	$ 25,344,556	**$ 70,148,188**
2012	Tanzania	$ 6,454,300	$ 6,342,028	$ 37,189,539	$ 12,904,198	**$ 62,890,065**
	Totals FY09-FY12	**$ 35,460,823**	**$ 34,765,859**	**$ 134,619,136**	**$ 74,612,536**	**$ 279,458,354**
2014 (est)	Tanzania					**$ 50,612,694**

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Tanzania's health sector has made progress in ensuring that systems and capacity exist to sustainably deliver and continuously improve health services that are high quality, equitable, efficient and evidence-based, including: supply chain, human resources for health, strategic information, and sector leadership, management and accountability. The country is still facing many of the challenges common to low-income countries with high disease burdens. PEPFAR Tanzania has worked tirelessly over the last year with the GF and the United Republic of Tanzania to solidify Phase II of the Round 8 HIV grant, which provides the country with most HIV-related commodities. PEPFAR Tanzania program staff and senior management will assist the Government of Tanzania to adopt and adapt to the Voluntary Pooled Procurement mechanism for HIV and malaria commodities. In addition, in FY 2014, PEPFAR Tanzania will continue to work to strengthen the entire public health supply chain system, starting at the central level of Medical Stores Department, to improve the availability of health commodities at all public health facilities.

Adequate, skilled human resources for health remain a major challenge for the health sector in general, and for HIV in particular. PEPFAR Tanzania will continue to help boost the quality and production of health care workers through support of scholarships, faculty training, curriculum development, and scaling up of distance education efforts with attention given to making investments that can be sustained by the United Republic of Tanzania. PEPFAR Tanzania will continue to build leadership capacity and skills of local government authorities to promote decentralization, and strengthen coordination between central, regional, and district levels. At the district and regional level, the focus will be on improving financial management, accountability, and budgeting.

The creation of a Private Public Health Partnership Forum to discuss health policy issues, mobilize private sector resources, and improve health service delivery, including care and treatment services through both public and private sectors is also a priority, as is supporting the development of the health care financing strategy, which will include a strategy for increasing domestic sources of financing. PEPFAR Tanzania is also supporting integration of data systems across health programs and donors by providing technical support to key government departments and aligning investments with multi-donor initiatives.

Country Engagement

Meeting the AIDS-free Generation targets require strong government systems that are efficiently implementing GF grants, the adoption of necessary policy changes, and utilizing data effectively to make informed decisions on the epidemic. Recently the Government of Tanzania has made several key policy decisions that will allow for rapid program scale-up and expansion, and the achievement of related targets through FY 2013 and FY 2014 including:

- Full adoption of the 2010 WHO ART Guidelines by the Government of Tanzania;
- Advancement of plans to implement PMTCT Option B+ ;
- Signature of the second phase of the GF Round 8 HIV grant;
- Decision by the United Republic of Tanzania to utilize the Voluntary Pooled Procurement mechanism; and
- Negotiation of replacement test kits after the recall of SD Bioline HIV-1/2 3.0.

PEPFAR Tanzania uses the Partnership Framework Implementation Plan (PFIP) as a guiding document for all technical interventions and systems and capacity development priorities. Engagement with the Tanzanian government has increased with the addition of routine PFIP reviews between PEPFAR Tanzania and Tanzanian counterparts. Political ownership and stewardship have been demonstrated recently as the country prepares the evaluation of two national strategic documents and the development of their successor strategies: the United Republic of Tanzania National Multi-Strategic Framework on HIV and AIDS III and the United Republic of Tanzania Health Sector HIV Strategic Plan III. The formation of these two critical national documents is timely for the renegotiation of the terms of the new PF. It is expected that the UNAIDS Investment Framework and the *Blueprint* will have a central role in all three documents. PEPFAR Tanzania will continue to increase institutional and community ownership with renewed investment in public-private partnerships, private sector engagement, indigenous implementing partners, organizational support to community networks and groups, and capacity-building of national and sub-national government institutions.

Uganda

Country Context

In September 2012, the Ministry of Health (MOH) released the results of the Uganda AIDS Indicator Survey (UAIS) 2011. It indicated that Uganda continues to experience a severe HIV epidemic. HIV prevalence in the general population (15 to 59 years old) is estimated to be 7.3 percent in 2011, compared to 6.4 percent in 2004-2005. HIV prevalence is higher among women (8.3 percent) than among men (6.1 percent). Compared to the 2004/5 UAIS survey, the magnitude of change in HIV prevalence varied across regions: Central, Western, Southwestern and Northern regions remain the worst-affected while modest declines in prevalence were recorded in the East-Central and Mid-Eastern regions. Of particular concern is the rise in HIV prevalence among young people aged 15-24 years generally and in all age groups specifically in the West Nile and North-East regions that previously were least affected.

The estimated number of people infected with HIV has risen to 1.39 million, 55 percent of whom are female and 14 percent are children under the age of 15 years. UNAIDS projects the number of new annual infections at 150,000 (2011), an increase from 120,000 in 2004. While access to ART has significantly increased over the last eight years, expansion has not been at a pace to keep up with the significant increases in new infections. In 2014, PEPFAR Uganda plans to support enrollment of an additional 206,684 new naïve clients on antiretroviral therapy (ART), which will translate to a net increase of 190,804 clients – exceeding the estimated annual new infections. With this continued treatment scale-up PEPFAR Uganda will provide support to the country in achieving its goal of universal access to HIV and AIDS prevention, care, treatment, social support, and protection by 2015.

PEPFAR Uganda has selected programmatic strategies that include:

- Initiating Option B+ (lifelong treatment for all HIV-positive pregnant women) to not only protect the newborn from the risk of HIV infection but also to treat the mother for her own health;
- Providing HIV counseling and testing (HCT) to key populations and patients seeking care in health facilities, and prioritizing voluntary medical male circumcision (VMMC) as a proven, highly effective approach to HIV prevention, and ensuring that interagency communications strategies are funded and capable to support the required demand creation of this initiative; and
- Improving access to ART, with particular attention to reaching children, and expanding access to HIV/AIDS basic care, ensuring that patients are followed up appropriately and retained in services.

Below is a table of PEPFAR Uganda's budget representing its major program areas.

Fiscal Year	Uganda Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 74,561,879	26%	$ 64,614,295	23%	$ 84,023,234	29%	$ 63,914,326	22%	$ 287,113,734
2010	$ 71,988,733	25%	$ 60,795,770	21%	$ 90,831,260	32%	$ 62,642,609	22%	$ 286,258,372
2011	$ 96,603,936	30%	$ 61,660,676	19%	$ 99,946,571	31%	$ 65,177,189	20%	$ 323,388,372
2012	$ 68,028,107	23%	$ 68,855,730	23%	$ 112,018,081	38%	$ 49,486,454	17%	$ 298,388,372
Total 2009-2012	**$ 311,182,655**	**26%**	**$ 255,926,471**	**21%**	**$ 386,819,146**	**32%**	**$ 241,220,578**	**20%**	**$1,195,148,850**
2014 (est)	**$ 73,138,313**	**23%**	**$ 68,506,598**	**22%**	**$ 120,470,234**	**38%**	**$ 51,802,856**	**17%**	**$ 313,918,000**

*Totals include planned funding for all accounts.
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Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Uganda	$ 16,368,486	$ 17,887,816	$ 13,311,143	$ 4,900,000	$ 632,500	$ -	$ 2,873,587	$ 18,588,347	**$ 74,561,879**
2010	Uganda	$ 14,857,079	$ 14,842,743	$ 13,863,111	$ 3,218,000	$ 1,002,500	$ -	$ 7,388,187	$ 16,817,113	**$ 71,988,733**
2011	Uganda	$ 40,116,071	$ 12,232,795	$ 15,673,067	$ 3,000,000	$ 632,500	$ -	$ 8,542,825	$ 16,406,678	**$ 96,603,936**
2012	Uganda	$ 5,171,223	$ 3,484,420	$ 11,275,292	$ 2,009,189	$ 300,000	$ -	$31,142,682	$ 14,645,301	**$ 68,028,107**
	Totals FY09-FY12	**$ 76,512,859**	**$ 48,447,774**	**$ 54,122,613**	**$ 13,127,189**	**$ 2,567,500**	**$ -**	**$49,947,281**	**$ 66,457,439**	**$ 311,182,655**
2014 (est)	Uganda									**$ 73,138,313**

*Totals include planned funding for all accounts.
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In FY 2014, the PEPFAR Uganda Prevention program will continue to focus on Option B+, scaling-up provider-initiated testing and counseling (PITC), targeted testing for key high risk groups, and VMMC.

Following a series of iterative discussions with stakeholders, the Ugandan government endorsed a phased initiation of Option B+. Regions to be prioritized at the outset will be those with the highest HIV prevalence. FY 2014 will continue to serve as a transition year for Uganda's prevention of mother-to-child transmission (PMTCT) program as stakeholders adjust to the policy shift from Option A to Option B+, with an aim for full transition by December 2013. PEPFAR's goal is to work with the Ugandan government to fast track stepwise accreditation and the upgrading of numerous health center level three facilities where the majority of HIV positive pregnant women attend antenatal care. This will help the Ugandan government reach its PMTCT targets. In FY 2014, PEPFAR Uganda will continue to improve the links between these

clinics and regional laboratory hubs to enhance easy access to essential laboratory services with particular emphasis on early infant diagnosis.

PEPFAR Uganda will prioritize targeted HCT and continue to tailor testing strategies to identify more HIV positive individuals. This transition means that the bulk of testing services will be delivered through PITC in health facilities and will be accompanied by a strategic outreach testing approach for high-risk populations and communities. The objective is to enhance early identification of HIV positive individuals, creating better and more efficient linkages to care and treatment, and ultimately mitigating their risk of transmitting HIV to their partners.

PEPFAR Uganda will continue to create demand for VMMC and transition the service delivery to be done by dedicated/roving VMMC teams at health facilities and utilization of models that optimize the volume and efficiency of male circumcision services. In FY 2014, to maximize access to training for skilled providers and optimize real time technical support to VMMC sites, additional training sites will be created within Regional Referral Hospitals, which will train and oversee services in approximately five districts each. Real time reporting will be critical as services are rolled out.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Uganda	$ 33,695,669	$ 38,287,874	$ 12,039,691	**$ 84,023,234**
2010	Uganda	$ 53,139,658	$ 27,841,791	$ 9,849,811	**$ 90,831,260**
2011	Uganda	$ 49,527,765	$ 38,310,639	$ 12,108,167	**$ 99,946,571**
2012	Uganda	$ 56,334,069	$ 49,272,829	$ 6,411,183	**$ 112,018,081**
	Totals FY09-FY12	**$ 192,697,161**	**$ 153,713,133**	**$ 40,408,852**	**$ 386,819,146**
2014 (est)	Uganda				**$ 120,470,234**

*Totals include planned funding for all accounts.
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In FY 2014, PEPFAR plans to support ART scale-up with emphasis on increasing the number of people who are eligible on treatment and scale-up of treatment (Option B+) for HIV positive pregnant women and children. In order to achieve its targets, PEPFAR will focus on:

- Improving linkages between prevention, testing, care and treatment for all who are eligible;
- Ensuring early initiation on treatment;
- Providing wider coverage and access to CD4 testing at facilities;

- Fast-tracking ART accreditation of lower level facilities such as Health Center II and III, implementing a response to ensure adequate access to a wide range of services for HIV-positive clients;
- Promoting an active search for HIV-exposed and HIV-infected infants;
- Supporting the MOH and districts to mobilize community structures to identify, link, and retain children in care, and treatment; and
- Maintaining adherence by strengthening facility/community linkages using linkage facilitators, a cadre of volunteers including PLHIV and religious and local leaders to monitor clients at community level as well as implementing quality improvement approach to support adherence and retention.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Uganda	$ 23,395,954	$ 5,564,403	$ 9,600,318	$ 26,053,620	**$ 64,614,295**
2010	Uganda	$ 21,065,481	$ 5,515,814	$ 9,037,881	$ 25,176,594	**$ 60,795,770**
2011	Uganda	$ 21,529,416	$ 6,193,814	$ 9,185,852	$ 24,751,594	**$ 61,660,676**
2012	Uganda	$ 34,850,743	$ 1,195,022	$ 7,364,979	$ 25,444,986	**$ 68,855,730**
	Totals FY09-FY12	**$ 100,841,594**	**$ 18,469,053**	**$ 35,189,030**	**$ 101,426,794**	**$ 255,926,471**
2014 (est)	Uganda					**$ 68,506,598**

* Totals include planned funding for all accounts. .
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In addition to its prevention strategy, PEPFAR Uganda will also prioritize developing a quality, comprehensive chronic care strategy to keep HIV-infected individuals healthier longer, better informed, and actively engaged in the response. Statistical modeling projects that there are an estimated 1,390,732 individuals living with HIV in Uganda. As of September 2012, PEPFAR Uganda had provided chronic care services to about 51 percent of the national need. In FY 2014, PEPFAR plans to support the Ugandan government's goal of achieving universal access of 80 percent in care by 2015. PEPFAR Uganda plans to identify additional HIV-positive individuals through HCT, VMMC, early infant diagnosis, and PMTCT services who will then be better linked to care and support services.

In pursuit of these targets, in FY 2014 PEPFAR Uganda will prioritize:

- Capacity building of peripheral public facilities with the aim of decentralizing care and support services into the lower level health facilities with a special focus on services for key populations;
- Improving retention in care though a continuous quality improvement process and active tracking of individuals lost to follow-up;

- Standardizing and integrating prevention with positive interventions across care and treatment services;
- Addressing the barriers to pediatric access to care and treatment by strengthening pediatric testing and treatment services;
- Prioritizing accreditation of lower level TB diagnostic and treatment units that are not currently providing ART and as a short-term measure;
- Supporting ART outreach to lower level TB treatment units that are not ART accredited sites;
- Strengthening the continuum of nutrition care through support for nutrition assessment, counseling, and support in HIV and antenatal clinics for adults, children and pregnant women; and
- Supporting economic strengthening and livelihoods at the community-level.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance and Systems**
2009	Uganda	$ 19,514,229	$ 17,523,972	$ 7,884,091	$ 18,992,034	**$ 63,914,326**
2010	Uganda	$ 13,800,894	$ 13,673,110	$ 12,360,979	$ 22,807,626	**$ 62,642,609**
2011	Uganda	$ 16,155,959	$ 12,535,910	$ 13,113,994	$ 23,371,326	**$ 65,177,189**
2012	Uganda	$ 17,764,488	$ 10,948,172	$ 10,029,559	$ 10,744,235	**$ 49,486,454**
	Totals FY09-FY12	**$ 67,235,570**	**$ 54,681,164**	**$ 43,388,623**	**$ 75,915,221**	**$ 241,220,578**
2014 (est)	Uganda					**$ 51,802,856**

*Totals include planned funding for all accounts.
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FY 2014 interventions also reflect the priorities of policy and strategic frameworks including the National Development Plan and Uganda AIDS Commission National HIV and AIDS Strategic Plan.

PEPFAR remains a cornerstone of Uganda's Global Health Initiative (GHI) strategy and aims to improve access to and delivery of health services. In support of several GHI principles, PEPFAR-funded interventions work to integrate one or more critical health system functions. PEPFAR's comprehensive partner programming and focus on the continuum of care has provided the platform upon which to strengthen the one-stop-shop for affordable services, including antenatal care (ANC). The PEPFAR Uganda team will also better integrate Saving Mothers, Giving Life (SMGL) and Presidential Malaria Initiative efforts into PMTCT and ANC platforms for greater programmatic impact. Additionally, through a unique donor-to-donor partnership with the United Kingdom's Department for International Development (DFID), they are able to ensure family planning commodities and outreach services are available in every district in Uganda.

PEPFAR Uganda will continue to focus on strengthening family planning (FP)/HIV integration and ensure that FP is available in every PEPFAR supported site. U.S. government programs combine both non-integrated and integrated interventions. The nature and extent of integration varies significantly due to programming history, funding levels, and emergent national demands. GHI affords PEPFAR the opportunity to better support U.S. government efforts to increase community advocacy for health in parallel with rising utilization of quality health services and align our programs, such as SMGL, FP, and PMTCT, to have greater impact on the beneficiaries and public health overall.

Country Engagement

The PEPFAR Uganda team is collaborating with the UNAIDS Investment Framework process which will result in a plan for sustainability. The sustainability plan will involve key actors in Uganda including UNAIDS, the Global Fund, the Government of Uganda, and other donors.

Implementation of the revised National Strategic Plan for HIV/AIDS 2010/11 – 2015/16 will require commitment to multi-sectoral linkages by all stakeholders as well as increasing partnership by the Ugandan government with U.S. government and other health donors.

Historically, the U.S. government has had a three-pronged approach to country ownership:

- Alignment of the PEPFAR portfolio to national policies and plans;
- Capacity building of the service delivery and health systems at district levels; and
- Public diplomacy to engender stronger national leadership.

In FY 2014, additional emphasis will be placed upon the leadership and stewardship of the Ugandan AIDS Commission (UAC) and MOH. In partnership with the U.S. government PEPFAR portfolio, both the UAC and MOH will be coordinating a multi-sectoral response with greater transparency. Encouraging and requiring the Ugandan government and MOH to commit will be an ever present challenge facing the country team.

The PEPFAR country team has been working jointly with the UAC and MOH through the whole range of programming activities which include: identification of priorities, designing of the appropriate response, management of the implementation process, and monitoring and evaluation. Cooperative agreements with the Ministry of Health, Uganda Capacity Program, Strengthening Decentralization for Sustainability Project, Health Initiatives for the Private Sector Project, and Civil Society Fund have significantly improved the ability of government (national and local), the private sector, and civil society to undertake their respective mandates in HIV/AIDS and broader health services delivery.

The U.S. government, led by the Ambassador, has raised the political profile of health with the President of Uganda and the executive and legislative branches of government. The U.S. government is an active member on the Global Fund (GF) Country Coordinating Mechanism (CCM) in Uganda, and U.S. government agencies are active members of the Health

Development Partner and AIDS Development Partner groups, as well as the Health Policy Advisory Committee. The U.S. government team has regular planning and strategic meetings with the GF's Fund Portfolio Manager and CCM members on a range of key issues for the HIV response which includes an active partnership on commodities supply.

In 2011, the Ugandan government appointed a new, dynamic Board Chair for the UAC. With assistance from the U.S. government, the CCM (which oversees GF grants) reconstituted its membership to enhance transparency. The newly inaugurated parliament has begun holding ministries and other government departments more accountable and engaging government to prioritize basic service delivery. Recently, the MOH's FY 2011/12 budget for maternal and child health was rejected due to the paucity of support for health worker salaries and its inflated training budget lines. This culminated into the release of funds for recruitment of additional health workers, which has already begun and will continue into next year.

Support for Uganda's HIV/AIDS response is provided by a diverse group of partners. The United Kingdom's DFID is currently re-evaluating their response and is exploring a broader investment and partnership within the HIV/AIDS sector. Danish, Swedish, and Irish aid all contribute to the Uganda Civil Society Fund. The UNITAID foundation will continue to support pediatric ARV drugs through FY 2014. The World Bank grants focus support for human resources and monitoring and evaluation systems which directly benefit the HIV/AIDS response.

Zambia

Country Context

The 2007 Zambia Demographic and Health Survey measured adult HIV prevalence at 14.3 percent. With a steady population of 13.1 million people, 61 percent of whom reside in rural areas and 39 percent in urban areas, Zambia has one of the world's most devastating HIV and AIDS epidemics. However, there is significant progress being made. According to the recent 2012 UNAIDS World AIDS Day Report, between 2001 and 2011 Zambia reduced new HIV infections by 58 percent and decreased AIDS-related deaths by more than 50 percent.

The vast majority of HIV transmission in Zambia is through heterosexual contact, exacerbated by high-risk sexual practices (such as multiple concurrent partnerships). Limited data suggests that slightly less than one percent of new infections are related to men having sex with men (MSM). Ten percent of transmission is from mother to child (MTCT). Zambia is home to approximately 600,000 AIDS-related orphans and vulnerable children (OVC). The Partnership Framework between the Government of the Republic of Zambia and the United States government, and the corresponding Partnership Framework Implementation Plan (PFIP) articulates strategic priorities for the period 2011-2015 that are directly aligned with and supportive of the four national priorities for the multi-sectoral HIV and AIDS response—prevention, treatment, care and support, and health systems strengthening. The Global Fund is also a key stakeholder in the HIV/AIDS response. PEPFAR Zambia collaborates with the Global Fund and related primary recipients to ensure activities including condom distribution, counseling and testing, antiretroviral treatment (ART) and monitoring, and supply chain management are closely coordinated with PEPFAR Zambia and the Government of the Republic of Zambia.

PEPFAR Zambia's program goals for FY 2014 include:

- Scale-up of HIV treatment for health and prevention, including support of Option B+ for elimination of MTCT;
- Scale-up of voluntary medical male circumcision (VMMC);
- Increasing the number of Zambians who know their HIV status through scale-up of HIV counseling and testing (HCT), with a specific emphasis on couples HCT;
- Integrating HIV programs with other health programs, with specific attention to HIV-family planning integration; and
- Increasing data on and coverage of services for key populations. Commodity availability and governance are two cross-cutting priorities identified for FY 2014 as those that underpin the HIV and AIDS response in Zambia.

Below is a table of PEPFAR Zambia's budget representing its major program areas.

Fiscal Year	Zambia Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 75,660,392	28%	$ 52,008,258	19%	$ 80,763,315	30%	$ 62,689,423	23%	$ 271,121,388
2010	$ 86,303,502	31%	$ 59,393,486	21%	$ 66,644,223	24%	$ 64,353,420	23%	$ 276,694,631
2011	$ 86,360,310	28%	$ 68,141,486	22%	$ 71,249,521	23%	$ 80,943,314	26%	$ 306,694,631
2012	$ 65,162,707	26%	$ 43,300,749	17%	$ 68,669,133	28%	$ 72,562,042	29%	$ 249,694,631
Total 2009-2012	**$ 248,324,204**	**29%**	**$ 179,543,230**	**21%**	**$ 218,657,059**	**26%**	**$ 207,986,157**	**24%**	**$ 854,510,650**
2014 (est)	**$ 88,285,495**	**30%**	**$ 53,687,964**	**18%**	**$ 75,803,729**	**25%**	**$ 79,881,812**	**27%**	**$ 297,659,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Zambia	$ 16,791,844	$ 17,576,028	$ 11,281,600	$ 4,000,000	$ 350,000	$ -	$ 5,477,738	$ 20,183,182	**$ 75,660,392**
2010	Zambia	$ 25,298,000	$ 16,337,628	$ 15,058,137	$ 2,300,000	$ -	$ -	$ 4,890,000	$ 22,419,737	**$ 86,303,502**
2011	Zambia	$ 24,744,500	$ 13,247,628	$ 18,814,000	$ 2,500,000	$ -	$ -	$ 5,470,000	$ 21,584,182	**$ 86,360,310**
2012	Zambia	$ 13,427,951	$ 6,077,493	$ 11,138,033	$ 2,021,339	$ -	$ -	$13,369,688	$ 19,128,203	**$ 65,162,707**
	Totals FY09-FY12	**$ 80,262,295**	**$ 53,238,777**	**$ 56,291,770**	**$ 10,821,339**	**$ 350,000**	**$ -**	**$29,207,426**	**$ 83,315,304**	**$ 313,486,911**
2014 (est)	Zambia									**$ 88,285,495**

*Totals include planned funding for all accounts.
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In FY 2014, the Zambian and U.S. governments will focus on scaling up effective combination HIV prevention strategies, including VMMC, prevention of mother-to-child transmission (PMTCT), and HCT with a focus on couples. Specific interventions will target the general population and vulnerable sub-groups with behavior change strategies, while integration and stronger linkages among services will be a major theme throughout the program. A new structured and theory-based behavior change communication program to support and improve health-seeking behaviors that increase uptake of highly effective prevention services will be implemented.

For FY 2014, PEPFAR Zambia has a robust plan to increase both the supply and demand of the VMMC program to more than double the clients reached in FY 2013. The program will scale up to new and hard-to-reach areas to increase access to quality-assured VMMC services in Zambia.

Strategies to increase the numbers of people served will include leveraging of public sector resources in the form of operating space and health workers, partnering with parliamentarians and traditional leaders in stimulating demand, augmenting fixed VMMC sites with mobile services, and VMMC campaigns. PEPFAR works in collaboration with the Gates Foundation, the Clinton Health Access Initiative (CHAI) and the Government of the Republic of Zambia on VMMC scale-up, although PEPFAR brings the majority of the financial resources to this activity in Zambia.

The PEPFAR Zambia PMTCT program will support the Ministry of Health (MOH) as the country begins implementing Option B+, treating all HIV infected women with lifelong ART. Emphasis is on building evidence-based approaches suitable for implementation in the Zambian setting, with the goal of filling the gaps in defining community-level program models, developing operational guidance, and monitoring and evaluation systems for standardized implementation. PEPFAR Zambia will strengthen linkages and services in early infant diagnosis (EID) and follow-up of HIV-exposed children at community, facility, and national levels, with a new focus on addressing weaknesses in program governance, including support to strengthen MOH EID program coordination capacity. The UNAIDS program also supports PMTCT and HCT services in the country, while the UN Joint Team supports HIV prevention among young people.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Zambia	$ 27,364,913	$ 45,036,356	$ 8,362,046	**$ 80,763,315**
2010	Zambia	$ 32,164,913	$ 26,791,009	$ 7,688,301	**$ 66,644,223**
2011	Zambia	$ 38,664,913	$ 25,089,307	$ 7,495,301	**$ 71,249,521**
2012	Zambia	$ 32,784,217	$ 29,226,314	$ 6,658,602	**$ 68,669,133**
	Totals FY09-FY12	**$ 130,978,956**	**$ 126,142,986**	**$ 30,204,250**	**$ 287,326,192**
2014 (est)	Zambia				**$ 75,803,729**

*Totals include planned funding for all accounts.
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The PEPFAR Zambia treatment program is responding to the Government of the Republic of Zambia's aspiration to treat all HIV-infected patients with ART regardless of CD4 count. In 2014, treatment services will be scaled up to treat all HIV-infected patients with CD4 counts below a threshold of 350, all HIV-infected partners in HIV-discordant couples, all HIV-infected patients with tuberculosis, all HIV-infected pregnant women, and all HIV/Hepatitis B co-infected patients.

The PEPFAR Zambia HIV treatment program will strengthen adherence support by providing psychosocial counseling to HIV-infected patients on treatment using trained healthcare workers, including lay counselors. Individuals that do not return for follow-up visits will be documented and traced. Continuity of care, follow-up of mother-infant pairs, and reduced loss to follow-up will also be facilitated by new training modules, improved functionality in the data capturing forms, and more simple reporting tools in the national electronic health records system. This system is currently active in over 700 facilities and services nearly 900,000 Zambians.

In addition to the Zambian and U.S. government's support for the national HIV treatment program, the Global Fund supports the procurement and supply of essential drugs and the CHAI supports drug access and laboratory systems strengthening.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Zambia	$ 16,385,479	$ 5,138,058	$ 11,774,828	$ 18,709,893	**$ 52,008,258**
2010	Zambia	$ 24,976,279	$ 5,491,314	$ 10,066,000	$ 18,859,893	**$ 59,393,486**
2011	Zambia	$ 25,606,279	$ 8,241,314	$ 11,642,000	$ 22,651,893	**$ 68,141,486**
2012	Zambia	$ 11,901,165	$ 6,838,853	$ 7,146,933	$ 17,413,798	**$ 43,300,749**
	Totals FY09-FY12	**$ 78,869,202**	**$ 25,709,539**	**$ 40,629,761**	**$ 77,635,477**	**$ 222,843,979**
2014 (est)	Zambia					**$ 53,687,964**

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In FY 2014, the U.S. government will fund advocacy work and training of health professionals to improve the quality of life for adults and children living with life-limiting illnesses. The PEPFAR Nutrition Assessment, Counseling and Support program for people living with and affected by HIV will expand to more sites, in coordination with Feed the Future and Scaling-Up Nutrition initiatives. The PEPFAR Zambia program will support linkage and entry into care following HIV testing, and retention in pre-ART and ART care by implementing the new ART guidelines, preventing and treating opportunistic infections, training more caregivers/volunteers, and strengthening linkages to household economic strengthening and livelihood activities. PEPFAR Zambia will improve retention of HIV-infected children in care by strengthening linkages/referrals with routine child health services, documentation, and long-term follow-up. PEPFAR will support the MOH to conduct a national TB prevalence survey in the ten provinces of Zambia. As more Zambians are initiated on ART, less support is required for home-based care activities.

In FY 2014, PEPFAR will focus on reducing the risk of HIV infection and the impact of AIDS among OVC in both public and community schools and strengthening linkages between OVC

and PMTCT programs. The U.S. government will also support surveys and research to ensure that the evidence base continues to grow and to inform better practices in OVC programming. There is a need for information on the extent, severity, and distribution of violence against children in Zambia.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Zambia	$ 18,300,000	$ 15,590,000	$ 16,676,028	$ 12,123,395	**$ 62,689,423**
2010	Zambia	$ 19,650,000	$ 15,975,000	$ 15,554,428	$ 13,173,992	**$ 64,353,420**
2011	Zambia	$ 20,350,000	$ 14,373,500	$ 30,495,127	$ 15,724,687	**$ 80,943,314**
2012	Zambia	$ 23,074,787	$ 7,117,699	$ 33,122,362	$ 9,247,194	**$ 72,562,042**
	Totals FY09-FY12	**$ 81,374,787**	**$ 53,056,199**	**$ 95,847,945**	**$ 50,269,268**	**$ 280,548,199**
2014 (est)	Zambia					**$ 79,881,812**

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Improved surveillance and data collection is a priority in FY 2014 for both the Government of the Republic of Zambia and the U.S. government. PEPFAR Zambia will develop individual and organizational-level capacity and systems to collect, store, analyze, and present HIV and AIDS-related information with direct technical and financial support to the Zambian government for both routine and survey data. In FY 2014, there is also an enhanced focus on data use in program planning and review, along with evaluation of combination prevention strategies. In FY 2014, PEPFAR Zambia will support a strengthened health workforce through provision of management courses, management for public health training, and pre-service training to increase the number of new healthcare workers. A new cross-sectoral democracy and governance project will address government accountability and citizen demand by improving public financial management in targeted service delivery entities within the health sector.

The U.S. government, the joint United Nations team, and Britain's Department for International Development support the National AIDS Council and other coordination structures. Many cooperating partners in the country are supporting the Zambian government's new *Governance and Management Capacity Strengthening Plan*, which harmonizes all the existing donor-specific and government capacity-building plans into one document.

Country Engagement

Both the MOH and a newly structured Ministry of Community Development, Mother and Child Health (MOCDMCH) participated in FY 2014 PEPFAR consultations, along with civil society stakeholders. In the past, the MOCDMCH had limited involvement in PEPFAR consultations, but now that this Ministry has oversight over community-level activities, it is now collaborating with PEPFAR Zambia to a much greater extent.

The Zambian government's increasing political ownership of its national HIV response is demonstrated by financial commitments for antiretroviral drugs (ARVs), health worker salaries, and infrastructure. The planned government budget for ARVs tripled from $10 million U.S. dollars (USD) in 2012 to approximately $33 million USD in 2013. The Zambian government has driven the policy shift to Option B+ for HIV positive pregnant women, as a first step in the phased approach toward a "test and treat" policy. They have also demonstrated increased political will and support for scale-up of VMMC. Members of Parliament and traditional leaders have publically endorsed and shared their own experiences in accessing VMMC services. Additionally, VMMC activities are included in the government's national budget.

Consultations with the MOH and MOCDMCH on PEPFAR's FY 2014 program led to increased PEPFAR support for family planning-HIV integration activities, strengthened evidence generation and surveillance activities, and mutual scale-up of treatment and PMTCT services.

Zimbabwe

Country Context

Zimbabwe continues to experience a generalized HIV epidemic with an estimated 1.2 million HIV-infected adults and children in 2011 and approximately 58,000 deaths each year. HIV is the leading cause of death among adults and accounts for over 27 percent of all deaths among mothers and infants. The maternal mortality rate nearly tripled between 1994 and 2010. Social, cultural, and economic factors contributing to HIV transmission include transactional sex, multiple and concurrent partners, alcohol abuse, low awareness of HIV infection status, lack of antiretroviral treatment (ART) use in undiagnosed individuals, poor treatment adherence, and low levels of male circumcision. While prevalence among youth has dropped significantly, it is worth noting that prevalence among girls was twice that of boys of the same age. Additionally, Zimbabwe‘s tuberculosis (TB) case rate (603 per 100,000) is one of the highest in the world. The TB epidemic in Zimbabwe is largely HIV driven with a very high TB/HIV co-infection rate (at 80 percent) with an increasing number of multidrug-resistant (MDR-TB) and extensively drug-resistant cases. TB is the second leading cause of adult morbidity and mortality in Zimbabwe.

PEPFAR investments in Zimbabwe are aligned with the 2011-2015 National Strategic Plan (ZNASPII) to ensure sustainability in the national efforts to scale-up HIV prevention, care, and treatment activities. PEPFAR’s programmatic priorities for FY 2014 are focused on accelerating access to treatment services, prevention of-mother-to-child HIV transmission (PMTCT), HIV counseling and testing (HCT), sexual prevention, support for orphans and vulnerable children (OVC), and voluntary medical male circumcision (VMMC) activities.

Below is a table of PEPFAR Zimbabwe’s budget representing its major program areas.

Fiscal Year	Zimbabwe Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 13,142,636	27%	$ 9,445,169	20%	$ 8,294,584	17%	$ 17,117,611	36%	$ 48,000,000
2010	$ 14,439,500	30%	$ 7,524,000	16%	$ 8,482,500	18%	$ 17,054,000	36%	$ 47,500,000
2011	$ 20,371,600	33%	$ 9,389,000	15%	$ 14,310,400	23%	$ 18,429,000	29%	$ 62,500,000
2012	$ 30,121,355	33%	$ 8,798,281	10%	$ 34,098,819	37%	$ 18,172,370	20%	$ 91,190,825
Total 2009-2012	**$ 78,075,091**	**31%**	**$ 35,156,450**	**14%**	**$ 65,186,303**	**26%**	**$ 70,772,981**	**28%**	**$ 249,190,825**
2014 (est)	**$ 31,732,847**	**34%**	**$ 10,912,993**	**12%**	**$ 31,313,070**	**34%**	**$ 18,886,091**	**20%**	**$ 92,845,000**

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Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Zimbabwe	$ 4,135,400	$ 1,555,494	$ 1,430,871	$ 800,000	$ -	$ -	$ 2,117,000	$ 3,103,871	**$ 13,142,636**
2010	Zimbabwe	$ 4,669,000	$ 1,451,500	$ 1,556,000	$ 1,800,000	$ -	$ -	$ 2,983,000	$ 1,980,000	**$ 14,439,500**
2011	Zimbabwe	$ 9,865,600	$ 1,274,000	$ 1,416,000	$ 800,000	$ 100,000	$ -	$ 4,936,000	$ 1,980,000	**$ 20,371,600**
2012	Zimbabwe	$ 4,672,609	$ 1,270,527	$ 1,501,209	$ 825,000	$ 100,000	$ -	$19,633,223	$ 2,118,787	**$ 30,121,355**
	Totals FY09-FY12	**$ 23,342,609**	**$ 5,551,521**	**$ 5,904,080**	**$ 4,225,000**	**$ 200,000**	**$ -**	**$29,669,223**	**$ 9,182,658**	**$ 78,075,091**
2014 (est)	Zimbabwe									**$ 31,732,847**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR Zimbabwe's 2014 prevention portfolio has several core interventions designed to reduce incidence and produce significant impact through both behavioral and biomedical approaches. Key among these include: condom (sexual prevention) programming, comprehensive VMMC services, PMTCT, and HCT which are complemented with behavior change communication (BCC) efforts to encourage behaviors that maximize impact of core interventions. While overall resources for abstinence/be faithful and blood safety activities will be significantly reduced, resources for VMMC will significantly increase in FY 2014 as the program accelerates efforts to increase coverage to 80 percent of all males. Specifically, new partners will be brought on board to expand service delivery, demand creation schemes will be expanded and efforts will also be made to integrate male circumcision services for HIV prevention into routine clinical care.

The U.S. government will also be supporting a number of new activities in FY 2014. To reduce the number of new pediatric infections, PEPFAR Zimbabwe will be supporting Zimbabwe's Families and Communities for the Elimination of Pediatric HIV program by providing PMTCT services at all maternal, newborn, and child health sites in all 62 districts of Zimbabwe. Through this activity, PEPFAR will support community initiatives designed to increase demand and retention of PMTCT and pediatric HIV care services. PEPFAR Zimbabwe will also support selected opportunistic infection (OI) and ART units at mission hospitals to provide PMTCT services as part of an integrated package of HIV/AIDS care. Pediatric HIV partners will support the national PMTCT unit in assessing the feasibility of Option B+. A new PMTCT costing study will be supported in 2014 to provide information on per patient cost of providing PMTCT services at public health facilities.

In 2014, PEPFAR will continue to provide support for national condom forecasting, condom logistics systems, and condom reporting for both male and female condoms. Social marketing efforts will focus on condom distribution through targeted high risk areas and outlets, as well as increasing coverage of male and female condoms in hard to reach areas. About 28.6 million male condoms will be distributed through a direct distribution mechanism to 8,000 retail outlets

and around 1.43 million female condoms through a network of 1,500 hair salons and barbers. Moreover, resources for FY 2014 activities will support injection safety activities including trainings for healthcare workers and strengthening of the post-exposure prophylaxis drug supply chain.

Donor efforts for prevention are coordinated through a number of mechanisms. A health development partners' forum meets on a monthly basis bringing together donors and multilateral organizations including the U.S. government, United Kingdom Development Program (DFID), World Health Organization, European Union, and United Nations. There is strong commitment to PMTCT at national level with the U.S. government collaborating closely with the Global Fund (GF), Children's Investment Fund Foundation, Clinton Health Access Initiative, and UNICEF to support the Zimbabwe government's vertical transmission elimination agenda. The Gates Foundation will continue to provide prevention resources primarily targeted to the Zimbabwe Defense Force to support VMMC scale-up efforts through December 2013.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Zimbabwe	$ 5,938,889	$ 1,200,844	$ 1,154,851	**$ 8,294,584**
2010	Zimbabwe	$ 5,625,000	$ 1,750,000	$ 1,107,500	**$ 8,482,500**
2011	Zimbabwe	$ 9,870,400	$ 3,520,000	$ 920,000	**$ 14,310,400**
2012	Zimbabwe	$ 20,347,243	$ 12,818,663	$ 932,913	**$ 34,098,819**
	Totals FY09-FY12	**$ 41,781,532**	**$ 19,289,507**	**$ 4,115,264**	**$ 65,186,303**
2014 (est)	Zimbabwe				**$ 31,313,070**

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The PEPFAR program in Zimbabwe works closely with the Ministry of Health and Child Welfare (MOHCW) to strengthen ART services within the existing health delivery system. The MOHCW, with support from donors and other non-state actors, has been in the forefront in developing policies, strategic plans, and guidelines which shape and determine the overall treatment program in Zimbabwe. PEPFAR not only contributes antiretroviral (ARV) drugs directly to the national program through a pooled supply and distribution system, but also pledges to support an integrated system of care through other support to the health system (testing and counseling, TB screening, CD4 cell counts, and post-test support services). One way PEPFAR Zimbabwe supports an integrated system of care is through a partnership with the Zimbabwe Association of Church Hospitals to increase the number of facilities providing OI and antiretroviral treatment (ART) services. Currently 24 ZACH sites provide treatment service. Additionally, a pool of mentors will be established who will provide site supervision to the participating facilities to improve the provision of OI/ART services.

The U.S. government will be scaling-up treatment services and will be procuring first-line ARVs for adult patients treated in public sector health facilities. The U.S. government will continue to work with the National AIDS Council (NAC), DFID, GF and MOHCW to support national quantification efforts to ensure availability of supply.

Under the leadership of the MOHCW Quality Assurance Directorate, the U.S. government team will also continue to support quality of care improvement programs in 50 sites across Zimbabwe. The PEPFAR Zimbabwe program will also continue to second three medical officer positions to MOHCW AIDS & TB Program: the National ART Coordinator, Deputy National ART Coordinator for Quality Assurance, and Assistant National ART Coordinator. FY 2014 resources will continue to support the funding of site readiness assessments and site supervision aimed at enhancing the MOHCW's ART scale-up activities, national quality of care initiative, and decentralization of ARV treatment.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Zimbabwe	$ 1,800,727	$ 777,409	$ 2,094,233	$ 4,772,800	**$ 9,445,169**
2010	Zimbabwe	$ 1,235,000	$ 769,000	$ 2,070,000	$ 3,450,000	**$ 7,524,000**
2011	Zimbabwe	$ 445,000	$ 669,000	$ 3,825,000	$ 4,450,000	**$ 9,389,000**
2012	Zimbabwe	$ 471,293	$ 606,206	$ 3,531,919	$ 4,188,863	**$ 8,798,281**
	Totals FY09-FY12	**$ 3,952,020**	**$ 2,821,615**	**$ 11,521,152**	**$ 16,861,663**	**$ 35,156,450**
2014 (est)	Zimbabwe					**$ 10,912,993**

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PEPFAR Zimbabwe's support to care encompasses a wide spectrum of interventions targeting HIV infected and affected adults and children. Top priorities in FY 2014 include: integration of quality improvement programs into ART clinics to continually improve retention, adherence, and response to ART, expanding access to early infant diagnosis (EID) and entry into care for HIV-exposed infants, integrating TB screening with mobile HIV testing services, and building the capacity of social welfare systems to enhance OVC care and support.

FY 2014 resources will be used to scale-up a TB/HIV integrated care model that was piloted in three clinics in Harare and Bulawayo in 2013. The integrated health care model will be scaled-up to an additional 20 sites to bring the total to 43. In addition, the U.S. government will continue to support MOHCW efforts to set up MDR-TB surveillance in strategic sites to provide national coverage. Health personnel from 65 district hospitals will participate in active surveillance for MDR-TB. Two reference laboratories (the National Microbiology Reference

Laboratory in Harare and the TB Reference Laboratory in Bulawayo) will be strengthened to provide culture and sensitivity analysis for suspected MDR TB cases.

PEPFAR Zimbabwe will also continue to fund care and support programs through the national "New Life" Program at13 sites nationwide. New Life enhances the continuum of care through focusing on psychosocial support, nutritional counseling, ART adherence counseling, and tracked referrals and linkages to HIV care, treatment, and support for HIV positive clients. All New Life sites have an outreach team complemented by peer counselors who provide ART adherence counseling support to 101 public sector ART/OI clinics nationwide. The program provides ART adherence counseling to over 200,000, technical assistance and training to about 350 people living with HIV/AIDS (PLHIV), and workplace-based support groups.

In FY 2014, PEPFAR Zimbabwe will also focus on reaching more out-of-school children with comprehensive services, scaling up early childhood interventions and models for reaching children with disabilities, expanding and enhancing economic strengthening interventions to reach more vulnerable families, expanding geographic coverage to under-served rural communities, and focusing on the special needs of adolescent girls. The U.S. government will provide vulnerable children with a minimum of one core service through proven models, as outlined in the 2012 PEPFAR Guidance for OVC Programming as well as the Government of Zimbabwe's National Action Plan for OVC.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Zimbabwe	$ 2,811,414	$ 2,473,293	$ 8,309,252	$ 3,523,652	**$ 17,117,611**
2010	Zimbabwe	$ 1,755,000	$ 2,875,000	$ 6,885,000	$ 5,539,000	**$ 17,054,000**
2011	Zimbabwe	$ 2,185,000	$ 3,175,000	$ 6,855,000	$ 6,214,000	**$ 18,429,000**
2012	Zimbabwe	$ 2,918,538	$ 3,003,794	$ 7,250,301	$ 4,999,737	**$ 18,172,370**
	Totals FY09-FY12	**$ 9,669,952**	**$ 11,527,087**	**$ 29,299,553**	**$ 20,276,389**	**$ 70,772,981**
2014 (est)	Zimbabwe					**$ 18,886,091**

*Totals include planned funding for all accounts.
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In FY 2014, the U.S. government, through the Zimbabwe National Quality Assurance Program, will continue to provide laboratory services with External Quality Assurance through Proficiency Testing. The U.S. government will continue to support national laboratory services by strengthening lab monitoring and evaluation systems, communicable disease surveillance, disease outbreak confirmation, and improve the availability of data for decision making. In FY 2014, the PEPFAR Zimbabwe team will assist the MOHCW with the establishment of a Laboratory Management Information System to effectively manage laboratory data. PEPFAR

support will provide point of care diagnostics for CD4 cells, EID, and viral load, thus supporting the national decentralization of lab services to the district as the basic unit working to offer health services.

PEPFAR Zimbabwe will also support the development of an integrated approach to logistics within the MOHCW by working closely to build the capacity of both the MOHCW's Directorate of Pharmacy Services and the National Pharmaceutical Company, who together manage the procurement and distribution of the other drugs and commodities for the national system. The assistance will help build a single, efficient, and integrated health logistics management and information system. Moreover, PEPFAR resources will continue to support the Zimbabwe government to ensure a continuous supply of competent healthcare workers through both pre- and in-service training. This training will support and strengthen the management, coordination, implementation, and monitoring of services, resulting in a stronger, more efficient, effective, and sustainable health care delivery system. Support will also be given to health professional associations, councils, and boards, all of whom are key actors in the training and development of health workers.

Under the Global Health Initiative Strategy (GHI), the U.S. government will provide an integrated delivery of health services with a particular emphasis on women and children while building the capacity of health systems for sustainable programming. These focus areas are oriented towards reducing morbidity and mortality related to HIV, TB, malaria, reproductive health and maternal, newborn, and child health conditions. Progress towards this goal will involve increasing availability of and access to quality health services. Moreover, in support of GHI, FY 2014 activities will improve efforts in health systems strengthening and the program will leverage DFID family planning resources at New Life and New Start centers. To support all health programs, an integrated system for supervision is being devised by the MOHCW and once completed, will be implemented using PEPFAR and other donor resources. Supporting the GHI principles of country ownership, activities remain focused on priorities set by the MOHCW. Similarly all PEPFAR projects are guided by national policies, use national training curricula and guidelines, and rely on pools of national trainers rather than implementing partners.

Country Engagement

The NAC and the MOHCW lead the national HIV/AIDS response and have outlined their goals in Zimbabwe's National Strategic Plan 2011-2015. While the level of institutional leadership within the MOHCW is high in terms of technical direction and policy setting, the capacity for implementation continues to be limited. For the MOHCW, low capacity is largely an outcome of limited national resources for programming, which affects its capacity to deploy and adequately train sufficient, experienced health professionals, provide adequate commodities, and provide a high level of monitoring and supervision to ensure high quality service delivery. As such, donor resources have been essential to national prevention, care, treatment, and health systems strengthening efforts. While the majority of HIV/AIDS-related activities are donor funded, Zimbabwe has not received the magnitude of donor funding that countries with similar HIV burden have been fortunate to access. Zimbabwe is facing potential critical shortages of

resources to achieve ambitious goals, particularly in the areas of treatment, PMTCT, and VMMC.

The U.S. government is a key partner, investing more than other bilateral donors in the HIV/AIDS response. The GF, however, remains the largest source of support to the national response with an annual investment through Round 8 of approximately $80 million annually for OVC activities, TB support, capacity building, and other care and support services. The PEPFAR Global Fund Liaison supports the continuous collaboration and coordination of PEPFAR and GF funded work in Zimbabwe. The Global Fund Liaison continues to be instrumental in supporting GF stakeholders and other partners in Zimbabwe in the application process for the Global Fund New Funding Model.

The focus of PEPFAR in Zimbabwe has historically been Zimbabwe government facilities and enhancing their capacity to offer high-quality, accessible services. The national ART program serves as a case in point. PEPFAR does not support specific patients at specific sites but rather works to strengthen the program as it cascades from the national level to lower levels through a variety of mechanisms. Despite the limited capacity of the Zimbabwe government to finance HIV/AIDS programming, the government has generally taken a robust leadership role in strategy development and coordination of donors and technical partners working in HIV/AIDS.

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Ukraine

Country Context

Ukraine is experiencing one of the most severe HIV/AIDS epidemics in Europe and the Commonwealth of Independent States (CIS), with an estimated 230,000 people aged 15 and over living with HIV at the end of 2011. In 2011, the HIV prevalence in adults aged 15-49 in Ukraine was estimated at 0.76 percent, with most of the epidemic concentrated in key populations, namely people who inject drugs (PWID), female sex workers (FSW), and men who have sex with men (MSM). Only slightly more than 124,000 patients with HIV/AIDS were under regular medical observation. Considering the overall estimation of people living with HIV (PLHIV), this suggests that a significant proportion of people with HIV are unaware of their status, and therefore unable to take adequate measures to preserve their health or prevent further transmission.

The HIV epidemic in Ukraine is evolving. Annually since 2008, more than half of newly registered HIV cases (excluding HIV-exposed infants) have been attributed to heterosexual transmission and the proportion of cases among PWID – who were once the primary drivers of the epidemic – has progressively decreased. However, there is indirect evidence that the majority of heterosexual cases occur among sexual partners of current or former injecting drug users. In 2012, a small decrease in cases to 20,754 was reported, marking the first annual decrease since 1999.

The U.S. government is Ukraine's largest bilateral partner in HIV/AIDS, and has maintained a strategic dialogue and collaborative development agenda with the Government of Ukraine at the national and local levels. This partnership deepened in February 15, 2011, when the Cabinet of Ministers of Ukraine represented by the Minister of Foreign Affairs signed a five-year HIV/AIDS Partnership Framework with PEPFAR (2011 – 2015). The Partnership Framework was reviewed by nine Ukrainian ministries and represents consensus on a five-year joint strategic agenda to scale up and sustain key components of HIV/AIDS programming. It has three objectives: reducing HIV transmission among key populations; improving the quality and cost effectiveness of HIV prevention, care, and treatment services for key populations; and strengthening health systems, leadership, institutions, policies, and resources to support the achievement of national AIDS program objectives.

Below is a table of PEPFAR Ukraine's budget representing its major program areas.

Fiscal Year	Ukraine Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 2,875,000	35%	$ 993,660	12%	$ -	0%	$ 4,309,340	53%	$ 8,178,000
2010	$ 3,097,000	26%	$ 800,000	7%	$ -	0%	$ 8,131,000	68%	$ 12,028,000
2011	$ 5,625,040	25%	$ 2,200,000	10%	$ -	0%	$ 14,352,960	65%	$ 22,178,000
2012	$ 3,183,154	28%	$ 1,344,226	12%	$ 425,824	4%	$ 6,599,796	57%	$ 11,553,000
Total 2009-2012	**$ 14,780,194**	**27%**	**$ 5,337,886**	**10%**	**$ 425,824**	**1%**	**$ 33,393,096**	**62%**	**$ 53,937,000**
2014 (est)	**$ 8,422,247**	**35%**	**$ 2,500,218**	**10%**	**$ 1,194,597**	**5%**	**$ 12,226,938**	**50%**	**$ 24,344,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Ukraine	$ -	$ 55,700	$ 1,219,300	$ -	$ -	$ 950,000	$ -	$ 650,000	**$ 2,875,000**
2010	Ukraine	$ -	$ 22,000	$ 1,150,000	$ 625,000	$ -	$ 1,300,000	$ -	$ -	**$ 3,097,000**
2011	Ukraine	$ -	$ -	$ 1,425,040	$ 800,000	$ -	$ 3,200,000	$ -	$ 200,000	**$ 5,625,040**
2012	Ukraine	$ -	$ 14,494	$ 1,215,582	$ 108,692	$ 250,000	$ 1,406,090	$ -	$ 188,296	**$ 3,183,154**
	Totals FY09-FY12	**$ -**	**$ 92,194**	**$ 5,009,922**	**$ 1,533,692**	**$ 250,000**	**$ 6,856,090**	**$ -**	**$ 1,038,296**	**$ 14,780,194**
2014 (est)	Ukraine									**$ 8,422,247**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The goal of PEPFAR Ukraine's HIV prevention program relates mainly to Partnership Framework Goal 1: to reduce the level of HIV transmission among key populations. The HIV prevention strategies for FY 2014 largely continue the approaches taken in FY 2013 and FY 2012, with PEPFAR Ukraine continuing to provide technical assistance to strengthen the overall quality and outcomes of Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) and Ukrainian Government programs. PEPFAR's prevention program is carefully designed to complement and leverage these other, larger resources.

Technical assistance will be provided to the Ukrainian government GF principal recipients, and local civil society organizations (CSOs) to enhance their HIV prevention programming to at-risk populations, ensuring these programs are evidence-driven, high quality, economical, and impactful in the nine focal oblasts most affected by the epidemic. Targeted populations include

PWID, MSM, FSW, most-at-risk adolescents (MARA), PLHIV, and sexual partners of key populations.

Additionally, PEPFAR Ukraine will design, pilot, evaluate, and disseminate information on technically-sound, cost-effective service delivery models that can be taken to scale with Ukrainian government and GF resources. These service delivery models include comprehensive prevention service packages for PWID, medication-assisted therapy (MAT) embedded within comprehensive HIV/AIDS services, and prevention-with-positives positive services. Of particular interest are models that target specific risk segments within at-risk populations. This might include PWID with overlapping risk behaviors (e.g., PWID that are FSW or MSM; MARA that are PWID), and more targeted behavior change communications.

PEPFAR Ukraine will support rapid formative assessments to investigate salient HIV prevention issues. This may include the causes behind and potential solutions to MAT dropout rates, FSW migration and seasonality patterns, or the profile and risk behaviors of "hidden" MSM. Other assistance will help ensure that technical assistance activities related to legislation, regulatory policy, and advocacy will result in action-oriented outcomes at the national and decentralized levels. This includes an enhanced and monitored human rights and public health approach to HIV prevention. Key legislative barriers to be addressed include undocumented youth and their access to HIV counseling and testing and (HCT) and comprehensive HIV/AIDS services.

With regard to preventing the medical transmission of HIV, PEPFAR Ukraine will provide targeted technical assistance to the Ministry of Health (MOH) to improve blood safety. The current blood safety program in Ukraine is implemented through regional blood safety centers with limited MOH financial support. Activities include the development of a low-risk volunteer donor oriented program, technical assistance to improve the blood monitoring and evaluation (M&E) system and cold chain, and the establishment of a quality assurance/quality control system to cover all laboratories in the blood donation system.

Anticipated efficiency gains are strengthened Ukrainian government ownership and increased publicly-provided HIV care services targeted to key populations, and programmatic and cost efficiencies from integrated prevention, care, and treatment services, as feasible within an inherently vertical health care system.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Ukraine	$ -	$ -	$ -	**$ -**
2010	Ukraine	$ -	$ -	$ -	**$ -**
2011	Ukraine	$ -	$ -	$ -	**$ -**
2012	Ukraine	$ 25,824	$ 400,000	$ -	**$ 425,824**
	Totals FY09-FY12	**$ 25,824**	**$ 400,000**	**$ -**	**$ 425,824**
2014 (est)	Ukraine				**$ 1,194,597**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The goal of PEPFAR Ukraine's treatment program relates mainly to Partnership Framework Goal 2: to improve the quality and cost effectiveness of treatment services for key populations. In FY 2014, technical priorities continue to be:

- Scaling up comprehensive treatment services to key populations; and
- Enhancing evidence-based approaches for HIV diagnostics and treatment, including strengthening quality assurance throughout the laboratory system.

These priorities build on the incremental gains achieved to date in treatment expansion and evidence-based HIV treatment. As the newly-formed agency responsible for the technical guidance, implementation, monitoring, surveillance, and epidemiologic research of the national AIDS and TB programs and a GF Principal Recipient (PR), the Ukrainian Center for Socially Dangerous Disease Control (U-CDC) will continue to receive extensive support from PEPFAR Ukraine. This includes technical assistance to improve and expand training in antiretroviral treatment (ART) and to strengthen HIV laboratory networks, data use, procurement, and supply management, and ART systems. The PEPFAR team remains prepared to offer additional assistance to the newly-formed U-CDC, particularly to support U-CDC's ongoing organizational development efforts.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Ukraine	$ -	$ -	$ 568,660	$ 425,000	**$ 993,660**
2010	Ukraine	$ -	$ -	$ 800,000	$ -	**$ 800,000**
2011	Ukraine	$ 200,000	$ -	$ 1,400,000	$ 600,000	**$ 2,200,000**
2012	Ukraine	$ 103,211	$ -	$ 989,953	$ 251,062	**$ 1,344,226**
	Totals FY09-FY12	**$ 303,211**	**$ -**	**$ 3,758,613**	**$ 1,276,062**	**$ 5,337,886**
2014 (est)	Ukraine					**$ 2,500,218**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, the PEPFAR Ukraine care program will continue to evolve in response to the changing epidemic and needs of the Ukrainian government and civil society toward the broader goal of improving the quality and cost effectiveness of care services for key populations. In FY 2014, technical priorities will continue to be:

- The scale up of the provision of state-of-the-art comprehensive care services to key populations; and
- The removal of legal and policy barriers toward the implementation of the national HIV/AIDS response, including factors that hamper service access, and strengthening the control of HIV-associated tuberculosis (TB).

Building national support for care services targeted to key populations, such as the provision of MAT, is a key step for the achievement of these priorities, as the national HIV/AIDS response in Ukraine continues to be adversely affected by conflicting public health and drug control policies. With respect to HIV-associated TB, PEPFAR will continue to support the Ukrainian government's efforts to improve availability and effectiveness of health services in TB/HIV care and to increase the Ukrainian government's capacity to provide quality services to TB and HIV patients. Specifically, PEPFAR Ukraine will support improved case detection and reduced barriers to appropriate TB and HIV treatment and care. Focal areas include the alignment of national TB/HIV guidelines and protocols to international standards, strengthening infection control, case management information systems, strengthening TB laboratories, and building linkages between TB/HIV co-infection service provision mechanisms. These include HIV testing for TB patients and effective referral for those infected, as well as TB screening for HIV patients and referral to TB services for suspected cases.

To improve the national TB laboratory diagnostics, PEPFAR Ukraine will help to increase overall laboratory network efficiency through implementation of a quality assurance system. PEPFAR Ukraine will also focus technical assistance in procurement and supply management to improve systems to assure continuous TB/HIV drugs availability. PEPFAR Ukraine will invest

in operations research that will develop and evaluate innovative and cost-effective approaches to the management of drug-sensitive and drug-resistant TB in the region.

Anticipated efficiency gains are strengthened Ukrainian government ownership and increased publicly-provided HIV care services targeted to key populations. Supporting the integration of prevention, care, and treatment services, as much as is possible within an inherently vertical health care system, will also result in some programmatic and cost efficiencies. Examples include the adoption of integrated, streamlined care models, such as the delivery of HIV, TB, and MAT treatments at a single site, as well as the increased participation of primary health care in the delivery of care services.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Ukraine	$ -	$ 655,340	$ 2,300,000	$ 1,354,000	**$ 4,309,340**
2010	Ukraine	$ 1,525,000	$ 850,000	$ 4,200,000	$ 1,556,000	**$ 8,131,000**
2011	Ukraine	$ 1,500,000	$ 2,050,000	$ 7,435,330	$ 3,367,630	**$ 14,352,960**
2012	Ukraine	$ 1,740,211	$ 1,026,600	$ 3,269,574	$ 563,411	**$ 6,599,796**
	Totals FY09-FY12	**$ 4,765,211**	**$ 4,581,940**	**$ 17,204,904**	**$ 6,841,041**	**$ 33,393,096**
2014 (est)	Ukraine					**$ 12,226,938**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The goal of PEPFAR Ukraine's program to improve governance relates mainly to Partnership Framework Goal 3: to strengthen the national and local HIV/AIDS response through improved leadership, capacity, institutions, systems, and policies. To this end, FY 2014 programs will focus on host country capacity and systems development, specifically in: health care financing, human resources for health (HRH), removal of barriers to services, strengthening GF Round HIV 10 PRs, and building civil society capacity.

Although Ukraine is currently undergoing health care reform, progress is hampered by the lack of delivery mechanisms, financing, and capacity. PEPFAR's investment in health care financing is, therefore, important to improving the sustainability, efficiency, and effectiveness of HIV-related services in the National AIDS Program. Health care financing investments are a new area of support for PEPFAR Ukraine, beginning in the FY 2013 Country Operational Plan and continuing in FY 2014. Technical assistance from PEPFAR Ukraine will promote optimized and increased financing for critical prioritized HIV/AIDS services to key populations, with improved budget execution at the national level and within up to ten high priority regions. This assistance aims to achieve active and meaningful involvement with top and middle management in the Ministry of Finance, as well as close collaboration with regional and local administration finance and planning departments, public health departments, and local health provider managers.

In FY 2014, PEPFAR Ukraine will also invest significant resources to optimize and strengthen HRH for the delivery and scale up of HIV/AIDS services targeting key populations. PEPFAR Ukraine will continue to provide capacity building assistance for health care staff of the national and regional AIDS centers, local healthcare workers, laboratory specialists, epidemiologists, M&E specialists, and community and CSO social workers. PEPFAR's assistance will also address incentive schemes and task-shifting options for health staff that provide critical HIV services for key populations. PEPFAR Ukraine will also support the development of the HRH National Strategy and Operational Plan(s) for the new 2014-18 National AIDS Program. This will include city- and oblast-level operational plans developed for the targeted high priority regional AIDS programs. PEPFAR will also invest in the development and rollout of a Human Resource Information System at the national level and within targeted geographic regions.

PEPFAR Ukraine will continue to support evidence-based HIV policy programming and implementation to remove barriers to services. Assistance in this area will advance critical policies for essential HIV/AIDS services to key populations, with focus on ART, MAT, HCT, and outreach prevention. Interventions under this component include various forms of technical assistance, training, capacity building, mentoring, and supervision.

PEPFAR Ukraine will also continue to support interventions to strengthen the capacity of the PRs that receive funding under the GF Round 10 HIV grant. One of the major challenges facing the successful implementation of the Round 10 grant is the ability of PRs to meet international standards in programming and management. Of particular interest is support to the newly established U-CDC. Recently formed from the merging of the Ukrainian AIDS Center and the National TB Center, this new organization is key to the successful implementation of both the GF Round 10 HIV and Round 9 TB grants. PEPFAR Ukraine assistance will be used to strengthen the Ukrainian Center for Socially Dangerous Disease Control's capacity to manage sub-recipients, improve the national M&E system, implement ART clinical management and monitoring, and meet international standards in procurement and supply management.

Country Engagement

The Ukrainian government has recognized the importance of addressing the HIV epidemic, and there is growing support for strengthened HIV/AIDS programs from both the executive and legislative branches of the Ukrainian government. The MOH is legally responsible for coordinating the national HIV/AIDS response, the details of which are laid out in the National AIDS Program. The MOH chairs the National Council for HIV/AIDS and TB that acts as the Country Coordination Mechanism (CCM) for the GF. In support of its HIV programs, Ukraine is currently implementing the GF Round 10 HIV grant, with a total estimated budget of $300 million for the period January 2012 through December 2016. Activities under Round 10 expand upon the work of previous rounds, adding a considerable element of health systems strengthening and de-centralization of HIV/AIDS services. The PEPFAR program in Ukraine leverages the considerable resources provided by the GF for HIV/AIDS prevention, care, and treatment activities for key populations and TB/HIV co-infection.

Recently there have been a number of changes within the MOH regarding the coordination and management of the national HIV/AIDS response. In late 2012, the Ukrainian AIDS Center - which was responsible for the technical guidance, implementation, monitoring, surveillance, and epidemiologic research of HIV/AIDS programs - merged with the MOH National TB Center to form U-CDC, which is now responsible for the technical guidance, implementation, monitoring, surveillance, and epidemiologic research of the national AIDS program. This role is different than that of the existing State Service of Ukraine to Counteract HIV/AIDS and Other Socially Dangerous Diseases. This agency reports to the Cabinet of Ministry of Ukraine via the Minister of Health and continues to be the central executive power body responsible for the development and implementation of the national policy on counteracting HIV/AIDS and other socially dangerous diseases (primarily TB).

The overall goal of the Ukrainian government and PEPFAR Ukraine partnership is to contribute to an increasingly sustainable national HIV/AIDS response. This includes a five year strategic approach, codified under the Partnership Framework that deepens cooperation, strengthens coordination, and enhances collaboration on programming of technical and financial resources in concerted support with other donors, primarily the GF. In addition, PEPFAR Ukraine plays a key role in supporting governance of the national HIV/AIDS response, such as helping to revitalize the previously dormant CCM and support technical working groups.

In FY 2014, PEPFAR Ukraine will continue to support the sustainability of the national HIV/AIDS response. This includes the purposeful and careful alignment of U.S. government investment with Ukrainian government and GF resources, and the delivery of measurable, value-adding technical assistance designed to enhance capacity, systems, and sustainability. Going forward, PEPFAR Ukraine anticipates more progress toward a sustainable national HIV/AIDS response. This includes greater Ukrainian government ownership of HIV/AIDS activities targeted to key populations, an increasingly functioning CCM, the inclusion of key public and civil society stakeholders – including law enforcement – in decision-making fora, use of state-of-the-art service delivery, and reduced barriers to integrated services.

Asia Regional Program

Country Context

PEPFAR Asia Regional Program (ARP) is a platform for technical assistance (TA) to national HIV/AIDS programs and their partners (including other PEPFAR programs) throughout Asia, with a special focus on the HIV responses in China, Laos, and Thailand. The unrivalled pace of development in parts of Asia is being accompanied by accelerated transmission of HIV/AIDS across borders, in urbanized areas, and among key populations. While HIV/AIDS programs in the region have made impressive progress, these gains have been uneven geographically and epidemiologically and most countries are still far from achieving universal access targets. Despite substantial evidence that smart investments in HIV prevention, testing, care, and treatment can prevent the spread of HIV among key populations, critical gaps persist. These gaps underscore the need to identify and implement innovative, life-saving approaches and practices, while at the same time strengthening and increasing the coverage of effective programs that already exist and building the country capacity needed for sustainable local ownership of the HIV/AIDS response.

Asia is home to the largest number of people living with HIV (PLHIV) outside sub-Saharan Africa. In 2011, there were nearly five million PLHIV in Asia. The epidemic is currently concentrated in key populations, including female sex workers (FSW), men who have sex with men (MSM), people who inject drugs (PWID), and transgendered individuals (TG). Although they are not driving the epidemic, vulnerable populations (such as migrant workers; people in conflict and disaster-affected areas; and the partners/spouses, children, and clients of key populations) also continue to have substantial incident and prevalent infections, and require HIV services. Building systems and country ownership contributes to fighting the disease among all populations, and is one of the focuses of PEPFAR ARP. The United Nations estimates that since 2001 the number of annual new infections in the region has declined by almost 25 percent (from 370,000 in 2001 to 280,000 in 2011). The declines have been greatest in countries in which the risks associated with sex work initially made the greatest contribution to the total number of new infections and in which there were strong political commitments to mitigate these risks by meeting the HIV prevention needs of sex workers (SW). Greater access to antiretroviral treatment (ART) and improvements made to underpinning systems, such as laboratory and strategic information systems, have made it possible to realize these political commitments. Unfortunately, the region is experiencing a resurgence in new HIV infections among key populations that is defying HIV/AIDS programs. Individuals engaged in multiple risk behaviors face the highest levels of risk. The relative contribution of different kinds of risk behaviors to local epidemics varies widely across countries.

Given that Asia is home to a number of emerging middle-income countries (including China, Laos, and Thailand), PEPFAR ARP will continue to focus on TA and capacity building for government and civil society in FY 2014. PEPFAR ARP represents an innovative and

sustainable approach: focusing on TA, developing strong health systems, and building capacity for countries to own and manage strong comprehensive programs. While service delivery is funded mainly by governments, gaps remain in capacity, quality, coverage, focus, and policy to achieve a comprehensive, successful response to the epidemic. As with many middle-income countries, wide disparities exist in China, Laos, and Thailand in terms of income, access to services, and HIV risk. PEPFAR ARP will continue to focus on areas where people remain at risk, coverage is low, and systems require improvement. Simultaneously, the team will emphasize sustainability, country ownership (with government leadership in partnership with civil society), and coordination of its strategies and activities with governments, other donors, international organizations, and local non-governmental organizations (NGOs) and community-based organizations (CBOs). PEPFAR ARP will use its presence in and close ties with HIV programs in the region (such as in Thailand) to identify, evaluate, and scale-up high quality models (including combination prevention for key populations and quality improvement for HIV/AIDS treatment and care) that can be incorporated into national systems throughout the region with host government or external support, such as from the Global Fund (GF).

Below is a table of PEPFAR ARP's budget representing its major program areas.

Fiscal Year	Asia Regional Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ -	N/A	$ -	N/A	$ -	N/A	$ -	N/A	$ -
2010	$ -	N/A	$ -	N/A	$ -	N/A	$ -	N/A	$ -
2011	$ -	N/A	$ -	N/A	$ -	N/A	$ -	N/A	$ -
2012	$ -	N/A	$ -	N/A	$ -	N/A	$ -	N/A	$ -
Total 2009-2012	**$ -**	**N/A**	**$ -**	**N/A**	**$ -**	**N/A**	**$ -**	**N/A**	**$ -**
2014 (est)	**$ 5,717,178**	**37%**	**$ 2,060,587**	**13%**	**$ 509,660**	**3%**	**$ 7,321,575**	**47%**	**$ 15,609,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Asia Regional Program did not complete a Country Operational Plan until FY 2013.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Asia Regional	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2010	Asia Regional	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2011	Asia Regional	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2012	Asia Regional	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Totals FY09-FY12	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
2014 (est)	Asia Regional									**$ 5,717,178**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Asia Regional Program did not complete a Country Operational Plan until FY 2013.

PEPFAR ARP will support regional efforts to make strategic, scientifically sound investments to enable countries to rapidly scale-up core HIV prevention interventions, such as increased access to and uptake of HIV testing and counseling, condoms, and other evidence-based, appropriately-targeted prevention interventions. The region contains demonstrated leadership in the prevention of new HIV infections among children that will be scaled up throughout the region.

China

Across all of its program areas, PEPFAR ARP support in China will involve collaboration with the Government of China to develop, implement, and evaluate interventions for key populations that can be scaled up nationally and disseminated globally. This support to the Government of China includes a strong emphasis on HIV surveillance and lab quality measures. PEPFAR ARP technical collaboration will also include strengthening data management and reporting and the development of monitoring and evaluation (M&E) guidelines and support for piloting effective service delivery models.

Laos

To prevent expansion of the HIV epidemic in Laos, the National Committee for the Control of AIDS has given priority, in its 2011–2015 national strategy, to keeping HIV prevalence in the general population and most-at-risk populations below 1 percent and 5 percent respectively, and to improve quality of life of PLHIV. The vision for ARP support to Laos is strategically placed TA that responds to these national priorities, while helping build a sustainable, country-owned response. PEPFAR ARP activities in FY 2014 will strengthen HIV prevention efforts through activities that directly target key populations and support programs to prevent mother-to-child HIV transmission (PMTCT), complemented by TA that supports prevention efforts through improved care and treatment services, laboratory quality services, surveillance, and utilization of strategic information for program planning.

Thailand

As described above, Thailand's HIV epidemic disproportionately affects key populations, including FSW, migrant workers, MSM, PWID, prisoners, and TG. PEPFAR ARP has developed and is working with the Thailand Ministry of Public Health (MOPH) to implement combination prevention interventions for key populations, with a particular emphasis on MSM, TG and FSW. In addition, PEPFAR ARP has key focused activities aligned with MOPH strategies targeting migrants, PWID, prisoners, and HIV-exposed infants. For MSM and TG, the MOPH's combination prevention program includes behavioral, biomedical, and structural elements that address primary, secondary, and tertiary prevention of HIV as part of the continuum of response.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Asia Regional	$ -	$ -	$ -	**$ -**
2010	Asia Regional	$ -	$ -	$ -	**$ -**
2011	Asia Regional	$ -	$ -	$ -	**$ -**
2012	Asia Regional	$ -	$ -	$ -	**$ -**
	Totals FY09-FY12	**$ -**	**$ -**	**$ -**	**$ -**
2014 (est)	Asia Regional				**$ 509,660**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Asia Regional Program did not complete a Country Operational Plan until FY 2013.

In 2014, PEPFAR ARP will continue to promote and indirectly support increased and accelerated access to treatment for PLHIV in the region.

China

In FY 2014, PEPFAR ARP will assist the Government of China to implement World Health Organization guidelines on treatment for sero-discordant couples, regardless of immune system status. To guide future work, the ARP will assist in evaluating the results of existing sero-discordant couple studies. PEPFAR ARP will also provide TA to the National Center for AIDS/STD Control and Prevention to conduct surveys on factors related to low ART initiation and retention in care among PWID. Protocols and research studies will be developed to investigate causes of death among PLHIV and ways to prevent transmission among sero-discordant couples.

Laos

In FY 2014, PEPFAR ARP will continue to strengthen care and treatment services in Laos to ensure earlier initiation of ART, improve retention, and prevent HIV drug resistance among PLHIV by providing TA to support a) a review of the national ART program and revision of national ART action plans, including restructuring of ART management to enhance the early access and retention of services, particular key populations; b) support for GF reprogramming requests; and c) improvement of ART quality and effectiveness of the treatment outcomes through enhanced monitoring.

Thailand

The Thai government priorities for HIV care and treatment include improving quality of care and treatment by focusing on infrastructure, financing, policy, and earlier access of patients to care. However, the involvement of a range of stakeholders, including multiple insurance schemes, MOPH, and the Bangkok Metropolitan Administration, makes coordination challenging. In Thailand, PEPFAR ARP TA will continue to build the capacity of traditional peer educators and outreach workers to take on additional roles across the continuum of prevention, care and treatment services in the community, including retention of high-risk and mobile populations in care, and provision of adherence support; and promoting and/or branding quality HIV service sites as part of a collaborative provider network.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Asia Regional	$ -	$ -	$ -	$ -	**$ -**
2010	Asia Regional	$ -	$ -	$ -	$ -	**$ -**
2011	Asia Regional	$ -	$ -	$ -	$ -	**$ -**
2012	Asia Regional	$ -	$ -	$ -	$ -	**$ -**
	Totals FY09-FY12	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
2014 (est)	Asia Regional					**$ 2,060,587**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Asia Regional Program did not complete a Country Operational Plan until FY 2013.

In FY 2014, PEPFAR ARP will continue to work across the region to promote access to affordable, high-quality HIV care and support for PLHIV (especially key populations) and their families. Throughout the region, PEPFAR ARP will:

- Support training and systems to mitigate stigma and discrimination towards key populations from health care providers and law enforcement;
- Conduct formative assessments regarding HIV and drug use; and
- Engage the private sector in developing technical systems and solutions to more effectively and efficiently reach and retain key populations in HIV services.

China

In China, PEPFAR ARP emphasizes early HIV case finding and linkages between HIV testing and counseling and (HCT) and care and treatment services. In FY 2014, the U.S. government will continue to collaborate with the Government of China to increase CD4 and viral load testing among PLHIV in high HIV epidemic areas, increase national ART coverage, improve treatment adherence, and promote use of optimal first-line regimens.

Laos

By 2015, the Laos National Program aims for 80 percent of key populations, TB patients, and sexually transmitted infection (STI) patients to be tested for HIV and know the results in the previous 12 months, and for more than 90 percent of adults/children in need to receive ART and the continuum of care for treatment adherence and support. In FY 2014, PEPFAR ARP will support greater access to HTC in Laos by:

- Providing TA to support development of the national strategic plan for HCT scale-up;
- Collaborating with the government and its partners to pilot and build capacity for HCT

service delivery and supervision; and

- Ensuring the accessibility, acceptability, and quality of HCT services for populations at risk, as well as the referral of HIV positive persons to care and treatment.

Thailand

PEPFAR ARP will focus on increasing coverage and efficiency of care and support services by enhancing the capacity of MOPH and CBOs operating in combination prevention sites and strengthening the continuum of prevention to care and treatment model for potential scale-up and replication to national, sub-national, and GF-funded sites. TA related to HIV care will specifically aim to strengthen linkages between HCT and access to facility-based and community-based care services, and promotion of adherence to care and treatment.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Asia Regional	$ -	$ -	$ -	$ -	**$ -**
2010	Asia Regional	$ -	$ -	$ -	$ -	**$ -**
2011	Asia Regional	$ -	$ -	$ -	$ -	**$ -**
2012	Asia Regional	$ -	$ -	$ -	$ -	**$ -**
	Totals FY09-FY12	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
2014 (est)	Asia Regional					**$ 7,321,575**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Asia Regional Program did not complete a Country Operational Plan until FY 2013.

China

PEPFAR ARP will assist the Government of China to develop national technical guidelines and successful models for scale-up. In FY 2014, PEPFAR ARP will contribute to writing guidelines on HIV testing, program evaluations, ARVs, surveillance, and laboratory management. While the Chinese HIV/AIDS epidemic is largely concentrated in key populations, it remains important to prevent the transmission of HIV, Hepatitis B virus (HBV), and syphilis from pregnant women to their children. The Chinese government aims to integrate PMTCT programs for these infections into routine maternal and child health services and, in FY 2014, the U.S. government will collaborate with the Government of China to support follow-up and referral between STI, HIV, and HBV services. This will help strengthen linkages between the vertical health systems responsible for antenatal care, CD4 testing, and ART provision.

Laos

Leadership and governance capacity building is one of the priorities of the Laos 2011-2015 National Strategy and Action Plan. Planned program goals include:

- Improving resource mobilization and financial management; and
- Bolstering coordination structures at the national and provincial levels with partnership between public, private, and civil societies.

In FY 2014, PEPFAR ARP will work to build capacity of the national human resources on development of policy advocacy documents through the synthesis of the existing strategic information for different intervention scenarios with the projected impacts and resource needs.

Thailand

The Thailand MOPH formerly both funded and provided healthcare services in Thailand. In 2006, the Royal Thai government created the National Health Security Office (NHSO) to fund services that the MOPH provides. In its role as a funder, NHSO determines the package of HIV testing, treatment, care, and support services provided under universal coverage. NHSO also funds key laboratory services, including external quality assessment for HIV serology and CD4 testing, HIV prevention services such as outreach and STI services, programs such as the pediatric HIV care network, and new initiatives including molecular testing for early infant diagnosis and highly active antiretroviral therapy (HAART) for PMTCT. MOPH provides HIV/AIDS care and treatment at approximately 900 public facilities. In FY 2014, PEPFAR ARP will continue to engage with and provide TA to support the MOPH, the NHSO, and other bodies governing and coordinating the HIV response in Thailand, as well as continuing to support GF planning, implementation, and performance.

While responding to country-specific needs and programs, PEPFAR ARP also provides TA for the development and implementation of laboratory quality systems and HIV testing quality assurance to other PEPFAR countries and regional laboratories in the Asia region. The program uses country-to-country technical collaborations (CCTC), complemented by international mentors when applicable, to strengthen the management and quality of laboratory services throughout the region. In 2014, PEPFAR ARP will continue to provide support to improve the quality of laboratory testing and quality programs for HIV and HIV-related diagnosis to other PEPFAR countries and regional laboratories through CCTCs between Cambodia, Ethiopia, Laos, Papua New Guinea, Thailand, Vietnam, Zambia, and other countries as needed.

Strategic information capacity in the region, including M&E capacity, has been strengthened in recent years. China, Laos, Thailand, and others are increasingly conducting systematic surveillance and collecting HIV-related data from national health and financing systems to inform decision-making. Thailand, for example, now uses data from national systems to drive HIV program improvements, such as to accelerate access to HIV testing and treatment for HIV-exposed infants and to adopt/implement international guidelines that lower the threshold for access to ART.

Country Engagement

In 2011, several countries in the region adopted ambitious targets associated with their commitment to realize the "Three Zeros" – zero new HIV infections, zero AIDS-related deaths, and zero HIV-related stigma and discrimination – by 2015. These governments, including China, Laos, and Thailand, pledged to reduce the number of new HIV infections in key populations by 50 percent, scale up ART coverage to 80 percent among PLHIV, and eliminate new HIV infections among children within the next three years. To support and monitor the progress of the "Three Zeros", PEPFAR ARP is actively involved in the Global Fund Country Coordinating Mechanisms (CCMs) in China, Laos, and Thailand. The PEPFAR ARP's representation and involvement in the CCMs serves to strengthen grant effectiveness and efficiency by developing and introducing improved systems, quality assurance mechanisms, and service-delivery platforms, and by supporting enhanced oversight, proposal development, and management.

High-level leadership in these governments is gradually making legislative changes in support of improved HIV responses. In China, for example, official state media reported that in 2008, for the first time, HIV/AIDS became China's leading cause of death among infectious diseases. During the past seven years, the Government of China has responded by increasing the amount of resources to their national response, and now has made public commitments to contracting with CBOs to provide services to key populations.

National financing for HIV programs in the region does not always reflect this political will however, varying substantially from country-to-country. While China, Malaysia, and Thailand use domestic resources to fund the bulk of their HIV responses, countries such as Cambodia, Laos, and Vietnam rely heavily on donor funding (such as from PEPFAR and the GF) and will need to mobilize domestic resources, reduce costs, and improve program focus and effectiveness to maintain their progress. Regardless of the extent of national financing however, nearly all countries face challenges in funding services that specifically target key populations.

PEPFAR ARP assistance will continue to contribute to a national HIV/AIDS program led, managed, and coordinated by government stakeholders and their in-country partners. In addition to fostering successful adoption, scale-up, and ownership of model programs, PEPFAR ARP supports dissemination of successful models through CCTC to other countries.

Burma

Country Context

The 2012 Global AIDS Response Progress Report published by UNAIDS describes the epidemic in Burma as concentrated, with HIV transmission primarily occurring in high risk sexual contacts between sex workers and their clients, men who have sex with men (MSM) and the sexual partners of these sub-populations. In addition, there is a high level of HIV transmission among injecting drug users through use of contaminated injecting equipment and transmission to sexual partners. Latest modeling estimated the HIV prevalence in the adult population (aged 15 and more) at 0.53% in 2011. For key populations most-at-risk, surveillance data from 2011 showed HIV prevalence in the sentinel groups at 9.6% in female sex workers (FSW), 7.8% in MSM, and 21.9% in male injecting drug users. All sentinel groups have shown a considerable decrease in prevalence over the last years.

It is estimated that around 216,000 people were living with HIV in Myanmar in 2011, of which 36% were female. In the same year, an estimated 18,000 people died of AIDS-related illness. Incidence was estimated at well above 8,000 new infections in 2011, confirming the continuing need for effective prevention efforts.

Following the political opening of Burma in 2012, PEPFAR and the Global Fund (GF) began working with the Ministry of Health to scale up the response in country. PEPFAR's focus is to support the scale up of the GF, build the capacity of the Ministry of Health to lead the national response, improve the data available to inform the national response, and to provide gap-filling service delivery, focusing especially on key populations.

Below is a table of PEPFAR Burma's budget representing its major program areas.

Fiscal Year	Burma Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ -	N/A	$ -	N/A	$ -	N/A	$ -	N/A	$ -
2010	$ -	N/A	$ -	N/A	$ -	N/A	$ -	N/A	$ -
2011	$ -	N/A	$ -	N/A	$ -	N/A	$ -	N/A	$ -
2012	$ -	N/A	$ -	N/A	$ -	N/A	$ -	N/A	$ -
Total 2009-2012	**$ -**	**N/A**	**$ -**	**N/A**	**$ -**	**N/A**	**$ -**	**N/A**	**$ -**
2014 (est)	**$ 1,503,432**	**16%**	**$ 1,040,576**	**11%**	**$ 709,892**	**8%**	**$ 5,991,099**	**65%**	**$ 9,245,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Burma did not complete a Country Operational Plan until FY 2013.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Burma	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2010	Burma	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2011	Burma	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2012	Burma	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Totals FY09-FY12	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2014 (est)	Burma									$ 1,503,432

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Burma did not complete a Country Operational Plan until FY 2013.

PEPFAR's prevention response has focused on the Targeted Outreach Program (TOP) Drop-In Centers, which provide HIV prevention services to key populations. The TOP was launched in 2004, and conducts HIV prevention programming with FSW in 19 cities throughout the country. TOP Centers distribute male and female condoms and personal lubricant using a peer-focused strategy. The project also offers health care focusing on sexual and reproductive health for FSW. A mid-term evaluation of this project was conducted in 2013, and will inform future programming directions.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	Operating Unit	HBHC: Adult Care and Support	PDCS: Pediatric Care and Support	HVTB:TB/HIV	HKID: OVCs	Total, Care
2009	Burma	$ -	$ -	$ -	$ -	$ -
2010	Burma	$ -	$ -	$ -	$ -	$ -
2011	Burma	$ -	$ -	$ -	$ -	$ -
2012	Burma	$ -	$ -	$ -	$ -	$ -
	Totals FY09-FY12	$ -	$ -	$ -	$ -	$ -
2014 (est)	Burma					$ 1,040,576

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Burma did not complete a country operational plan until FY 2013.

Care services are largely funded by the Global Fund and other donors. As such, PEPFAR supports these efforts by building the capacity of the Ministry of Health to coordinate donor

activities, including conducting donor assessments, convening donors, and supporting the development of clinical guidelines to ensure a consistent, high-quality level of care are provided through private, public, and donor-funded activities.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Burma	$ -	$ -	$ -	**$ -**
2010	Burma	$ -	$ -	$ -	**$ -**
2011	Burma	$ -	$ -	$ -	**$ -**
2012	Burma	$ -	$ -	$ -	**$ -**
	Totals FY09-FY12	**$ -**	**$ -**	**$ -**	**$ -**
2014 (est)	Burma				**$ 709,892**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Burma did not complete a Country Operational Plan until FY 2013.

Treatment services are also largely funded by the GF and other donors. Similarly, PEPFAR Burma's capacity building efforts with the Ministry of Health help coordinate donor activities and set clinical guidelines. In addition, PEPFAR Burma supports efforts at procuring commodities and improving the supply chain to ensure needed drugs are available.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Burma	$ -	$ -	$ -	$ -	**$ -**
2010	Burma	$ -	$ -	$ -	$ -	**$ -**
2011	Burma	$ -	$ -	$ -	$ -	**$ -**
2012	Burma	$ -	$ -	$ -	$ -	**$ -**
	Totals FY09-FY12	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
2014 (est)	Burma					**$ 5,991,099**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Burma did not complete a Country Operational Plan until FY 2013.

The bulk of PEPFAR Burma's work in country focuses on governance and systems. As described above, PEPFAR Burma's work to build the capacity of the Ministry of Health to coordinate the donor response is at the core of the governance activities. From a health system strengthening perspective, PEPFAR Burma's focus continues to be on improving commodities procurement processes and the logistics and supply chain. Finally, a key focus of PEPFAR Burma's work has been to improve surveillance and monitoring and evaluation activities.

Country Engagement

Country ownership has been at the forefront of the PEPFAR program since it was expanded in 2012. The PEPFAR Burma team works closely with the Ministry of Health to build their capacity to lead the national response. The team also works closely to coordinate with GF activities.

Cambodia

Country Context

Cambodia has established itself as a global leader in the fight against HIV/AIDS. The country has cut adult infection rates in the general population by more than half in the past 14 years and has provided HIV treatment to over 80 percent of eligible individuals since services were established in 2003. Adult HIV prevalence was estimated to be 0.7 percent in 2012, compared to 1.7 percent in 1998.

- The HIV epidemic in Cambodia continues to be primarily heterosexually driven, with high prevalence in key populations and persons engaged in high-risk behaviors. Female entertainment workers had an estimated HIV prevalence of 4.6 percent in 2010. Prevalence was nearly triple that (14 percent) among those with more than seven partners per week.
- Men who engage in multiple and/or concurrent sexual partnerships in urban settings are also a population that could help re-fuel the HIV epidemic by serving as a "bridge" for HIV transmission between entertainment workers and lower-risk women in the general population.
- People who inject drugs (PWID) are especially vulnerable to HIV with prevalence estimated at 26 percent in 2012. In 2010, the National Center for HIV/AIDS, Dermatology, and Sexually Transmitted Diseases (NCHADS) estimated that Cambodia was home to only about 3,300 injecting drug users. The vast majority of them resided in the urban capital of Phnom Penh.

The PEPFAR program in Cambodia is evolving from a service-delivery platform focused on addressing gaps in the national program to a technical-assistance platform focused on enhancing the impact and reducing the cost of Cambodia's national response to HIV/AIDS. To reduce Cambodia's dependence on external funding for HIV service-delivery, the PEPFAR Cambodia program will introduce and evaluate innovation, evidence-based, replicable, cost-effective HIV prevention, care, and treatment approaches for implementation by Cambodian non-governmental and public-sector health providers. PEPFAR Cambodia supported activities will improve the technical and management capacity of health care providers, policy makers, organizations, and institutions in the national HIV/AIDS response.

Below is a table of PEPFAR Cambodia's budget representing its major program areas.

Fiscal Year	Cambodia Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 9,102,665	51%	$ 2,408,194	13%	$ 1,426,676	8%	$ 5,062,465	28%	$ 18,000,000
2010	$ 8,605,843	47%	$ 2,728,050	15%	$ 1,043,402	6%	$ 6,122,705	33%	$ 18,500,000
2011	$ 8,139,547	44%	$ 3,498,991	19%	$ 748,801	4%	$ 6,112,661	33%	$ 18,500,000
2012	$ 6,262,273	42%	$ 2,525,386	17%	$ 779,940	5%	$ 5,432,401	36%	$ 15,000,000
Total 2009-2012	**$ 32,110,328**	**46%**	**$ 11,160,621**	**16%**	**$ 3,998,819**	**6%**	**$ 22,730,232**	**32%**	**$ 70,000,000**
2014 (est)	**$ 5,123,403**	**34%**	**$ 3,057,297**	**21%**	**$ 1,068,440**	**7%**	**$ 5,608,860**	**38%**	**$ 14,858,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Cambodia	$ 1,073,640	$ 667,419	$ 6,134,670	$ -	$ -	$ 607,865	$ -	$ 619,071	**$ 9,102,665**
2010	Cambodia	$ 865,058	$ 343,298	$ 5,824,193	$ 500,000	$ -	$ 500,000	$ -	$ 573,294	**$ 8,605,843**
2011	Cambodia	$ 598,059	$ 286,497	$ 5,658,106	$ 450,000	$ -	$ 474,000	$ -	$ 672,885	**$ 8,139,547**
2012	Cambodia	$ 829,320	$ 33,100	$ 3,652,070	$ 672,812	$ -	$ 307,458	$ -	$ 767,513	**$ 6,262,273**
	Totals FY09-FY12	**$ 3,366,077**	**$ 1,330,314**	**$ 21,269,039**	**$ 1,622,812**	**$ -**	**$ 1,889,323**	**$ -**	**$ 2,632,763**	**$ 32,110,328**
2014 (est)	Cambodia									**$ 5,123,403**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, PEPFAR Cambodia's program will support the Ministry of Health's (MOH) revised HIV guidelines that were issued in 2013. Eliminating new infections in Cambodia with limited resources will require prevention activities to be focused on key populations, including female entertainment workers, their prospective male clients and partners, men who have sex with men (MSM), transgender persons, and PWID.

PEPFAR Cambodia's prevention investments aim to:

- Identify and meet the needs of key populations and prevent mother-to-child transmission (PMTCT); Improve access to a client-friendly package of clinical and community prevention services, including early access to treatment, in coordination with the partner government;

- Mentor government and civil society staff in oversight and management of prevention activities; and
- Enable Cambodia's national HIV program to improve activity coordination, eliminate duplicative donor investments, and stretch all available resources further for greatest impact.

PEPFAR Cambodia's program continues to refine host-government HIV prevention programming and policy by introducing and rigorously evaluating high-impact, low-cost prevention services for people facing the greatest HIV infection risks. For example, linking members of high-risk populations to HIV testing and counseling services has been a persistent barrier to HIV diagnosis and treatment. As a result of PEPFAR Cambodia advocacy efforts and performance data gathered from PEPFAR supported pilots, the MOH approved implementation of rapid HIV tests at the community level in 2012. In 2013, activities to introduce and evaluate other new testing models and other innovations to avoid new infections will be initiated at U.S. government supported sites and later scaled-up with Global Fund (GF) and/or other resources.

Prevention programming will continue to change in FY 2014, moving away from direct service delivery and emphasizing technical assistance. This is evidenced in PEPFAR's support to the Cambodian government's goal of virtual elimination of new HIV infections by 2020. Rather than providing the requisite services directly, PEPFAR implementing agencies will focus on fostering local capabilities to provide quality, integrated, and cost-effective prevention services. Further evidence of the shift towards sustainability is demonstrated by the significant change in the total amount of funds going directly to local Cambodian implementing partners, both civil society and host government. In FY 2012, 38 percent of the PEPFAR program budget went directly to local organizations. In FY 2013, this figure has jumped to over 87 percent, with the majority going to local non-governmental organization (NGO) partners. This is the result of continued prioritization of a country-owned program and is an outcome of PEPFAR's earlier investments in building management systems and human capacity in the Cambodian public health and non-governmental sectors.

In addition to PEPFAR, the GF, several United Nations agencies, the Australian Agency for International Development (AusAID) and the Clinton Health Access Initiative are active in the HIV/AIDS sector and support varying levels of prevention services. A notable collaboration between PEPFAR, AusAID and the GF is joint funding for the "Police Community Partnership Initiative," which seeks to engage the police, high-risk populations, and community members as allies in public health and safety.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Cambodia	$ -	$ 1,158,896.0	$ 267,780.0	**$ 1,426,676**
2010	Cambodia	$ -	$ 735,266	$ 308,136	**$ 1,043,402**
2011	Cambodia	$ -	$ 553,000	$ 195,801	**$ 748,801**
2012	Cambodia	$ 50,217	$ 531,879	$ 197,844	**$ 779,940**
	Totals FY09-FY11	**$ 50,217**	**$ 2,979,041**	**$ 969,561**	**$ 3,998,819**
2014 (est)	Cambodia				**$ 1,068,440**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The MOH in Cambodia has been successful in providing treatment to the majority of those in need and in establishing integrated care, treatment, and prevention models. However, many challenges remain. Some include late initiation of treatment, loss to follow-up, and low diagnosis of treatment failure and accompanying switch to second-line treatment.

In FY 2014, PEPFAR Cambodia will work with the MOH to support initiation of antiretroviral treatment (ART) at a CD4 cell count of 500 for HIV positive individuals within sero-discordant couples (one partner is HIV positive and the other is HIV negative), and advocate for earlier initiation of treatment for individuals who engage in high-risk behaviors. PEPFAR Cambodia will also provide technical support to help ensure that patients' CD4 cell counts are regularly monitored and that patients are appropriately counseled about the need for regular follow-up visits and promptly provided ART once eligible. PEPFAR support for PMTCT activities has helped make pediatric HIV elimination an achievable goal. If current trends continue, Cambodia is projected to be well on its way to virtual elimination.

Treatment programming has continued to change, shifting away from direct service delivery and increasingly providing technical assistance. Accordingly, PEPFAR Cambodia will continue to support the review and revision of standard operating procedures, guidelines, and training curricula to reflect global best practices for HIV prevention, care, and treatment; TB/HIV co-infection care and treatment; home-based care; and voluntary counseling and testing.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Cambodia	$ 875,360	$ 151,844	$ 527,205	$ 853,785	**$ 2,408,194**
2010	Cambodia	$ 1,071,431	$ 193,313	$ 382,835	$ 1,080,471	**$ 2,728,050**
2011	Cambodia	$ 1,511,554	$ 142,500	$ 733,707	$ 1,111,230	**$ 3,498,991**
2012	Cambodia	$ 1,154,131	$ 174,699	$ 710,771	$ 485,785	**$ 2,525,386**
	Totals FY09-FY12	**$ 4,612,476**	**$ 662,356**	**$ 2,354,518**	**$ 3,531,271**	**$ 11,160,621**
2014 (est)	Cambodia					**$ 3,057,297**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The MOH in Cambodia has been similarly successful in providing care and support services to people living with HIV. The "Continuum of Prevention, Care and Treatment" is being implemented nationwide in 60 care and treatment facilities. In 2012, 66 percent of the estimated 74,572 adults (individuals 15 years of age or older) living with HIV in Cambodia received HIV care and support.

In FY 2014, the U.S. government support for HIV care will focus on:

- Supporting, evaluating, and improving community/peer-initiated counseling;
- Testing the model established by the MOH to identify undiagnosed people living with HIV through active case detection and immediate enrollment into pre-ART;
- Strengthening referral and tracking systems among communities and facilities through piloting a unique identifier system and building capacity for analysis and use of program data;
- Improving access to and quality of care by integrating HIV, reproductive health, psychosocial counseling, and tuberculosis (TB) services provided by health care staff in facilities and by teams of home- and community-based care volunteers in communities;
- Improving the quality of HIV care and treatment services in collaboration with NCHADS through support for quality improvement systems that standardize use of program data to inform changes in clinical practice;
- Improving the quality of pediatric care services and increasing coverage of ART among eligible children through active case follow-up and the training and mentoring of health care providers and public health managers at local and national levels;
- Integrating HIV community-care services with those of other health programs, such as village health support groups, to take advantage of established structures and reduce implementation costs; and
- Improving the quality of services for orphans and vulnerable children (OVC), including strengthening referrals to other health, education, and social support systems.

PEPFAR Cambodia will increasingly build the capacity of home- and community-based care teams to deliver HIV and social support services to children affected by or vulnerable to HIV/AIDS. These community-based interventions will be linked to health facilities to ensure that OVC have access to HIV counseling and testing, HIV prophylaxis, early HIV diagnosis and follow-up for HIV-exposed infants, prevention and treatment of opportunistic infections, and pediatric ART.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Cambodia	$ 948,246	$ 1,473,100	$ 1,566,468	$ 1,074,651	**$ 5,062,465**
2010	Cambodia	$ 398,900	$ 949,425	$ 1,344,900	$ 3,429,480	**$ 6,122,705**
2011	Cambodia	$ 357,000	$ 872,425	$ 1,366,948	$ 3,516,288	**$ 6,112,661**
2012	Cambodia	555,127	1,254,402	912,682	2,710,190	**$ 5,432,401**
	Totals FY09-FY12	**$ 2,259,273**	**$ 4,549,352**	**$ 5,190,998**	**$ 10,730,609**	**$ 22,730,232**
2014 (est)	Cambodia					**$ 5,608,860**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

At a strategic level, PEPFAR Cambodia continues to shift towards a primarily technical assistance program, decreasing its provision of direct service delivery and instead concentrating its efforts on fostering local capacity – governmental and non-governmental – to sustain high impact, high quality, and cost-effective prevention, care, and treatment services.

Almost all HIV treatment in Cambodia is provided through public-sector institutions by MOH staff. Both U.S. government and implementing partner staff participate in the Cambodian government-led technical working groups that establish protocols for service delivery and surveillance in Cambodia. U.S. government staff members advise on the development of national and provincial annual action plans for HIV and other health issues. As part of its reform agenda, the Cambodian government is decentralizing management of health care to provinces and districts. PEPFAR Cambodia implementing agencies are supporting local public health providers to develop leadership and management skills that are essential for a well-functioning health system.

Cambodia's National Health Workforce Development Plan, 2006-2015, guides PEPFAR's human resources for health (HRH) strategy. PEPFAR Cambodia actively participates in the national HRH technical working group led by the ministry and co-chaired by World Health Organization (WHO) to address challenges and problems. In line with PEPFAR's goal to develop sustainable human resources in FY 2014, PEPFAR Cambodia is providing funding and

technical support for pre- and in-service training, faculty development, and mentoring to improve HIV prevention, care, and treatment services through improved skills of health care workers and program managers.

Additional support in FY 2014 for governance and systems will include:

- Conducting and funding data-use workshops to improve the capacity of public health workers, program directors, and civil society partners to collect, analyze, and use programmatic data;
- Developing electronic databases that use unique identifier codes to track individuals confidentially across community and clinical services, supporting aggregation and analysis of information collected in continuous quality improvement and ART site databases to improve patient management, and improving the use of data for decision making at the facility level through supportive supervision and on-site technical assistance; and
- Supporting the development of a sustainable public-health laboratory system for HIV. Laboratories supported by PEPFAR Cambodia will continue to be enrolled in external quality-control schemes to monitor their performance. In addition, PEPFAR Cambodia is supporting the National Reference Laboratory, the Bureau of Medical Laboratory Services, and provincial health authorities to become accredited under international standards.

Country Engagement

PEPFAR Cambodia continues to enjoy a robust relationship with the Cambodian government, which established itself as a global leader in the fight against HIV/AIDS early on. The Royal Government of Cambodia has and continues to provide a regulatory framework that is conducive to the HIV response, as evidenced by its success in cutting adult infection rates in the general population by more than half in the past 14 years.

All activities supported by PEPFAR Cambodia are aligned with Cambodia's National Strategic Plan for HIV/AIDS, 2011-2015 and Cambodia 3.0 – the ambitious government-led goal of virtual elimination of new HIV infections by 2020 by improving active case finding with early referrals for treatment and identifying new strategies to monitor and increase retention of people living with HIV/AIDS in care and treatment programs.

PEPFAR has contributed substantially to Cambodia's achievements, historically providing almost 40 percent of the financial resources behind the national response and establishing the surveillance, service delivery, and quality-assurance platforms needed for achievement of national goals as well as the objectives of investments by the GF, and the Royal Government of Cambodia.

The Cambodian government continues to respond quickly to evolving international normative guidance by rapidly establishing new or revised local policies and standard operating procedures. This track record of rapidly adopting and scaling up HIV service delivery innovations suggests

that Cambodia is well positioned to serve as a regional model for the introduction of treatment-as-prevention interventions among individuals at high risk for HIV. This includes sero-discordant couples, HIV positive pregnant women, female entertainment workers, MSM, and transgender persons in accordance with forthcoming normative guidance.

While the United States is by far the largest *bilateral* donor to the HIV/AIDS response in Cambodia, the GF is now the largest donor in the HIV sector on an annual basis contributing more than 40 percent of the overall resources for HIV (*This estimate is from the National AIDS Spending Assessment conducted in 2010 and is likely now an underestimate. New data will be available later in 2013).* All ARV medications in Cambodia are procured with GF resources. The GF depends upon an all-volunteer Country Coordinating Committee that is responsible for oversight and proposal development. Experts from the WHO recently reviewed the GF HIV services program. Their forthcoming recommendations will inform technical approaches of both the GF and PEPFAR programs in FY 2014.

Indonesia

Country Context

Throughout most of Indonesia, HIV/AIDS remains a concentrated epidemic, with highest prevalence among sex workers, intravenous drug users, and transgender persons in medium and large cities and major ports. In the two provinces that make up Papua in the far eastern part of Indonesia, HIV/AIDS is a generalized epidemic, with a 2006 prevalence of 2.4 percent.

With treatment and care services for HIV/AIDS in Indonesia fully supported by the Government of Indonesia and the Global Fund (GF), the overarching goal of PEPFAR Indonesia is prevention of sexual transmission of HIV/AIDS. Specifically PEPFAR is expanding the use of high impact prevention interventions and building the capacity of local governments and civil society organizations to reach high risk groups with prevention and treatment interventions. In coordination with the Australian Agency for International Development (AusAID) and the Indonesia government, PEPFAR is also improving access to key prevention and treatment services in Papua, where the epidemic is most severe. In FY 2014, the PEPFAR team is also building the capacity of key Indonesian government partners to monitor, evaluate, and analyze strategic information on the HIV epidemic/s in Indonesia.

Below is a table of PEPFAR Indonesia's budget representing its major program areas.

Fiscal Year	Indonesia Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 5,885,000	65%	$ 795,000	9%	$ 150,000	2%	$ 2,170,000	24%	$ 9,000,000
2010	$ 7,154,411	55%	$ 795,000	6%	$ 165,000	1%	$ 4,885,589	38%	$ 13,000,000
2011	$ 5,746,620	44%	$ 807,257	6%	$ 100,000	1%	$ 6,346,123	49%	$ 13,000,000
2012	$ 1,819,029	32%	$ 435,649	8%	$ 103,323	2%	$ 3,391,999	59%	$ 5,750,000
Total 2009-2012	**$ 20,605,060**	**51%**	**$ 2,832,906**	**7%**	**$ 518,323**	**1%**	**$ 16,793,711**	**41%**	**$ 40,750,000**
2014 (est)	**$ 3,883,580**	**49%**	**$ 215,813**	**3%**	**$ 20,000**	**0%**	**$ 3,880,607**	**49%**	**$ 8,000,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Indonesia	$ 35,000	$ -	$ 5,500,000	$ -	$ -	$ -	$ -	$ 350,000	**$ 5,885,000**
2010	Indonesia	$ 35,000	$ -	$ 6,767,411	$ -	$ -	$ -	$ -	$ 352,000	**$ 7,154,411**
2011	Indonesia	$ 25,000	$ -	$ 4,796,638	$ -	$ -	$ 262,177	$ -	$ 662,805	**$ 5,746,620**
2012	Indonesia	$ 125,842	$ -	$ 902,723	$ -	$ -	$ 238,403	$ 84,138	$ 467,923	**$ 1,819,029**
	Totals FY09-FY12	**$ 220,842**	**$ -**	**$ 17,966,772**	**$ -**	**$ -**	**$ 500,580**	**$ 84,138**	**$ 1,832,728**	**$ 20,605,060**
2014 (est)	Indonesia									**$ 3,883,580**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR Indonesia's priorities for FY 2014 build on the incremental gains made in previous fiscal years which included close coordination with UNAIDS, the World Health Organization (WHO) and the GF. PEPFAR in Indonesia will continue to focus on accelerating prevention interventions, particularly condom promotion among key populations and high-risk men. It will also work to enhance the capacity of key Indonesian government partners in the area of monitoring and evaluation. With the military, training will be conducted in peer education, and testing and counseling, as well as in management of tuberculosis and other opportunistic infections. Technical assistance will also be provided in care services to address opportunistic infections at regional and local levels. Acceleration of condom promotion will continue to be an important priority in FY 2014. PEPFAR will collaborate with the GF and Indonesian government to support the initiation of a nationwide condom marketing plan.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Indonesia	$ -	$ 150,000	$ -	**$ 150,000**
2010	Indonesia	$ -	$ 165,000	$ -	**$ 165,000**
2011	Indonesia	$ -	$ 100,000	$ -	**$ 100,000**
2012	Indonesia	$ -	$ 103,323	$ -	**$ 103,323**
	Totals FY09-FY12	**$ -**	**$ 518,323**	**$ -**	**$ 518,323**
2014 (est)	Indonesia				**$ 20,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In Indonesia, the Ministry of Health (MOH) provides antiretroviral treatment (ART) for people living with HIV/AIDS (PLHIV) using local resources and the GF. PEPFAR Indonesia, in turn, focuses its treatment program on building the capacity of local civil society organizations (CSOs), which include GF sub-recipients, in the following areas: access to services for opportunistic infection prevention, treatment, and diagnosis; Tuberculosis (TB) testing and treatment; ART and clinical care; case management; home-based care; and outreach to key populations for access to HIV testing, counseling, and treatment services.

The goal of the treatment program is to support the Indonesian government's efforts to deliver treatment to PLHIV by building the capacity of local civil society actors involved in treatment activities and by developing the Indonesian government's ability to use strategic information to better track and manage treatment services. The focus and activities of PEPFAR Indonesia's treatment program for FY 2014 is a continuation of what was done in FY 2013.

While the GF supplies much of the funding for treatment in Indonesia, AusAID has worked closely with the MOH and partners in Papua to improve antiretroviral (ARV) drug supply chain management and supports treatment in 120 sites in Papua. The PEPFAR Indonesia treatment effort in Papua is similar to treatment program in the rest of the country and focuses on improving health system capacity in Papua, support for CSOs, and support to improve the information and patient management. PEPFAR Indonesia's work to this end is closely coordinated with the efforts of these partners.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Indonesia	$ 640,000	$ -	$ 155,000	$ -	**$ 795,000**
2010	Indonesia	$ 640,000	$ -	$ 155,000	$ -	**$ 795,000**
2011	Indonesia	$ 707,257	$ -	$ 100,000	$ -	**$ 807,257**
2012	Indonesia	$ 242,253		$ 193,396		**$ 435,649**
	Totals FY09-FY12	**$ 2,229,510**	**$ -**	**$ 603,396**	**$ -**	**$ 2,832,906**
2014 (est)	Indonesia					**$ 215,813**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

As with treatment services, care services are fully supported by the MOH and the GF. PEPFAR Indonesia's engagement is focused on increasing the number of PLHIV receiving community-based care and support and increasing the number of TB/HIV affected people receiving appropriate treatment for both diseases. In FY 2014, this work will continue to be done in direct partnership and collaboration with MOH, the GF, and with local CSOs.

In FY 2014, CSOs will continue to play a key role in establishing networks to link clients to community-based health facilities and facilitating referrals to enable at-risk populations to access care, support, and treatment services when they are living with HIV. PEPFAR Indonesia's CSOs will deliver care, provide support and treatment, facilitate treatment adherence, and provide psychosocial support for PLHIV.

PEPFAR Indonesia will also continue to coordinate closely with other partners in Indonesia for the delivery of care services, namely with AusAID, the GF grantees, and UN partners. In Papua in particular, AusAID supports substantial programs in care and treatment for HIV/AIDS patients, which complement the work PEPFAR Indonesia supports in that region.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Indonesia	$ 69,500	$ 190,000	$ 360,000	$ 1,550,500	**$ 2,170,000**
2010	Indonesia	$ 40,000	$ 650,000	$ 3,360,000	$ 835,589	**$ 4,885,589**
2011	Indonesia	$ 130,000	$ 703,628	$ 4,617,495	$ 895,000	**$ 6,346,123**
2012	Indonesia	$ 103,323	$ 837,757	$ 2,025,127	$ 425,792	**$ 3,391,999**
	Totals FY09-FY12	**$ 342,823**	**$ 2,381,385**	**$ 10,362,622**	**$ 3,706,881**	**$ 16,793,711**
2014 (est)	Indonesia					**$ 3,880,607**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Given investments in HIV/AIDS from the GF and increasing funding from the Indonesian government, PEPFAR's efforts will continue to be built around technical assistance. The emphasis is on building the organizational performance and further development of overall health systems at provincial and district government institutions, including advocacy for increasing local resource allocation and improved planning capacity.

In FY 2014, PEPFAR Indonesia will continue its FY 2013 efforts on building the organizational performance of CSOs and local governments. At the national level, PEPFAR Indonesia will also support government efforts to use and share high quality data to monitor and report on program performance ensuring effective implementation and accountability. PEPFAR Indonesia efforts are strategically focused to increase political ownership, institutional ownership, and capacity to plan and implement effective programs and interventions using appropriate data.

In Papua, PEPFAR Indonesia will continue its work in health systems strengthening and integration in partnership with U.S. Agency for International Development (USAID) democracy and governance programs. This approach will help PEPFAR better reach at-risk populations and promote condom usage and sexually-transmitted infection services. Building sustainable CSOs that can reach marginalized at-risk populations that the government cannot reach, will improve service delivery in Papua.

Country Engagement

PEPFAR Indonesia program objectives, interventions, and benchmarks align with, and operate in support of, the Indonesia National HIV Strategy and Action Plan and work in close partnership with the National AIDS Commission, MOH, and Indonesian Armed forces to improve management and prevention of HIV/AIDS in the military. PEPFAR Indonesia will continue FY 2013 engagement strategies in FY 2014. U.S. government program plans and areas of focus are developed jointly with these government partners. In addition, PEPFAR Indonesia works closely with GF principal recipients and the GF Country Coordination Mechanism to ensure effective coordination.

The Indonesian government has significantly increased its resource allocation for HIV-related work, increasing from $11 million in 2006 to $38 million in 2010. PEPFAR Indonesia will coordinate with the government to ensure that as policy gaps are identified, they will be addressed in support of a comprehensive HIV/AIDS response.

PEPFAR Indonesia supports building the technical and management capabilities to oversee programs and activities at different levels of the government and civil response. In FY 2014, PEPFAR will support local government agencies in developing institutional capacity to better leverage funding through collaborations between other local governments and CSOs, develop new public-private partnerships, and improve their efficiency by utilizing existing community resources. The U.S. government program also focuses on building SI capacity at all levels in collaboration with the Indonesian government, MOH, National AIDS Commission, and other development partners, as well as expanded use of data and information to monitor and improve program performance.

Papua New Guinea (PNG)

Country Context

Papua New Guinea (PNG) has an estimated population of 7 million people, which accounts for well over half of the 10 million total persons living in the 22 Pacific Island states. PNG is a diverse country with 85 percent living in rural areas, and more than 700 languages. While PNG has enjoyed recent economic progress and has bright prospects for future revenue growth, growth has not been inclusive or broad based. The country still ranks a very low 153 out of 187 on the Human Development Index. According to the World Health Organization, PNG has the lowest health status in the Pacific region. Among the leading causes of mortality are HIV/AIDS, tuberculosis (TB), pneumonia, and malaria. TB and pneumonia have high prevalence rates and are often associated with HIV infection. National TB/HIV co-infection rates are very high at 9 percent, and TB/HIV co-infection even higher in Port Moresby at 23 percent.

PNG has the highest prevalence of HIV/AIDS among the Pacific Island Nations. Ninety-five percent of HIV cases reported in the Pacific between 1987 and 2008 were Papua New Guineans. The Government of PNG estimates that there are 34,000 people living with HIV in the country (31,000 adults and 3,100 children). The first HIV case was reported in 1987 and reported cases have increased steadily since that time. HIV transmission is primarily heterosexual; important contextual factors include high rates of sexually transmitted infections (STIs) with limited availability of effective treatment, early sexual debut, multiple and concurrent sexual partners including polygamy, sexual violence and rape, transactional sex, low and inconsistent condom use, increased mobility especially of men for work, and use of marijuana and alcohol. Illicit drug injection has been documented but is still thought to be very rare in PNG.

While much is still unknown about the current and future status of the HIV epidemic in PNG, there is sufficient data to conclude that the epidemic has extended beyond urban and peri-urban areas to rural areas. Though HIV has been reported in all 22 provinces, the epidemic appears to show a geographical focus in the five Highlands provinces, home to 40 percent of the nation's population but reporting 60 percent of the total number of HIV cases in 2010 (National Department of Health (NDOH), 2011). Further, it is believed that the epidemic is concentrated in locations with a convergence of risk behaviors such as urban centers, along key transport routes (e.g., Highlands Highway), mining areas such as Liquefied Natural Gas sites, and other rural economic enclaves. While national HIV prevalence for adults is estimated at nearly one percent, HIV infection rates are much higher among key populations compared to the general population. A 2010 integrated bio-behavioral survey conducted in the capital city of Port Moresby showed that female sex workers (FSW) had a prevalence of 19 percent. For men who have sex with men (MSM) HIV prevalence was 14.1 percent and for transgender women HIV prevalence was 23.7 percent.

Limited human and organizational capacity and poorly functioning health systems are the main causes of PNG's low health status. The lack of skilled human resources and the Government of PNG's limited capacity for operational management and financial accountability has led to the

deterioration of the health infrastructure. Despite these challenges, there have been recent efforts to scale up service delivery in key areas.

In FY 2014, PEPFAR PNG will continue to focus on providing targeted technical assistance to the national response by (1) developing community level service delivery models, (2) providing technical assistance to the Government of PNG particularly in the areas of strategic information and laboratory systems, and (3) building the capacity of civil society organizations that reach key populations.

Below is a table of PEPFAR PNG's budget representing its major program areas.

Fiscal Year	Papua New Guinea Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ -	N/A	$ -	N/A	$ -	N/A	$ -	N/A	$ -
2010	$ -	N/A	$ -	N/A	$ -	N/A	$ -	N/A	$ -
2011	$ -	N/A	$ -	N/A	$ -	N/A	$ -	N/A	$ -
2012	$ -	N/A	$ -	N/A	$ -	N/A	$ -	N/A	$ -
Total 2009-2012	**$ -**	**N/A**	**$ -**	**N/A**	**$ -**	**N/A**	**$ -**	**N/A**	**$ -**
2014 (est)	**$ 1,584,678**	**32%**	**$ 489,929**	**10%**	**$ 249,311**	**5%**	**$ 2,606,082**	**53%**	**$ 4,930,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Papua New Guinea did not complete a Country Operational Plan until FY 2013.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Papua New Guinea	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2010	Papua New Guinea	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2011	Papua New Guinea	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2012	Papua New Guinea	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Totals FY09-FY12	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
2014 (est)	Papua New Guinea									**$ 1,584,678**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Papua New Guinea did not complete a Country Operational Plan until FY 2013.

In FY 2014, PEPFAR PNG will continue to strengthen and expand prevention models focused on key populations and men and women with multiple concurrent sexual partners as well as to provide linkages to government and Global Fund financed care and treatment services in the National Capital District (NCD) and Madang Province. Additionally, the program will continue providing technical assistance to provincial counterparts and to integrate gender-based violence (GBV) interventions into programming.

PEPFAR PNG is also strengthening national prevention of mother-to-child HIV transmission (PMTCT) service delivery through technical assistance and scale-up of the HIVQUAL-PMTCT model (an HIV/AIDS care and treatment quality improvement initiative) for improved performance monitoring. The model is being implemented at five regional hospitals with plans for scale-up. In addition, information technology and epidemiological support is being provided to the NDOH for enhanced implementation of the national PMTCT strategic information system. PEPFAR PNG will also provide technical assistance to strategically assess PMTCT at HIVQUAL sites which will include a basic analysis of monitoring and evaluation data. This will inform development of program activities to address GBV while providing links to Family Support Centers.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Papua New Guinea	$ -	$ -	$ -	$ -	**$ -**
2010	Papua New Guinea	$ -	$ -	$ -	$ -	**$ -**
2011	Papua New Guinea	$ -	$ -	$ -	$ -	**$ -**
2012	Papua New Guinea	$ -	$ -	$ -	$ -	**$ -**
	Totals FY09-FY12	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
2014 (est)	Papua New Guinea					**$ 489,929**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Papua New Guinea did not complete a Country Operational Plan until FY 2013.

At the community level, PEPFAR PNG will continue to train hospital staff in two districts to deliver quality services to key populations. Additionally, PEPFAR PNG will continue to provide technical assistance to the Ministry of Health (MOH) to strengthen their capacity to lead the national HIV response in the areas of HIV testing and counseling and treatment and care.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Papua New Guinea	$ -	$ -	$ -	$ -	**$ -**
2010	Papua New Guinea	$ -	$ -	$ -	$ -	**$ -**
2011	Papua New Guinea	$ -	$ -	$ -	$ -	**$ -**
2012	Papua New Guinea	$ -	$ -	$ -	$ -	**$ -**
	Totals FY09-FY12	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
2014 (est)	Papua New Guinea					**$ 2,606,082**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Papua New Guinea did not complete a Country Operational Plan until FY 2013.

In FY 2014, PEPFAR PNG will continue to provide health systems strengthening to the National Department of Health and provincial health offices to improve:

- Laboratory quality systems through the strengthening of external quality assurance scheme and quality management systems; and
- Systems strengthening for HIV surveillance and monitoring and evaluation (M&E) systems including epidemiological and IT support.

PEPFAR PNG will replicate the standardized Clinical Operating Guidelines in four clinics in the National Capital District and Madang Province. Additionally, PEPFAR PNG will provide intensive technical assistance to strengthen the national HIV surveillance system and the utilization of data for epidemic monitoring and program planning purposes. This will be accomplished through:

- Ongoing epidemiological and information technology technical assistance for the implementation of an integrated computerized national HIV surveillance and M&E database system;
- Building the capacity of national and provincial surveillance staff for data collection, management, analysis and national HIV estimates & projections modeling; and
- Technical assistance for data collection, data analysis, and review to inform programming to improve the health of women and girls, and gender-based violence.

PEPFAR PNG is also supporting the first national household integrated bio-behavioral survey (IBBS) that will provide a wealth of much-needed information on the status of the epidemic including HIV prevalence and risk behaviors in PNG. In addition to the IBBS data on risk estimates, census data will serve to estimate the number of key populations in PNG.

Country Engagement

PEPFAR PNG has developed and refined its strategies and implementation plans in close consultation with the Government of PNG and civil society stakeholders. Additionally, the U.S. government is transparent in sharing its total funding for programs in-country and engages the Government of PNG in resource allocation decisions. The PEPFAR country platform in PNG fits the category of "targeted assistance" in that key priorities, strategies, and activities are focused on capacity building and technical assistance with some limited direct funding to government and non-governmental partners for replicable models of service delivery among key populations.

Vietnam

Country Context

Vietnam has a concentrated HIV epidemic. There were an estimated 250,000 people living with HIV in Vietnam at the end of 2011. Approximately 14,000 new infections have been reported annually from 2009 to 2011. The epidemic in Vietnam is comprised of many sub-epidemics across the country and remains concentrated primarily among three populations defined by high levels of HIV-transmission risk behaviors: people who inject drugs (PWID), men who have sex with men (MSM), and female sex workers (FSW). Injection drug use is the leading contributor to the transmission of HIV in Vietnam, further fueled through sexual transmission. While the national HIV prevalence rate is 0.43 percent for ages 15-49, data from the 2009 HIV/STI Integrated Behavioral and Biological Survey Round II and annual sentinel HIV surveillance (HSS) estimates that as many as 40 percent of the estimated 220,000 PWID (range: 100,000-335,000) are living with HIV. HIV prevalence among PWID is particularly high in provinces including Ho Chi Minh City (48 percent), Hai Phong (48 percent), Dien Bien (56 percent), and Quanh Ninh (56 percent).

Since its launch in 2005, PEPFAR Vietnam has been the major contributor to HIV prevention, care, and treatment in Vietnam. PEPFAR Vietnam is beginning the process of transitioning the program from a direct service delivery model to one with greater focus on technical assistance. This entails identifying not only program elements that can be streamlined and improved for greater cost-efficiency and quality, but also a specific transition process of human resources and commodities, particularly antiretroviral (ARV) drug costs for the Government of Vietnam.

PEPFAR Vietnam's Country Operational Plan 2013 activities reflect a honing and continuation of previously approved activities with a focus on implementation of PEPFAR Vietnam's Partnership Framework and the Road Maps of the PEPFAR Blueprint. Priorities that support the goals of the Vietnam Partnership Framework are:

- Increasing access to quality HIV/AIDS prevention, care, and treatment services for key populations;
- Strengthening health systems; and
- Improving upon and sustaining national engagement in the HIV/AIDS response.

These goals are also embedded within the PEPFAR Blueprint principles of high impact interventions, smart investments, shared responsibility, and incorporating science to drive results.

Below is a table of PEPFAR Vietnam's budget representing its major program areas.

Fiscal Year	Vietnam Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 30,886,143	34%	$ 20,674,953	23%	$ 12,379,008	14%	$ 25,913,064	29%	$ 89,853,168
2010	$ 28,718,974	29%	$ 19,120,000	20%	$ 13,716,000	14%	$ 36,278,194	37%	$ 97,833,168
2011	$ 23,364,981	28%	$ 12,027,168	14%	$ 20,228,719	24%	$ 29,212,300	34%	$ 84,833,168
2012	$ 19,715,697	28%	$ 9,193,819	13%	$ 18,422,004	26%	$ 22,501,648	32%	$ 69,833,168
Total 2009-2012	**$ 102,685,795**	**30%**	**$ 61,015,940**	**18%**	**$ 64,745,731**	**19%**	**$ 113,905,206**	**33%**	**$ 342,352,672**
2014 (est)	**$ 16,395,525**	**29%**	**$ 7,499,182**	**13%**	**$ 16,662,724**	**29%**	**$ 16,797,570**	**29%**	**$ 57,355,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Vietnam	$ 4,635,485	$ 1,808,397	$ 9,385,144	$ -	$ 140,639	$ 9,575,211	$ -	$ 5,341,267	**$ 30,886,143**
2010	Vietnam	$ 4,373,000	$ 1,560,547	$ 7,875,242	$ 636,500	$ 420,639	$ 8,902,868	$ -	$ 4,950,178	**$ 28,718,974**
2011	Vietnam	$ 1,689,979	$ -	$ 7,077,900	$ 554,400	$ 388,080	$ 9,957,550	$ -	$ 3,697,072	**$ 23,364,981**
2012	Vietnam	$ 1,203,889	$ -	$ 6,307,594	$ -	$ -	$ 7,881,992	$ -	$ 4,322,222	**$ 19,715,697**
	Totals FY09-FY12	**$ 11,902,353**	**$ 3,368,944**	**$ 30,645,880**	**$ 1,190,900**	**$ 949,358**	**$ 36,317,621**	**$ -**	**$ 18,310,739**	**$ 102,685,795**
2014 (est)	Vietnam									**$ 16,395,525**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In Vietnam, HIV prevalence remains highest among key population groups of PWID, FSW, and MSM. In line with PEPFAR Vietnam's first Partnership Framework goal to increase access to quality HIV/AIDS prevention, care, and treatment services for these key populations, PEPFAR Vietnam will continue to provide technical support to the Government of Vietnam to ensure the continued quality and coverage of patients on ARV treatment, core prevention services including methadone maintenance treatment (MMT) and HIV testing and counseling (HCT), effective linkages of patients to services, and retention in care. PEPFAR Vietnam will also continue to tailor behavior change communication and outreach activities, including new injectors, sexual partners of these high-risk groups, as well as venue- and street-based FSW.

As PEPFAR Vietnam's financial resources decline over time and as the Government of Vietnam assumes increased ownership of the program, it is anticipated that the model of service delivery

will change and many clinics may shift from stand-alone HIV, MMT, or HCT clinics to clinics integrated into the public healthcare system. With this shift will also come challenges of potentially increased barriers to uptake by the highly stigmatized high-risk populations that PEPFAR targets.

PEPFAR Vietnam's flagship support for MMT will continue, with the strategic direction to transfer the majority of service delivery support beginning in 2015. In 2010, PEPFAR Vietnam made a decision to only support the opening of new sites where province authorities could commit to assuming full responsibility within three years. For the MMT sites that opened in 2010, PEPFAR Vietnam anticipates full transitions during the 2013-14 implementation cycles, with some select provinces already absorbing the cost of service delivery support. PEPFAR Vietnam will continue a three-pronged approach focused on capacity building through training and mentoring at medical universities and mental health institutions; strengthening the methadone supply chain; and technical assistance (TA) to MMT sites including sites not otherwise supported by PEPFAR. On-site TA is prioritized to locations where the operational cost is paid by the local government or where a patient co-pay model exists.

PEPFAR Vietnam anticipates that the Government of Vietnam's November 2012 adoption of a new medication assisted therapy (MAT) decree will greatly expand the scope of MAT in Vietnam. This decree formally recognizes addiction as a chronic relapsing disorder for which medication should be used, when available, to treat affected individuals. It also reflects an important policy shift for Vietnam, namely, the replacement of the former MMT admission process involving local police and commune government screening, with an ethical and routine health care procedure whereby patients can voluntarily admit themselves to MMT clinics without the fear of administrative penalty.

While this is a major advocacy success for the U.S. government and the international community, like most policies and decisions in Vietnam, the enforcement of the decree will be dependent upon national government's political and financial commitment at both central and provincial levels. Adequate resource allocation from the government will help PEPFAR Vietnam transition its own MMT support more quickly, enabling PEPFAR Vietnam to focus on expanding its TA role for this critical intervention. Currently, PEPFAR Vietnam procures methadone for the majority of patients on MMT in the country.

PEPFAR Vietnam will continue to prioritize program pilots for key populations in FY 2013 and FY 2014. For example, PEPFAR provides technical leadership and financial support to the pilot for Treatment as Prevention in two provinces through partnership with the World Health Organization (WHO). PEPFAR Vietnam will also continue to implement new modalities in peer outreach to more precisely target those at greatest risk and PLHIV in the community. Activities include implementing new models for voluntary counseling and testing (VCT) to increase testing coverage among key populations, point of care diagnosis, and integrated service delivery approaches to minimize loss to follow-up across the continuum of prevention to care and treatment.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Vietnam	$ 2,480,000	$ 8,732,226	$ 1,166,782	**$ 12,379,008**
2010	Vietnam	$ 6,650,000	$ 6,248,000	$ 818,000	**$ 13,716,000**
2011	Vietnam	$ 14,000,000	$ 5,357,445	$ 871,274	**$ 20,228,719**
2012	Vietnam	$ 10,000,000	$ 7,329,043	$ 1,092,961	**$ 18,422,004**
	Totals FY09-FY12	**$ 33,130,000**	**$ 27,666,714**	**$ 3,949,017**	**$ 64,745,731**
2014 (est)	Vietnam				**$ 16,662,724**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR Vietnam continues to contribute towards Vietnam's national target of ARV treatment with an active transfer of clinics and patients to the government's HIV/AIDS National Targeted Program. This transition continues to be a significant step toward long-term sustainability of HIV treatment programs in Vietnam.

Throughout this transition, continued treatment access remains an objective for PEPFAR Vietnam. While PEPFAR Vietnam has already given early notification to the Government of Vietnam that they will not be able to continue their current level of ARV procurement in the years ahead, the care and treatment program will continue to maintain its enrollment rate of ARV treatment for adults and children in PEPFAR Vietnam's focus provinces, continuing to support the government to attain their 2015 targets. To support this effort, PEPFAR plans to shift Human Resources for Health costs back to the national government through joint, detailed transition planning at the provincial government level.

PEPFAR Vietnam will address human resources gaps by initiating policies for task shifting where feasible. For example, PEPFAR Vietnam activities will continue to employ site-level supporters for treatment adherence to counsel and monitor patients. Crucial to patient adherence, these community-based treatment supporters are embedded in many outpatient clinics (OPCs). Another approach will be to strengthen counseling quality. Peer educator counseling training within the VCT program will be revised to increase referrals to the treatment system. At the OPC level, PLHIV peer educator skills will be strengthened through training and mentorship by government and other staff.

With the aim to have a mechanism for an integrated supply chain management system for all HIV commodities, PEPFAR Vietnam will support the Vietnam Administration for HIV/AIDS Control (VAAC) to merge different supply chains for ARV, methadone, and lab commodities into a single system. As the largest proportion of the program budget, commodity transition is a leading priority for PEPFAR's transition planning.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Vietnam	$ 13,423,836	$ 1,378,782	$ 2,554,011	$ 3,318,324	**$ 20,674,953**
2010	Vietnam	$ 10,611,500	$ 1,756,000	$ 3,042,500	$ 3,710,000	**$ 19,120,000**
2011	Vietnam	$ 6,948,695	$ 1,383,797	$ 2,556,186	$ 1,138,490	**$ 12,027,168**
2012	Vietnam	$ 5,542,671	$ 472,961	$ 2,230,226	$ 947,961	**$ 9,193,819**
	Totals FY09-FY12	**$ 36,526,702**	**$ 4,991,540**	**$ 10,382,923**	**$ 9,114,775**	**$ 61,015,940**
2014 (est)	Vietnam					**$ 7,499,182**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR Vietnam uses a patient and family centered approach to increase access to and strengthen linkages and referrals within HIV prevention, care, and treatment services. This model, which PEPFAR Vietnam helped develop, is being adopted by the Government of Vietnam and expanded nationwide with Global Fund support. Where possible, PEPFAR Vietnam will promote integration of facility-based services like ART, MMT, and VCT, with community-based services.

Going forward, PEPFAR support will focus on technical assistance to improve the government's capacity to:

- Increase patient uptake for care services;
- Mitigate loss to follow-up for clients testing HIV-positive;
- Reduce mortality;
- Improve quality of life for HIV patients; and
- Increase sustainability of care services.

PEPFAR Vietnam will also continue to care for PLHIV by supporting local governments' efforts to simplify and streamline their service delivery sites. If and as appropriate, PEPFAR Vietnam will support the integration of district service delivery sites with low caseloads into other clinical services, such as the primary healthcare system. Integration of low volume sites would allow districts to prioritize the maintenance of high volume comprehensive HIV sites in each province/city.

In line with the national strategy, PEPFAR Vietnam, along with the Global Fund, continues to promote the integration of streamlined care and support programs within the national government's healthcare and social welfare systems, transitioning PEPFAR-funded care and support staff to full-time employees of the government. Additional care activities, such as adherence counseling, spiritual support, and psychosocial support will be transferred to community-based implementers, including PLHIV networks.

PEPFAR Vietnam's work in OVC supports the overarching objectives of the U.S. Action Plan on Children in Adversity. The targeted OVC activities within PEPFAR Vietnam's portfolio work with the government to reach both children and their caretakers, through a family-centered approach, with access to healthcare, nutrition, protection and legal aid, psychosocial support, and shelter. As PEPFAR Vietnam transitions services to government and local partners, strengthening coordination with other partners to support the government's implementation of the National Plan of Action for children affected by HIV/AIDS will be a priority. PEPFAR Vietnam will support building capacity for the Ministry of Labor, Invalids and Social Affairs (MOLISA), the Ministry of Health (MOH), and civil society to gradually transfer OVC programs to national government authorities and the community, with a focus on the provincial level.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Vietnam	$ 6,251,683	$ 7,279,311	$ 4,455,568	$ 7,926,502	**$ 25,913,064**
2010	Vietnam	$ 4,811,500	$ 5,570,861	$ 6,853,950	$ 19,041,883	**$ 36,278,194**
2011	Vietnam	$ 4,598,770	$ 5,385,916	$ 3,575,000	$ 15,652,614	**$ 29,212,300**
2012	Vietnam	$ 4,628,147	$ 5,553,710	$ 2,978,178	$ 9,341,613	**$ 22,501,648**
	Totals FY09-FY12	**$ 20,290,100**	**$ 23,789,798**	**$ 17,862,696**	**$ 51,962,612**	**$ 113,905,206**
2014 (est)	Vietnam					**$ 16,797,570**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In line with PEPFAR's third Partnership Framework goal to strengthen and sustain national engagement in the HIV/AIDS response, PEPFAR Vietnam continues efforts to integrate HIV/AIDS programming into the existing health system. Vietnam's public health system remains vertical, decentralized, and fragmented. The national HIV/AIDS program is under the National Committee for AIDS, Drugs and Prostitution Prevention and Control, and led by a Deputy Prime Minister. This inter-ministerial group is required to coordinate the national HIV response. The HIV response is only one of the committee's responsibilities, and the operational and implementation functions of the national response have been authorized to the VAAC, a department within the MOH. Forging a coherent HIV response is challenging because each of the ministries involved (Health; Public Security; Labor, Invalids and Social Affairs) have their own projects, funding, reporting requirements, and relationships with donors.

While policy is made at the national level, implementation is left to each of the 64 provinces with varying results that makes coordinating a comprehensive HIV response complex and results in fragmented decision-making. PEPFAR Vietnam continues to make significant progress in

promoting greater consistency in the HIV legal and policy framework in Vietnam, and has witnessed promising changes in the legal and policy environments.

A significant recent health systems achievement was the Government of Vietnam's decision to assign development of a "Renovation Plan" to the Ministry of Labor, Invalids and Social Affairs (MOLISA), indicating a shift away from the country's mandatory drug detention system, known as 06 centers, towards community-based drug treatment. The PEPFAR Vietnam team is encouraged by this step forward, though they remain concerned that the Plan's scope will be too narrowly focused on only the detention aspect of the system. In FY 2014, the PEPFAR Vietnam team is committed to working with all elements of the Vietnam system under a principle of constructive engagement toward the shift away from a mandatory drug detention system to a public health approach to preventing and treating drug addiction.

The chief governance and systems priorities are the successful implementation of both the national and provincial joint planning committees that PEPFAR Vietnam has negotiated with the Ministry of Health. At the national level, the joint planning team is led by VAAC and the U.S. government, with representation from various ministries of the Government of Vietnam, other development partners, and select implementing partners. This team will be expected to provide recommendations upstream to the national Partnership Framework Steering Committee and guidance downstream to the provincial level joint planning teams.

Country Engagement

Country ownership embodies myriad issues. In an environment that operates on heavily compartmentalized information-sharing, the continued patience and willingness of the U.S. government to act through indigenous systems remain paramount. The expectation of co-financing and accelerated country ownership is one put upon the country by external development partners, chiefly PEPFAR and the Global Fund. It is within this context that PEPFAR Vietnam continues to progress towards a TA model in 2013.

Concurrent with significant decreases in available PEPFAR resources since FY 2010, the U.S. government has taken an aggressive role to improve harmonization of all available HIV/AIDS resources, both national government and donor, in Vietnam to help ensure a sustainable national HIV/AIDS response that is embedded within the broader healthcare and social work system. This harmonization is a key part of the sustainability planning process.

PEPFAR Vietnam works with the national government to support the broad goals of the Partnership Framework: increased access to quality HIV/AIDS prevention; care and treatment services for key populations; strengthened health systems; and strengthened and sustained national engagement, including civil society and private sector, in the HIV/AIDS response. PEPFAR Vietnam's priority is to strengthen country ownership as PEPFAR-implemented services are made sustainable through government and local partners.

PEPFAR Vietnam's program sustainability plan will pursue a phased approach to garner consensus of line ministries, provincial Peoples' Committees, and community groups, including

civil society organizations and community-based organizations. PEPFAR Vietnam is working with Government of Vietnam to cluster and integrate existing HIV-related services and to decentralize service delivery to the commune level, where appropriate. PEPFAR Vietnam will provide TA to support the government to monitor and evaluate efficiencies and cost-effectiveness in this process. The PEPFAR Vietnam team is in dialogue with the government to transition its fiscal support for human resources for health. PEPFAR Vietnam also will support research on the cost of service-providers to improve efficiency. Additionally, PEPFAR Vietnam will support shifts in financing for the national HIV program, promoting mobilization of increasing resources from private and public sectors.

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Central Asia Region

Country Context

Central Asia is one of the few regions in the world where the HIV epidemic is still on the rise. The World Health Organization (WHO) estimated in 2011 that the number of new cases diagnosed in the Central Asia Republics (CAR) increased 14-fold between 2000 and 2011 (WHO European Action Plan for HIV/AIDS for 2012-2015, 2011).

Currently concentrated in less than 1 percent of the population, the HIV epidemic in the CAR continues to be driven primarily by injection drug use which follows the flow of heroin through urban centers and along drug transport corridors from Afghanistan through Tajikistan, Turkmenistan, Uzbekistan, Kyrgyzstan, and Kazakhstan.

The United Nations Office on Drugs and Crime (UNODC) estimates that 20 percent of heroin shipped from Afghanistan passes through CAR and approximately 11 metric tons per year are consumed in the region, where people who inject drugs (PWID) constitute up to 1 percent of the adult population. Estimates from 2009 show HIV prevalence among PWID ranges from 3 percent in Kazakhstan to 18 percent in Tajikistan and 14 percent in Kyrgyzstan. Recent data indicate a steady increase in the percentage of sexually transmitted HIV infections in CAR from 2006 to 2009; however, most cases are believed to be sexual partners of PWID. In addition to people living with HIV/AIDS (PLHIV), sex workers, men who have sex with men (MSM), and prisoners are considered key populations for HIV.

In FY 2014, PEPFAR will continue to prioritize the following objectives, outlined in the Central Asia strategy:

- Improving access to quality HIV prevention, care, and treatment services to reduce the transmission and impact of the HIV epidemic;
- Strengthening the capacity of the health system to deliver improved, expanded, equitable and sustainable HIV/AIDS services for key populations, PLHIV and their families, and other affected populations; and
- Building the capacity of the public and private sectors to collect, analyze, manage, and utilize data for evidence-based planning and policymaking.

Below is a table of PEPFAR CAR's budget representing its major program areas.

Fiscal Year	Central Asia Regional Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
2010	$ 9,015,215	57%	$ 615,550	4%	$ 160,550	1%	$ 6,022,685	38%	$ 15,814,000
2011	$ 7,771,783	49%	$ 710,305	4%	$ 325,695	2%	$ 7,006,217	44%	$ 15,814,000
2012	$ 783,985	15%	$ 158,001	3%	$ 162,897	3%	$ 4,057,532	79%	$ 5,162,415
Total 2009-2012	**$ 17,570,983**	**48%**	**$ 1,483,856**	**4%**	**$ 649,142**	**2%**	**$ 17,086,434**	**46%**	**$ 36,790,415**
2014 (est)	**$ 5,808,226**	**42%**	**$ 562,017**	**4%**	**$ 483,671**	**4%**	**$ 6,840,086**	**50%**	**$ 13,694,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
***Central Asia Regional did not complete a Country Operational Plan until FY 2010.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Central Asia Regional	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2010	Central Asia Regional	$ -	$ -	$ 2,330,370	$ 29,000	$ 42,100	$ 5,857,625	$ -	$ 756,120	**$ 9,015,215**
2011	Central Asia Regional	$ -	$ -	$ 2,094,628	$ 509,000	$ 237,530	$ 4,215,695	$ -	$ 714,930	**$ 7,771,783**
2012	Central Asia Regional	$ -	$ -	$ 150,899	$ 17,818	$ 21,636	$ 470,213	$ -	$ 123,419	**$ 783,985**
	Totals FY09-FY12	**$ -**	**$ -**	**$ 4,575,897**	**$ 555,818**	**$ 301,266**	**$ 10,543,533**	**$ -**	**$ 1,594,469**	**$ 17,570,983**
2014 (est)	Central Asia Regional									**$ 5,805,226**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
***Central Asia Regional did not complete a Country Operational Plan until FY 2010.

In FY 2014, PEPFAR CAR will continue efforts to improve access of key populations to comprehensive HIV prevention services by building on existing outreach services. The focus will be on scaling-up services, particularly for PWID, and their sexual partners, PLHIV, sex workers, MSM, and prisoners.

PEPFAR CAR will expand outreach efforts to PWID prison populations and supporting other approaches with local civil society groups and the public sector. In order to provide key populations with better coordinated care, PEPFAR CAR will integrate outreach with facility-based prevention, treatment and care services, including evidence-based prevention of sexual transmission, HIV counseling and testing (HCT), medication-assisted treatment (MAT), and

psychosocial and clinical support services. Strengthened collaboration between government and the non-governmental sectors will aim to increase access to more comprehensive services, reduce constraints to care, and improve adherence to treatment.

PEPFAR CAR will continue to provide technical assistance to Ministries of Health in Kazakhstan, Kyrgyzstan, and Tajikistan to implement comprehensive HIV prevention services for PWID, their sex partners, MSM, and sex workers in selected sites. Specifically, PEPFAR CAR will continue to support provider-initiated counseling and testing for key populations. PEPFAR CAR will also continue to strategically allocate resources to strengthen the capacity of country institutions, including Regional AIDS Centers, Ministries of Health, Country Coordination Mechanisms, and non-governmental organizations, to steward and implement a national AIDS response that reduces the risk of HIV transmission.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Central Asia Regional	$ -	$ -	$ -	**$ -**
2010	Central Asia Regional	$ -	$ 160,550	$ -	**$ 160,550**
2011	Central Asia Regional	$ -	$ 325,695	$ -	**$ 325,695**
2012	Central Asia Regional	$ -	$ 162,897	$ -	**$ 162,897**
	Totals FY09-FY12	**$ -**	**$ 649,142**	**$ -**	**$ 649,142**
2014 (est)	Central Asia Regional				**$ 483,671**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
***Central Asia Regional did not complete a Country Operational Plan until FY 2010.

PEPFAR CAR continues to provide technical assistance to enhance individual, institutional, and organizational capacity for providing comprehensive HIV care and treatment in Kazakhstan, Kyrgyzstan, and Tajikistan. It will also continue to support Ministries of Health in these countries to institutionalize the Electronic HIV Case Management System, as well as selected AIDS Centers to implement comprehensive patient-centered, multidisciplinary, service-delivery approaches.

With treatment serving as a key prevention intervention, PEPFAR will aim to both increase the number of people going into treatment and improve treatment quality. Enhanced technical assistance pilots will improve the quality of care and treatment services with training and mentoring support at two sites in Kyrgyzstan, three sites in Kazakhstan, and three sites in Tajikistan. It will support revision of national protocols on HIV clinical management; and assist in the development of training materials on clinical management of HIV.

PEPFAR continues to work closely with all partners to develop and implement laboratory quality management systems, protocols, and standard operating procedures, including those for viral load and CD4 cell testing. Technical assistance will also be provided to strengthen referral linkages and information exchange between clinical, regional, and national reference laboratories. The PEPFAR CAR team will work closely with the country Ministries of Health and the Global Fund on AIDS, TB and Malaria (GF) Project Implementation Units to develop and implement effective systems for forecasting and stocking laboratory supplies.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Central Asia Regional	$ -	$ -	$ -	$ -	**$ -**
2010	Central Asia Regional	$ 615,550	$ -	$ -	$ -	**$ 615,550**
2011	Central Asia Regional	$ 710,305	$ -	$ -	$ -	**$ 710,305**
2012	Central Asia Regional	$ 158,001	$ -	$ -	$ -	**$ 158,001**
	Totals FY09-FY12	**$ 1,483,856**	**$ -**	**$ -**	**$ -**	**$ 1,483,856**
2014 (est)	Central Asia Regional					**$ 562,017**

*Totals include planned funding for all accounts.
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***Central Asia Regional did not complete a Country Operational Plan until FY 2010.

Through NGO based outreach activities and in selected service delivery sites in Kazakhstan, Kyrgyzstan, and Tajikistan, PEPFAR CAR will collaboratively pilot and monitor rapid testing interventions as a tool to promote access to care by key populations.

PEPFAR CAR will continue to provide technical assistance in implementing clinical guidelines and service protocols for delivering a minimum package of services to PLHIV through regional AIDS Centers. The package of services and integration of the clinical care guidelines into the daily practice of the AIDS Centers will help PEPFAR CAR move toward higher retention rates, improved quality of life, and better treatment outcomes for PLHIV.

PEPFAR CAR will continue to support the improvement of strategic information under care and support by integrating unique identifier codes (UICs) into national health information systems thereby strengthening patient tracking systems. These UICs are easy to remember, alpha-numeric codes that provide key data about the client, including age and gender, without including any information that can be easily used to identify that person. UICs have been found to improve referral and monitoring of clients among various services, while simultaneously reducing some stigma and discrimination that key populations face when accessing services. PEPFAR CAR will also continue, providing technical assistance to improve the frequency and content of data feedback to community and facility level staff and program implementers, as well as continuing to train national and local partners on data collection, analysis, and dissemination.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Central Asia Regional	$ -	$ -	$ -	$ -	**$ -**
2010	Central Asia Regional	$ 1,379,000	$ 1,446,910	$ 15,800	$ 3,180,975	**$ 6,022,685**
2011	Central Asia Regional	$ 850,920	$ 817,571	$ 237,727	$ 5,099,999	**$ 7,006,217**
2012	Central Asia Regional	$ 496,416	$ 377,514	$ 2,061,778	$ 1,121,824	**$ 4,057,532**
	Totals FY09-FY12	**$ 2,726,336**	**$ 2,641,995**	**$ 2,315,305**	**$ 9,402,798**	**$ 17,086,434**
2014 (est)	Central Asia Regional					**$ 6,840,086**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
***Central Asia Regional did not complete a Country Operational Plan until FY 2010.

PEPFAR CAR will continue to partner with the respective governments in Central Asia countries to build national HIV/AIDS programs that are inclusive, accessible, provide quality services for key populations, and achieve planned outcomes. PEPFAR will continue to improve governance by providing adequate local resources for HIV/AIDS programs, and fostering health policies and systems that facilitate access to comprehensive care. In addition, the legislative, regulatory, and attitudinal barriers that constrain key populations' access to services will be addressed. Information systems needed to measure accessibility, effectiveness, and efficiency of HIV/AIDS services will also be prioritized.

In developing and implementing FY 2014 programs, PEPFAR CAR will emphasize approaches across the region that support national program goals and are leveraged with efforts of other development partners to maximize impact, sustainability, and efficient use of PEPFAR resources.

PEPFAR funding in CAR will continue to enhance leadership and governance of national HIV/AIDS programs, particularly Country Coordination Mechanisms, and sub-national governance structures. PEPFAR will support governing bodies in monitoring the implementation of HIV/AIDS activities; collecting sound data; tracking progress against local HIV/AIDS targets and indicators; engaging in HIV/AIDS policy advocacy efforts; and supporting the development of regional HIV/AIDS strategies. At the organizational level, PEPFAR activities will systematically enhance the management, programmatic and technical capabilities of public sector facilities and NGOs.

A PEPFAR CAR priority is to coordinate closely on all activities with the GF, the largest HIV donor in the region. The CAR team follows a three-pronged approach with the GF: provision of expertise to help GF-funded programs function more effectively; assistance to recipient countries to become and remain eligible to receive future GF grants; and partnership with implementing partners of GF and other donors to scale up best practices and improve HIV program quality.

Country Engagement

Government capacity, leadership, ownership, and political will to support services for key populations vary across Kazakhstan, Kyrgyzstan, and Tajikistan. Kazakhstan, for example, has significant financial resources. However, policies to support evidence-based approaches, such as social contracting of NGOs and expansion of services, have not led to the scale up of targeted services for key populations. Tajikistan and Kyrgyzstan are entirely dependent on donor resources in HIV/AIDS, with still-nascent capacities that require continued assistance in systems and institutional strengthening. Overall, countries across the Central Asia region require ongoing advocacy to promote public sector providers in delivering services to key populations.

U.S. government programs in the region face continuing challenges in terms of promoting country ownership of HIV/AIDS activities for key populations. The cancellation of Round 11 of the GF and provision of limited Transitional Funding has led to the near-depletion of GF HIV grant funds in Tajikistan. There is also potential curtailment of funding for NGOs providing services to key populations as well as for next year's Integrated Biological and Behavioral Surveillance survey. In Kazakhstan, underdeveloped NGO funding/social contracting mechanisms and continuing discrimination against key populations constrains award of funding for related activities. More comprehensive support for services at the local level, rather than one-off local activities, need to be emphasized. Declining funding from the GF has also led to more limited support for service delivery at the country level with greater focus on treatment and procurement of drugs, which could lead to service interruptions.

With the assistance of a GF liaison supported with FY 2013 resources, the U.S. government plans to engage in country discussions to support CAR country transition to the GF's new funding mechanism. The new funding mechanism puts greater emphasis on strategic investments in HIV. The U.S. government also plans to initiate a new partnership with UNAIDS to assist in the implementation of country level Investment Framework planning in Tajikistan, Kyrgyzstan, and Kazakhstan. The U.S. government will support the development and strengthening of framework policy documents such as national HIV/AIDS laws, national HIV/AIDS operational plans, and/or prevention strategies that endorse high impact interventions such as medication assisted treatment and that impose policies that support the reduction of stigma and discrimination for PLHIV and key populations.

India

Country Context

The Government of India has achieved substantial progress in containing the spread of HIV, with an overall reduction of 58 percent in estimated annual new HIV infections among the adult population during the last decade. Despite these achievements, India has the world's third largest HIV epidemic in terms of numbers of people infected. In 2011, there were an estimated 2.1 million people living with HIV (PLHIV).

- India has a concentrated HIV epidemic driven by infections among key populations, which in India include men who have sex with men (MSM), female sex workers (FSW), transgendered individuals, and people who inject drugs (PWID).
- Single male migrants and truckers have been identified at increased risk for HIV, and also serve as bridge populations facilitating HIV transmission between key populations and lower-risk, often rural populations.
- The geographic focus of new infections is shifting in India, with some low-prevalence states showing troubling increases in new infections over the past two years. In 2011, ten low-prevalence states accounted for 57 percent of the estimated 116,000 new infections.

Taking into consideration India's vast size, its 1.2 billion population, and substantial domestic resources, PEPFAR India maintains a highly focused portfolio that provides high-level, high-impact technical assistance to the Indian government and its partners, to facilitate implementation of the National AIDS Control Program (NACP). All PEPFAR India investments are designed to provide targeted technical assistance that maximizes impact on the HIV epidemic in India by strengthening capacity in critical program areas within the Indian government, the private sector, and with civil society partners. Both the Center for Disease Control and Prevention and U.S. Agency for International Development have bilateral agreements with the Indian government that identify specific areas of focus, based on the technical strengths of the agency and the prioritized needs of the national program. CDC's agreement (signed May 2010) expands and deepens technical assistance to the Indian government in laboratory systems, strategic information, and human capacity development.

India continues to be in a dynamic stage of its HIV response. With the Global Fund (GF) providing significant funding for PMTCT, HIV care and support, and antiretroviral treatment (ART) drug procurement, PEPFAR India's focus remains the provision of technical assistance to maximize GF grant performance.

PEPFAR India's key priorities for FY 2014 include:

- High-level technical assistance to support the roll-out of the fourth phase of the NACP (NACP-IV) and comprehensive HIV services among key populations and infected migrants; and
- Supporting the Indian government to identify, assess, prioritize, and implement better integration with other health programs.

Below is a table of PEPFAR India's budget representing its major program areas.

Fiscal Year	India Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 9,868,832	32%	$ 5,331,470	18%	$ 993,260	3%	$ 14,256,438	47%	$ 30,450,000
2010	$ 5,175,232	16%	$ 3,868,857	12%	$ 740,511	2%	$ 23,215,400	70%	$ 33,000,000
2011	$ 6,660,667	20%	$ 1,920,000	6%	$ 425,000	1%	$ 23,994,333	73%	$ 33,000,000
2012	$ 8,574,783	31%	$ 543,178	2%	$ 1,207,966	4%	$ 17,674,073	63%	$ 28,000,000
Total 2009-2012	**$ 30,279,514**	**24%**	**$ 11,663,505**	**9%**	**$ 3,366,737**	**3%**	**$ 79,140,244**	**64%**	**$ 124,450,000**
2014 (est)	**$ 4,373,194**	**18%**	**$ 1,564,685**	**6%**	**$ 277,293**	**1%**	**$ 18,525,828**	**75%**	**$ 24,741,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY11) & FY13 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	India	$ 723,295	$ 1,301,497	$ 6,238,101	$ -	$ 10,000	$ 50,000	$ -	$ 1,545,939	**$ 9,868,832**
2010	India	$ 680,351	$ 734,362	$ 2,689,955	$ -	$ -	$ -	$ -	$ 1,070,564	**$ 5,175,232**
2011	India	$ 1,100,000	$ 1,040,667	$ 3,440,000	$ -	$ -	$ 200,000	$ -	$ 880,000	**$ 6,660,667**
2012	India	$ 2,592,053	$ 27,959	$ 5,345,792	$ -	$ -	$ 50,000	$ -	$ 558,979	**$ 8,574,783**
	Totals FY09-FY12	**$ 5,095,699**	**$ 3,104,485**	**$ 17,713,848**	**$ -**	**$ 10,000**	**$ 300,000**	**$ -**	**$ 4,055,482**	**$ 30,279,514**
2014 (est)	India									**$ 4,373,194**

*Totals include planned funding for all accounts..
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

All PEPFAR India investments will provide targeted technical assistance that further increases the capacity of the Indian government, the private sector, and civil society partners, to plan, implement, monitor, and evaluate the national program. The U.S. government will support direct services only in the context of demonstration projects that are designed to test interventions and service delivery models for adoption and scale-up by the Indian government. Technical collaboration at the national level also continues to support development of evidence-informed policies and guidelines.

The Indian government's comprehensive targeted prevention interventions for key populations include a range of services including HIV counseling and testing (HCT), condom provision, and other evidence-based prevention activities; and sexually transmitted infection and TB screening. The U.S. government will continue to invest in developing prevention-to-care continuum models

and in capacity strengthening of the national and state systems that oversee implementation of these interventions. PEPFAR India's commitment to support expanded access to prevention services for key populations is reflected in projects through the private sector, and through innovative uses of technology to serve hard-to-reach populations, as well as by demand-generation activities supporting services through communications strategies.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	India	$ -	$ 968,260	$ 25,000	**$ 993,260**
2010	India	$ -	$ 718,511	$ 22,000	**$ 740,511**
2011	India	$ -	$ 355,000	$ 70,000	**$ 425,000**
2012	India	$ -	$ 1,207,966	$ -	**$ 1,207,966**
	Totals FY09-FY12	**$ -**	**$ 3,249,737**	**$ 117,000**	**$ 3,366,737**
2014 (est)	India				**$ 277,293**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

While the U. S. government does not contribute funds to procure antiretroviral drugs in India or support direct provision of ART services, it will continue to support high quality policy and technical support to improve access to and the quality of ART services. The U.S. government will also provide technical assistance to the National AIDS Control Organization (NACO) in implementing an effective continuum of care approach that links prevention, testing, care and treatment, while also integrating ART with tuberculosis (TB) and primary health care services.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	India	$ 3,245,142	$ 291,290	$ 369,700	$ 1,425,338	**$ 5,331,470**
2010	India	$ 2,386,009	$ 190,017	$ 115,000	$ 1,177,831	**$ 3,868,857**
2011	India	$ 700,000	$ 70,000	$ 120,000	$ 1,030,000	**$ 1,920,000**
2012	India	$ 259,628	$ -	$ 66,775	$ 216,775	**$ 543,178**
	Totals FY09-FY12	**$ 6,590,779**	**$ 551,307**	**$ 671,475**	**$ 3,849,944**	**$ 11,663,505**
2014 (est)	India					**$ 1,564,685**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

U.S. government staff and partners provide technical input that informs national policies and guidelines through participation in NACO Technical Resource Groups. In FY 2014, the U.S. government will also support policy through:

- Continued investments in the expanding network of HIV Centers of Excellence and State Nursing Councils, which strengthen the HIV skills of trained health care professionals through a range of model in-service training programs;
- Targeted technical assistance to NACO and the Revised National Tuberculosis Control Program, to further consolidate HIV-TB collaborative activities and scale up successful models for integrated services; and
- Support for quality services for orphans and vulnerable children (OVC) in higher-prevalence districts.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	India	$ 288,698	$ 4,135,896	$ 7,360,466	$ 2,471,378	**$ 14,256,438**
2010	India	$ 660,000	$ 5,210,335	$ 12,530,993	$ 4,814,072	**$ 23,215,400**
2011	India	$ 939,400	$ 6,099,774	$ 13,763,159	$ 3,192,000	**$ 23,994,333**
2012	India	$ 962,900	$ 4,076,131	$ 10,570,487	$ 2,064,555	**$ 17,674,073**
	Totals FY09-FY12	**$ 1,888,098**	**$ 15,446,005**	**$ 33,654,618**	**$ 10,477,450**	**$ 61,466,171**
2014 (est)	India					**$ 18,525,828**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

U. S. government investments in FY 2014 will support NACO's recently-launched prioritized research agenda for NACP-IV, including technical assistance for a range of prioritized data analyses, operational research, and surveys. The U.S. government will continue to work with partners on HIV prevalence estimates, projections and trend analyses, monitoring of ART and prevention of mother-to-child transmission (PMTCT), cohort analyses, operations research, and district epidemiological profiling.

The U.S. government will continue its strong partnership with NACO's Laboratory Services Division and India's network of 13 national and 117 state reference labs, through ongoing work on laboratory accreditation and quality assurance for HIV, STI, and Hepatitis A and B virus diagnostics. New investments will expand lab strengthening activities to support capacity and quality assurance in laboratories of the National Blood Transfusion Council.

New investments will also provide targeted technical assistance to the Indian government's supply chain management systems for HIV drugs and commodities. The activity will focus on forecasting, inventory management, and distribution systems, which are important to effective functioning of all NACO programs.

Country Engagement

The Indian government already leads and substantially funds its national program. Under NACP-IV (2012-2017), domestic resources will fund an estimated 80-90 percent of the HIV response in India. This represents a major increase from the previous five years, where international donors supported approximately 75 percent of overall costs for the national program.

Through strong national leadership and coordinated management of prioritized state and district programs, India has done remarkably well in communicating its program and policies throughout the country. In particular, NACO continues to effectively manage the contributions of development partners to ensure optimal support for priority activities. Through a consultative process, NACO recently developed a prioritized HIV/AIDS research agenda to support the implementation of NACP-IV, reflecting a continued commitment to use data to make programmatic adjustments and improve results.

All PEPFAR India investments are identified and developed through an ongoing consultative process with the Indian government, in close coordination with other development partners, to ensure that donor resources, including the GF resources, are leveraged to optimize efforts in a range of program areas.

The U.S. government is a member of the Development Partner Joint Review Team that reviews the progress of the NACP, and which collaborated with the Indian government and other development partners in designing NACP-IV. The U.S. government also represents the bilateral constituency on the GF Country Coordinating Mechanism, overseeing India's large GF programs, and serves on its Oversight Committee.

U. S government support for sustainability of India's program prioritizes continued collaboration with NACO and State AIDS Control Societies to:

- Ensure that policies and guidelines meet global standards;
- Test, implement, and share innovative approaches; and
- Establish quality improvement systems.

The Indian government has the resources and capacity to take on initiatives begun through U.S. government funding. The U.S. government has piloted and evaluated numerous innovations to improve service delivery, subsequently adopted and scaled up by the Indian government. District action plans, non-governmental organization selection criteria, and behavior change communication tools and strategies have all emerged from U.S. government programs, and were later scaled up nationally by the Indian government.

PEPFAR India provides a model cost-effective technical cooperation program, building efficiencies into all its investments. PEPFAR India strategically invests in value-added activities that leverage the considerable investments of the Indian government, the World Bank, the GF, and other partners. As India rolls out its fourth NACP (2012-2017), the U.S. government, now as the largest bilateral technical and funding partner, has a unique opportunity to support the

continued strong technical collaborations that have contributed to dramatic successes in India's HIV response.

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Caribbean Region

Country Context

The U.S. PEPFAR Caribbean Regional program encompasses 11 countries and includes Antigua and Barbuda, Bahamas, Barbados, Dominica, Grenada, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago. The Caribbean has higher HIV rates than any region outside of sub-Saharan Africa. The adult HIV prevalence of 1 percent is almost twice that of North America (0.6), and more than twice that of Latin America (0.4). Unprotected sex between men and women—especially paid sex—is believed to be the main mode of HIV transmission in this region; however, evidence indicates that substantial transmission is also occurring among men who have sex with men(MSM). In the eleven countries of the Caribbean Regional Program, data is limited and prevalence rates are missing for the general population and key populations. However, in the countries with data, prevalence rates in the general population range from a low of 1 percent in Suriname to a high of 2.8 percent in the Bahamas. An estimated 60,000 people live with HIV in the eleven countries of the Caribbean Regional program. The HIV epidemic varies within countries and across the region. For example, HIV affects young women 1.2 to 3 times more than young males in the Bahamas and Barbados, while in Jamaica, Suriname, and Trinidad and Tobago the reverse is true.

2014 is the final year of the Caribbean Regional Partnership Framework (PF), signed in June, 2010. The activities proposed for 2014 conclude the existing PF, and prepare for the next phase of PEPFAR's contribution to the regional response to HIV and AIDS. The Caribbean Community Pan-Caribbean Partnership Against HIV/AIDS Caribbean Regional Strategic Framework (CRSF), upon which the Partnership Framework is based, has been extended through 2018. The CSRF describes a shared vision that emphasizes: strengthening HIV prevention services and resources; improving national and regional capacity for surveillance, monitoring, and evaluation; strengthening national and regional laboratory diagnostic and monitoring capacity; developing human resources for improved healthcare service delivery; and supporting national governments' capacity to implement effective, sustainable national HIV/AIDS programs. This second phase of the CRSF includes: a greater contribution from national governments in their national HIV/AIDS programs; stronger investment in health systems; inclusion of human rights issues and integration of sexual and reproductive health and HIV/AIDS; universal access and capacity building for civil society and key populations; and shared ownership and development of a sustainability framework. The PEPFAR Caribbean Region program supports these new priority areas.

Below is a table of PEPFAR Caribbean Regional's budget representing its major program areas.

Fiscal Year	Carribean Regional Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 6,027,610	32%	$ 1,319,120	7%	$ 240,336	1%	$ 11,412,934	60%	$ 19,000,000
2010	$ 7,181,474	31%	$ 1,131,535	5%	$ 286,056	1%	$ 14,700,935	63%	$ 23,300,000
2011	$ 8,095,000	35%	$ 780,000	3%	$ 218,000	1%	$ 14,207,000	61%	$ 23,300,000
2012	$ 7,018,281	32%	$ 765,106	3%	$ 420,000	2%	$ 13,988,013	63%	$ 22,191,400
Total 2009-2012	**$ 28,322,365**	**32%**	**$ 3,995,761**	**5%**	**$ 1,164,392**	**1%**	**$ 54,308,882**	**62%**	**$ 87,791,400**
2014 (est)	**$ 6,904,739**	**30%**	**$ 658,176**	**3%**	**$ 432,219**	**2%**	**$ 14,918,867**	**65%**	**$ 22,914,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Caribbean Regional	$ 200,000	$ 112,000	$ 5,345,860	$ -	$ -	$ -	$ -	$ 369,750	**$ 6,027,610**
2010	Caribbean Regional	$ 200,000	$ 190,474	$ 6,095,000	$ -	$ -	$ -	$ -	$ 696,000	**$ 7,181,474**
2011	Caribbean Regional	$ -	$ -	$ 6,885,880	$ -	$ -	$ -	$ -	$ 1,209,120	**$ 8,095,000**
2012	Caribbean Regional	$ 38,000		$ 6,015,935					$ 964,346	**$ 7,018,281**
	Totals FY09-FY12	**$ 438,000**	**$ 302,474**	**$ 24,342,675**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 3,239,216**	**$ 28,322,365**
2014 (est)	Caribbean Regional									**$ 6,904,739**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The vast majority of the PEPFAR prevention programming in the Caribbean region goes to capacity building and stigma reduction activities. There is limited direct service provision done in the majority of the countries in the regional program. The exception is in Jamaica and in targeted ways in seven other countries where PEPFAR provides more direct service provision of a combination-prevention approach. (The goal of combination prevention is to reduce the transmission of HIV by implementing a combination of behavioral, biological, and structural interventions that are carefully selected to meet the needs of a population). These interventions include: peer-based outreach and targeted behavior change communication interventions coupled with condom and lubricant distribution to MSM, commercial sex workers (CSWs) and clients of CSWs; targeted community and facility-based testing and counseling, in close collaboration with the Ministries of Health and civil society partners, to increase the number of individuals who

know their HIV status; and prevention with positives (PwP) services to increase access and delivery of services for people living with HIV (PLHIV).

These activities are being coupled with strengthening the ability of civil society partners to effectively engage in the HIV response; facilitating appropriate HIV, human rights, and gender-based violence (GBV) advocacy efforts and policy reform; and supporting focused efforts to mitigate stigma and discrimination in all prevention activities in all countries. Technically skilled volunteers will continue to be placed in governmental and non-governmental organizations assisting with capacity strengthening to manage administrative and programmatic operations. This valuable human resource remains a major support to host countries. Similarly, in military settings, the integration of HIV computer-based post-test counseling programs will be supported as a contribution to sustainability efforts in response to human resource constraints.

In FY 2014, prevention activities will be expanded to include marginalized mining populations who frequently are clients of CSWs in remote areas in Suriname and Jamaica that are underserved. Ministries of Health have begun to expand their reach to these high-risk populations in a concerted effort to provide greater access to HIV education, treatment, and care services. Further, prevention program advisory groups comprised of national stakeholders, including civil society partners, have been established in each of the Eastern Caribbean countries to facilitate greater programmatic buy-in, country ownership, and plans for transitioning U.S. government and other donor assistance.

This year there will also be a renewed focus on sexual and GBV and its relationship to HIV/AIDS. This relationship is now better understood and appreciated within the region. The U.S. government team will work to enhance the coordination of policies and programming across sectors to address GBV, stigma and discrimination, and harmful gender norms; increase the availability and direct use of data on GBV, stigma and discrimination, and harmful gender norms to inform HIV health system strengthening priorities in policy and programs; and strengthen institutional capacity at the community level to address GBV, stigma and discrimination, and harmful gender norms within HIV programs. Overall, prevention programs will focus to further promote appropriate knowledge transfer for long-term sustainability.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Caribbean Regional	$ -	$ 240,336	$ -	**$ 240,336**
2010	Caribbean Regional	$ -	$ 286,056	$ -	**$ 286,056**
2011	Caribbean Regional	$ -	$ 218,000	$ -	**$ 218,000**
2012	Caribbean Regional	$ -	$ 420,000	$ -	**$ 420,000**
	Totals FY09-FY12	**$ -**	**$ 1,164,392**	**$ -**	**$ 1,164,392**
2014 (est)	Caribbean Regional				**$ 432,219**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR does not support any direct treatment service delivery in the Caribbean. Instead, treatment programs are financed through a combination of Global Fund grants, World Bank loans, and self-financed by national governments. PEPFAR's role in supporting ART treatment in the Caribbean is to help governments address barriers to increasing treatment coverage and improving the quality of treatment services. PEPFAR and UNAIDS also works with each government to plan for the long-term financing of treatment programs.

As a result, countries are taking on an increasing share of treatment financing on their own, as in the Bahamas, Trinidad and Tobago, and Suriname where 100 percent of antiretrviral (ARV) costs are paid by the national governments.

In FY 2014, technical assistance will continue to be provided to Ministries of Health (MOH) in the 11 Partnership Framework countries for national level adaptations to the Caribbean Regional Treatment Guidelines as needed and relevant. Training curricula used by the Caribbean HIV/AIDS Regional Training Network, for both in-service and pre-service training, will reflect these regional or country specific guidelines to ensure consistent messaging to health care workers and systems of care.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Caribbean Regional	$ 819,120	$ -	$ -	$ 500,000	**$ 1,319,120**
2010	Caribbean Regional	$ 1,131,535	$ -	$ -	$ -	**$ 1,131,535**
2011	Caribbean Regional	$ 780,000	$ -	$ -	$ -	**$ 780,000**
2012	Caribbean Regional	$ 724,346	$ -	$ 40,760	$ -	**$ 765,106**
	Totals FY09-FY12	**$ 3,455,001**	**$ -**	**$ 40,760**	**$ 500,000**	**$ 3,995,761**
2014 (est)	Caribbean Regional					**$ 658,176**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The overall U.S. government strategy in FY 2014 will focus on care of key populations and PLHIV. The strategy addresses the need for a holistic approach to the management of PLHIV. This includes incorporating psychosocial, nutritional and adherence support, and information on sexual and reproductive health into HIV/AIDS care and support programs. It also involves improving access to non-stigmatizing health services, creating an enabling environment for prevention programs, strengthening the links between the private and public sectors, and linking the public sector response to the community level. There will be an increased focus on multidisciplinary care training, including physicians, nurses, pharmacists, laboratory staff, social workers, nutritionists, other ancillary health care providers, and PLHIV. Training will also support the movement toward integration of HIV care into primary care. Key components of the strategy are to strengthen prevention with positives (PwP) services, improve access to effective PwP services, and integrate HIV/AIDS services into primary health care. Improving data quality to inform programming and strengthening point-of-care laboratory services are also important aspects of the U.S. government strategy.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Caribbean Regional	$ 3,559,000	$ 3,350,000	$ 3,203,934	$ 1,300,000	**$ 11,412,934**
2010	Caribbean Regional	$ 1,905,000	$ 3,052,409	$ 4,077,733	$ 5,665,793	**$ 14,700,935**
2011	Caribbean Regional	$ 1,764,000	$ 3,395,000	$ 4,993,000	$ 4,055,000	**$ 14,207,000**
2012	Caribbean Regional	$ 1,853,754	$ 3,545,523	$ 5,665,568	$ 2,923,168	**$ 13,988,013**
	Totals FY09-FY12	**$ 9,081,754**	**$ 13,342,932**	**$ 17,940,235**	**$ 13,943,961**	**$ 54,308,882**
2014 (est)	Caribbean Regional					**$ 14,918,867**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

There continue to be persisting challenges facing the region including weak leadership and management, human resources for health (HRH) shortages, lack of sustainable HIV and health financing, and a shortage of strategic information together with a culture of not using evidence for decision-making. The strategies and activities for 2014 will continue to address identified gaps in these areas and work towards sustainability of the programs.

FY 2014 HRH activities related to quality improvement, integrating community health workers into the continuum of the response, strengthening regulatory bodies and professional associations, and developing and implementing HRH policies and guidelines will continue. HRH capacity building activities include strengthening of the governance infrastructure to support human resource development, recruitment, retention planning (including task shifting), and management of the health workforce based on countries' identified needs.

The U.S. government also aims to support greater private sector engagement in FY 2014. Recent work in the region shows a nascent understanding or inclusion of the private sector, including the not-for-profit sector, across all health systems areas. Identifying strategies to systematically include the private sector in public health planning and policy processes, including building the capacity of the public sector to work with the private sector, will strengthen the ability to strategically leverage private sector resources.

In order to address limited regional capacity in collecting, analyzing, and using health financing data, continued capacity building opportunities will be provided for conducting National Health Accounts (NHA) estimations, and strengthening existing institutions to routinely produce NHA data, as well as implement household health expenditure surveys to measure out-of-pocket expenditures and quantify use of private health sector services. Further support will be provided for ensuring ongoing, sustainable financing. Several areas of technical cooperation have emerged including:

- Providing financial training courses with Ministry of Health (MOH) officials to assist them in understanding how to better communicate budget needs to Ministry of Finance officials;
- Conducting costing and cost-benefit analyses to support governments in understanding their costs of running facilities and potential packages of services; and
- Supporting regional bodies in developing business plans for the future beyond Global Fund eligibility.

In addition, cost-benefit analysis will assist governments who are currently contemplating health financing reforms and still are unsure of which benefits should be covered. In the Caribbean, this is important for PLHIV because while governments are trying to streamline HIV services into primary care they may not be properly allocating necessary funds to ensure that the quality of service is maintained. Given that the epidemic in the Caribbean is concentrated, data is critical for decision making and focused programming is necessary in key populations. The PEPFAR Caribbean Regional team has worked collaboratively with national governments and regional entities to assist in filling some of the data gaps and will continue to do so with FY 2014 funding. PEPFAR Caribbean Regional provides technical assistance to MOHs to implement SI activities to build capacity within the region.

The SI objectives of the Partnership Framework Implementation Plan (PFIP) include increasing the capacity of Caribbean national governments and regional organizations to collect and use quality, timely HIV/AIDS data to better characterize the epidemic and improve programs, policies, and health services. With 11 national governments to assist, PEPFAR Caribbean Regional has made strides with several of the national governments and continues to reach others with technical assistance. Given the various levels of capabilities within the MOHs, uptake of programming is varied. To date, PEPFAR Caribbean Regional has assisted several countries in developing data standards and standard operating procedures, as well as in strengthening data collected by studies in key populations. Formative assessments have been completed in the Bahamas and are underway in Antigua and Barbuda. These will inform the development of larger bio-behavioral surveillance (BBS) studies. BSS surveys for MSM and FSW are currently underway in Trinidad and Tobago and Barbados.

Country Engagement

The Caribbean Regional Program has brought concrete technical assistance and capacity building to the region, and enhanced countries' abilities to manage their HIV programs and resources through training and technical assistance in the areas of prevention, SI, laboratory systems and services, and health systems strengthening. However, there is a need to build capacity for greater country ownership and sustainability. The strategies outlined in the Partnership Framework and PFIP remain relevant to strengthening partner countries’ capacity to plan, oversee, finance, and manage their national response to HIV and AIDS and to deliver quality services with the participation of PLHIV, civil society, and the private sector. Strengthening health systems will also improve equity and access to quality affordable health services for key populations. Ultimately program integration and the focused interventions in health systems strengthening (HSS) will lead to intentional spillover in evidence based planning for health services other than HIV, and improved policies to address gaps in other diseases.

Central America Region

Country Context

The Central America Region, including Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama, is characterized by a concentrated HIV/AIDS epidemic with low prevalence among the general population. However, the region illustrates high prevalence among certain subgroups such as men who have sex with men (MSM), transgender persons, male and female sex workers (SW), clients of sex workers and their partners, certain ethnic groups, and mobile populations.

Overall HIV prevalence in adults across the Central America Region ranges from 0.2 percent in Nicaragua to a high of 2.3 percent in Belize. These relatively low national percentages mask the concentrated epidemic among key populations. Belize, a country which geographically, politically, and culturally straddles both Central America and the Caribbean, is an exception in the region with a prevalence rate above 1 percent, but still has an epidemic driven by similar key populations.

Data continue to demonstrate that transgender populations, female sex workers (FSW) and MSM, are the populations with the highest HIV prevalence rates in the region. For example, recent results show the prevalence for MSM in specific areas ranging from 7.5 to 13.9 percent. These numbers reflect declines among MSM in all countries, suggesting that condom promotion and other behavior change communication prevention efforts have had a positive impact. Additionally, the transgender population is a relatively small but very high-risk group. HIV prevalence rates for some surveyed transgender populations ranged from 14.6 to 23.3 percent across the region.

In addition to filling needed gaps in working directly with key populations, PEPFAR Central America will continue to engage with governments on all levels and explore creative ways to foster dialogue and collaboration between national and regional leaders and the most affected and marginalized key populations. U.S. government efforts to build the technical, management, and leadership capacity of small civil society groups representing key populations will improve their ability to respond to community needs and their effectiveness in advocacy and coordination with the government, including entering into contractual and financing relationships with governments to carry out activities.

In FY 2014, the Central America Regional U.S. government team will continue to be guided by the Regional Partnership Framework (PF) and Global Health Initiative (GHI) principles with a clear commitment to country ownership. U.S. government efforts to support priorities identified in the PF will continue in FY 2014 as PEPFAR activities work to strengthen health systems through capacity building in laboratory, supply chain management, and quality continuum of care and services, as well as improving generation of, access to, and use of strategic information (SI). A major internal change for FY 2014 is the completed consolidation of all formerly bilateral U.S. government agency HIV/AIDS programs into one regional PEPFAR agency program. While coordination between regional and bilateral programming has always existed,

the development of the FY 2014 Regional Operational Plan represents a significant and positive shift in planning PEPFAR activities in the region in one coordinated manner.

Below is a table of PEPFAR Central America's budget representing its major program areas.

Fiscal Year	Central America Regional Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ -	0%	$ -	0%	$ -	0%	$ -	0%	$ -
2010	$ 3,886,718	31%	$ 430,548	3%	$ -	0%	$ 8,269,734	66%	$ 12,587,000
2011	$ 2,806,933	22%	$ 1,005,209	8%	$ -	0%	$ 8,774,858	70%	$ 12,587,000
2012	$ 6,121,906	28%	$ 2,108,856	10%	$ -	0%	$ 13,383,238	62%	$ 21,614,000
Total 2009-2012	**$ 12,815,557**	**27%**	**$ 3,544,613**	**8%**	**$ -**	**0%**	**$ 30,427,830**	**65%**	**$ 46,788,000**
2014 (est)	**$ 5,940,386**	**28%**	**$ 2,456,579**	**12%**	**$ -**	**0%**	**$ 12,850,035**	**60%**	**$ 21,247,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Central America Regional	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2010	Central America Regional	$ -	$ -	$ 2,905,334	$ -	$ -	$ -	$ -	$ 981,384	**$ 3,886,718**
2011	Central America Regional	$ -	$ -	$ 1,962,968	$ -	$ -	$ -	$ -	$ 843,965	**$ 2,806,933**
2012	Central America Regional	$ -	$ -	$ 4,624,554	$ -	$ -	$ -	$ -	$ 1,497,352	**$ 6,121,906**
	Totals FY09-FY12	**$ -**	**$ -**	**$ 9,492,856**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 3,322,701**	**$ 12,815,557**
2014 (est)	Central America Regional									**$ 5,940,386**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, PEPFAR Central America will continue to develop its model to estimate the reach of prevention to key populations in each country. This model will serve as a tool to better understand gaps in PEPFAR's investment in the region. PEPFAR Central America will also focus on strengthening prevention efforts for transgender women and people living with HIV (PLHIV). These two key populations are at high-risk for stigmatization. Activities with other identified key populations such as MSM and SW will also continue. Gender will also be included as a crosscutting theme in PEPFAR's work with key populations in the Central America region. With resources from the Key Populations Challenge Fund, PEPFAR Central America will expand implementation of prevention services at local organizations in Honduras and Nicaragua.

Prevention with Positives will continue to be a strategic priority for PEPFAR Central America. The team will support multiple trainings on the minimum package of prevention services. In the Central America Region, it is estimated that 2 out of 3 PLHIV do not know their HIV status or that of their partners. Improving identification of HIV-positive individuals and sero-discordant couples (in which one partner is HIV positive and the other is HIV negative) and offering treatment early to PLHIV will reduce the risk of transmission and reduce morbidity and mortality experienced by PLHIV.

The Sexually-Transmitted Infection Sentinel Surveillance and Control strategy (VICITS) is an HIV prevention strategy for key populations combining improved sexually transmitted infection (STI) diagnosis and treatment, condom distribution, targeted counseling, and antiretroviral (ARV) referral, and includes a surveillance information system. VICITS activities in FY 2014 will focus on expanding the number of key populations reached by increasing services to currently served populations and by piloting this strategy among new key groups.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Central America Regional	$ -	$ -	$ -	**$ -**
2010	Central America Regional	$ -	$ -	$ -	**$ -**
2011	Central America Regional	$ -	$ -	$ -	**$ -**
2012	Central America Regional	$ -	$ -	$ -	**$ -**
	Totals FY09-FY12	**$ -**	**$ -**	**$ -**	**$ -**
2014 (est)	Central America Regional				**$ -**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, PEPFAR Central America will continue to be a technical assistance region that offers no direct treatment services. With additional grant support from the Global Fund (GF), national governments in the region will continue to be the primary source for antiretroviral treatment (ART).

PEPFAR Central America will support several initiatives including social network referral and the piloting of a health navigator program to facilitate linkages to HIV care and treatment services among PLHIV. For example, collaborative efforts in Panama and Honduras will result in new clinics that reach key populations and offer ARV treatment. Additionally, PEPFAR Central America will continue work in strengthening services and systems for HIV/AIDS treatment focused on key populations.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Central America Regional	$ -	$ -	$ -	$ -	**$ -**
2010	Central America Regional	$ 258,048	$ -	$ 172,500	$ -	**$ 430,548**
2011	Central America Regional	$ 546,975	$ -	$ 458,234	$ -	**$ 1,005,209**
2012	Central America Regional	$ 1,598,454	$ -	$ 510,402	$ -	**$ 2,108,856**
	Totals FY09-FY12	**$ 2,403,477**	**$ -**	**$ 1,141,136**	**$ -**	**$ 3,544,613**
2014 (est)	Central America Regional					**$ 2,456,579**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, PEPFAR Central America is funding programs in adult care and support, both clinic-based and community-based activities for HIV-infected people, their families, and their community. Activities will target:

- Improvement of performance of human resources for health by applying accepted performance standards, systematizing and institutionalizing the performance improvement strategy, and ensuring supportive supervision at secondary and tertiary level facilities;
- Building human resources for health capacity at both the pre-service and in-service levels through revisions and updates of curricular content and teaching methods;
- Monitoring care and treatment services by establishing a performance information system; and
- Integrating care and treatment with community-based support to ensure complementary services and promotion of HIV prevention. This will include access to HIV testing and promoting better practices for retention, reference to other services such as family planning, cervical cancer prevention, early diagnosis of opportunistic infections, nutrition counseling, and social support.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Central America Regional	$ -	$ -	$ -	$ -	**$ -**
2010	Central America Regional	$ 399,686	$ 2,843,177	$ 2,751,871	$ 2,275,000	**$ 8,269,734**
2011	Central America Regional	$ 558,750	$ 1,886,410	$ 4,650,898	$ 1,678,800	**$ 8,774,858**
2012	Central America Regional	$ 276,400	$ 3,464,202	$ 7,854,687	$ 1,787,949	**$ 13,383,238**
	Totals FY09-FY12	**$ 1,234,836**	**$ 8,193,789**	**$ 15,257,456**	**$ 5,741,749**	**$ 30,427,830**
2014 (est)	Central America Regional					**$ 12,850,035**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, the U.S. government is planning to expand its work to more hospitals and community networks and to support the institutionalization of the strategy across various countries in the region. In Nicaragua, all health systems strengthening (HSS) activities supporting the Ministry of Health (MOH) finished in September 2012.

PEPFAR Central America has supported 90 hospitals in six countries to improve the quality of services to PLHIV. At the local level, PEPFAR Central America supports 27 community networks promoting adherence and self-care in PLHIV and primary and secondary prevention activities with other key populations. Training in stigma and discrimination and gender issues is a key part of strengthening these networks, as is the development of advocacy skills to demand better and qualified services at the local level. In FY 2014, the U.S. government is planning to expand these activities to more hospitals and community networks and to support the institutionalization of the strategy across various countries in the region.

In FY 2014, PEPFAR Central America will continue supporting initiatives to strengthen national supply chains with an emphasis on HIV programs in Guatemala, El Salvador, Panama, and other countries in the region. The technical assistance provided to governments contributes to improved storage conditions, distribution systems, logistics, information systems, quantification processes, systems design, and procurement, especially of ARVs, testing, and other HIV commodities. In Honduras, technical assistance focuses on building sustained organizational capacity within the MOH and civil society to partner via decentralized contracts to provide HIV testing services to key populations. There will also be a focus on promoting regional actions to support an ongoing sustainability strategy.

Building capacity in the area of lab remains a major priority for PEPFAR Central America and includes working with National Laboratories to promote their leadership role in their respective countries. In FY 2014, the U.S. government will continue to support the establishment of a regional lab network for HIV, STI, Mycotic Infections and tuberculosis (TB). PEPFAR Central America will work collaboratively to provide assistance for training, technology transfer, and exchange within the region.

PEPFAR Central America will continue supporting the improvement of data collection, analysis and use of strategic information, and sustaining regular reporting processes with NASA, the National Response Report, UNAIDS, and Stigma and Discrimination Monitoring, among others. There will be an emphasis on conducting cost effectiveness analyses in order to address the reduced funding from donors in the region.

Country Engagement

With the majority of the PEPFAR investments in the region supporting technical assistance, country ownership is at the heart of the Central American Regional program. PEPFAR Central America provides support to programs that are in many senses already owned by countries or regions - whether U.S. government partners are working to improve the quality of HIV related services at a public hospital, or building the capacity of a key populations-focused non-governmental organization (NGO). In FY 2014, the U.S. government team plans to continue efforts on building country ownership and articulate its meaning. PEPFAR Central America has played a key role in supporting the development of regional and national strategic plans that better reflect the reality of the region's concentrated epidemic. For example, the Honduran MOH recently decentralized contract awarding to NGOs that provide services to key populations.

All PEPFAR Central America activities are reviewed and validated and often developed jointly with host country government and civil society counterparts at different levels. All activities must clearly align with the national strategic plan in each country. At the country level, discussions are held with the Global Fund and other donors to ensure there is no duplication of efforts. In preparation for FY 2014 planning, the U.S. government held a series of meetings across the region in 2013 to assess the advances and challenges in each country in implementing the partnership framework.

Dominican Republic

Country Context

The Dominican Republic (DR) shares the Island of Hispaniola with Haiti. Its population is approximately 9.7 million (2010 census), with an HIV sero-prevalence of 0.8 percent, per the Demographic Health Survey (DHS)/2007. The epidemic is largely driven by heterosexual practices, including multiple partners and transactional sex. Men who have sex with men (MSM), transgender, and commercial sex workers (both men and women) exhibit higher sero-prevalence than the national level. Residents of Bateyes and women with fewer than four years of formal education are affected by the epidemic out of proportion to their percentage in the general population. UNAIDS and the Ministry of Health (MOH) (2011) estimate that in 2012 nearly 44,000 persons (adults and children) were living with HIV and approximately 1,700 deaths were attributable to AIDS. MOH data (December 2012) indicate that 21,579 persons (20,496 adults and 1083 children) were on antiretroviral (ARV) therapy, an increase of over 2100 persons (11 percent) since November 2011.

In FY 2014, PEPFAR DR will continue to work with key populations to prevent new infections. Priority areas for PEPFAR include:

- Prevention of mother-to-child transmission (PMTCT): Redefining the U.S. government interagency approach and working with the MOH technical group for PMTCT; redefining target hospitals; and focusing on service delivery level and systems strengthening.
- Counseling and testing and (HCT): Working with MOH service delivery facilities, as part of PMTCT; expanding testing coverage to include more pregnant women and involve more men in HCT as part of the Gender Challenge Program; and providing same-day delivery of results to patients.
- Prevention among key populations: Continuing support to non-governmental organizations (NGOs) that work with commercial sex workers (CSWs), men who have sex with men (MSM), youth, women, the military, and drug users. Priority will be placed on interventions targeting migratory groups, most of which are of Haitian origin and/or descent.
- Systems strengthening (especially in procurement and logistics, HR, and information systems): improving information and data collection and flow for more informed decision making; preventing stockouts of drugs and reagents; focusing on increased DR government procurement of reagents, rapid tests, and eventually ARV drugs; and working with the MOH on the HR audit and the personnel and policy implications.

Below is a table of PEPFAR DR's budget representing its major program areas.

Fiscal Year	Dominican Republic Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 8,454,000	37%	$ 2,525,000	11%	$ 525,000	2%	$ 11,412,934	50%	$ 22,916,934
2010	$ 7,978,800	51%	$ 2,800,000	18%	$ 747,882	5%	$ 3,973,318	26%	$ 15,500,000
2011	$ 5,790,909	37%	$ 2,600,000	17%	$ 750,000	5%	$ 6,359,091	41%	$ 15,500,000
2012	$ 4,201,853	49%	$ 1,238,623	15%	$ 270,257	3%	$ 2,789,267	33%	$ 8,500,000
Total 2009-2012	**$ 26,425,562**	**42%**	**$ 9,163,623**	**15%**	**$ 2,293,139**	**4%**	**$ 24,534,610**	**39%**	**$ 62,416,934**
2014 (est)	**8,237,811**	**58%**	**525,532**	**4%**	**61,878**	**0%**	**5,461,778**	**38%**	**$ 14,287,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Dominican Republic	$ 2,181,000	$ 1,480,000	$ 3,003,000	$ 700,000	$ -	$ -	$ -	$ 1,090,000	**$ 8,454,000**
2010	Dominican Republic	$ 1,350,000	$ 481,800	$ 3,675,500	$ 1,721,500	$ -	$ -	$ -	$ 750,000	**$ 7,978,800**
2011	Dominican Republic	$ 1,032,809	$ 100,000	$ 3,708,100	$ 500,000	$ -	$ -	$ -	$ 450,000	**$ 5,790,909**
2012	Dominican Republic	$ 682,490	$ 48,986	$ 3,110,504	$ 100,424	$ -	$ -	$ 84	$ 259,365	**$ 4,201,853**
	Totals FY09-FY12	**$ 5,246,299**	**$ 2,110,786**	**$ 13,497,104**	**$ 3,021,924**	**$ -**	**$ -**	**$ 84**	**$ 2,549,365**	**$ 26,425,562**
2014 (est)	Dominican Republic									**$ 8,237,811**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

While the 2011 AIDS law addresses prevention needs for key population, enforcement will continue to be the primary issue.

In FY 2014, PEPFAR will provide funding to NGOs representing people living with HIV, (PLHIV) and to a number of other NGOs representing women, sex workers, MSM, migrant populations, in- and out-of-school youth, and drug users (injecting and non-injecting). PEPFAR contractors will provide technical oversight to the work of the NGOs. The PEPFAR DR team will continue to work with prevention among military staff and their families through a Department of Defense (DOD) program implemented along the border with Haiti. Additionally, Peace Corps programs will continue to work on HIV prevention and other health-seeking

behaviors with their community youth groups through the "*Escojo Mi Vida*" (I choose my life) program. The PEPFAR DR team will ensure a continuum of care for key populations.

PEPFAR DR will continue to provide assistance to strengthen both hospital lab capacity and the quality of counseling and testing services. This approach will enable PEPFAR to place resources more precisely at the points of greatest need throughout the country. With the encouragement of the PEPFAR DR team, the MOH has established a PMTCT working group that is currently coordinating the work of the donors working in this area and developing a national PMTCT strategy. Other donors, some from the UN group, work in PMTCT in different hospitals around the country. Most of these programs are "small," limited to only one or two hospitals each.

PEPFAR DR has initiated a qualitative research activity to improve our understanding of the HIV prevention and care needs of CSWs and MSM living with HIV, under the "Positive Health, Dignity and Prevention" (PHDP) rubric. This project will be implemented through 2014, by NGOs which work with CSWs and MSM, and a private health clinic

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Dominican Republic	$ -	$ 250,000	$ 275,000	**$ 525,000**
2010	Dominican Republic	$ -	$ 697,882	$ 50,000	**$ 747,882**
2011	Dominican Republic	$ 100,000	$ 500,000	$ 150,000	**$ 750,000**
2012	Dominican Republic	$ 48,986	$ 115,232	$ 106,039	**$ 270,257**
	Totals FY09-FY11	**$ 148,986**	**$ 1,563,114**	**$ 581,039**	**$ 2,293,139**
2014 (est)	Dominican Republic				**$ 61,878**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2012, the PEPFAR team carried out an internal review of its PMTCT program. The result was a reorientation of PEPFAR assistance to focus on 16 key hospitals based on the number of births attended and the sero-prevalence rate. The revised PEPFAR program was presented to and approved by the MOH. Building on these revisions, PEPFAR DR assistance activities for FY 2014 at each hospital will strengthen lab capacity and expand the HCT component to all pregnant women (and their partners, if appropriate). Improving PMTCT coverage is a priority for the MOH and the Global Fund and a number of other cooperating agencies also work in PMTCT. So the expectation is that the DR government and other donors will provide appropriate attention and funding to this program.

Issues of adult and pediatric treatment, including the appropriate ARV regimens, will be seminar topics at the forthcoming Dominican Infectology Congress, which is partially supported by

PEPFAR. In the context of MOH attention to its patient and ARV information systems (see below), the conclusions of this Congress will be important. PEPFAR will be involved in helping to bring appropriate speakers and in working with the MOH to consider and implement the recommendations, especially in terms of treatment regimens.

The MOH information systems, which provide data on numbers and location of patients, their ARV regimens, inventories of ARVs, rapid and infant test kits, reagents, and other key information, have serious weaknesses. The MOH has convened a technical working group and specifically requested the participation of PEPFAR DR to identify these deficiencies and recommend improvements in the systems, including linkages between the information system and the procurement process. PEPFAR DR will work with the MOH in FY 2014 on this important component of the MOH's program.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Dominican Republic	$ 925,000	$ 500,000	$ 350,000	$ 750,000	**$ 2,525,000**
2010	Dominican Republic	$ 600,000	$ -	$ 1,000,000	$ 1,200,000	**$ 2,800,000**
2011	Dominican Republic	$ 550,000	$ 350,000	$ 500,000	$ 1,200,000	**$ 2,600,000**
2012	Dominican Republic	550,779	352,469	292,988	42,387	**$ 1,238,623**
	Totals FY09-FY12	**$ 2,625,779**	**$ 1,202,469**	**$ 2,142,988**	**$ 3,192,387**	**$ 9,163,623**
2014 (est)	Dominican Republic					**$ 525,532**

*Totals include planned funding for all accounts.
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PEPFAR is the major contributor to care activities in the DR. The Dominican government receives most of its funding for care activities from the Global Fund. Other donors do not contribute significant resources to this area.

In FY 2014, nine NGOs, funded by PEPFAR, will continue to provide care services to adults and children living with HIV. PEPFAR will continue to advocate for the integration of early infant diagnosis testing and pediatric treatment and care services into the maternal-child health services package offered in the maternity hospitals where PEPFAR provides assistance. A USAID project will provide care and support services to orphans and vulnerable children (OVC).

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Dominican Republic	$ 3,559,000	$ 3,350,000	$ 3,203,934	$ 1,300,000	**$ 11,412,934**
2010	Dominican Republic	$ 700,000	$ 250,000	$ 719,000	$ 2,304,318	**$ 3,973,318**
2011	Dominican Republic	$ 1,046,500	$ 775,000	$ 1,504,824	$ 3,032,767	**$ 6,359,091**
2012	Dominican Republic	$ 392,788	$ 626,750	$ 747,848	$ 1,021,881	**$ 2,789,267**
	Totals FY09-FY12	**$ 5,698,288**	**$ 5,001,750**	**$ 6,175,606**	**$ 7,658,966**	**$ 24,534,610**
2014 (est)	Dominican Republic					**$ 5,461,778**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, the U.S. government will continue to provide technical assistance and support to the Domincan government in developing and implementing the National Monitoring and Evaluation (M&E) Plan, part of an effort to define and establish a single national M&E system. PEPFAR DR technical support to implement a unified procurement and logistics system will continue. This assistance will include training of national and regional health teams in the procurement system, and support a designated MOH procurement office. This is a priority for the MOH, PEPFAR DR, and the Global Fund.

In 2011, PEPFAR supported the MOH in carrying out a human resources audit. The results have uncovered dramatic perversions in the system. The Minister of Health has announced his intention to use the audit to revamp the HR system. In FY 2014, these efforts will continue to be supported through the USAID funded Capacity Plus project, which provides technical assistance to the MOH in human resource areas, such as determining the appropriate number of positions in a given area, preparing job descriptions and profiles of an ideal candidate, candidate selection, and personnel evaluations. The European Union and the Inter-American Development Bank, through the Dominican government Social Cabinet (which is chaired by the vice president), have also contributed resources to develop and operate a new HR computerized information system.

Country Engagement

The U.S. government has engaged collaboratively with the Dominican government and supported national programs since the initiation of HIV/AIDS-related assistance in the late 1980s. The PEPFAR DR program acknowledges the Dominican government as the leader of the National Response. Civil society and other cooperating agencies participate in and work through the Global Fund Country Coordinating Mechanism (CCM). The CCM is chaired by an MOH Vice Minister, who is knowledgeable and involved in the National Response. Over the past three years, the U.S. government has carried out a number of consultation workshops with five Dominican government Ministries and a number of non-governmental partners, prior to

finalizing the Partnership Framework, country operational plans, and the Global Health Initiative strategy. These workshops have resulted in an excellent dialogue which informed and ensured the alignment of U.S. government programs with national priorities.

PEPFAR DR plans to continue to engage the Dominican government at the technical and policy levels. Public policy dialogue will revolve around enforcement of the 2011 AIDS Law, especially regarding the reduction of stigma and discrimination against PLHIV. Given the new reality of Global Fund assistance, the team will dialogue with and encourage the Dominican government to invest more of its own resources in the health sector generally and the National Response specifically, in order to strengthen its financial ownership of its program. Additionally, the U.S. government signed a Partnership Framework (PF) with the Government of the Dominican Republic in 2010. The PF supports the implementation of the National Response to the HIV/AIDS epidemic, and especially the goal of mitigating the effect of the epidemic. Program elements emphasized in the PF include: health systems strengthening, strengthening of labs, strategic information, procurement and logistics, monitoring and evaluation, surveillance and data for decision making, and human resources.

Guyana

Country Context

The HIV prevalence rate in Guyana has progressively decreased among the general population over the last six years. At the end of 2009, UNAIDS estimated Guyana's HIV prevalence to be at 1.2 percent, with approximately 5,900 persons living with HIV. With a prevalence rate consistently greater than one percent among antenatal women, the local epidemic is just above the minimum threshold of a generalized epidemic. Locally, heterosexual contact is the main mode of transmission and is driven by the high levels of multiple concurrent partnerships and casual sexual relationships. HIV/AIDS is the leading cause of death in Guyana among people ages 25-44, the most economically active population segment. Although general population prevalence may be low, surveillance data for key populations from both the 2005 and 2009 Biological and Behavioral studies reveals a concentrated epidemic among high-risk populations, including men who have sex with men (MSM) (21.2 percent, 2005; 19.4 percent, 2009) and female commercial sex workers (FSW) (26.6 percent, 2005; 16.6 percent, 2009). A 2011 surveillance study among members of the military revealed a low HIV prevalence (0.2 percent), but the prevalence of other sexually transmitted infections (STIs) was significant (21.4 percent).

As PEPFAR transitions from an emergency response to promoting sustainable country programs, support in Guyana is shifting from direct assistance for services to a limited technical assistance collaborative model. To guide this transition, the PEPFAR team has developed a vision statement for the five-year period of 2012-2017, which takes into consideration the funding levels and infrastructure that have evolved since 2003 and the need to transfer the costs of a sustainable system to local public and private institutions and other donors. This vision is linked directly to Guyana's level of country ownership along all four dimensions: political ownership, institutional/community ownership, capabilities, and accountability. During this phase, PEPFAR/Guyana will focus on establishing a framework for productive policy dialogue to accomplish transition benchmarks for sustaining investments. In FY 2014, PEPFAR Guyana will continue to advance the transition from dialogue to responsible action around the challenging issues of human resource integration and the sustainability of non-governmental organizations (NGOs) as part of the national response.

Below is a table of PEPFAR Guyana's budget representing its major program areas.

Fiscal Year	Guyana Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 6,154,680	30%	$ 3,191,879	16%	$ 5,346,862	26%	$ 5,838,154	28%	$ 20,531,575
2010	$ 4,820,128	27%	$ 2,399,582	13%	$ 3,590,295	20%	$ 7,371,570	41%	$ 18,181,575
2011	$ 3,215,926	22%	$ 1,988,115	13%	$ 3,277,331	22%	$ 6,400,203	43%	$ 14,881,575
2012	$ 3,151,391	27%	$ 1,835,018	15%	$ 1,894,236	16%	$ 5,000,930	42%	$ 11,881,575
Total 2009-2012	**$ 17,342,125**	**26%**	**$ 9,414,594**	**14%**	**$ 14,108,724**	**22%**	**$ 24,610,857**	**38%**	**$ 65,476,300**
2014 (est)	**$ 1,308,656**	**19%**	**$ 977,062**	**14%**	**$ 845,787**	**12%**	**$ 3,684,495**	**54%**	**$ 6,816,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Guyana	$ 596,488	$ 1,257,735	$ 1,777,291	$ 1,277,642	$ 105,000	$ -	$ -	$ 1,140,524	**$ 6,154,680**
2010	Guyana	$ 563,792	$ 553,456	$ 1,743,003	$ 477,109	$ 401,646	$ 2,000	$ 3,000	$ 1,076,122	**$ 4,820,128**
2011	Guyana	$ 597,750	$ 204,170	$ 1,736,302	$ 70,000	$ -	$ 2,000	$ 3,000	$ 602,704	**$ 3,215,926**
2012	Guyana	$ 624,518	$ -	$ 1,089,419	$ 691,880	$ 5,711	$ 5,711	$ 3,807	$ 730,345	**$ 3,151,391**
	Totals FY09-FY12	**$ 2,382,548**	**$ 2,015,361**	**$ 6,346,015**	**$ 2,516,631**	**$ 512,357**	**$ 9,711**	**$ 9,807**	**$ 3,549,695**	**$ 17,342,125**
2014 (est)	Guyana									**$ 1,308,656**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, the U.S. government prevention strategy will focus on evidence-based approaches and combination prevention strategies. Following the Guyana Prevention Assessment in February 2010, the U.S. government interagency team worked to align activities and implement the technical team's recommendations, particularly in the prioritization of activities for key populations and other vulnerable populations (OVP). Additionally, planning and implementation of strategies to transition mature prevention activities to the Ministry of Health (MOH), Global Fund (GF), and other stakeholders is underway and will intensify during FY 2014. The U.S. government team will increase prevention programs to reduce new infections and further decrease the cost of care and management of persons living with HIV/AIDS (PLHIV). Activities include: expanding programs that aim to reduce HIV prevalence within key populations and OVP who are disproportionately affected with high prevalence levels; strengthening prevention of mother-to-child transmission (PMTCT) activities; continuing to

support the safe blood program; increasing access to voluntary counseling and testing (VCT) and provider-initiated testing and counseling (PITC) for high risk-groups; collecting and reviewing qualitative data on high risk populations; and improving prevention activities for PLHIV. Additionally, gender-based violence (GBV) will continue to be a major focus of all prevention activities.

In FY 2014, the U.S. government prevention program will continue to build on current platforms for successfully reaching key populations, to incorporate innovative approaches to increase access and remove barriers to services, and to replicate and expand proven prevention models for key populations. In keeping with PEPFAR guidance, the minimum package of services will continue to be offered to both MSM and FSW by U.S. government-supported NGOs. These services are accessible when public sector sites are closed and include: peer education and outreach to locations considered "hot spots", risk reduction counseling, condom and lubricant promotion and distribution, HCT, STI screening and treatment, referrals to HIV care and treatment (including PMTCT), referrals to mental health and substance abuse treatment services, and linkages to other health, social, economic, and legal services.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Guyana	$ 2,192,864	$ 3,153,998	$ -	**$ 5,346,862**
2010	Guyana	$ 772,197	$ 2,790,725	$ 27,373	**$ 3,590,295**
2011	Guyana	$ 2,121,954	$ 1,098,760	$ 56,617	**$ 3,277,331**
2012	Guyana	$ 640,000	$ 1,147,843	$ 106,393	**$ 1,894,236**
	Totals FY09-FY12	**$ 5,727,015**	**$ 8,191,326**	**$ 190,383**	**$ 14,108,724**
2014 (est)	Guyana				**$ 845,787**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, HIV care and treatment services will continue to be delivered by the Ministry of Health and faith-based organizations through a network of 15 treatment facilities, fixed sites that are located in the higher prevalence regions and staffed by physicians trained in HIV treatment. Extension of the treatment program to remote geographical regions has been enhanced by a mobile unit. The treatment service received a boost when the Francis-Xavier Bagnoud Center, through PEPFAR support, trained and mentored a number of MEDEX (medical assistants) in the management of HIV. MEDEX are stationed in the hinterland regions and supportive supervision is provided by the HIV trained physician staffing the mobile unit. The national program was able to provide free-of-charge antiretroviral drugs (ARVs) to all eligible patients. To help sustain these accomplishments, adult HIV/AIDS treatment will be increasingly transitioned from international NGOs to local partners.

The U.S. government has transitioned treatment services to the MOH and will continue to support institutional strengthening and capacity building for implementation of the new treatment guidelines in a manner that is feasible and promotes equitable access. Continued technical, programmatic, and administrative support in future years will be necessary to ensure sustainability and access to high quality treatment services by these local partners.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Guyana	$ 1,598,458	$ -	$ 338,885	$ 1,254,536	**$ 3,191,879**
2010	Guyana	$ 1,148,619	$ 48,619	$ 217,966	$ 984,378	**$ 2,399,582**
2011	Guyana	$ 1,148,917	$ -	$ 221,000	$ 618,198	**$ 1,988,115**
2012	Guyana	$ 930,522	$ 50,143	$ 333,759	$ 520,594	**$ 1,835,018**
	Totals FY09-FY12	**$ 4,826,516**	**$ 98,762**	**$ 1,111,610**	**$ 3,377,706**	**$ 9,414,594**
2014 (est)	Guyana					**$ 977,062**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, the PEPFAR programmatic vision is to transition from scaling-up services to improving the quality of services, building capacity, shifting from direct service delivery to a limited technical assistance model, and promoting sustainability.

Program priorities include: addressing stigma and disclosure to enhance uptake of care and support services, particularly for key populations and OVP groups; supporting a comprehensive package of care services delivered in facility and home-based settings through a family-centered approach; strengthening linkages to PMTCT services, the cervical cancer program, and provider-initiated testing in health care facilities; strengthening bi-directional referrals from the facility into community-based programs and vice versa (emphasis will be placed on following up with clients to ensure they are accessing the referrals and receiving needed services); monitoring the quality and delivery of care services; strengthening case navigation to trace clients who have defaulted from the program; establishing and/or enhancing partnerships with existing public sector social services; strengthening referrals to reproductive health/family planning services; strengthening the capacity of families and communities to provide care; and strengthening data quality.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Guyana	$ 992,788	$ 1,374,743	$ 1,300,860	$ 2,169,763	**$ 5,838,154**
2010	Guyana	$ 823,566	$ 945,099	$ 3,167,780	$ 2,435,125	**$ 7,371,570**
2011	Guyana	$ 644,000	$ 820,002	$ 1,969,852	$ 2,966,349	**$ 6,400,203**
2012	Guyana	$ 441,880	$ 841,422	$ 2,101,010	$ 1,616,618	**$ 5,000,930**
	Totals FY09-FY12	**$ 2,902,234**	**$ 3,981,266**	**$ 8,539,502**	**$ 9,187,855**	**$ 24,610,857**
2014 (est)	Guyana					**$ 3,684,495**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, the U.S. government will collaborate with the MOH to transition aspects of the HIV/AIDS program, which has been catalyzed through PEPFAR support and assistance, to the Government of Guyana and other stakeholders, including the GF. Assessments will be made of each program area for transition and detailed timelines and budgets will be developed to enable the transfer to occur systematically. The overall aim is to work with the Government of Guyana through a limited technical collaboration model. Such a model fosters country ownership, which is critical to ensuring the sustainability of the national HIV/AIDS response and infrastructure. PEPFAR Guyana will continue to actively engage the government and other stakeholders to ensure that the transition of direct services and country ownership remains a priority and that the necessary action is taken to achieve transition benchmarks. The PEPFAR team will also identify assistance required to support transition, develop a monitoring and evaluation framework for transition, and determine the nature of PEPFAR support as the transition advances.

The PEPFAR Guyana program will shift its focus to building partner capacity to respond to HIV/AIDS effectively and efficiently, thereby ensuring that the vision of intensified country partnership and ownership is reflected in U.S. government programs. PEPFAR strategies will be evidence-based to prioritize the most important and effective HIV/AIDS mitigation interventions and strategies while simultaneously increasing local country capacity to develop and implement financially and technically sustainable programs.

Country Engagement

Guyana has owned the HIV/AIDS epidemic from a philosophical, if not financial, perspective. It has clearly stated its strategic objectives in numerous national strategic plans; has convened many stakeholder meetings, with the participation of the PEPFAR team; and has been very adept at generating resources from the international community, including PEPFAR and the GF. The Government of Guyana is also leading the process in the sense that it defines its priorities and finds the resources to implement them, rather than molding its priorities to those of donors. Though the MOH has taken leadership in implementing and coordinating activities, these efforts have not been entirely effective. Guyana also has not taken the necessary leadership role in some areas that require greater attention: particularly disclosure of health information and addressing the continued challenges of staff recruitment, retention, and supervision.

Haiti

Country Context

Haiti's estimated 135,000 people living with HIV (PLHIV) constitute the greatest burden of HIV/AIDS in the Caribbean region. This is exacerbated by the highest rate of tuberculosis (TB) in the Western Hemisphere. The HIV/AIDS epidemic is marked by higher prevalence rates in major cities and is driven by key populations, such as commercial sex workers (CSWs) and men who have sex with men (MSM), and the social conditions of women and youth. An estimated 55 percent of the country's approximately ten million people live on less than one dollar a day. There is a shortage of health workers, low retention of nurses and doctors, and gaps in services across all levels of the health system.

Encouragingly, 72 percent of PLHIV eligible to receive antiretroviral treatment (ART) were receiving it and 65 percent of all pregnant women were tested for HIV as of December 2012. The PEPFAR program has been instrumental in scaling up HIV services while building the Ministry of Health (MOH) capacity to sustain the HIV response over the long term. In FY 2014, Haiti is poised to cross historic milestones in its HIV/AIDS response. It is projected that by mid-2013 the country will achieve universal access to ART – meaning that, according to national guidelines, 80 percent of those estimated to need ART are receiving it - while health systems strengthening projects detailed in the Partnership Framework Implementation Plan (PFIP) for Health will be progressing in earnest. These two themes: 1) universal access and 2) country ownership through health systems strengthening underpin major shifts and important advances in the PEPFAR/Haiti portfolio and are reflected throughout the program.

Below is a table of PEPFAR Haiti's budget representing its major program areas.

Fiscal Year	Haiti Program Planned Area Totals and Percentages								
	PREVENTION	% of Total Fiscal Year	CARE	% of Total Fiscal Year	TREATMENT	% of Total Fiscal Year	GOVERNANCE & SYSTEMS	% of Total Fiscal Year	TOTALS
2009	$ 29,321,488	22%	$ 35,312,346	27%	$ 35,032,679	27%	$ 30,867,500	24%	$ 130,534,013
2010	$ 24,209,664	15%	$ 24,447,246	15%	$ 35,735,629	22%	$ 79,700,459	49%	$ 164,092,998
2011	$ 29,065,814	18%	$ 36,061,441	23%	$ 38,246,211	24%	$ 55,169,532	35%	$ 158,542,998
2012	$ 29,077,985	20%	$ 38,581,010	27%	$ 31,662,392	22%	$ 44,221,611	31%	$ 143,542,998
Total 2009-2012	**$ 111,674,951**	**19%**	**$ 134,402,043**	**23%**	**$ 140,676,911**	**24%**	**$ 209,959,102**	**35%**	**$ 596,713,007**
2014 (est)	**$ 25,402,806**	**20%**	**$ 27,609,146**	**22%**	**$ 25,726,000**	**20%**	**$ 47,961,048**	**38%**	**$ 126,699,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY12) & FY14 Estimate										
Fiscal Year	Operating Unit	MTCT: PMTCT	HVAB: Abstinence and Fidelity	HVOP: Other Prevention	HMBL: Blood Safety	HMIN: Injection Safety	IDUP: Injecting and non-Inj. Drug Use	CIRC: Male Circumcision	HVCT: Counseling and Testing	Total, Prevention
2009	Haiti	$ 4,800,000	$ 5,172,473	$ 6,175,000	$ 6,500,000	$ 749,015	$ -	$ -	$ 5,925,000	**$ 29,321,488**
2010	Haiti	$ 6,060,800	$ 3,070,000	$ 5,201,000	$ 3,318,482	$ 850,000	$ -	$ -	$ 5,709,382	**$ 24,209,664**
2011	Haiti	$ 6,063,000	$ 2,505,832	$ 6,250,000	$ 5,798,482	$ 1,200,000	$ -	$ -	$ 7,248,500	**$ 29,065,814**
2012	Haiti	$ 11,277,748	$ 1,357,250	$ 3,984,243	$ 3,894,453	$ 1,034,049			$ 7,530,242	**$ 29,077,985**
	Totals FY09-FY12	**$ 28,201,548**	**$ 12,105,555**	**$ 21,610,243**	**$ 19,511,417**	**$ 3,833,064**	**$ -**	**$ -**	**$ 26,413,124**	**$ 111,674,951**
2014 (est)	Haiti									**$ 25,402,806**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Increasing evidence has shown that HIV transmission is driven in large part by unprotected transactional and commercial sexual activities, and the widespread practice of multiple (and often trans-generational) concurrent sexual partnerships in the general population. In response, Haiti's prevention portfolio is completing a fundamental shift in FY 2014 toward better serving at-risk populations, particularly CSWs and MSM. This "reshaping" of the portfolio consists of:

- Formalizing referral arrangements to link key populations to client-friendly clinical services;
- Ensuring consistent provision of quality prevention with positive (PwP) services; and
- Supporting a national treatment adherence strategy to reduce transmission risk within the HIV positive population.

In FY 2014, linkages between facility and community-based service partners will be formalized through strategic plans to promote active referral between key population 'hot spots' and nearby clinical services. In support of this effort, the mapping of hot spots, such as bars, brothels, duty-free factory zones, public beaches, and cross-border areas will be updated, with a point of focus to coordinate CSW activities with the PEPFAR Dominican Republic program.

Community-based referral and support programs are being shifted to create stronger links to facilities through scale up of the number and use of community health workers, an MOH priority. These efforts will expand services related to HIV rapid testing, TB screening and diagnostics, and family planning. Networking between all levels of the health system and reliable referral and counter referral are important for the performance of the program, and the U.S. government is working toward strengthening those activities particularly in areas of concentrated U.S. government development investments known as the "development corridors". Coverage and accessibility of HIV testing and counseling, including expanded use point-of-care testing and an emphasis on testing all TB patients for HIV and linking co-infected patients to services, remains a focus for the program.

The main focus of the prevention of mother-to-child transmission (PMTCT) program is to support the national objective of universal access to PMTCT services for HIV positive pregnant women and the virtual elimination of mother-to-child HIV transmission in Haiti. There are an estimated 300,000 pregnancies each year in Haiti, of which 7,000 mothers are likely to be HIV positive. In FY 2012, U.S. government partners tested over 200,000 pregnant women for HIV for the first time; 5,824 pregnant women were identified as HIV positive and 4,791 of those of those women received ARVs to prevent HIV transmission from mother to child. Having these mothers on ARVs will reduce incidence of HIV in the future.

Treatment

TREATMENT (FY09 - FY12) & FY14 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Haiti	$ 4,600,000	$ 27,012,679	$ 3,420,000	**$ 35,032,679**
2010	Haiti	$ 6,000,000	$ 26,224,679	$ 3,510,950	**$ 35,735,629**
2011	Haiti	$ 6,270,000	$ 27,782,961	$ 4,193,250	**$ 38,246,211**
2012	Haiti	$ 6,255,849	$ 19,798,245	$ 5,608,298	**$ 31,662,392**
	Totals FY09-FY12	**$ 23,125,849**	**$ 100,818,564**	**$ 16,732,498**	**$ 140,676,911**
2014 (est)	Haiti				**$ 25,726,000**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The PEPFAR program's driving goal is to achieve universal access to quality prevention, treatment, and care services. At the close of FY 2012, 41,000 patients were receiving ART. The program is prioritizing a variety of activities for FY 2014 to ensure that the success of achieving universal access is augmented with improvements in quality of services and the targeting of key populations. Accelerating the shift toward PMTCT Option B+ (putting HIV positive pregnant women on ART for life) and fast tracking patients from care to treatment are central to the U.S. government service delivery strategy. To ensure that quality of services continues to improve as coverage increases, U.S. government is implementing a range of quality assurance and quality improvement projects that:

- Improve MOH's oversight of facilities;
- Increase the frequency and coordination of U.S. government site monitoring; and
- Use site data to improve programs.

In FY 2014, efforts to expand the use of data to improve site-level reporting and management for decision making will continue, including greater utilization of the electronic medical record system, as well as fostering earlier initiation through readily available lab data and patient staging information. Facilities will receive continued support to institutionalize quality

improvement practices through establishment of site teams to monitor data on a routine basis and develop action plans to address identified issues. Additional support is also directed at the departmental level, supporting departmental teams tasked with conducting reviews of site level outcomes and performance. This model will continue to be expanded with additional resources and project support in FY 2013.

Care

CARE (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HBHC: Adult Care and Support**	**PDCS: Pediatric Care and Support**	**HVTB:TB/HIV**	**HKID: OVCs**	**Total, Care**
2009	Haiti	$ 12,025,000	$ 3,380,000	$ 5,770,000	$ 14,137,346	**$ 35,312,346**
2010	Haiti	$ 9,448,482	$ 2,667,282	$ 3,271,482	$ 9,060,000	**$ 24,447,246**
2011	Haiti	$ 11,498,300	$ 6,013,327	$ 6,834,814	$ 11,715,000	**$ 36,061,441**
2012	Haiti	$ 15,495,116	$ 3,963,298	$ 7,615,550	$ 11,507,046	**$ 38,581,010**
	Totals FY09-FY12	**$ 48,466,898**	**$ 16,023,907**	**$ 23,491,846**	**$ 46,419,392**	**$ 134,402,043**
2014 (est)	Haiti					**$ 27,609,146**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2014, the care program is conducting an overall shift in community support to a model that supports communities through facility-based networks. A greater emphasis on use of community health workers as the mechanism for community outreach should facilitate active linkages to services more effectively than the previous model. At the end of fiscal year 2012, over 83,000 HIV positive adults and children were enrolled in comprehensive clinical care programs.

Additionally, efforts are underway to effectively link the most vulnerable families with malnourished children to livelihood, food security activities, and household economic strengthening. In FY 2014, a package of services for children will be expanded and build upon earlier work that expanded early infant diagnosis coverage to 82 percent of all newborns to HIV positive mothers enrolled in PMTCT services. The nutritional components of the HIV pediatric care package have now been improved through the implementation of WHO recommendations on infant and young child nutrition. These improvements will further address key causes of illness/death in children in Haiti, including diarrhea, pneumonia, and malnutrition.

During FY 2012, PEPFAR Haiti supported services for women and girls affected by gender-based violence (GBV), particularly in the internally displaced person camps. This support will continue through FY 2013 and FY 2014 for such services, including reproductive health services as well as psychosocial support, HIV counseling and testing (HCT), and advice on how women and girls can adopt measures to increase their legal rights and protection. In spring 2013 the Violence Against Children Survey will be released by the Government of Haiti along with a

multi-sectoral response plan supported by the U.S. government. The results of this survey will inform activities in FY 2014.

To further improve tuberculosis (TB)/HIV integration, the U.S. government will continue to train HIV providers in TB treatment, while deepening collaboration with TB treatment providers. In FY 2013, U.S. government will place special emphasis on increasing the rate of HIV testing in TB settings and among TB patients, an area that lagged behind the much higher rates of TB testing for HIV patients. Additionally, U.S. government will work with all providers to improve infection control efforts, including increased use of site monitoring to ensure measures are consistently in place. TB screening of HIV-tested clients will continue to be ensured through systematic application of standardized testing protocols.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY12) & FY14 Estimate						
Fiscal Year	**Operating Unit**	**HLAB: Laboratory**	**HVSI: Strategic Information**	**OHSS: Health Systems**	**HVMS: Management and Operations**	**Total, Governance & Systems**
2009	Haiti	$ 10,885,000	$ 8,400,000	$ 5,812,000	$ 5,770,500	**$ 30,867,500**
2010	Haiti	$ 11,524,382	$ 6,680,000	$ 55,166,950	$ 6,329,127	**$ 79,700,459**
2011	Haiti	$ 13,832,964	$ 8,389,500	$ 22,903,968	$ 10,043,100	**$ 55,169,532**
2012	Haiti	$ 13,795,255	$ 10,380,481	$ 13,306,157	$ 6,739,718	**$ 44,221,611**
	Totals FY09-FY12	**$ 50,037,601**	**$ 33,849,981**	**$ 97,189,075**	**$ 28,882,445**	**$ 209,959,102**
2014 (est)	Haiti					**$ 47,961,048**

*Totals include planned funding for all accounts.
** FY 2013 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2013 Country Operational Plans, a detailed FY 2013 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The post-earthquake U.S. government Haiti strategy focuses on three main areas in health systems strengthening:

- Increasing support to MOH in strengthening systems and governance;
- Developing comprehensive health care referral networks within specific U.S. government-supported 'development corridors'; and
- Rebuilding and reforming the management of public health infrastructure. The U.S. government, including PEPFAR support, is providing capacity building and technical implementation support directly to units within the MOH.

One set of activities focuses on human resource management and health financing. PEPFAR Haiti will support institutional capacity building, process, and policy design to assist the MOH in implementing relevant strategies. Another set of health systems strengthening activities aims to link the Haitian population to functional referral networks in order to organize, monitor, and reinforce the performance and quality of health providers. Technical assistance will help MOH manage partners' resources and establish a policy for linking quality improvement principles and practices with results-based financing outcome validation.

In FY 2014, the U.S. government will continue to use the foundations put in place by PEPFAR Haiti to build the overall health information system. A priority in the Partnership Framework, the U.S. government and the Government of Haiti will, with other development partners, support an integrated health information platform owned and managed by the Government of Haiti. The effort will define a strategic approach to develop a national information system architecture that integrates service quality data, service reporting, commodity tracking, and active surveillance systems. It is envisioned that consolidating reporting streams, both from existing systems and from ones currently under development, into a centralized information hub within the MOH will have a dramatic impact on the Government of Haiti's ability to manage the health sector. Importantly, U.S. government will embed significant capacity in MOH's planning and evaluation unit to oversee these activities and improve MOH governance of strategic information in Haiti.

Country Engagement

In 2012, the U.S. – Haiti Health Partnership Framework (2012-2017) was developed and signed, laying out a mutually-accountable, joint strategic agenda to accelerate the development of Haiti's public health services to reach the Millennium Development Goals. The Partnership Framework also marked a redoubled commitment by the U.S. government to support the Government of Haiti in coordinating, overseeing, and eventually absorbing health sector activities now so often provided through development partners. In the short term, the Government of Haiti is taking an increased role in U.S. government procurement processes, serving as technical advisors in the development of projects, while managing steadily increasing resources through direct government-to-government bilateral agreements. As the MOH's capacity improves, the U.S. government's expressed intent over the five years of the Partnership Framework is to transfer these PEPFAR mechanisms to MOH as a cornerstone of health programming and assistance.

In line with the Partnership Framework's overarching emphasis on health systems strengthening, the U.S. government is engaging the MOH, the Ministries of Finance, and Planning and External Cooperation, and the Prime Minister's Office in pragmatic planning to transform Haiti's health sector into a high-impact, domestically-financed model over the long term. The U.S. government is coordinating with the MOH on management of contractor service delivery and financial performance, including utilization of costing analyses to identify and prioritize high impact activities as a focus of the program moving forward. A key example is continued joint PEPFAR-Global Fund resource mapping and data verification exercises to achieve lower service costs and validate results.

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SECTION V: HEADQUARTERS OPERATIONAL PLAN

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Headquarters Operational Plan (HOP) Executive Summary

FY 2009 – FY 2012 Headquarters Operational Plan Approved GHP-State Funding, Technical Oversight and Management, and FY 2014 Request

	GHP-State				
	FY 2009	FY 2010	FY 2011	FY 2012	FY 2014 Request
S/GAC, Oversight/Management	**$ 127,407,692**	**$ 145,838,332**	**$ 172,153,634**	**$ 174,096,000**	**$ 186,874,000**
Other Agency Costs	$ 113,407,692	$ 131,838,332	$ 158,181,634	$ 159,846,000	$ 172,374,000
OGAC Administrative Costs	$ 14,000,000	$ 14,000,000	$ 13,972,000	$ 14,250,000	$ 14,500,000

Table explanation: The table presents a summary of all approved Technical Oversight and Management funds from the GHP-State account programmed through the Headquarters Operational Plan (HOP) from FY 2009 – FY 2012, and FY 2014 estimate. FY 2013 653a funding levels for the Technical Oversight and Management are "To Be Determined" pending final approval of the Office of the Director of Foreign Assistance (F).

The Headquarters Operational Plan (HOP) captures costs associated with staff at implementing agency headquarters working specifically on PEPFAR and activities implemented by headquarters in support of field programs. The primary role of agency headquarters (HQ) operations is to support field staff and country-level efforts towards PEPFAR goals. The HOP is used to plan and approve PEPFAR-funded activities at the headquarters level, including the Department of State (DoS); U.S. Agency for International Development (USAID); Department of Health and Human Services (HHS) and its operating agencies; Peace Corps (PC); and Department of Defense (DOD).

FY 2014 Technical Oversight and Management Funds

Technical Oversight and Management (TOM) funds support direct and indirect expenses including salary, benefits, travel, supplies, professional services, and equipment for PEPFAR implementing agencies. Calculations and request for indirect cost reimbursement are included in each agency's HOP TOM submission, where direct headquarters costs are currently detailed and requested by the agencies for reimbursement by S/GAC. The total indirect cost per agency changes each year based on changes in the cost variables.

Department of State (DoS): DoS includes several offices that are key players in PEPFAR, including the Office of the U.S. Global AIDS Coordinator (S/GAC), Bureau of Intelligence and Research (INR), and Western Hemisphere Affairs (WHA). The funds for TOM support direct expenses including salary, benefits, and travel.

U.S. Agency for International Development (USAID): PEPFAR HQ funding supports program funds technical assistance and other activities to further PEPFAR policy and programmatic objectives in the field, at headquarters, and internationally. It utilizes existing contractual mechanisms within USAID to the maximum extent possible. TOM funds support

direct and indirect expenses including salary, benefits, travel, supplies, professional services, and equipment.

Department of Health and Human Services (HHS): HHS includes several agencies that are key players in PEPFAR such as the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the National Institute of Health (NIH), the Food and Drug Administration (FDA) and the Substance Abuse and Mental Health Services Administration (SAMHSA). HHS efforts are coordinated by the Office of the Secretary/Office of Global Affairs (OGA). TOM funds support direct and indirect expenses including salary, benefits, and travel, overhead, operation and maintenance of facilities, and advisory and assistance services.

Peace Corps: Headquarters PEPFAR-funded staff members provide recruitment, placement, and training support to PEPFAR-funded volunteers as well as technical oversight and management to Peace Corps posts that receive PEPFAR (GHP) funding and are implementing PEPFAR activities. TOM funds support direct and indirect expenses including salary, benefits, travel, supplies, professional services, and equipment to strengthen the service of Peace Corps Volunteers contributing to the HIV response in their overseas assignments.

Department of Defense (DOD): DOD's primary goals under PEPFAR include supporting military-to-military HIV/AIDS awareness and prevention education; developing military-specific HIV/AIDS policies; providing counseling, testing, and HIV-related palliative care for military members and their families; and, supporting clinical and laboratory infrastructure development. TOM funds support direct and indirect expenses including personnel, equipment, supplies, services, professional development, travel, and transportation.

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