Office of the United States Global AIDS Coordinator

CONGRESSIONAL BUDGET JUSTIFICATION SUPPLEMENT

Fiscal Year 2015

Congressional Budget Justification
Supplement

PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR)

Fiscal Year 2015

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United States Department of State

Washington, D.C. 20520
www.state.gov

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) 2015 Congressional Budget Justification for Foreign Operations (CBJ). 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 2015 request. The Office of the U.S. Global AIDS Coordinator intends to begin implementing these programs upon availability of FY 2015 funding.

The FY 2015 budget expands upon President Obama's commitment to the goal of an AIDS-free generation through shared responsibility, accountability, and impact. This budget will build upon the historic accomplishment of supporting 6.7 million on treatment and move the world closer to and beyond a tipping point in the fight against AIDS. The FY 2015 budget will continue support for scale-up of combination prevention and treatment interventions in high-burden countries and key populations, expand program expenditure analysis, and leverage our collective buying power with other donors, while simultaneously increasing the capacity of countries to sustain and support these efforts over time.

With your support, I look forward to working hand-in-hand with all our partner countries to save lives through smart investments that maximize the impact of each dollar we provide.

Sincerely,

Deborah Birx, 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 U.S. government's PEPFAR Business
COP – Country Operational Plan
COPRS – Country Operational Plan and Reporting System
CSH – Child Survival and 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 Initiative
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. State Department)
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 (U.S. 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 1: PEPFAR BUDGET OVERVIEW

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PEPFAR Fiscal Year 2015 Budget Overview

Under President Obama's Fiscal Year (FY) 2015 budget request, the United States will remain the world's largest contributor to the global response to HIV/AIDS. Our country will continue to lead efforts to implement scientifically proven interventions that save lives, control the epidemic, and work toward achieving an AIDS-free generation, as outlined in the *PEPFAR Blueprint for Creating an AIDS-free Generation*. Reaching the goal of an AIDS-free generation is a shared responsibility among host country governments, civil society, development partners, multilateral organizations, the private sector, and others. PEPFAR remains firmly committed to its foundational principles of making smart investments based on sound science, good public health, a human rights approach, and focusing on the accountability, transparency, and impact of our work.

PEPFAR Priorities and Goals

In FY 2015, PEPFAR will further increase its efficiency and maximize its impact. This will include driving down the cost of commodities; utilizing expenditure analysis data to rigorously monitor program impact; employing the highest yield interventions and targeting specific populations and risk behaviors; pushing services to the lowest appropriate level of delivery and service provider while maintaining high-quality care; and strengthening coordination with other donors, particularly the Global Fund to Fight AIDS, Tuberculosis and Malaria (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* reflects lessons learned from PEPFAR's vast experience with AIDS-related programs and PEPFAR's ongoing commitment to targeting evidence-based interventions for populations at greatest risk and supporting countries in building sustainable health systems that can deliver in the long term.

On World AIDS Day 2013, President Obama announced that PEPFAR had either met or exceeded all of the ambitious targets he set on World AIDS 2011, including by directly supporting more than 6.7 million people on antiretroviral treatment (ART) as of September 30, 2013 – a four-fold increase since 2008.

Key Accomplishments

Saving Lives

PEPFAR represents America's commitment to saving lives and the shared responsibility of all global partners toward achieving an AIDS-free generation. As previously stated, at the end of FY 2013, PEPFAR directly supported more than 6.7 million men, women, and children on ART. In June 2013, Secretary Kerry announced that the one-millionth baby had been born HIV-free as a result of PEPFAR's commitment to preventing mother-to-child HIV transmission (PMTCT). In FY 2013, PEPFAR supported HIV testing and counseling (HTC) for more than 57.7 million

people, providing a critical entry point to prevention, treatment, and care. Of those receiving PEPFAR-supported HTC, more than 12.8 million were pregnant women. For the 780,000 of these pregnant women who tested positive for HIV, PEPFAR provided antiretroviral medications for PMTCT. In FY 2013 alone, due to PEPFAR support, 95 percent of these babies were born HIV-free (including 240,000 that would otherwise have been infected). Over the past two years, over 1.5 million HIV-positive pregnant women received these interventions to prevent mother-to-child transmission and improve maternal health, meeting the President's 2011 World AIDS Day goal.

At the end of FY 2013, PEPFAR had supported more than 4.2 million voluntary medical male circumcisions (VMMC) for HIV prevention procedures in east and southern Africa. By the end of calendar year 2013, PEPFAR reached the President's 2011 World AIDS Day VMMC goal of 4.7 million. In FY 2013, PEPFAR also supported 17 million people with care and support, including more than 5 million orphans and vulnerable children.

PMTCT: In FY 2015, PEPFAR will continue to invest considerable resources into PMTCT – an investment that has already paid enormous dividends. As outlined in the *Blueprint*, PEPFAR remains fully committed to working toward the elimination of new HIV infections among children by 2015 and keeping their mothers alive. Through PEPFAR's PMTCT Acceleration Initiative, launched in FY 2009, PEPFAR has increased investments in the 13 highest burden countries. PEPFAR has also worked with partner countries to develop strategies to expand access to quality services to prevent transmission of HIV from mothers to their children, to ensure that mothers eligible for lifelong treatment receive it, and that every infant infected with HIV is immediately initiated on lifelong ART. These efforts are paying off dramatically; since 2001, new HIV infections among children have declined by 58 percent globally.

The Option B+ regimen offers all pregnant or breastfeeding women living with HIV lifelong ART, rather than relying on laboratory testing to determine eligibility for treatment. It reduces mother-to-child transmission to less than five percent and maintains the mother's health; provides lifelong reduction of HIV transmission to uninfected sexual partners; and supports PMTCT in future pregnancies. In the first year of implementation of Option B+ in Malawi, the number of pregnant or breastfeeding women living with HIV on antiretroviral therapy in the country increased by an extraordinary 700 percent, and the estimated number of infant infections averted nearly quadrupled.

VMMC: In FY 2015, PEPFAR will maintain its commitment to expanding access to VMMC, with a continued focus on 14 east and southern African countries where this intervention can have the greatest impact on the epidemic. In May 2013, PrePex became the first medical device for adult male circumcision to receive World Health Organization (WHO) prequalification as an alternative to the conventional surgical circumcision methods already recognized by the WHO. Medical devices like PrePex may change the landscape of VMMC scale-up by simplifying the procedure and increasing access.

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 2015, 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 require ART each year. Yet, despite these gains, ART coverage for children under 15 years of age and living with HIV in low- and middle-income countries remains disproportionally low at 24 percent (compared with 38 percent for adults), based on the most recent World Health Organization ART guidelines. HIV develops very rapidly among infants and children, and without treatment, half of children living with HIV will die of AIDS-related causes before they are two years of age.

In FY 2015, in order to address 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, as well as older children and adolescents; and 4) retention of children and adolescents in life-long care and treatment. The decentralization of ART for pregnant and breastfeeding women that is occurring as countries transition to Option B and B+ regimens will further aid these efforts. It 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.

Key Populations: Reaching key populations at highest risk for HIV is a priority for smart investments outlined in the *Blueprint*. In FY 2015, PEPFAR will ensure countries are targeting funds for expanding HIV services delivery and technical assistance to key populations. PEPFAR will continue to do so through implementing targeted initiatives for key populations, including: 1) the Key Populations Challenge Fund, a $33 million dollar investment designed to stimulate a greater programmatic response for and commitment to 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 key populations networks to increase access to and uptake of HIV services.

Data for Decision Making: In FY 2015, the PEPFAR Expenditure Analysis (EA) Initiative will continue to 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 on treatment for one year. In FY 2015, all grants, cooperative agreements, and contracts using funds appropriated under PEPFAR will continue to 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.

HIV/Tuberculosis (TB) Co-Infection: TB is the leading cause of death among people living with HIV in sub-Saharan Africa – accounting for more than 1,000 lives lost each day. Given this enormous human toll, in FY 2015 PEPFAR will continue to address the deadly links between TB and HIV as a top policy and programmatic priority. PEPFAR aims to dramatically reduce the impact of HIV-associated TB through a combination of early identification and treatment of TB, preventive therapy, and infection control activities, and is also working to accelerate early access to ART for co-infected patients. In all of these efforts, PEPFAR closely coordinates with national TB and AIDS programs, multilateral institutions, and other partners to strengthen systems that address TB and HIV.

In FY 2015, PEPFAR will continue its efforts to support scale up of the Cepheid GeneXpert® MTB/RIF test, an innovative, fully automated molecular diagnostic test for TB. This test enables programs to diagnose TB more quickly, which can help reduce TB transmission and decrease mortality. PEPFAR and USAID are partnering closely with UNITAID and the Bill & Melinda Gates Foundation in a public-private partnership to reduce the cost of Xpert MTB/RIF cartridges by 40 percent. As of December 2013, a total of 2,021 GeneXpert instruments and 5,219,960 Xpert MTB/TIF cartridges had been procured in the public sector in 98 countries.

Impact on Broader Health Systems: In addition to TB, 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. The rate of progress in reducing new HIV infections among children and TB-related mortality among people living with HIV has accelerated dramatically in recent years. 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. In FY 2015, 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-led partnerships. The PEPFAR platform will be a strategic 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.

Promoting Shared Responsibility

Advancing PEPFAR Country Health Partnerships (CHPs): The United States' has evolved its relationship with host countries to one of a true and enduring partnership – engendering a fundamental shift from aid to co-investing, and positioning countries to assume greater responsibility in responding to the epidemic. South Africa, Botswana, Namibia, and Zambia – have invested far more of their own financial resources in support of their national AIDS responses, and these countries as well as others have assumed greater managerial and technical oversight of their national AIDS programs.

In September 2013, Secretary Kerry announced the launch of PEPFAR Country Health Partnerships (CHPs), which are being initially rolled out in South Africa, Rwanda, and Namibia. Building on the success of PEPFAR's Partnership Frameworks, PEPFAR CHPs will advance the principle of country engagement by securing a partnership based on greater transparency, co-investment, and joint decision-making. In FY 2015, PEPFAR will continue implementation of CHPs in these initial countries, and expand CHPs to other PEPFAR partner countries.

Private Sector Engagement: PEPFAR has long supported and promoted the critical role that private sector engagement and public-private partnerships (PPPs) play in strengthening and extending the principle of shared responsibility to achieve an AIDS-free generation.
To date, PEPFAR has leveraged nearly $400 million in private resources with over $335 million in matched U.S. government funding. This accounts for more than 300 distinct public-private partnerships across 21 countries that span PEPFAR's prevention, care, and treatment portfolios. In 2013, PEPFAR announced $10 million in additional funding to incentivize new PPPs at the country level. In FY 2015, PEPFAR will continue to implement existing PPPs, and rollout a series of new PPPs supported with this additional funding.

The Global Fund to Fight AIDS, TB and Malaria: 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 Global Fund strengthen its promise as an efficient, long-term channel for funding evidence-based, high-impact interventions. In FY 2015, the United States will continue to

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 Global 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.

In countries where both PEPFAR and the Global Fund are present, improved program coordination, decreased costs, and greater efficiencies between the respective investments are helping to increase the coverage of essential HIV services and save more lives. In FY 2015, the U.S. contribution to the Global Fund will provide critical financial resources to support implementation 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 has significantly shifted 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 ultimately benefits PEPFAR's planning and advance our collective goal of 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 two dollars from other sources. 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.

On December 2-3, 2013, the Obama Administration hosted world leaders, who gathered in Washington, D.C, for the Fourth Voluntary Replenishment to demonstrate global unity in a launch of funding commitments for the fight against AIDS, TB, and malaria over the next 3 years. Over $12 billion was pledged by 25 countries, the European Commission, private foundations, corporations, and faith-based organizations. This amount represents the largest combined contribution ever committed to combatting these three deadly diseases – a 30 percent increase from the Third Replenishment in 2010.

By law, the United States cannot provide more than 33 percent of total Global Fund contributions. The FY 2015 President's budget request more than fully funds the U.S. pledge to the Global Fund based on current commitments from other donors. The United States continues to challenge other donors by committing to seek from Congress $1 for every $2 contributed by other donors to the Global Fund, up to a possible $5 billion total from the United States until September 2014.

Conclusion

The Administration's FY 2015 budget request will permit PEPFAR to help ensure people currently on treatment do not fall off. In order to rapidly scale-up the HIV prevention, treatment, and care services that science shows will have the greatest impact on controlling the epidemic in each country context, as stated in the *PEPFAR Blueprint*, we will need to redouble all of our efforts to bring other resources to the table including partner countries, other donor nations, foundations, and the private sector. It is only through a shared responsibility that the promise of an AIDS-free generation will be realized.

SECTION II: PEPFAR FUNDING FOR INTERNATIONAL PARTNERS

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PEPFAR Funding for International Partnerships

International Partnerships	Fiscal Year					
	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2015 request
Global Fund	**$ 1,000,000,000**	**$ 1,050,000,000**	**$ 1,045,800,000**	**$ 1,300,000,000**	**$ 1,490,592,423**	**$ 1,650,000,000**
GHP-State	$ 600,000,000	$ 750,000,000	$ 748,500,000	$ 1,300,000,000	$ 1,490,592,423	$ 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**	**$ 42,792,127**	**$ 45,000,000**
GHP-State	$ 40,000,000	$ 43,000,000	$ 42,914,000	$ 45,000,000	$ 42,792,127	$ 45,000,000

Table explanation: Includes FY 2009 – FY 2013 funding as enacted by Congress and contributed to International Partners from all appropriations, and as requested in FY 2015.

International Partnerships: The U.S. government's bilateral and multilateral investments continue to build upon a long-term and sustainable approach to combating AIDS, tuberculosis (TB), and malaria. Through mutually-supportive and increasingly integrated programming, PEPFAR, the President's Malaria Initiative (PMI), and our bilateral TB program work closely with key partners, including the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), World Health Organization (WHO), and United Nations agencies led by the Joint United Nations Program on HIV/AIDS (UNAIDS). In addition, PEPFAR and the President's Malaria Initiative (PMI) have strong partnerships with non-governmental organizations, including faith- and community-based organizations, other national governments, and the private sector.

The FY 2015 request continues to support the U.S. government's ongoing work with international partners. To this end, the U.S. government continues to leverage U.S. taxpayer resources by mobilizing and sustaining political will, strengthening international policies and standards, and encourages shared responsibility among international donors and stakeholders through a country-led response.

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund)

Table explanation: Includes FY 2009 – FY 2013 funding as enacted by Congress and contributed to the Global Fund from all appropriations, and as requested in FY 2014 and FY 2015.
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.

The Global Fund remains the U.S. government's largest partner in the fight against AIDS, TB, and malaria. To date, the Global Fund has programs in 150 countries, an estimated 5.3 million people on antiretroviral (ARV) drugs, 11 million new cases of TB detected and treated, and 340 million bed nets distributed to protect families from malaria acquisition. As its largest donor, the

U.S. government has a strategic interest in supporting a strong, effective, and efficient Global Fund — one that collaborates closely with U.S government bilateral programs to maximize our collective impact in addressing the HIV, TB, and malaria pandemics. The U.S government has continued to lead the push forward toward sustaining the real and visible changes in how the Global Fund conducts business, as evidenced by the rollout of the Global Fund's New Funding Model (NFM) in 2014. The NFM will create improved operations and grant impact, increased oversight over resources, and a more strategic resource allocation.

The U.S. FY 2015 budget request of $1.35 billion is a reflection of the need to continue to build momentum as the Global Fund rolls out the new funding model while also encouraging traditional and new donors to increase their contribution. It also acknowledges the Fund's accomplishments in restructuring its business model and reinforces our confidence that the Global Fund is a smart investment. The United States and other donors expressed this confidence at the Global Fund's Fourth Voluntary Replenishment Conference last December, pledging in excess of $12 billion over the next three years—the largest amount ever committed to fighting AIDS, TB, and malaria. The U.S. government's FY 2015 contribution to the Fund increases the impact of U.S. AIDS, TB, and malaria programs, which are complementary to and deeply interdependent with Global Fund-financed programs. This improved programmatic relationship is critical as U.S. government programs seek to achieve strong bilateral program results, reach more people with quality services, leverage contributions from other donors, expand the geographic reach of our investment, and promote shared responsibility among donors and implementers.

By continuing our strong investment in the Global Fund, the U.S. government will continue to ensure that Global Fund resources are invested in a fully-coordinated and complementary manner that falls 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. PEPFAR, PMI, 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 present. 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.

Our FY 2015 investment will convey to donors that the United States is committed to the Global Fund, but also reiterate that donors —whether the private sector, implementing countries, or the domestic resources of recipient nations —must increase their contribution. The U.S. government is prevented by law from contributing more than 33 percent of the total cumulative contributions to the Fund. While the Global Fund has catalyzed international investment in the global response to HIV/AIDS, TB, and malaria—including from the private sector and from non-G8 donors—it is essential that donors, both traditional and emerging, continue to support the international response in a significant way given the scale of unmet need.

The U.S. government is committed to strengthening public and private sector support for the Global Fund which will be essential for successful implementation of the new funding model in 2014-2016. To this end, the U.S. government has committed to contribute $1 for every $2 contributed by other donors through September 2014. Working through U.S. government diplomatic channels, the United States will encourage nations with emerging economies and natural resource wealth to shoulder an increasing share of domestic HIV financing. The U.S. government will continue to work together with the Global Fund Secretariat and Board to target priority donors for new or increased contributions to the Global Fund. U.S. embassies in targeted countries will raise this issue in diplomatic discussions.

Strong investments in and collaboration between U.S. bilateral health programs and the Global Fund make sense as we increasingly focus on country ownership and technical cooperation. In order to achieve a durable response to HIV/AIDS, TB, and malaria, the U.S. government needs 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.

Joint United Nations Program on HIV/AIDS (UNAIDS)

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 2015 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 Programme Coordination 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 partner with UNAIDS. In FY 2015, efforts will be made to ensure strong coordination at the country level, including a special focus on operationalizing the principles of the investment approach, 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. This approach is also being leveraged to advance sustainability planning and PEPFAR's Country Health Partnerships.

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 SUMMARY TABLES FY 2009-2015

Table 1: FY 2015 Request for PEPFAR Countries

$ in Thousands	FY 2015 Request	
State, Region, Operating Unit	**GHP-State**	**GHP-USAID**
TOTAL	**5,370,000**	**330,000**
Africa	**3,332,686**	**87,910**
Angola	12,899	4,400
Botswana	57,804	-
Burundi	15,360	3,500
Cameroon	34,175	1,500
Cote d'Ivoire	138,405	-
Democratic Republic of the Congo	59,975	9,200
Djibouti	1,800	-
Ethiopia	147,213	-
Ghana	6,797	5,500
Kenya	371,680	-
Lesotho	27,288	6,400
Liberia	800	2,700
Malawi	67,988	15,500
Mali	1,500	3,000
Mozambique	274,001	-
Namibia	43,513	-
Nigeria	456,652	-
Rwanda	78,559	-
Senegal	1,535	3,000
Sierra Leone	500	-
South Africa	409,550	-
South Sudan	11,790	2,010
Swaziland	36,413	6,900
Tanzania	372,381	-
Uganda	320,176	-
Zambia	304,282	-
Zimbabwe	77,250	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	**83,627**	**25,250**
Burma	9,000	1,000
Cambodia	5,122	9,000
Indonesia	250	7,750
Papua New Guinea	3,700	2,500
Vietnam	58,142	-
Asia Regional Program	7,413	5,000
Europe and Eurasia	**22,015**	**2,500**
Ukraine	22,015	2,500
South and Central Asia	**38,494**	**4,000**
India	26,000	-
Central Asia Regional	12,494	1,000
Nepal	-	3,000
Western Hemisphere	**167,444**	**21,091**
Brazil	500	-
Dominican Republic	8,363	5,750
Guyana	6,636	-
Haiti	124,013	-
Caribbean Regional	15,331	6,950
Central America Regional	12,601	8,391
S/GAC Additional Funding	**1,725,734**	**-**
S/GAC, Additional Funding for Country Programs	115,565	-
S/GAC, International Partnerships	1,395,000	-
S/GAC, Oversight/Management	135,169	-
S/GAC, Technical Support/Strategic Information/Evaluation	80,000	-
GH		**189,249**
GH/IP - Commodity Fund		20,335
GH/IP - International AIDS Vaccine Initiative (IAVI)		28,710
GH/IP - Microbicides		45,000
Global Health - Core		95,204

Table explanation: Includes FY 2015 GHP-State and GHP-USAID requests for all PEPFAR countries and for headquarters HIV/AIDS programs.

Table 2: PEPFAR FY 2014 Estimate for PEPFAR Countries

$ in Thousands	FY 2014 Estimate	
State, Region, Operating Unit	**GHP-State**	**GHP-USAID**
TOTAL	**5,670,000**	**330,000**
Africa	**3,357,686**	**87,910**
Angola	9,899	4,400
Botswana	57,804	-
Burundi	15,360	3,500
Cameroon	34,175	1,500
Cote d'Ivoire	118,405	-
Democratic Republic of the Congo	51,975	9,200
Djibouti	1,800	-
Ethiopia	132,213	-
Ghana	6,797	5,500
Kenya	371,680	-
Lesotho	27,288	6,400
Liberia	800	2,700
Malawi	67,988	15,500
Mali	1,500	3,000
Mozambique	274,001	-
Namibia	58,513	-
Nigeria	456,652	-
Rwanda	88,559	-
Senegal	1,535	3,000
Sierra Leone	500	-
South Africa	455,550	-
South Sudan	11,790	2,010
Swaziland	36,413	6,900
Tanzania	372,381	-
Uganda	320,176	-
Zambia	304,282	-
Zimbabwe	77,250	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	**88,627**	**25,250**
Burma	9,000	1,000
Cambodia	5,122	9,000
Indonesia	250	7,750
Papua New Guinea	3,700	2,500
Vietnam	63,142	-
Asia Regional Program	7,413	5,000
Europe and Eurasia	**12,015**	**2,500**
Ukraine	12,015	2,500
South and Central Asia	**38,494**	**4,000**
India	26,000	-
Nepal	-	3,000
Central Asia Regional	12,494	1,000
Western Hemisphere	**162,443**	**21,091**
Brazil	500	-
Dominican Republic	8,363	5,750
Guyana	6,636	-
Haiti	124,013	-
Carribean Regional	10,331	6,950
Central America Regional	12,600	8,391
S/GAC Additional Funding	**2,010,735**	**-**
S/GAC, Additional Funding for Country Programs	100,566	-
S/GAC, International Partnerships	1,695,000	-
S/GAC, Oversight/Management	135,169	-
S/GAC, Technical Support/Strategic Information/Evaluation	80,000	-
GH		**189,249**
GH/IP Commodity Fund	-	20,335
GH/IP - International AIDS Vaccine Initiative (IAVI)	-	28,710
GH/IP - Microbicides	-	45,000
GH - Core	-	95,204

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

Table 3: FY 2015 Request for PEPFAR Operational Plan by Country (GHP-State and GHP-USAID Accounts only)

	FY 2015 Request	
State, Region, Operating Unit	**GHP-State**	**GHP-USAID**
Africa	**3,324,151**	**71,410**
Angola	12,899	4,400
Botswana	57,804	-
Burundi	15,360	3,500
Cameroon	34,175	1,500
Cote d'Ivoire	138,405	-
Democratic Republic of the Congo	59,975	9,200
Ethiopia	147,213	-
Ghana	6,797	5,500
Kenya	371,680	-
Lesotho	27,288	6,400
Malawi	67,988	15,500
Mozambique	274,001	-
Namibia	43,513	-
Nigeria	456,652	-
Rwanda	78,559	-
South Africa	409,550	-
South Sudan	11,790	2,010
Swaziland	36,413	6,900
Tanzania	372,381	-
Uganda	320,176	-
Zambia	304,282	-
Zimbabwe	77,250	16,500
East Asia and Pacific	**76,214**	**25,250**
Burma	9,000	1,000
Cambodia	5,122	9,000
Indonesia	250	7,750
Papua New Guinea	3,700	2,500
Vietnam	58,142	-
Asia Regional Program	7,413	5,000
Europe and Eurasia	**22,015**	**2,500**
Ukraine	22,015	2,500
South and Central Asia	**38,494**	**1,000**
India	26,000	-
Central Asia Regional	12,494	1,000
Western Hemisphere	**166,944**	**21,091**
Dominican Republic	8,363	5,750
Guyana	6,636	-
Haiti	124,013	-
Carribean Regional	15,331	6,950
Central America Regional	12,601	8,391

Table explanation: Includes FY 2015 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 2013 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**	**FY 2013**
Africa	**$3,793.1**	**$3,730.2**	**$3,875.4**	**$ 3,223.9**	**$ 3,311.2**
Angola	$ 17.0	$ 17.7	$ 17.7	$ 17.7	$ 13.7
Botswana	$ 95.1	$ 87.0	$ 84.4	$ 75.9	$ 60.8
Burundi	$ -	$ -	$ 18.5	$ 8.5	$ 18.9
Cameroon	$ -	$ -	$ 24.3	$ 14.3	$ 26.3
Cote d'Ivoire	$ 124.8	$ 119.1	$ 105.2	$ 130.2	$ 139.7
Democratic Republic of Congo	$ 33.0	$ 31.3	$ 51.3	$ 25.4	$ 45.2
Ethiopia	$ 346.0	$ 291.3	$ 293.0	$ 185.1	$ 160.1
Ghana	$ 17.5	$ 13.0	$ 15.0	$ 15.0	$ 12.5
Kenya	$ 565.0	$ 548.1	$ 517.3	$ 260.0	$ 275.0
Lesotho	$ 28.3	$ 29.2	$ 34.2	$ 16.8	$ 34.2
Malawi	$ 45.7	$ 55.3	$ 65.0	$ 70.0	$ 75.0
Mozambique	$ 252.9	$ 269.1	$ 268.8	$ 231.1	$ 262.0
Namibia	$ 107.9	$ 102.6	$ 102.6	$ 90.3	$ 34.2
Nigeria	$ 442.3	$ 459.2	$ 488.6	$ 478.6	$ 458.6
Rwanda	$ 147.6	$ 131.4	$ 115.4	$ 105.4	$ 95.4
South Africa	$ 561.3	$ 560.4	$ 549.1	$ 523.7	$ 484.0
Sudan	$ 8.8	$ 9.5	$ 14.5	$ 14.5	$ 16.1
Swaziland	$ 32.4	$ 37.5	$ 60.8	$ 32.5	$ 26.8
Tanzania	$ 361.2	$ 358.0	$ 357.2	$ 289.6	$ 348.0
Uganda	$ 287.1	$ 286.3	$ 323.4	$ 298.4	$ 323.4
Zambia	$ 271.1	$ 276.7	$ 306.7	$ 249.7	$ 306.5
Zimbabwe	$ 48.0	$ 47.5	$ 62.5	$ 91.2	$ 95.0
East Asia and Pacific	**$ 132.7**	**$ 144.8**	**$ 129.8**	**$ 102.1**	**$ 124.3**
Asia Regional Program	$ -	$ -	$ -	$ -	$ 16.5
Burma	$ -	$ -	$ -	$ -	$ 10.0
Cambodia	$ 18.0	$ 18.5	$ 18.5	$ 15.0	$ 15.0
China	$ 10.3	$ 10.0	$ 8.0	$ 6.0	$ -
Indonesia	$ 9.0	$ 13.0	$ 13.0	$ 5.8	$ 8.0
Papua New Guinea	$ -	$ -	$ -	$ -	$ 5.0
Thailand	$ 5.5	$ 5.5	$ 5.5	$ 5.5	$ -
Vietnam	$ 89.9	$ 97.8	$ 84.8	$ 69.8	$ 69.8
Europe and Eurasia	**$ 16.2**	**$ 18.0**	**$ 27.2**	**$ 11.6**	**$ 15.0**
Russia	$ 8.0	$ 6.0	$ 5.0	$ -	$ -
Ukraine	$ 8.2	$ 12.0	$ 22.2	$ 11.6	$ 15.0
South and Central Asia	**$ 30.5**	**$ 48.8**	**$ 48.8**	**$ 33.2**	**$ 22.8**
Central Asia Regional	NA	$ 15.8	$ 15.8	$ 5.2	$ 14.0
India	$ 30.5	$ 33.0	$ 33.0	$ 28.0	$ 8.8
Western Hemisphere	**$ 187.3**	**$ 233.7**	**$ 224.8**	**$ 207.7**	**$ 202.4**
Caribbean Regional	$ 19.0	$ 23.3	$ 23.3	$ 22.2	$ 23.3
Central America Regional	NA	$ 12.6	$ 12.6	$ 21.6	$ 21.6
Dominican Republic	$ 17.3	$ 15.5	$ 15.5	$ 8.5	$ 14.5
Guyana	$ 20.5	$ 18.2	$ 14.9	$ 11.9	$ 9.5
Haiti	$ 130.5	$ 164.1	$ 158.5	$ 143.5	$ 133.5
Grand Total	**$4,159.7**	**$4,175.6**	**$4,306.0**	**$ 3,578.5**	**$ 3,675.7**

Table explanation: Includes all sources of approved funding supporting activities in PEPFAR Operational Plans for FY 2009 through FY 2013. 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 5: FY 2009 – FY 2013 Approved Funding in PEPFAR Operational Plans by Funding Source

	FY 2009					FY 2010					FY 2011				
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
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**
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
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
Burundi	NA					NA					$ -	$ 3,500,000	$ 15,000,000		$ 18,500,000
Cameroon	NA					NA					$ 1,500,000	$ 1,500,000	$ 21,250,000		$ 24,250,000
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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**
Asia Regional Program															
Burma															
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
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
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
Papua New Guinea															
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
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
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**
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
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**
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
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
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**
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
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
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
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
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
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**

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 5: FY 2009 – FY 2013 Approved Funding in PEPFAR Operational Plans by Funding Source (continued)

	FY 2012					FY 2013			
State Region, Operating Unit	GAP	GHP-USAID	GHP-State	Central GHP-State	Total All Funding Sources	GAP	GHP-USAID	GHP-State	Total All Funding Sources
Africa	**$ 70,979,000**	**$ 71,410,000**	**$ 2,984,217,934**	**$ 97,337,164**	**$ 3,223,944,098**	**$ 74,601,801**	**$ 71,410,000**	**$ 3,165,231,763**	**$ 3,311,243,564**
Angola	$ 3,000,000	$ 4,400,000	$ 10,300,000	-	$ 17,700,000	$ 2,009,380	$ 4,400,000	$ 7,290,620	$ 13,700,000
Botswana	$ 7,147,000	-	$ 66,000,000	$ 2,786,962	$ 75,933,962	$ 6,493,117	-	$ 54,269,013	$ 60,762,130
Burundi	-	$ 3,500,000	$ 5,000,000	-	$ 8,500,000	-	$ 3,500,000	$ 15,360,000	$ 18,860,000
Cameroon	$ 1,500,000	$ 1,500,000	$ 11,250,000	-	$ 14,250,000	$ 925,252	$ 1,500,000	$ 23,824,748	$ 26,250,000
Cote d' Ivoire	$ 5,153,000	-	$ 118,305,051	$ 6,722,257	$ 130,180,308	$ 4,911,616	-	$ 134,768,692	$ 139,680,308
Democratic Republic of the Congo	$ 2,415,000	$ 9,200,000	$ 13,769,690	-	$ 25,384,690	$ 1,267,198	$ 9,200,000	$ 34,754,098	$ 45,221,296
Ethiopia	$ 3,863,000	-	$ 181,239,987	-	$ 185,102,987	$ 3,301,720	$ -	$ 156,791,923	$ 160,093,643
Ghana	$ 500,000	$ 5,500,000	$ 9,000,000	-	$ 15,000,000	$ 330,262	$ 5,500,000	$ 6,669,738	$ 12,500,000
Kenya	$ 8,121,000	-	$ 241,512,003	$ 10,405,680	$ 260,038,683	$ 5,415,044	$ -	$ 269,584,956	$ 275,000,000
Lesotho	$ 1,150,000	$ 6,400,000	$ 9,235,000	-	$ 16,785,000	$ 1,035,376	$ 6,400,000	$ 26,764,624	$ 34,200,000
Malawi	$ 3,052,000	$ 15,500,000	$ 51,448,000	-	$ 70,000,000	$ 1,486,541	$ 15,500,000	$ 58,013,459	$ 75,000,000
Mozambique	$ 2,337,000	$ -	$ 224,238,909	$ 4,500,000	$ 231,075,909	$ 4,863,474	-	$ 257,099,739	$ 261,963,213
Namibia	$ 1,500,000	-	$ 88,809,181	-	$ 90,309,181	$ 2,122,963	-	$ 32,125,930	$ 34,248,893
Nigeria	$ 3,056,000	$ -	$ 461,227,282	$ 14,330,999	$ 478,614,281	$ 2,868,591	-	$ 455,745,690	$ 458,614,281
Rwanda	$ 1,135,000	$ -	$ 99,072,239	$ 5,221,139	$ 105,428,378	$ 3,328,008	$ -	$ 92,100,370	$ 95,428,378
South Africa	$ 4,043,000	$ -	$ 509,968,500	$ 9,729,351	$ 523,740,851	$ 6,664,801	-	$ 477,335,199	$ 484,000,000
South Sudan	$ 500,000	$ 2,010,000	$ 12,036,000	-	$ 14,546,000	$ 396,891	$ 2,010,000	$ 13,689,109	$ 16,096,000
Swaziland	$ 1,200,000	$ 6,900,000	$ 24,424,819	-	$ 32,524,819	$ 746,332	$ 6,900,000	$ 19,153,668	$ 26,800,000
Tanzania	$ 3,683,000	-	$ 268,616,142	$ 17,256,079	$ 289,555,221	$ 7,307,878	-	$ 340,669,806	$ 347,977,684
Uganda	$ 8,040,000	-	$ 284,083,697	$ 6,264,675	$ 298,388,372	$ 7,248,240	-	$ 316,140,132	$ 323,388,372
Zambia	$ 2,914,000	$ -	$ 226,660,609	$ 20,120,022	$ 249,694,631	$ 5,234,117	-	$ 301,225,249	$ 306,459,366
Zimbabwe	$ 6,670,000	$ 16,500,000	$ 68,020,825	-	$ 91,190,825	$ 6,645,000	$ 16,500,000	$ 71,855,000	$ 95,000,000
East Asia and Pacific	**$ 12,855,000**	**$ 15,750,000**	**$ 73,478,168**	**$ -**	**$ 102,083,168**	**$ 11,558,548**	**$ 25,250,000**	**$ 87,554,620**	**$ 124,363,168**
Asia Regional Program						$ 5,998,430	$ 5,000,000	5531570	$ 16,530,000
Burma						**$ -**	$ 1,000,000	$ 9,000,000	$ 10,000,000
Cambodia	$ 3,000,000	$ 9,000,000	$ 3,000,000	$ -	$ 15,000,000	$ 1,255,212	9,000,000	4,744,788	$ 15,000,000
China	$ 3,000,000	-	$ 3,000,000	$ -	$ 6,000,000	$ -	$ -	$ -	$ -
Indonesia	-	$ 5,750,000	$ -	$ -	$ 5,750,000	$ -	7,750,000	$ 250,000	$ 8,000,000
Papua New Guinea						$ 147,500	$ 2,500,000	$ 2,352,500	$ 5,000,000
Thailand	$ 4,000,000	$ 1,000,000	$ 500,000	$ -	$ 5,500,000	$ -	$ -	$ -	$ -
Vietnam	$ 2,855,000	-	$ 66,978,168	$ -	$ 69,833,168	$ 4,157,406	$ -	$ 65,675,762	$ 69,833,168
Europe and Eurasia	**$ 300,000**	**$ 2,500,000**	**$ 8,753,000**	**$ -**	**$ 11,553,000**	**$ 637,437**	**$ 2,500,000**	**$ 11,862,563**	**$ 15,000,000**
Russia	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -
Ukraine	$ 300,000	$ 2,500,000	$ 8,753,000	$ -	$ 11,553,000	637,437	2,500,000	11,862,563	$ 15,000,000
South and Central Asia	**$ 3,560,000**	**$ 19,000,000**	**$ 10,602,415**	**$ -**		**$ 4,135,119**	**$ 1,000,000**	**$ 17,622,331**	**$ 22,757,450**
Central Asia Regional	$ 560,000	$ 1,000,000	$ 3,602,415	$ -	$ 5,162,415	2,785,090	1,000,000	10,214,910	$ 14,000,000
India	$ 3,000,000	$ 18,000,000	$ 7,000,000	$ -	$ 28,000,000	1,350,029	0	7,407,421	$ 8,757,450
Western Hemisphere	**$ 6,225,000**	**$ 20,109,200**	**$ 180,936,734**	**$ 459,039**	**$ 207,729,973**	**$ 8,983,555**	**$ 24,952,920**	**$ 168,486,527**	**$ 202,423,002**
Caribbean Regional	$ 1,500,000	$ 6,950,000	$ 13,741,400	$ -	$ 22,191,400	1,841,198	6,950,000	14,508,802	$ 23,300,000
Central America Regional	$ 1,025,000	$ 8,391,000	$ 12,198,000	$ -	$ 21,614,000	970,080	12,252,920	8,391,000	$ 21,614,000
Dominican Republic	$ 500,000	$ 4,768,200	$ 3,231,800	$ -	$ 8,500,000	1,628,349	5,750,000	7,121,651	$ 14,500,000
Guyana	$ 1,200,000	$ -	$ 10,525,215	$ 156,360	$ 11,881,575	865,739		8,600,265	$ 9,466,004
Haiti	$ 2,000,000	-	$ 141,240,319	$ 302,679	$ 143,542,998	3,678,189		129,864,809	$ 133,542,998
Grand Total	**$ 93,919,000**	**$ 128,769,200**	**$ 3,257,988,251**	**$ 97,796,203**	**$ 3,578,472,654**	**$ 99,916,460**	**$ 125,112,920**	**$ 3,450,757,804**	**$ 3,675,787,184**

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 2009-2013 Approved Funding in PEPFAR Operational Plans, by Country and Implementing Agency

	FY 2009							FY 2010							FY 2011						
Sum of Approved Funding in Millions	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	
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**
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
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
Burundi				NA							NA				$ 0.2	$-	$ -	$ -	$ 0.1	$ 18.2	$ 18.5
Cameroon				NA							NA				$ -	$-	$ 16.9	$ 1.1	$ 1.3	$ 5.0	$ 24.3
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
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
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
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
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
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
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
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
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
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
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
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
Sudan			$ 3.7			$ 5.1	$ 8.8			$ 4.2			$ 5.3	$ 9.5	$ 0.9	$-	$ 6.7	$ -	$ -	$ 6.9	$ 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
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
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
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
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
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**
Asia Regional Program																					
Burma																					
Cambodia			$ 4.0			$ 14.1	$ 18.0			$ 4.5			$ 14.1	$ 18.5	$ -	$-	$ 4.5	$ -	$ -	$ 14.1	$ 18.5
China			$ 4.4			$ 5.9	$ 10.3			$ 4.5			$ 5.5	$ 10.0	$ -	$-	$ 4.0	$ -	$ -	$ 4.0	$ 8.0
Indonesia	$ 0.3					$ 8.8	$ 9.0	$ 0.3	$ -	$ -	$ -	$ -	$ 12.8	$ 13.0	$ 0.3	$-	$ -	$ -	$ -	$ 12.8	$ 13.0
Papua New Guinea																					
Thailand	$ -		$ 4.3	$ -		$ 1.3	$ 5.5			$ 4.2			$ 1.3	$ 5.5	$ -	$-	$ 4.2	$ -	$ -	$ 1.3	$ 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
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**
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
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**
Central Asia Regional				NA						$ 6.9	$ 0.1	$ -	$ 8.8	$ 15.8	$ -	$-	$ 7.8	$ 0.3	$ -	$ 7.8	$ 15.8
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
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**
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
Central America Regional				NA				$ 0.7		$ 3.9	$ 0.1		$ 7.8	$ 12.6	$ 0.9	$-	$ 3.4	$ 0.1	$ -	$ 8.1	$ 12.6
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
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
Haiti			$ 79.1			$ 51.4	$ 130.5	$ -	$ -	$ 71.8	$ -	$15.1	$ 77.2	$ 164.1	$ -	$-	$ 96.7	$ -	$ 0.1	$ 61.8	$ 158.5
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**

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 6: FY 2009-2013 Approved Funding in PEPFAR Operational Plans, by Country and Implementing Agency (continued)

	FY 2012							FY 2013						
Sum of Approved Funding in Millions	Implementing Agency						TOTAL	Implementing Agency						TOTAL
State Region, Operating Unit	DoD	DOL	HHS	Peace Corps	State	USAID		DoD	DOL	HHS	Peace Corps	State	USAID	
Africa	**$ 84.0**	**$ 0.2**	**$ 1,535.5**	**$25.3**	**$ 48.7**	**$ 1,534.7**	**$ 3,223.9**	**$ 98.7**	**$ -**	**$ 1,478.2**	**$25.7**	**$ 21.7**	**$ 1,688.3**	**$ 3,312.7**
Angola	$ 1.5	$ -	$ 6.1	$ -	$ -	$ 10.1	$ 17.7	$ -	$ -	$ 3.6	$ -	$ -	$ 10.1	$ 13.7
Botswana	$ 2.2	$ -	$ 54.0	$ 2.0	$ 1.6	$ 16.1	$ 75.9	$ 1.4	$ -	$ 39.7	$ 2.3	$ 1.0	$ 16.3	$ 60.8
Burundi	$ 0.3	$ -	$ -	$ -	$ 0.1	$ 8.1	$ 8.5	$ 1.0	$ -	$ -	$ -	$ 0.1	$ 17.8	$ 18.9
Cameroon	$ 5.0	$ -	$ 8.3	$ 1.0	$ 1.0	$ 3.5	$ 14.3	$ 0.9	$ -	$ 18.2	$ 0.8	$ 0.4	$ 6.0	$ 26.3
Cote d'Ivoire	$ 0.3	$ -	$ 66.7	$ -	$ -	$ 63.2	$ 130.2	$ 0.2	$ -	$ 82.3	$ -	$ 0.2	$ 57.1	$ 139.7
Democratic Republic of Congo	$ -	$ -	$ 9.6	$ -	$ 0.6	$ 15.2	$ 25.4	$ 1.4	$ -	$ 23.8	$ -	$ 0.3	$ 19.9	$ 45.2
Ethiopia	$ 0.6	$ -	$ 100.6	$ 2.2	$ 18.1	$ 63.6	$ 185.1	$ 1.6	$ -	$ 68.4	$ 2.4	$ 2.8	$ 85.0	$ 160.1
Ghana	$ 0.3	$ -	$ 3.4	$ 0.3	$ 0.2	$ 10.8	$ 15.0	$ -	$ -	$ 2.2	$ 0.3	$ 0.2	$ 9.9	$ 12.5
Kenya	$ 10.0	$ -	$ 200.4	$ 1.6	$ 1.3	$ 46.7	$ 260.0	$ 23.0	$ -	$ 170.6	$ 1.4	$ 1.0	$ 79.0	$ 275.0
Lesotho	$ -	$ -	$ 7.3	$ 0.6	$ 0.4	$ 8.5	$ 16.8	$ 0.9	$ -	$ 12.3	$ 0.6	$ 0.3	$ 20.1	$ 34.2
Malawi	$ 0.1	$ -	$ 30.9	$ 1.7	$ 0.2	$ 37.1	$ 70.0	$ 2.0	$ -	$ 31.2	$ 1.9	$ 0.7	$ 39.2	$ 75.0
Mozambique	$ -	$ -	$ 110.8	$ 1.8	$ 2.0	$ 116.5	$ 231.1	$ 3.1	$ -	$ 123.5	$ 2.8	$ 3.5	$ 129.1	$ 262.0
Namibia	$ 2.4	$ -	$ 47.2	$ 1.5	$ 0.8	$ 38.4	$ 90.3	$ 0.8	$ -	$ 17.0	$ -	$ -	$ 16.5	$ 34.2
Nigeria	$ 14.9	$ -	$ 216.5	$ -	$ 0.5	$ 246.7	$ 478.6	$ 8.7	$ -	$ 167.4	$ -	$ 0.6	$ 281.8	$ 458.6
Rwanda	$ 3.3	$ -	$ 52.1	$ 1.6	$ 0.3	$ 48.2	$ 105.4	$ 3.0	$ -	$ 43.9	$ 1.2	$ 0.4	$ 46.9	$ 95.4
South Africa	$ 2.7	$ -	$ 214.7	$ 2.4	$ 5.3	$ 298.7	$ 523.7	$ 0.3	$ -	$ 199.4	$ 2.4	$ 5.3	$ 276.6	$ 484.0
Sudan	$ 1.4	$ -	$ 6.1	$ -	$ -	$ 7.1	$ 14.5	$ 1.4	$ -	$ 7.4	$ -	$ 0.3	$ 7.4	$ 16.4
Swaziland	$ -	$ 0.2	$ 17.2	$ 0.8	$ 0.7	$ 13.6	$ 32.5	$ -	$ -	$ 14.7	$ 1.0	$ -	$ 10.8	$ 26.5
Tanzania	$ 14.5	$ -	$ 122.9	$ 2.0	$ 3.9	$ 146.3	$ 289.6	$ 24.2	$ -	$ 145.6	$ 2.3	$ 1.3	$ 174.6	$ 348.0
Uganda	$ 10.7	$ -	$ 161.1	$ 2.2	$ 3.5	$ 120.8	$ 298.4	$ 10.8	$ -	$ 174.6	$ 2.2	$ 1.2	$ 135.6	$ 324.4
Zambia	$ 13.9	$ -	$ 78.2	$ 3.7	$ 2.0	$ 151.8	$ 249.7	$ 14.2	$ -	$ 105.6	$ 4.2	$ 1.9	$ 180.6	$ 306.5
Zimbabwe	$ -	$ -	$ 21.5	$ -	$ 6.3	$ 63.5	$ 91.2	$ -	$ -	$ 26.9	$ -	$ 0.3	$ 68.3	$ 95.5
East Asia and Pacific	**$ -**	**$ -**	**$ 43.0**	**$0.04**	**$ 0.2**	**$ 58.8**	**$ 102.1**	**$ 0.3**	**$ -**	**$ 35.5**	**$ -**	**$ 0.1**	**$ 62.0**	**$ 124.4**
Asia Regional Program								$ 0.3	$ -	$ 10.1	$0.04	$ -	$ 6.1	$ 16.5
Burma								$ -	$ -	$ 3.3	$ -	$ -	$ 6.8	$ 10.0
Cambodia	$ -	$ -	$ 4.5	$ -	$ -	$ 10.6	$ 15.0	$ -	$ -	$ 4.4	$ -	$ -	$ 10.6	$ 15.0
China	$ -	$ -	$ 4.3	$ -	$ -	$ 1.7	$ 6.0	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Indonesia	$ -	$ -	$ -	$ -	$ -	$ 5.8	$ 5.8	$ 0.3	$ -	$ -	$ -	$ -	$ 7.8	$ 8.0
Papua New Guinea								$ -	$ -	$ 1.3	$ -	$ -	$ 3.8	$ 5.0
Thailand	$ -	$ -	$ 4.2	$0.04	$ -	$ 1.2	$ 5.5	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Vietnam	$ -	$ -	$ 30.0	$ -	$ 0.2	$ 39.6	$ 69.8	$ -		$ 29.9	$ -	$ 0.1	$ 39.9	$ 69.8
Europe and Eurasia	**$ -**	**$ -**	**$ 4.6**	**$ 0.4**	**$ -**	**$ 6.6**	**$ 11.6**	**$ 0.2**	**$ -**	**$ 4.8**	**$ 0.4**	**$ -**	**$ 9.6**	**$ 15.0**
Russia	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Ukraine	$ -	$ -	$ 4.6	$ 0.4		$ 6.6	$ 11.6	$ 0.2	$ -	$ 4.8	$ 0.4	$ -	$ 9.6	$ 15.0
South and Central Asia	**$ -**	**$ 0.2**	**$ 9.1**	**$ 0.1**	**$ -**	**$ 23.8**	**$ 33.2**	**$ -**	**$ -**	**$ 15.7**	**$ 0.1**	**$ -**	**$ 6.9**	**$ 22.8**
Central Asia Regional	$ -	$ -	$ 1.6	$ 0.1	$ -	$ 3.4	$ 5.2	$ -	$ -	$ 6.9	$ 0.1	$ -	$ 6.9	$ 14.0
India	$ -	$ 0.2	$ 7.5	$ -	$ -	$ 20.4	$ 28.0	$ -	$ -	$ 8.8	$ -	$ -	$ -	$ 8.8
Western Hemisphere	**$ 0.8**	**$ 0.2**	**$ 112.9**	**$ 2.2**	**$ 0.6**	**$ 91.1**	**$ 207.7**	**$ 0.2**	**$ -**	**$ 112.4**	**$ 1.8**	**$ 1.5**	**$ 85.0**	**$ 200.9**
Caribbean Regional	$ 0.3	$ -	$ 11.0	$ 0.5	$ 0.2	$ 10.3	$ 22.2	$ -	$ -	$ 10.3	$ 0.4	$ 1.2	$ 11.5	$ 23.3
Central America Regional	$ 0.5	$ -	$ 4.5	$ 0.3	$ 0.2	$ 16.1	$ 21.6	$ -	$ -	$ 5.2	$ 0.3	$ 0.2	$ 16.9	$ 22.6
Dominican Republic	$ -	$ -	$ 2.5	$ 1.3	$ -	$ 4.8	$ 8.5	$ -	$ -	$ 5.9	$ 1.0	$ -	$ 7.6	$ 14.5
Guyana	$ -	$ 0.2	$ 5.9	$ 0.1	$ 0.2	$ 5.5	$ 11.9	$ 0.2		$ 4.4	$ 0.1	$ 0.1	$ 4.7	$ 9.5
Haiti	$ -	$ -	$ 89.1	$ -	$ -	$ 54.5	$ 143.5	$ -	$ -	$ 86.7	$ -	$ -	$ 44.3	$ 131.0
Grand Total	**$ 84.7**	**$ 0.5**	**$ 1,705.1**	**$28.0**	**$ 49.5**	**$ 1,715.0**	**$ 3,578.5**	**$ 99.6**	**$ -**	**$ 1,660.0**	**$28.1**	**$ 23.3**	**$ 1,864.7**	**$ 3,675.7**

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 2013 Headquarters Operational Plan Approved GHP-State Funding, Technical Oversight and Management, and FY 2015 Request

	GHP-State					
	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2015 Request
S/GAC Oversight/Management	**$127,407,692**	**$145,838,332**	**$172,153,634**	**$174,096,000**	**$154,961,364**	**$152,669,000**
Other Agency Costs	$113,407,692	$131,838,332	$158,181,634	$159,846,000	$141,410,524	$135,169,000
OGAC Administrative Costs	$14,000,000	$14,000,000	$13,972,000	$14,250,000	$13,550,840	$17,500,000

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 2013, and FY 2015 estimate.

Table 8: FY 2009 – FY 2013 PEPFAR Funding for International Partners, and FY 2015 Request

International Partnerships	Fiscal Year					
	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2015 request
Global Fund	**$ 1,000,000,000**	**$ 1,050,000,000**	**$ 1,045,800,000**	**$ 1,300,000,000**	**$ 1,490,592,423**	**$ 1,650,000,000**
GHP-State	$ 600,000,000	$ 750,000,000	$ 748,500,000	$ 1,300,000,000	$ 1,490,592,423	$ 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**	**$ 42,792,127**	**$ 45,000,000**
GHP-State	$ 40,000,000	$ 43,000,000	$ 42,914,000	$ 45,000,000	$ 42,792,127	$ 45,000,000

Table explanation: Includes FY 2009 – FY 2013 funding as enacted by Congress and contributed to the Global Fund and to support the Join United National Program on HIV/AIDS (UNAIDS) from all appropriations, and as requested in FY 2015.

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.

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SECTION IV: COUNTRY OPERATIONAL PLAN EXECUTIVE SUMMARIES

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Angola

Country Context

Angola has a generalized HIV/AIDS epidemic prevalence rate of 2.3% and an estimated 230,912 adults and 30,969 children living with HIV/AIDS (UNAIDS 2012 Report). Those primarily impacted by the epidemic are women, youth, and key populations. 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.

After twenty-seven years of civil war, Angola has returned to peace and stability and is making significant strides toward rebuilding its infrastructure and improving the health and well-being of its people. Since 2002, the Government of the Republic of Angola has kept the peace: repairing war-torn infrastructure, imposing macroeconomic reform on its natural resource wealth, and rebuilding the confidence of its people. Despite this laudable progress, Angola remains a country at a critical crossroads on its path to true development commensurate with its middle-income status. The Economist Intelligence Unit named Angola "the fastest growing economy in the world" for the decade from 2001-2011 but in spite of this growing wealth Angola still has had one of the highest rates of maternal mortality and fertility in the world. Angola is also one of a few countries in Africa where new HIV infections and AIDS-related deaths have increased in recent years.

The general population of Angola is estimated to be 22,714,547 with the capital, Luanda, housing approximately 30% of its citizenry. A national census, not done since the 1970s, is scheduled for May 2014. Despite open borders after the war, the Angola HIV/AIDS epidemic has remained relatively low and stable unlike its bordering neighbors. The reason for Angola's relatively low rate in the region is not known but has been linked to the insularity due to the war. High-risk behavior, low education standards, and inadequate surveillance make Angola a highly vulnerable country to trends being reversed for reducing the HIV/AIDS burden. In fact, Angola is the only priority country enlisted in the 'Global Plan towards the elimination of new HIV infections among children by 2015 and keeping mothers alive' where the number of new infections among children increased between 2009 and 2012.

HIV rates among key populations, including sex workers (SW) and men having sex with men (MSM) are higher than the average. Although data suggests that heterosexual sex accounts for 79.2% of all HIV cases, KPs account for a larger proportion of new infections through heterosexual transmissions. Among SWs the rate is estimated to be as high 23%. The rate for MSM is 8.2%. PEPFAR Angola is the only development partner supporting key population HIV prevention, especially for MSM. The second route of transmission of HIV in the country is vertically through mother to child transmission (MTCT), which stands at approximately 6%. Blood transfusions are third with a rate of 2% of all reported cases.

The Government of the Republic of Angola has already invested hundreds of millions of dollars in large-scale infrastructure projects to slowly rebuild the roads, rails, schools, and hospitals needed for public welfare and economic development, and the Government of the Republic of Angola now embraces the more difficult task of rapidly raising government performance and responsibility with extensive capacity gaps and relatively low institutional memory. While the Government of the Republic of Angola is clearly taking the lead on planning and executing its own development projects, international partners also have a pivotal role to play in determining how Angola's policy is formulated and reformed to advance the country's development objectives.

PEPFAR programming will continue to target the priority provinces selected by the Government of the Republic of Angola. PEPFAR's Implementing Partners (IPs) work in Luanda, Huambo, Huila, Benguela, and Cunene assisting the Government of the Republic of Angola with prevention to key population activities, prevention of mother to child transmission (PMTCT), health systems strengthening (HSS), and strategic information (SI) interventions. The Department of Defense (DOD) prevention and capacity building programs are national in nature, given that they strengthen the Angolan Armed Forces (FAA) in all their military installations.

Below is a table 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
2013	$ 5,468,256	40%	$ -	0%	$ 34,000	0%	$ 8,197,744	60%	$ 13,700,000
Total 2009-2013	**$ 34,121,996**	**41%**	**$ 550,000**	**1%**	**$ 34,000**	**0%**	**$ 49,094,004**	**59%**	**$ 83,800,000**
2015 (est)	**$ 6,937,252**	**40%**	**$ 1,117,963**	**6%**	**$ 947,326**	**5%**	**$ 8,296,459**	**48%**	**$ 17,299,000**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Angola	$ 876,885	$ 600,000	$ 2,983,000	$ 78,371	$ -	$ -	$ -	$ 930,000	**$ 5,468,256**
	Totals FY09-FY13	**$ 3,101,885**	**$ 5,159,870**	**$ 19,761,870**	**$ 1,978,371**	**$ -**	**$ -**	**$ -**	**$ 4,120,000**	**$ 34,121,996**
2015 (est)	Angola									**$ 6,937,252**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 2015, the PEPFAR team's prevention activities will support the Government of the Republic of Angola's expansion of PMTCT services.

FY 2015 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. In FY 2015, PEPFAR will continue to improve target population access to social marketing of condoms and support high levels of demand for and correct and consistent use of condoms. PEPFAR will procure fewer socially marketed condoms as the condom market grows while continuing to support demand creation and communication programs focusing on women and gender issues. Health communication programs will be designed to understand and address social and gender-related norms/barriers that hinder male uptake of services and/or male participation in HIV prevention efforts and reproductive health. Female condoms are made available through clinical settings and the prevention activities with the military also include condom distribution too.

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 KP 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.

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 2015 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.

The expansion of HIV counseling and testing continues to be a Government of the Republic of Angola and Instituto National de Luta Contra a SIDA (INLS) priority. FY 2015 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 2015, 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.

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 2015 activities will continue to support the INLS's efforts in decentralizing the roll-out of elimination of mother to child transition by expanding PMTCT services to additional centers, assisting in the training of nurses and doctors in improved HIV diagnosis, shifting to Option B+ treatment.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Angola	$ 1,383,505	$ 704,590	$ 3,822,460	$ 2,287,189	**$ 8,197,744**
	Totals FY09-FY13	**$ 4,333,252**	**$ 7,801,047**	**$ 17,568,098**	**$ 19,391,607**	**$ 49,094,004**
2015 (est)	Angola					**$ 8,296,459**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2014 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 2015 is to improve human and institutional capacity within the Ministry of Health (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.

The health systems strengthening priorities for FY 2015 are: strengthening the supply chain, evaluating national blood safety, and ensuring a functional National Reference Laboratory. In FY 2015, 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.

PEPFAR activities will continue to focus on strengthening laboratory quality assurance systems in Angola. 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. Strategic information priorities for FY 2015 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; strengthening the Angola Institutional Review Board (IRC) 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. 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 2015, a PEPFAR partner, in conjunction with the Angolan Military, will design a research project to provide pertinent HIV related data along the Namibian border to improve targeting in their prevention efforts.

In FY 2015, 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 2015 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

Credible elections were held in 2012 in which the President and members of the National Assembly were chosen for 5-year terms of office. Shortly thereafter, the newly elected Angolan government released the country's first comprehensive national development plan, 2012-2017.

Subsequently the MOH also launched its first national health development plan, which has been improved and supplemented by late 2013 commitments by President dos Santos and the MOH to double efforts on HIV/AIDS prevention with the government's "HIV (prevention) Acceleration Plan." PEPFAR is working closely with the Government of the Republic of Angola and international development partners to implement the Angolan government's HIV Acceleration Plan, which seeks to obtain "Countdown to Zero" objectives by reducing the number of new HIV infections among children by 90%, and reducing the number of AIDS-related maternal deaths 50%, by 2015.

In FY 2015, PEPFAR will continue to focus on prevention and HSS. Over the next two years, programming will continue to reflect the mission's three major strategic components: HSS, targeted prevention focusing on key population (SW, MSM) and other vulnerable populations (military and mobile/migrant), rolling put PMTCT and Option B+, with a possible pivotal shift to fostering Public Private Partnerships (PPPs). In FY 2015 and beyond, there will be more of an emphasis on transitioning capacity building responsibility to Angolan authorities, while building on opportunities to provide catalyzing and innovative approaches that fuse with private sector interests to support the Government of the Republic of Angola efforts. In terms of health policy, there will continue to be a significant shift towards decentralization in FY 2015, 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 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.

The Government of the Republic of Angola provides the majority of funding for the HIV/AIDS response, which is estimated to be 56.7%. According to the UNGASS 2012 report, 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. PEPFAR is a voting member on the Global Fund's Country Coordinating Mechanism (CCM), and is part of the sub-committee for HIV/AIDS. The U.S. government contributes technical expertise to the CCM and participates in coordinated planning and leveraging of donor funds through a health partners technical working group. 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. A priority will be to continue the task of strengthening relationships between the Government of the Republic of Angola and its relevant entities as well as other donor partners.

Botswana

Country Context

The United States and Botswana partnership through the President's Emergency Plan for AIDS Relief (PEPFAR/B) has yielded many benefits over the years, both in responding to HIV and AIDS in-country as well as adding to the global body of knowledge about the epidemic. Botswana, a sparsely populated country with an estimated 2.1 million people still faces a prolonged and severe HIV epidemic and has the second highest HIV prevalence in the world. In 2012 UNAIDS reported a prevalence of 23 percent for adults aged 15-49 with an estimated 340,000 Batswana living with HIV, of which 226,763 are on antiretroviral therapy (ART) Batswana women and girls are disproportionately affected by HIV, and prevalence is higher among females (20.4 percent) than males (14.2 percent). The highest HIV prevalence is among females aged 30-34 years at 49 percent. Tuberculosis (TB) remains the leading cause of death in people living with HIV (PLHIV), and is responsible for 13 percent of adult deaths and 40 percent of deaths among PLHIV. Maternal mortality related to HIV complications is high, and cervical cancer is the leading cause of cancer deaths among women.

According to the National AIDS Coordinating Agency (NACA), key drivers of Botswana's generalized epidemic are multiple and concurrent sexual partnerships, adolescent and intergenerational sex, alcohol and high-risk sex, stigma and discrimination, low uptake of male circumcision and gender-based violence (GBV). The epidemic varies within different geographical regions, communities, age groups, with urbanization and, most pronouncedly, by gender.

The health partnership with Botswana has resulted in a clear record of success. Botswana has made remarkable advances in preventing HIV during the last decade, and the spread of new HIV infections has slowed sharply. Botswana is one of a handful of countries that has reached the "tipping point" – where for every one new person on treatment, there is less than one person becoming newly infected. 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 2013, 98.4 percent of those eligible for ART, using a CD4 standard of less than 350, are receiving it. PEPFAR Botswana's work will build upon past successes while filling critical gaps identified in the Partnership Framework, signed in 2010. FY 2015 activities represent the continuation of prior efforts focused on preventing new infections and caring for those affected by HIV. PEPFAR will continue to support the Government of Botswana in maximizing the quality, coverage and impact of its HIV and AIDS national response.

Below is a table 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
2013	$ 14,536,519	24%	$ 11,906,680	20%	$ 2,115,743	3%	$ 32,203,188	53%	$ 60,762,130
Total 2009-2013	**$ 125,951,042**	**31%**	**$ 75,292,335**	**19%**	**$ 46,487,490**	**12%**	**$ 155,487,250**	**39%**	**$ 403,218,117**
2015 (est)	**$ 12,445,545**	**22%**	**$ 12,530,948**	**22%**	**$ 3,822,494**	**7%**	**$ 29,005,013**	**50%**	**$ 57,804,000**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Botswana	$ 1,842,458	$ 660,791	$ 4,719,416	$ 257,182	$ 87,807		$ 1,879,164	$ 5,089,701	**$ 14,536,519**
	Totals FY09-FY13	**$16,505,794**	**$ 15,748,347**	**$ 26,879,542**	**$ 4,231,189**	**$ 2,985,088**	**$ -**	**$26,074,840**	**$ 33,526,242**	**$ 125,951,042**
2015 (est)	Botswana									**$ 12,445,545**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 2015 include continuing to bolster 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 (TA) and monitoring provided by PEPFAR. PEPFAR Botswana is also seeking a more focused, cost-effective and geographically targeted HIV Counseling and Testing (HCT) program. These priorities are in close alignment with those of the Government of Botswana priorities outlined in the National HIV Strategic Framework II (2010-2016), and the National Operational Plan (2011-2016).

In FY 2015, PEPFAR will address gaps identified by a portfolio review in blood safety relating to blood safety quality, donor mobilization and retention, data utilization, blood supply and service costing PEPFAR will provide targeted TA to the National Blood Transfusion Service for the development of a national blood donor mobilization and retention strategy. With this

investment we aim to improve the collection of whole blood, reduce HIV reactivity to less than 1 percent, and facilitate an on-site, in-service training of NBTS staff to address critical TA needs.

In FY 2014, PEPFAR restructured the Botswana safe male circumcision program to a single-partner model to improve performance and reduce the high cost per patient circumcised. Activities were divided into three phases: preparatory, demand creation, and service delivery. The effectiveness of demand creation activities are enhanced by recruiting locally-based mobilizers and by securing support of traditional leaders and local authorities. In FY 2015, PEPFAR will continue to invest in the single partner approach with hopes to expand. Clients who are tested HIV positive will continue to be referred to treatment, care and support services.

In FY 2015, the budget for HCT has been reduced. A greater emphasis will be placed on targeted outreach testing in high prevalence districts through non-governmental organizations (NGOs) as well as strengthening linkages to services for both HIV-negative and -positive persons for continuity of care. The FY2015 objectives for investing in gender and prevention of GBV are crosscutting and include assisting the Government of Botswana and civil society to expand comprehensive, quality GBV services to survivors, increasing awareness of GBV in Botswana by supporting development and implementation of community action plans and assisting the Government of Botswana to implement surveillance and monitoring systems to track GBV events.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Botswana	$ 131,858	$ 1,739,839	$ 244,046	**$ 2,115,743**
	Totals FY09-FY13	**$ 26,158,341**	**$ 17,118,189**	**$ 3,210,960**	**$ 46,487,490**
2015 (est)	Botswana				**$ 3,822,494**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Botswana's ratio of new HIV infections to the increase in new patients on treatment (the "tipping point") was 0.5 in 2011, suggesting that the country is getting ahead of the epidemic. In FY 2015, PEPFAR assistance in Botswana will continue to focus on strengthening the national HIV program through effective coordination and joint planning with the Government of Botswana and other implementing partners. PEPFAR's main focus is now on providing TA to the Government of Botswana training and mentoring health care providers and strengthening the supply chain. 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.
PEPFAR funding for ARV purchases ended in the FY 2013 COP. As of November 2013 the Botswana Masa treatment program now covers 226,763 patients who are receiving ART. This represents 98.4 percent of those eligible using a CD4 cell count standard of <350. PEPFAR-funded direct provision of HIV treatment is restricted to one program that supports nursing staff in a pediatric HIV treatment center and providing treatment to a small group of non Batswana citizens at a refugee camp that are not eligible for the Government of Botswana supplied ART.

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 - FY13) & FY15 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**
2013	Botswana	$ 2,635,789	$ 506,758	$ 5,219,547	$ 3,544,586	**$ 11,906,680**
	Totals FY09-FY13	**$ 20,340,315**	**$ 3,821,848**	**$ 24,988,159**	**$ 26,142,013**	**$ 75,292,335**
2015 (est)	Botswana					**$ 12,530,948**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The Government of Botswana has led the Care and Treatment response in Botswana, and PEPFAR continues to fill critical gaps through TA and by building local capacity. Key priorities for the next two years include the provision of CTX (Cotrimoxazole) prophylaxis, TB screening and pre-ART care, including PHDP. For TB/HIV, priority areas include isoniazid preventive therapy (IPT), infection control and intensified case finding, as well as an increased focus on addressing Multi-Drug Resistant Tuberculosis (MDR-TB).

PEPFAR FY 2015 priorities include strengthening the linkages between clinical and community care for orphan and vulnerable children and their family members; strengthening M&E for OVC with an emphasis on program evaluations; and, supporting the Government of Botswana implementation of guidelines and policies that address the needs of vulnerable children. Other priorities include increasing access to livelihood opportunities – such as education – for OVC

and their families, and strengthening the capacity of local civil society organizations (CSO) to deliver services.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Botswana	$ 3,463,494	$ 7,103,624	$ 11,036,269	$ 10,599,801	**$ 32,203,188**
	Totals FY09-FY13	**$ 19,710,363**	**$ 20,346,345**	**$ 38,326,797**	**$ 55,500,358**	**$ 133,883,863**
2015 (est)	Botswana					**$ 29,005,013**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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.

PEPFAR will incorporate quality, linkage, engagement and retention strategies into programmatic activities. Funding in FY 2015 is allocated for quality improvement efforts in both prevention and treatment programs. These efforts will incorporate ongoing practices already in place, such as the Site Monitoring System, laboratory accreditation efforts and training and mentoring activities for health care providers participating in the national HIV treatment program.

To ensure health systems strengthening (HSS) activities in Botswana have a sustained impact on a national scale, FY 2015 program activities are consolidated to three priority areas:

1. Enhancing capacity of CSOs to improve access to delivery of health services;
2. Ensuring that HIV services availability is integrated into health financing strategies and reforms required for a sustainable country-led HIV response; and,
3. Capacitating districts to maintain/expand delivery of HIV services (primarily District Health Management Teams, also District AIDS Coordinators) in the context of decentralized governance and organization of services.

Botswana has one of the most successful PMTCT programs in sub-Saharan Africa. Because PMTCT was considered to be a mature program that was being successfully managed by the MoH, PEPFAR will only be providing minimal TA and SI support. In FY 2015, PEPFAR will support the roll out of an integrated HIV data system nationwide, which will improve the management of HIV-positive clients as they traverse the continuum of care.

Country Engagement

Botswana's HIV and AIDS response has evolved over the years due to political support, community involvement and commitment and funding from development partners like PEPFAR. Nearly 80 percent of funds are "public funds" that include central government funds, World Bank reimbursable loans and Medical Aid. PEPFAR remains the primary source of international funding, and there is limited funding from the private sector. Public spending is primarily on care and treatment services for people living with HIV and AIDS, which include the procurement of ARV drugs and laboratory reagents for HIV monitoring. PEPFAR Botswana is committed to a thoughtful transitioning of responsibility for the HIV/AIDS service delivery programs to the Government of Botswana 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 2015. Ongoing technical assistance and monitoring will be supported by the PEPFAR team.

The cost of treating the disease is taking a toll on the economy, and PEPFAR support is scheduled to decline just as Botswana contemplates a future without diamond revenues, which have allowed the country to provide ARVs to all citizens who are eligible.

However, PEPFAR remains vigilant to commitments to empower the Government of Botswana to plan, oversee, manage, deliver and finance their own HIV and AIDS response. PEPFAR's investments in FY 2015 take steps toward this goal, in addition to advancing quality health programs responsive to the needs of those who access them.

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 disproportionately affected. Among men having sex with men (MSM) the rate was 2.4 and 3 percent within the male prisoner population.

In FY 2015, the PEPFAR program in Burundi will 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.
PEPFAR HIV/AIDS assistance is aligned with the national strategic plan and regular consultations with the Government of Burundi are frequently held. The 2012-2016 HIV strategic plan was prepared with technical assistance from PEPFAR and is currently undergoing a full mid-term review with PEPFAR's support. The results of this review will re-focus Burundi's HIV/AIDS priorities and set the country up to complete the requirements for the Global Fund's new funding model.

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 to manage progress and results.

The PEPFAR Burundi program will also focus on improving service delivery and strengthening the health system in 2015. 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, PEPFAR will negotiate with the Government of Burundi to ensure key populations receive equal attention in the national strategic plans for health and HIV/AIDS for focused programming. PEPFAR will provide the required technical assistance to make sure that the specific needs of key populations are addressed.

In FY 2015, PEPFAR will continue to partner with the Global Fund 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 Global Fund to ensure that lifelong treatment needs generated from the PMTCT platform are 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
2013	$ 8,556,649	45%	$ 1,652,409	9%	$ 2,150,331	11%	$ 6,500,611	34%	$ 18,860,000
Total 2009-2013	**$ 25,778,208**	**56%**	**$ 4,599,365**	**10%**	**$ 3,886,982**	**8%**	**$ 11,595,445**	**25%**	**$ 45,860,000**
2015 (est)	**$ 6,565,532**	**35%**	**$ 1,549,080**	**8%**	**$ 2,933,835**	**16%**	**$ 7,811,553**	**41%**	**$ 18,860,000**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 - FY13) & FY15 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**
2013	Burundi	$ 2,906,618	$ 750,064	$ 3,728,492	$ -	$ -	$ -	$ -	$ 1,171,475	**$ 8,556,649**
	Totals FY09-FY13	**$ 14,472,564**	**$ 2,350,608**	**$ 6,075,448**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 2,879,588**	**$ 25,778,208**
2015 (est)	Burundi									**$ 6,565,532**

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

In FY 2015, PEPFAR's response to HIV prevention will include continued development of the combination prevention framework for key populations and the general population. Prevention activities will identify new cases, reduce new infections, and increase access to prevention, care and treatment services. The activities will be gradually s scaled up over time, working closely with the Global Fund and the Government of Burundi.

In FY 2015, PEPFAR will use new data to increase coverage for programs targeting key populations, such as FSWs and their clients, MSM, and other vulnerable populations. The data

will also focus programming on key locations with the most need and ensure prevention messages, condom distribution, treatment for Sexually Transmitted Infections (STI), and HIV counseling and testing (HCT).

In addition, laboratory quality, and performance will be a significant focus in FY 2015.Work has already started to support a national working group to develop guidelines, a framework, and a transport system to ensure effective linkages with all aspects of the Government of Burundi, Global Fund, and PEPFAR program including prevention, testing, PMTCT, and treatment. The transport system will allow infant blood samples to be delivered quickly to HIV lab testing facilities and then for the results to be transported back to the clinic.

HCT will be integrated into all program areas. These include ensuring support for national and provincial HCT oversight functions, supporting the update of the HCT algorithm, as well as proficiency testing, quantification and procurement of reagents, and training of staff.

In FY 2015, PEPFAR Burundi will expand coverage of PMTCT in eight PEPFAR supported provinces that represent over 50 percent of the population of Burundi. Technical assistance will be provided to non-PEPFAR supported provinces. PMTCT activities will be focused on community mobilization and quality improvement at different service delivery levels. PEPFAR will continue its support of commodity procurement while providing technical assistance to avoid stock outs at the national level.

Additional interventions will include linkages following HIV testing and diagnosis to nutrition and malaria care, and ongoing HIV prevention for HIV-negative mothers. Interventions such as referrals and access to care and treatment, family planning, antiretroviral therapy (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.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Burundi	$ 1,208,202	$ 521,289	$ 420,840	**$ 2,150,331**
	Totals FY09-FY13	**$ 1,308,202**	**$ 1,467,684**	**$ 1,111,096**	**$ 3,886,982**
2015 (est)	Burundi				**$ 2,933,835**

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

In line with the new World Health Organization (WHO) guidelines for treatment, PEPFAR will support lifelong treatment generated by the PMTCT platform and improve linkages with the Global Fund and Government of Burundi to provide ART and other treatment services to the majority of those eligible. Over the next two years, ART will be expanded via technical assistance to the Government of Burundi, in charge of the national HIV response.

In FY 2015, PEPFAR will continue to partner with the Global Fund treatment program to provide non-PMTCT ART and technical assistance. Technical assistance will support various levels of Burundi's health system: from training and supervision of health providers to provision of home-based care and support services. PEPFAR will work closely with the Government of Burundi and the Global Fund to ensure that lifelong treatment needs generated from the PMTCT platform are assured over time. Specific coordination and mapping activities have been implemented and will continue to occur to ensure a non-duplicative, but coordinated, effective response nationally.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Burundi	$ 944,735	$ 5,362	$ -	$ 702,312	**$ 1,652,409**
	Totals FY09-FY13	**$ 2,689,435**	**$ 5,362**	**$ -**	**$ 1,904,568**	**$ 4,599,365**
2015 (est)	Burundi					**$ 1,549,080**

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

In FY 2015, PEPFAR Burundi will continue to complement the Global Fund's TB work by ensuring systematic TB screening of HIV positive individuals. The cross-referral system between HIV/AIDS and TB settings will also be reinforced. HIV/TB co-infection rate in Burundi currently exceeds 20 percent. TB is the most common opportunistic infection among people living with HIV/AIDS (PLHIV). PEPFAR will continue focusing on integrated service delivery by leveraging the antenatal care (ANC) platform for PMTCT, family planning, malaria in pregnancy, and emergency obstetric and neonatal care. .

PEPFAR Burundi program will continue to provide a family-centered orphans and vulnerable children (OVC) care approach using home-based care providers to identify and provide care and support for OVC. PEPFAR will continue to collaborate with including 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 related activities such as domestic violence reduction and mitigation and human trafficking.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Burundi	$ -	$ 1,005,193	$ 3,480,169	$ 2,015,249	**$ 6,500,611**
	Totals FY09-FY13	**$ -**	**$ 2,042,201**	**$ 5,658,869**	**$ 3,894,375**	**$ 11,595,445**
2015 (est)	Burundi					**$ 7,811,553**

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*** Burundi did not complete a Country Operational Plan until FY 2011.

In FY 2015, PEPFAR will utilize its expertise in improving many areas of the health system including: supply chain design, laboratory, quality assurance, human resources for health, health management information, and strategic information.

In FY 2015, the PEPFAR program will focus on strengthening the laboratory system. Laboratory activities will be supported starting with the creation of a national laboratory technical working group (TWG), which will develop guidelines and a framework, to ensure technicians are trained effectively. PMTCT activities, HCT, ART, malaria, and all Maternal Child Health (MCH) activities will benefit from the improved system. The TWG will ensure guidelines include that a minimum package of HIV laboratory services are required, as well as a plan for a laboratory transport system to allow for timely, efficient, and accurate results.

PEPFAR will also focus on addressing the weaknesses of the supply chain system which continue to pose a challenge to Burundi's service delivery. PEPFAR has worked closely over the last few years with the Government of Burundi and the Global Fund to ensure improved supply chain systems through training and coaching on procurement, quantification, warehousing systems, and monitoring and evaluation. PEPFAR will continue to support the implementation of a Supply Chain work plan with various partners and key stakeholders (PEPFAR, UNICEF, Global Fund, and the Government of Burundi). Some of these activities include:

- In collaboration with PEPFAR's implementing partners, ensure the procurement and delivery of PEPFAR-funded commodities are reliable;
- Support coordination with the Ministry of Public Health and Fight Against AIDS (MOHA) to maximize commodity forecasting and procurement, and monitor the supply chain;
- Support the definition and establishment of a harmonized, standardized system for tracking commodities in the supply chain; and

- In collaboration with in-country partners, develop a framework for measuring performance of the supply chain in areas linked to supply chain support.

Country Engagement

PEPFAR and the Government of Burundi have six years of positive collaboration and partnership. The PEPFAR-supported HIV/AIDS program has been designed to support, sustain and strengthen HIV/AIDS prevention, while emphasizing national and local capacity building along with key policy and structural reforms.

PEPFAR continues to capitalize on the Government of Burundi's high level of ownership and commitment to fighting HIV/AIDS. PEPFAR has helped build an effective, mutually accountable partnership This paradigm aligns with the Global Health Initiative and PEPFAR core principles, which place an emphasis on effective, efficient, and country-led platforms for the sustainable delivery of essential services and public health programs.

In FY 2015, PEPFAR will support the Government of Burundi in implementing the Burundi HIV/AIDS National Strategic Plan, National Health Development Plan, and Poverty Reduction Strategy by:

1. Improving access to high-quality HIV/AIDS prevention and care services;
2. Decentralizing HIV/AIDS services especially PMTCT services;
3. Building the capacity of civil society organizations to provide direct HIV/AIDS services; and
4. 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, PEPFAR 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 2015 PEPFAR will assist the Government of Burundi to rollout the recommendations.

The Global Fund is a key player in the health sector and provides a significant share of funding to combat HIV/AIDS, TB, and Malaria in Burundi. PEPFAR is currently a voting member on the Global Fund Country Coordinating Mechanism (CCM) and is sits on a technical committee of the CCM in charge developing proposals. In FY 2015, PEPFAR will be working closely with the Global Fund to make sure that necessary synergies are established and efforts to avoid duplication are successful. The PEPFAR Burundi team will also continue to work closely with the East Africa Regional Global Fund Liaison based in Nairobi to support Global Fund 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 therapy (ART). At the end of December 2012, the government placed 121,000 PLHIV on ART, representing 52 percent coverage.

PEPFAR's funding and technical assistance is designed to strengthen Cameroon's health structures and systems at the national and local levels, to integrate HIV services, and to build country ownership. PEPFAR has prioritized four of Cameroon's ten regions that contain 74 percent of adults and 80 percent of children in need of antiretroviral therapy (ART). Programmatically, PEPFAR has played an effective leadership role in prevention of mother-to-child transmission (PMTCT), prevention for key populations, and systems strengthening for laboratory and blood safety. In the past, PEPFAR has provided limited support for HIV/AIDS care and (except for emergency orders of antiretroviral drugs (ARVs)), no direct support for treatment services, which are provided by public, private, and faith-based health facilities with support from the Government of Cameroon and the Global Fund.

In FY 2015, PEPFAR will focus efforts on improving the quality of its prevention and systems strengthening programs and launch activities in two new program areas: ARV procurement and support for HIV/AIDS treatment and care. Concentrating on Cameroon's four highest-prevalence regions, PEPFAR's priorities include:

1. Supporting the Government of Cameroon to implement and scale up PMTCT and Option B+.
2. Support ART and care through ARV procurement and technical assistance.

3. Improving the quality, and extend the reach, of prevention and care programming for key populations and other vulnerable populations (PLHIV, military personnel and their communities, orphans and vulnerable children (OVC)).
4. Strengthening linkages among facility-based prevention, care, and treatment services and between facility and community-based services (including care and support for OVC) to ensure a functioning continuum of response (CoR).
5. Strengthening the supply chain at the national, regional, divisional, and district levels to build capacity and ensure reliable supplies, timely deliveries, and more efficient stock management.
6. Strengthening the laboratory system through establishment of a National Public Health Laboratory (NPHL), lab accreditation, and quality assurance (QA) systems.
7. Supporting the Government of Cameroon's initiatives to ensure a safe and reliable blood-supply system.
8. Supporting the Cameroonian government in establishing a functioning health management information system (HMIS).

Below is a table 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
2013	$ 14,526,748	55%	$ 2,446,743	9%	$ 143,162	< 1%	$ 9,133,347	35%	$ 26,250,000
Total 2009-2013	**$ 36,265,292**	**56%**	**$ 4,963,506**	**8%**	**$ 154,653**	**< 1%**	**$ 23,366,549**	**36%**	**$ 64,750,000**
2015 (est)	**$ 10,874,330**	**30%**	**$ 4,891,856**	**14%**	**$ 13,743,558**	**39%**	**$ 6,165,255**	**17%**	**$ 35,675,000**

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

Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Cameroon	$ 11,002,867	$ -	$ 1,895,998	$ 800,000	$ -	$ -	$ -	$ 827,883	**$ 14,526,748**
	Totals FY09-FY13	**$ 28,579,342**	**$ 190,440**	**$ 3,764,299**	**$ 2,311,500**	**$ -**	**$ -**	**$ -**	**$ 1,419,711**	**$ 36,265,292**
2015 (est)	Cameroon									**$ 10,874,330**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 2015, PEPFAR will support the Government of Cameroon to: scale-up PMTCT, increase coverage to support key populations, and enhance the Government of Cameroon's capacity to ensure safe blood transfusions. Because of regional disparities in HIV burden and associated response, PEPFAR support will continue to target its four regions with high HIV prevalence, where joint agency resources will be leveraged for better outcomes. In FY 2015, programming for key populations will continue to target commercial centers of the South and East regions, where PEPFAR has established drop-in centers, and expand to the Adamaoua region, which registers the highest HIV prevalence among FSW (48.4 percent) and has no sustained HIV/AIDS prevention interventions.

HIV-prevention interventions constitute a critical component of PEPFAR Cameroon's program. Key interventions in FY 2015 will include, HIV counseling and testing (HCT) at health facilities and through mobile clinics, psychosocial support, condom and lubricants distribution, and economic strengthening activities. Moreover, PEPFAR's blood safety program will strengthen new regional blood centers, train staff, help establish a quality system working toward accreditation and proficiency testing, and help develop a communications package to increase voluntary non-remunerated blood donations and assist in the creation of a national blood transfusion program. Community-based activities that link pregnant women to facilities with access to safe blood will directly contribute to improvements in maternal mortality (hemorrhaging currently accounts for 40 percent of maternal mortality).

Treatment

TREATMENT (FY09 - FY13) & FY15 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	$ -	$ -	$ -	**$ -**
2013	Cameroon	$ -	$ 143,162	$ -	**$ 143,162**
	Totals FY09-FY13	**$ -**	**$ 154,653**	**$ -**	**$ 154,653**
2015 (est)	Cameroon				**$ 13,743,558**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
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Since 2012, the Government of Cameroon, the Global Fund, and the Clinton Health Access Initiative have primarily supported the costs of ARVs. Due to delays in fulfilling the Global Fund Round 10 conditions, Cameroon experienced stock-outs of first-line ARVs in 2012 and 2013. The Government of Cameroon mobilized support and funding from PEPFAR on two occasions through the Emergency Commodity Fund as well as funding from the Global Fund, World Bank, the French Government, and the Office of the Cameroon President to address the immediate crisis and ensure coverage through 2014.

Given uncertainties in the Government of Cameroon and the Global Fund timelines for releasing funds, continued financial gaps for ARVs appear likely. To contribute towards the prevention of ARV stock-outs, PEPFAR will program funds for the procurement of ARVs to support PMTCT implementation and provide buffer stock for other antiretroviral therapy (ART) patients in its four high-burden regions. PEPFAR will also work with the Government of Cameroon, the Global Fund, and other stakeholders to improve forecasting, procurement, stock management and distribution systems.

In FY 2015, PEPFAR will leverage its PMTCT platform to expand support to the ART program through ARV procurement and technical assistance aimed at improving linkages, retention, and quality of ART services. This technical assistance will cover all ART sites in the four PEPFAR focus regions (all co-located with PMTCT sites, and all providing both adult and pediatric ART). Priority activities will include ARV procurement, technical assistance for revision of ART guidelines, and expanded site monitoring.

Specific activities to improve pediatric ART in FY 2015 will include training in pediatric HIV care, expanded early infant diagnosis (EID) coverage through training, commodities, and lab analysis support, an active search strategy for pediatric HIV/AIDS using HIV-infected parents or siblings as entry points, and strong linkages between OVC and pediatric ART/care services

In FY 2015, PEPFAR will support the Government of Cameroon's goal of eliminating MTCT by extending the coverage and improving the quality of PMTCT services. Working in four regions, PEPFAR will:

1. Strengthen PMTCT/MNCH integration and coordination through regular PMTCT/pediatric care and treatment technical working group (TWG) meetings, training, a national system for staff mentoring and supervision, and regular site program coordination meetings.
2. Support the rollout of Option B+ starting with co-located ART/PMTCT sites.
3. Support implementation of comprehensive family-centered PMTCT services, including expanded early infant diagnosis (EID), with stronger linkages to community care (including OVC care).
4. Strengthen linkages with care and treatment services along with intensive pediatric HIV case finding, HIV testing and counseling (HCT) for partners and children, effective referral/counter-referral systems, and community-based follow-up for retention.
5. Extend PMTCT coverage to target military communities and expand services to target adolescent girls and FSWs through community linkages.
6. Strengthen the PMTCT monitoring and evaluation (monitoring & evaluation) system through training in the use of new PMTCT/MNCH registers and rollout of District Health Information System (DHIS2) software.
7. Enhance quality in the PMTCT, care, and ART service delivery system through a national mentoring system (including tools and training), support for regular staff mentoring and formative supervision visits, and updating of norms and standards for PMTCT, care, and ART.

8. Strengthen the PMTCT/MNCH commodities system through ARV procurement and support to improve forecasting, procurement, management, and distribution of HIV drugs and commodities.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Cameroon	$ 692,883	$ 388,000	$ -	$ 1,365,860	**$ 2,446,743**
	Totals FY09-FY13	**$ 1,219,977**	**$ 1,413,166**	**$ -**	**$ 2,330,363**	**$ 4,963,506**
2015 (est)	Cameroon					**$ 4,891,856**

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

In FY 2015, care and support priorities include ensuring co-trimoxazole preventive therapy, CD4 testing, basic screening for TB, promotion of malaria prevention, provision of water-purification products, screening and referral for STIs, nutritional assessment and counseling, treatment adherence counseling, psychosocial support, and routine use of community health workers to support ART retention and linkages to OVC services. In addition, pediatric care and support will prioritize increasing country capacity to provide EID with linkages to HIV services, including OVC services. These care interventions will be implemented at all supported PMTCT and ART sites (including military sites) in the four regions where PEPFAR operates as well as key population drop-in centers and other community sites.

In FY 2015, OVC activities will support the development of standard procedures and quality improvement approaches for OVC care and support, identify and strengthen networks of community providers, and support economic-strengthening activities. OVC care and support activities will also wrap around other PEPFAR activities (PMTCT, ART, drop-in centers, etc.) for maximum efficiency and impact.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Cameroon	$ 3,062,363	$ 1,459,567	$ 1,724,108	$ 2,887,309	**$ 9,133,347**
	Totals FY09-FY13	**$ 7,247,967**	**$ 2,865,787**	**$ 4,281,002**	**$ 8,971,793**	**$ 23,366,549**
2015 (est)	Cameroon					**$ 6,165,255**

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

PEPFAR's goal is to reach sustainable impact with a strong country-owned HIV/AIDS response leading toward an AIDS-free generation. Among many systems that require strengthening, PEPFAR will focus on critical weaknesses that must be addressed in order for PEPFAR-funded interventions targeting national priorities to succeed.

In FY 2015, 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 will 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.

All PEPFAR investments are designed to strengthen the country's capacity to lead, sustainably manage, and increasingly finance an effective national response. This includes promoting:

- Political ownership and stewardship, with U.S. advocacy for increased Government of Cameroon health-sector spending and timely realization of the Cameroonian government's significant financial contributions for HIV/AIDS;
- Mutual accountability, with U.S. encouragement of civil society organizations that play a constructive role in advocacy and monitoring;
- Capacity building, with extensive U.S. support for training and mentoring; and
- Institutional and community ownership, including prioritizing work with Cameroonian partners.

In all planning, Cameroon's National Strategic Plan helps guide PEPFAR's selection of priorities. Joint planning and decision making, while still nascent, are being strengthened through Cameroon's Ministry of Health participation in PEPFAR's portfolio review and country operational plan development. Ongoing Government of Cameroon dialogue with the private sector on innovative and sustainable ARV financing represents enormous potential for the national HIV/AIDS response and for future PEPFAR engagement. PEPFAR is also working to increase collaboration with civil society and other donors.

In FY 2015, 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. Political tensions remain high, as former President Laurent Gbagbo is detained at the International Criminal Court in The Hague awaiting trial for war crimes, and the next presidential election is slated for October 2015.

PEPFAR Côte d'Ivoire worked 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. Analyses comparing national AIDS Indicator Survey (AIS) findings from 2005 with DHS 2012 data indicate that the country is experiencing a mixed HIV/AIDS epidemic that has changed in gender, age, and geographic distribution. HIV prevalence among adults decreased from 4.7 percent in 2005 to 3.7 percent, 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 titled *Survey of HIV and Associated Risk Factors among Men Who Have Sex with Men (MSM) in Côte d'Ivoire* indicate an HIV prevalence of 18 percent. Gender inequality and GBV heighten HIV risk across all socio-economic and cultural backgrounds.

In FY 2015, PEPFAR Côte d'Ivoire will continue to align its geographical focus with the most updated epidemiological data available. PEPFAR Côte d'Ivoire will focus on sustaining gains made in Abidjan while scaling up the quality and quantity of HIV services outside of the capital. In geographical focus areas, PEPFAR Côte d'Ivoire will continue to work on accelerating the scale-up of combination prevention programs.

PEPFAR Côte d'Ivoire will increase and improve collaboration with the decentralized Government of Côte d'Ivoire entities, including regional and district level government health offices and health providers, following major PEPFAR and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) geographic redistribution in 2013. The redistribution was aimed at improving partner consolidation, streamlining service delivery, increasing the capacity development of service providers, and improving supply chain management.

In FY 2015, the PEPFAR program in Côte d'Ivoire will focus on:

- Geographical alignment of programs with the most updated epidemiological information available;
- Treatment and prevention of mother-to-child transmission (PMTCT), including continued increases in enrollment and retention of patients in antiretroviral therapy (ART) and PMTCT, as well as continued support for the rollout of Option B+ (ART throughout pregnancy and breastfeeding for affected women);
- Developing a stronger decentralized supply chain through better tracking of antiretroviral drugs (ARVs);
- Directing the prevention program towards key populations including a greater focus on condom supply and demand;
- Increasing access to care and treatment for pediatric patients under five years of age through a combination of community and health care strategies, as well as improving early infant diagnosis (EID); and
- Improving 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).

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
2013	$ 32,778,663	23%	$ 29,829,415	21%	$ 50,116,296	36%	$ 26,955,934	19%	$ 139,680,308
Total 2009-2013	**$ 152,920,196**	**25%**	**$ 120,969,180**	**20%**	**$ 211,445,376**	**34%**	**$ 133,665,743**	**22%**	**$ 619,000,495**
2015 (est)	**$ 23,585,971**	**17%**	**$ 26,271,597**	**19%**	**$ 57,327,018**	**41%**	**$ 31,220,414**	**23%**	**$ 138,405,000**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Cote d'Ivoire	$ 11,466,922	$ 2,421,335	$ 7,673,133	$ 3,081,641	$ 550,318	$ -	$ -	$ 7,585,314	**$ 32,778,663**
	Totals FY09-FY13	**$ 40,658,496**	**$ 21,820,217**	**$ 33,178,148**	**$ 16,600,516**	**$ 5,035,698**	**$ -**	**$ -**	**$ 35,627,121**	**$ 152,920,196**
2015 (est)	Cote d'Ivoire									**$ 23,585,971**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, PEPFAR Côte d'Ivoire's program will include prevention activities focused on:

- PMTCT, including continued transition to Option B+, greater EID, and strengthening of integration and linkages with related programs;
- Prevention of sexual transmission through a strengthened combination prevention response with key populations and other vulnerable populations;
- Availability of condoms and uptake, including socially marketed condoms;
- Integration of Positive Health, Dignity, and Prevention (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);
- HIV counseling and testing (HCT), including linkages to combination prevention programs; and
- Capacity building of government partners and community based organizations (CBOs) in the various areas of HIV prevention.

PEPFAR Côte d'Ivoire will continue to align its prevention portfolio with the newest epidemiological data, focusing on high prevalence areas for greater impact. The number of implementing partners has been reduced to improve efficiency and allow for improved oversight. Given limited resources, realignment has focused on concentrating prevention strategies in a few key geographic areas and improving coordination with the Global Fund.

PEPFAR Côte d'Ivoire will improve access and use of testing, counseling, treatment, and PHDP services for key populations. In addition, it will also increase focus on higher risk sub-populations of the general population, such as HIV-negative pregnant women and people accessing treatment for sexually transmitted infections (STIs).

Blood safety interventions will continue to expand equitable access to blood and blood products at the local level. In FY 2015, the focus will be on improving logistics management and supply chain management of blood and blood products. 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 - FY13) & FY15 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**
2013	Cote d'Ivoire	$ 22,788,892	$ 24,539,432	$ 2,787,972	**$ 50,116,296**
	Totals FY09-FY13	**$ 114,040,154**	**$ 85,174,046**	**$ 12,231,176**	**$ 211,445,376**
2015 (est)	Cote d'Ivoire				**$ 57,327,018**

*Totals include planned funding for all accounts.
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In FY 2015, PEPFAR Côte d'Ivoire's program will include treatment and PMTCT activities focused on:

- Increasing the quality of ART services as well as retention of HIV-positive patients through intensified site-level support;
- Strengthening community mobilization to increase uptake of PMTCT and maternal health services for HIV-positive women, and strengthening linkages between PMTCT and family planning services;
- Providing support to the effective implementation of new ART and PMTCT guidelines at all supported sites and continue rollout Option B+, with support from the United Nations Children's Fund (UNICEF);
- Strengthening treatment of pediatric HIV/AIDS and EID through support to increase decentralized capacity for these programs strengthen linkages between EID and pediatric HIV programs;
- Improving the supply chain system, including efficiency of antiretroviral (ARV) purchases; and
- 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 further exploring opportunities for support for HIV/AIDS services in private for-profit clinics.

As with other technical aspects of the program, PEPFAR Côte d'Ivoire has reorganized the geographic distribution of implementing partners in order to prioritize efforts, improve efficiency, and allow partners to concentrate on ART retention and quality.

PEPFAR Côte d'Ivoire will continue providing technical assistance to the Ministry of Health and the Fight against AIDS (MSLS) in development and implementation of treatment-related quality standards, approaches, and indicators.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Cote d'Ivoire	$ 10,269,272	$ 2,711,884	$ 4,223,908	$ 12,624,351	**$ 29,829,415**
	Totals FY09-FY13	**$ 41,816,895**	**$ 10,303,848**	**$ 18,235,998**	**$ 50,612,439**	**$ 120,969,180**
2015 (est)	Cote d'Ivoire					**$ 26,271,597**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, the PEPFAR Côte d'Ivoire team will continue its work on geographic consolidation of its care and support work into high-impact intervention zones, particularly for PLHIV and OVC.

In FY 2015, PEPFAR and the Government of Côte d'Ivoire will continue to work towards improving the quality and reach of care and support services for 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. PEPFAR Côte d'Ivoire will continue to strengthen linkages between facility and community-based services and between pediatric HIV/AIDS programs and other services, including PHDP, community home-based care and treatment services.

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). In the last few years, PHDP interventions increased substantially in uptake and coverage.

In FY 2015, PEPFAR will also continue supporting the scale-up of nutrition support and ensuring availability and uptake of water purification products for HIV-positive patients. In collaboration with the World Food Program and the National Nutrition program, PEPFAR Côte d'Ivoire will provide food and nutrition support to adults and children through PMTCT, treatment, and community-based programs.

PEPFAR will continue to prioritize family-centered models of care and support, with emphasis on community mobilization for HCT, using OVC as an entry point for family-based approaches to clinical services, including PHDP for PLHIV households. PEPFAR Côte d'Ivoire will continue to strengthen linkages between pediatric HIV/AIDS programs (and participating health care facilities) and services for 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.

A recent evaluation of the national pediatric care and treatment program found weaknesses throughout the system. PEPFAR Côte d'Ivoire will work to address these weaknesses through strengthening of provider-initiated counseling and testing (PICT) for children at all points of entry, home visits, and other pediatric care interventions. Through support to the Ministry of Solidarity, Women, Families, and Children (MSFFE), PEPFAR will also work with the government of Côte d'Ivoire to improve district level coordination among government agencies and civil society.

In FY 2015, PEPFAR Côte d'Ivoire will continue supporting clinical partners to integrate HIV testing, care, and treatment into TB centers and improve TB diagnostics among PLHIV. PEPFAR will support Côte d'Ivoire's national TB control program (PNLT) in comprehensive TB/HIV co-management and decentralizing multidrug-resistant tuberculosis (MDR-TB) treatment, and support scale-up of PICT in all TB clinics. 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.

PEPFAR Côte d'Ivoire will continue to work to improve TB diagnostics among PLHIV with diagnostics technology through support for use and maintenance of GenXpert. PEPFAR will continue to work with the World Health Organization (WHO) to ensure that national guidelines requiring 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 Global Fund to track and treat detected multidrug-resistant tuberculosis (MDR-TB) cases, and work with the government to ensure a national committee is put in place to ensure the revision of testing algorithms.

In FY 2015, PEPFAR Côte d'Ivoire will increase its focus on gender awareness throughout all its HIV/AIDS programs, including reaching more girls and women with care and treatment services, positive-prevention interventions for young HIV-positive women, stigma-reduction campaigns, and integration of family planning services.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Cote d'Ivoire	$ 8,767,469	$ 4,367,173	$ 7,915,388	$ 5,905,904	**$ 26,955,934**
	Totals FY09-FY13	**$ 28,339,002**	**$ 23,936,488**	**$ 41,650,444**	**$ 39,739,809**	**$ 133,665,743**
2015 (est)	Cote d'Ivoire					**$ 31,220,414**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, PEPFAR Côte d'Ivoire will continue to provide technical assistance for the development and implementation of decentralized health development plans in twelve regions. 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.

In alignment with the National Strategic Plan for HIV/AIDS, PEPFAR Côte d'Ivoire will continue to support efforts to build shared responsibility, coordination, sustainability, and management capacities at all levels among government agencies and civil society. National institutions include the Ministry of Health and the Fight against AIDS (MSLS), the national program of medical care for people living with HIV within the MSLS (PNPEC), the Ministry of Education, the Ministry of the Solidarity of the Family, Women and Child (MSFFE), the National Program for Orphans and Vulnerable Children (PNOEV), the National Public Health Reference Laboratory (LNSP), the National Institute of Training of Health Workers (INFAS), Institut Pasteur-CI, and the Directorate for Medical Infrastructure.

As Global Fund performance is essential for PEPFAR's success, PEPFAR will continue to work closely with the Global Fund Country Coordinating Mechanism (CCM) to improve its management structure and governance, including participation in the CCM HIV sub-committee. PEPFAR will focus on ensuring that the CCM committees have strengthened capacity in the critical functions of the CCM, including grant oversight, and that PRs and civil society advocacy networks have strengthening leadership and management skills to implement, monitor, and evaluate programs.

In FY 2015, PEPFAR Côte d'Ivoire will continue full implementation of its governance and systems portfolio, rooted in the health systems strengthening (HSS) strategy (developed in 2013) with input from the government of Côte d'Ivoire and partners, and supported by the Global

Fund, the French Development Agency, and United Nations agencies. In FY 2015, ongoing HSS investments will include:

- Advocacy and support for HSS policies, especially task shifting;
- Technical and financial assistance to government ministries and agencies responsible for ensuring comprehensive HIV services;
- Support to institutions to improve training to personnel providing HIV services;
- Support for regulatory bodies and associations responsible for HIV/AIDS-related registration and credentials.

PEPFAR also will continue to work with the Government of Côte d'Ivoire and other stakeholders to formalize a policy of task shifting among health workers, empowering nurses and midwives to fulfill more HIV/AIDS-related service delivery tasks.

PEPFAR Côte d'Ivoire will provide continuing technical and material support to the MSLS for policy application and development 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.

In FY 2015, PEPFAR will continue to collaborate with stakeholders in strengthening the national supply chain system, with particular emphasis on the supply chain workforce, including capacity building for the Public Health Pharmacy (PSP) to increase skills in forecasting, warehousing, distribution, and tracking of commodities to eventually transition procurement responsibility. PEPFAR will continue to focus on strengthening decentralized commodities management, including providing ongoing support to five SCMS sub-offices and the 20 regional pharmacists it negotiated with the MSLS.

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 Global Fund 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 strategic information efforts will assist in building government and NGO capacity to regularly collect, compile, analyze, verify, 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 activities and data collection, conducting surveys and surveillance, and developing health management information systems (HMIS). In FY 2015, PEPFAR will continue implementing the Strategic Information Management System initiated in FY2014. PEPFAR Côte d'Ivoire also will support studies to strengthen the national evidence base and improve monitoring, evaluation, and reporting skills of implementing partners.

In FY 2015, PEPFAR Côte d'Ivoire will focus on continued support for national institutions to coordinate lab activities, increase educational capacities, support the national program to maintain lab equipment and develop lab policies, support the national TB program, and roll out

GenXpert nationwide. PEPFAR will support training for lab professionals, implementation of decentralized EID and viral load at three regions with highest HIV prevalence, and will develop a comprehensive external quality assessment program for lab-related issues.

Country Engagement

PEPFAR is the largest partner in the national response to HIV/AIDS in Côte d'Ivoire. Country engagement will continue to fulfill the joint 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.

The PEPFAR team will continue to work with the Government of Côte d'Ivoire on providing technical assistance focused on capacity building and quality improvement for HIV/AIDS prevention, care, and treatment programs.

PEPFAR Côte d'Ivoire promotes all major coordination efforts, including HIV/AIDS Technical Working Groups (TWGs), and participates in regular donor coordination meetings with the United Nations, European Union, and French Development Agency (AFD). PEPFAR Côte d'Ivoire participates in the Global Fund CCM and will continue to be instrumental in moving HIV Global Fund grants forward.

PEPFAR Côte d'Ivoire has worked to ensure coverage and support to the national response on an interim basis as feasible in response to limited Global Fund contributions and implementation delays during the last two years, with funding to country just recently resuming. Global Fund Principal Recipients (PRs) are implementing Phase Two of their Round Nine HIV grant. As PEPFAR takes over more clinical services previously covered by the Global Fund, the Global Fund has moved to more procurement of essential commodities, freeing more PEPFAR funds for site support and decentralized service delivery.

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 Congo's ability to provide basic services.

DRC's HIV epidemic is generalized, with a prevalence of 1.0–1.2 percent (ages 15-49) based on 2013 UNAIDS estimates. According to the same projections there is an estimated 32,000 deaths due to AIDS, as well as 170,000 people eligible for antiretroviral therapy (ART) with an estimated 32,000 mothers in need of ART. The majority of HIV transmission in DRC is through heterosexual contact, exacerbated by high-risk sexual practices (such as multiple concurrent partners) and low or inconsistent condom use. Pregnant women are particularly at risk with antenatal care (ANC) surveillance data from 2013 indicating that pregnant women have a prevalence roughly twice that of other women at around 2 percent. Although there is insufficient data on the location, typology, and dynamics of key populations and high-risk groups, the 2012 Integrated Biological and Behavioral Surveillance Survey (IBBS) indicates that HIV prevalence among female sex workers (FSW) is ten times higher compared to the general population in Kinshasa and Katanga with low condom usage during transactional sex.

In an effort to maximize available resources and increase impact, the PEPFAR program will continue focusing efforts 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 in FY 2015. The PEPFAR team has completed its transition towards a health zone model where PEPFAR is focusing efforts in select health zones in three provinces in Kinshasa, Katanga, and Orientale, to increase coverage and a comprehensive package of services. 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 (ARV) 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
2013	$ 66,229,130	30%	$ 52,445,278	24%	$ 43,137,792	20%	$ 58,002,739	26%	$ 219,814,939
Total 2009-2013	**$ 126,453,926**	**35%**	**$ 88,333,563**	**24%**	**$ 48,755,142**	**14%**	**$ 97,185,593**	**27%**	**$ 360,728,224**
2015 (est)	**$ 15,939,308**	**23%**	**$ 25,675,036**	**37%**	**$ 13,574,689**	**20%**	**$ 13,985,968**	**20%**	**$ 69,175,000**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	DRC	$ 27,732,589	$ 2,181,174	$ 19,883,516	$ 3,677,860	$ 4,194,390	$ -	$ 761,321	$ 7,798,280	**$ 66,229,130**
	Totals FY09-FY13	**$ 53,100,373**	**$ 9,712,271**	**$ 33,021,897**	**$ 6,925,145**	**$ 4,663,505**	**$ -**	**$ 761,321**	**$ 18,269,414**	**$ 126,453,926**
2015 (est)	DRC									**$ 15,939,308**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PMTCT remains a key priority of the PEPFAR DRC program. In 2015 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 2015, 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 (TA) to support the Ministry of Health (MOH) and the National Blood Transfusion Program (PNTS) 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 no longer implement generalized HIV counseling and testing (HCT) in low prevalence non-priority provinces and will focus efforts on 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 one percent to support combination prevention activities.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	DRC	$ 1,483,576	$ 37,720,514	$ 3,933,702	**$ 43,137,792**
	Totals FY09-FY13	**$ 1,502,692**	**$ 41,563,755**	**$ 5,688,695**	**$ 48,755,142**
2015 (est)	DRC				**$ 13,574,689**

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In the Democratic Republic of Congo, only an estimated 10 percent of individuals eligible for ART are receiving treatment and only 5 percent 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 support lifelong treatment for pregnant mothers and their families in PEPFAR supported health zones (HZ) and will also continue support for an Option B+ pilot in Katanga in collaboration with UNICEF. In 2015, 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. In FY 2015, PEPFAR will commence new quality assurance and quality improvement activities to improve quality standards at PEPFAR supported sites.

Care

CARE (FY09 - FY13) & FY15 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**
2013	DRC	$ 24,137,458	$ 3,161,364	$ 6,813,319	$ 18,333,137	**$ 52,445,278**
	Totals FY09-FY13	**$ 35,041,319**	**$ 6,075,124**	**$ 14,531,359**	**$ 32,685,761**	**$ 88,333,563**
2015 (est)	DRC					**$ 25,675,036**

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In FY 2015, 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 package with linkages between health facilities and communities within targeted HZ. 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 2015, new OVC implementing partners will focus efforts 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 Democratic Republic of Congo 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 - FY13) & FY15 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**
2013	DRC	$ 8,422,162	$ 16,576,318	$ 22,933,720	$ 10,070,539	**$ 58,002,739**
	Totals FY09-FY13	**$ 12,991,957**	**$ 26,501,969**	**$ 30,570,458**	**$ 27,121,209**	**$ 97,185,593**
2015 (est)	DRC					**$ 13,985,968**

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PEPFAR remains committed to building leadership and fostering country ownership as outlined in the Partnership Framework (PF). The U.S. government program 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, 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 2015, 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. Additionally, PEPFAR DRC will support an AIDS Indicator Survey (AIS), key population mapping and size estimation to ensure that data remains the key vehicle to drive programming and investments.

Country Engagement

PEPFAR's role in the national HIV/AIDS response is directly aligned with the MOH National Health Development Plan for 2011-2015 which covers major causes of mortality and morbidity in the country. The main goals of both Global Health Initiative, (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 National AIDS Control Program (PNLS) and the National Multi-Sectorial Program for the Fight against AIDS (PNMLS). In FY 2014, the PEPFAR DRC team substantially supported the PNLS in its development of the 2014-2017 (NSP), and will maintain efforts to support PNLS as it operationalizes the UNAIDS Investment Case. PEPFAR DRC will also continue to advocate 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 90 million. Despite impressive economic growth, Ethiopia remains a low-income country with a real per capita income of US $471 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 173 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 (DHS) 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 the 2005 DHS data suggests stable low HIV prevalence of 0.6 percent in rural areas, but substantial declines from 5.5 percent to 4.2 percent in urban areas. 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).

SPECTRUM (a modeling system) projections combining DHS and antenatal care (ANC) data estimate a rapidly declining mixed epidemic where incidence has fallen to 0.03 percent, a 60 percent reduction since 2005. Available data suggests that the majority of new HIV infections are caused by sexual transmission, especially within sero-discordant couples and among key populations. Among the general population, HIV/AIDS awareness is extensive.

Ethiopia is one of 25 countries in Africa that has shown at least a 50 percent decrease in new infections and the number of deaths due to HIV/AIDS since 2005. It is also one of the 13 countries to pass the “tipping point”, where the number of HIV-positive patients starting on anti-retroviral treatment (ART) exceeds the number of new infections.

In FY 2015, PEPFAR Ethiopia will continue programs and activities in support of the Government of Ethiopia’s Growth and Transition Plan (GTP), as well as the 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 PEPFAR 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. The Government of Ethiopia has recently adopted the 2013 World Health Organization (WHO) revised guidelines for initiation of ART for all adult patients at CD4<500, treatment for all HIV/Tuberculosis (TB) co-infected

patients, treatment for all HIV-positive pediatric patients, and rollout of Option B+ (ART throughout pregnancy and breastfeeding for affected women).
In FY 2015, PEPFAR Ethiopia will focus on saving lives and preventing new HIV infections. It intends to consolidate gains achieved to date, continue program realignment, consolidate implementing partners, and focus on country ownership. PEPFAR Ethiopia will utilize the most updated available epidemiological information and site-level strategic information to inform a more targeted evidence-based program, and will continue the momentum to transition activities to the Ethiopian government, civil society, and the private sector.

Focus activities include:

- The major components of the clinical care and treatment program within the public sector, including implementation of WHO guidelines, support for adherence, laboratory technical assistance, and ongoing quality improvement measures;
- Combination prevention activities;
- Ongoing health systems strengthening (HSS) technical assistance to strengthen the supply chain, health management information systems (HMIS), and human resources for health (HRH); and
- Programs to support orphans and vulnerable children (OVC).

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
2013	$ 42,098,104	26%	$ 39,638,092	25%	$ 38,895,076	24%	$ 39,462,371	25%	$ 160,093,643
Total 2009-2013	**$ 340,668,837**	**27%**	**$ 272,370,317**	**21%**	**$ 332,456,443**	**26%**	**$ 329,956,678**	**26%**	**$1,275,452,275**
2015 (est)	**$ 19,018,865**	**13%**	**$ 23,952,428**	**16%**	**$ 60,264,165**	**41%**	**$ 43,977,543**	**30%**	**$ 147,213,000**

*Totals include planned funding for all accounts.
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Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Ethiopia	$16,525,814	$ 1,444,921	$ 12,606,125	$ 2,740,528	$ 3,391,283	$ -	$ 761,175	$ 4,628,258	**$ 42,098,104**
	Totals FY09-FY13	**$95,903,577**	**$ 29,593,668**	**$ 132,264,167**	**$ 14,133,276**	**$ 21,399,436**	**$ 14,226**	**$ 3,301,920**	**$ 44,058,567**	**$ 340,668,837**
2015 (est)	Ethiopia									**$ 19,018,865**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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. PEPFAR will focus its prevention efforts on key populations (particularly commercial sex workers (CSWs)), discordant couples, and other at-risk populations as the main drivers of the epidemic. These populations include mobile populations, daily laborers, migrant workers, uniformed services, sexually active unmarried urban youth, divorced or widowed adults, and clients of CSWs. There will continue to be an increased focus on geographic regions that 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. PEPFAR Ethiopia will continue to support a national condom strategy.

A hallmark of FY 2015 will be accelerated work on prevention of mother-to-child transmission of HIV (PMTCT). The government of Ethiopia is prioritizing PMTCT, and PEPFAR Ethiopia will support its accelerated plan to improve PMTCT, including the rollout of Option B+ and ongoing advocacy to focus PMTCT efforts in geographic areas where the HIV prevalence is highest, including urban areas, market towns, and other hotspots. Although the Ethiopian government is taking the lead in community mobilization through its "Health Development Army," a community mobilization initiative to encourage retention and reduce loss to follow-up, PEPFAR Ethiopia will continue to support efforts to increase demand for ANC and PMTCT services and promote better integration of services at facilities, including leveraging bilateral resources.

A major focus for PMTCT in FY 2015 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 therapy (ART). In order to better capture the impact of these efforts, PEPFAR Ethiopia will continue to 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 also begin redirecting its support to higher volume clinics and provide technical assistance to regional

health bureaus (RHBs) to oversee services in lower yielding facilities in preparation for transition.

PEPFAR Ethiopia will provide continued and more targeted support for HIV counseling and testing (HCT) to maximize coverage and improve quality assurance for testing of key populations. Fewer HCT investments will be made in populations with low prevalence, such as university students and farm workers. Prevention focused on low-prevalence populations or the general population will shift to the Ethiopian government or other donors. In regions with low HIV prevalence, PEPFAR support for provider-initiated counseling and testing (PICT) will be through selected clinics with potential for higher prevalence, including TB, ANC, and sexually-transmitted infection (STI) clinics. PEPFAR will also promote decreasing the frequency of repeat testing to every six months in high-risk groups, and will work to ensure that rapid test kits (RTKs) are re-validated in line with WHO guidelines.

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, voluntary medical male circumcision (VMMC) activities are focused in Gambela region and within the uniformed services.

In FY 2015, PEPFAR will increase its focus on improving linkages and referrals from outreach to testing and clinical services. In sites where PEPFAR provides HCT, a standard of accompanied referral for HIV-positive cases will be employed.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Ethiopia	$ -	$ 35,485,156	$ 3,409,920	**$ 38,895,076**
	Totals FY09-FY13	**$ 28,921,821**	**$ 277,340,899**	**$ 26,193,723**	**$ 332,456,443**
2015 (est)	Ethiopia				**$ 60,264,165**

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PEPFAR Ethiopia will continue support for the provision of quality ART in varying facilities in areas with the highest prevalence. PEPFAR Ethiopia will continue to focus on treatment linkage, engagement, and retention of all people living with HIV (PLHIV) within the health network and between health facilities and community services. In FY 2015, PEPFAR Ethiopia will continue to consolidate the transition of the comprehensive clinical care and treatment program to RHBs with a single technical assistance transition partner. Local partners also will be engaged in

building the capacity of RHBs. Maintaining and improving quality of clinical services will continue to be strengthened and monitored during and after this transition.

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 CSWs.

In FY 2015, PEPFAR Ethiopia will work to better identify children at risk of HIV infection through improved EID, specifically family matrices, index case testing, expanded outreach to OVC populations, and improved linkages to HCT, care, and treatment. Moreover, in FY 2015 PEPFAR Ethiopia will have a renewed focus on increasing access to and quality of pediatric HIV care. PEPFAR will promote PICT services at child health care service delivery points, enhanced linkages through case managers, improved quality of pediatric HIV/AIDS care, linkages to OVC programs, and strengthened monitoring and evaluation of pediatric programs.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Ethiopia	$ 18,824,641	$ 1,280,017	$ 4,453,434	$ 15,080,000	**$ 39,638,092**
	Totals FY09-FY13	**$ 109,679,860**	**$ 11,474,698**	**$ 34,487,797**	**$ 116,727,962**	**$ 272,370,317**
2015 (est)	Ethiopia					**$ 23,952,428**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, PEPFAR Ethiopia will continue to focus on strengthening the entire continuum of care, with renewed focus on improving retention within HIV care and treatment services. Community level interventions, implemented through associations and networks of PLHIV for peer support and adherence counseling, will be utilized. 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. There will also be additional focus on integration of HIV/AIDS services into other routine health services, such as ANC, TB, family planning, and reproductive health. PEPFAR will provide capacity building efforts as the program looks forward to transition of these programs to community partners.

Adult care and support activities, built on a family-centered approach, will continue to include clinical assessments, viral load testing; routinely providing co-trimoxazole prophylaxis; components of Positive Health, Dignity, and Prevention (PHDP); nutritional support as both therapeutic and supplementary feeding for eligible PLHIV; PLHIV support groups; psychosocial care; and the basic preventive package (water guard, de-worming, condoms, insecticide-treated nets) when required.

In FY 2015, PEPFAR Ethiopia will focus on integration of TB/HIV services into other health programs, and improve TB/HIV access for key populations. PEPFAR will work to consolidate the TB gains made in previous years.

PEPFAR is also focusing on pediatric HIV services, especially accelerating case finding and increasing enrollment in care and treatment. Through a more targeted approach to care and treatment services, PEPFAR will continue to support the provision of technical assistance to support a comprehensive pediatric HIV service package, including growth assessments, counseling and support for infant feeding, testing for and management of opportunistic infections (including TB), basic preventive services, and nutritional support. To ensure retention in care, referral networks will be reinforced, including strengthened linkages between pediatric care, PMTCT, and OVC programs. PEPFAR will continue to focus on strengthening EID and task shifting.

PEPFAR Ethiopia will continue to aim to reduce vulnerability among OVC and their families by strengthening systems and structures to deliver quality essential services and increase household resiliency, and improve OVC program retention. These activities will include economic strengthening for OVC and nutritional and psychosocial support, as well as technical assistance to increase task-shifting, improve OVC guidelines, monitoring & evaluation related to OVC, and access to key services.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Ethiopia	$ 5,753,125	$ 9,764,771	$ 19,489,722	$ 4,454,753	**$ 39,462,371**
	Totals FY09-FY13	**$ 62,476,956**	**$ 74,871,730**	**$ 117,521,024**	**$ 75,086,968**	**$ 329,956,678**
2015 (est)	Ethiopia					**$ 43,977,543**

*Totals include planned funding for all accounts.
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PEPFAR Ethiopia will directly provide key technical and managerial support both at the federal Ministry of Health (MOH) and RHB levels which includes the federal/regional HIV/AIDS Prevention and Control Office (HAPCO) structure. In FY 2015, PEPFAR will continue support

to MOH and RHBs in leadership, management, and governance related capacity building activities aimed at improved coordination and management of HIV/AIDS services, including training, regulatory reform, and quality improvement. This will include strengthening local professional associations, improved service standardization, and strengthening of certification and accreditation (both health workers and health sites) 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 2015. Human resources for health programs will include: pre-service and postgraduate training of key health cadres and the development of in-service training centers resulting in gradual transition of demand-driven training to in-country, primarily government, partners. PEPFAR support for pre-service training will be complemented by the centrally funded Medical Education Partnership Initiative (MEPI) and Nursing Education Partnership Initiative (NEPI), telemedicine and e-learning opportunities, and support for FMHACA to develop legal and regulatory frameworks for licensing and certification of health professionals and accreditation of facilities. In continued support of task shifting, in FY 2015 PEPFAR will continue to provide comprehensive support for training of health extension workers, establishing a social worker education program, and training a broad range of community health and para-social workers.

In coordination with other development partners, including the WHO and United Nations agencies, PEPFAR has been a key player in strengthening health systems in Ethiopia. PEPFAR Ethiopia will continue strategically support HSS activities, including supply chain and logistics, and health finance.

In FY 2015, PEPFAR Ethiopia will also continue to support private facilities to expand their role in the delivery of HIV services, including improving regulations affecting the private sector.

PEPFAR will continue to support capacity building of the public health supply chain and regulatory system, primarily through HAPCO and the Pharmaceutical Funds and Supply Agency (PFSA). 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. This is the national Government of Ethiopia's plan to manage pharmaceutical logistics in-country. In FY 2015, PEPFAR will shift to a systems development approach to create a more comprehensive, effective, and efficient supply chain. Supply chain activities include: support to the Government of Ethiopia to monitor and regulate pharmaceuticals and better conduct quantifications, forecasts, and procurement planning for HIV commodities; improve warehousing, especially standard operating procedures (SOPs) and storage capacity; capacity building at the site level to monitor stock; capacity building to FMHACA to increase regulatory, monitoring & evaluation, and strategic information capabilities; and improved strategic information systems related to supply chain management.

PEPFAR Ethiopia will continue to support the Ethiopian Government's integrated national laboratory master plan, including support for expansion of the integrated national external quality assurance program, covering ART, CD4, viral load, and others, with emphasis on ensuring quality in all testing facilities and building regional capacity. In FY 2015, lab support will focus on strengthening EID, strengthening quality assurance and capacity building for

regional labs, continued systematic implementation of WHO/Regional Office for Africa (AFRO) accreditation, support for existing point of care tests and introduction of new equipment, and continued support for ART monitoring. Implementation of the PEPFAR-supported MOH equipment maintenance strategy to better decentralize equipment maintenance to regions will be an FY 2015 priority.

PEPFAR will continue to support surveillance systems, monitoring & evaluation, national health management information systems (HMIS), population based surveys, HIV case surveillance, and training in monitoring & evaluation, biostatics, and other strategic information areas. PEPFAR Ethiopia will continue to work closely with the Government of Ethiopia on planning, development, and implementation of the AIDS Indicator Survey (AIS), which will provide more detailed AIDS-specific data and complement the forthcoming DHS-plus.

In addition, PEPFAR will continue to support the MOH and RHBs through targeted technical assistance to implement health sector financing reforms, including support to establish legal frameworks, training, strengthening facility governance and management, and improved access to health insurance schemes.

Country Engagement

FY 2015 will continue to build upon a series of key Ethiopian government strategic plans spanning the next five years. This foundation will provide a strong platform for the PEPFAR program. There is strong country ownership of programs with open dialogue around how PEPFAR contributes to Ethiopia's strategic directions.

Along with Global Fund and UNAIDS, PEPFAR is supporting the Government of Ethiopia's efforts to develop the Investment Case, and seeking to best leverage available resources within this framework. There will continue to be increased information-sharing on the supply chain to ensure availability of supplies and reduce duplication of inputs from Global Fund and PEPFAR.

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

As the Ethiopian government begins to take more ownership of the HIV/AIDS program, especially the care and treatment programs, PEPFAR 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 2013. Sexual transmission accounts for over 80 percent of new infections. 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 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. 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 (PHDP) for people living with HIV (PLHIV); and
- Strengthening national systems to carry out the nation's prevention, treatment, and care programs.

Below is a table 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
2013	$ 5,777,789	46%	$ 1,401,581	11%	$ -	0%	$ 5,320,630	43%	$ 12,500,000
Total 2009-2013	**$ 33,219,342**	**47%**	**$ 7,621,413**	**11%**	**$ 2,402,824**	**3%**	**$ 27,115,648**	**39%**	**$ 70,359,227**
2015 (est)	**$ 4,068,566**	**33%**	**$ 2,365,016**	**19%**	**$ -**	**0%**	**$ 5,863,418**	**48%**	**$ 12,297,000**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Ghana	$ -	$ -	$ 4,977,789	$ -	$ -	$ 300,000	$ -	$ 500,000	**$ 5,777,789**
	Totals FY09-FY13	**$ 1,935,832**	**$ 1,500,000**	**$ 23,464,310**	**$ 530,000**	**$ -**	**$ 690,000**	**$ 260,000**	**$ 4,839,200**	**$ 33,219,342**
2015 (est)	Ghana									**$ 4,068,566**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 is through a suite of mutually reinforcing interventions to address the risks of transmission and acquisition including biomedical, behavioral, and structural. Activities include 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. 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 2015 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 with 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.

The PEPFAR program continues to be closely aligned with the Ghana National HIV and AIDS Strategic Plan (2011-2015) and continues to focus on HIV combination prevention among key populations, their clients, and their intimate partners. In FY 2015, PEPFAR Ghana will expand efforts to improve the quality of clinical and community services and to strengthen linkages between community and health system services. In particular, a community based quality assurance system for key populations interventions will be introduced nationally across interventions, irrespective of the funding source.

PEPFAR Ghana will continue to support to civil society organizations (CSOs) to improve the capacity of community services to monitor, evaluate and improve the quality of their services for

key populations and PLHIV. It will support the strengthening of bidirectional linkages between clinical and community programs services and will promote the provision of timely referrals to ensure access to critical prevention, care, support, and treatment services.

PEPFAR Ghana will continue to support community-based organizations (CBOs) to deliver quality services including HIV diagnosis, case management, and the provision of other support to PLHIV.

PEPFAR Ghana will support the finalization and dissemination of national standard operating procedures which define and standardize the quality of HIV services provided by community-based organizations (CBOs). The US government will also continue to support NGOs/CBOs to function as umbrella organizations which manage the provision of services by other NGOs/CBOs. In addition, the US government will continue to provide support to strengthen CBO institutional capacities in the areas of grant/proposal development, financial management, monitoring, evaluation and reporting.

Treatment

TREATMENT (FY09 - FY13) & FY15 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	$ -	$ -	$ -	**$ -**
2013	Ghana	$ -	$ -	$ -	**$ -**
	Totals FY09-FY13	**$ -**	**$ 1,542,824**	**$ 860,000**	**$ 2,402,824**
2015 (est)	Ghana				**$ -**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 2015, but will support strengthening of the supply chain.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Ghana	$ 1,101,581	$ -	$ 300,000	$ -	**$ 1,401,581**
	Totals FY09-FY13	**$ 3,417,413**	**$ 854,000**	**$ 1,940,000**	**$ 1,410,000**	**$ 7,621,413**
2015 (est)	Ghana					**$ 2,365,016**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The positive health, dignity, and prevention (PHDP) program for PLHIV program will continue to work through monthly meetings of 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 Ghana military's capacity to conduct quality HIV and AIDS programming and help provide lab accreditation.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Ghana	$ 908,500	$ 1,187,750	$ 2,256,740	$ 967,640	**$ 5,320,630**
	Totals FY09-FY13	**$ 4,435,612**	**$ 7,470,186**	**$ 7,758,134**	**$ 7,451,716**	**$ 27,115,648**
2015 (est)	Ghana					**$ 5,863,418**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 technical assistance to strengthen data quality. 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.

PEPFAR Ghana has supported strengthening of the Global Fund Country Coordinating Mechanism in its new functions under the Global Fund New Funding Mechanism that started 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 adults between the ages of 15-49 is 6.3 percent. HIV prevalence in Kenya varies considerably by geographical region, age, sex, location and socio-economic status. . Significant differences exist in HIV prevalence by age and gender. For pregnant women, antenatal care (ANC) HIV prevalence currently stands at 7.4 percent (ANC sentinel surveillance 2011). People in the top wealth quintiles have higher prevalence at 7.2 percent compared to those of lower quintile (4.6 percent) (Kenya AIDS Epidemic Survey 2011). 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.

PEPFAR Kenya key priorities in FY 2015 include treatment scale-up, supporting Option 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 2015 the PEPFAR team and Kenyan government will work on a road map for sustainability planning and increased country ownership. In FY 2015, PEPFAR Kenya will continue to align its geographical focus with the most updated epidemiological data available.

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

Fiscal Year	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
2009	$ 159,575,761	28%	$ 118,515,077	21%	$ 194,393,690	34%	$ 92,471,065	16%	$ 564,955,593
2010	$ 151,999,111	28%	$ 113,194,154	21%	$ 190,984,440	35%	$ 91,941,736	17%	$ 548,119,441
2011	$ 149,725,654	29%	$ 111,424,380	22%	$ 172,649,013	33%	$ 83,488,128	16%	$ 517,287,175
2012	$ 89,747,085	35%	$ 60,206,328	23%	$ 59,123,573	23%	$ 50,961,697	20%	$ 260,038,683
2013	$ 92,102,393	33%	$ 48,925,817	18%	$ 88,867,000	32%	$ 45,104,790	16%	$ 275,000,000
Total 2009-2013	**$ 643,150,004**	**34%**	**$ 452,265,756**	**24%**	**$ 706,017,716**	**37%**	**$ 363,967,416**	**19%**	**$1,890,400,892**
2015 (est)	**$ 85,971,780**	**23%**	**$ 91,918,332**	**25%**	**$ 142,324,049**	**38%**	**$ 51,465,839**	**14%**	**$ 371,680,000**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Kenya	$ 25,912,303	$ 4,732,027	$ 16,069,804	$ 5,693,072	$ 3,271,338	$ 3,993,979	$12,405,190	$ 20,024,680	**$ 92,102,393**
	Totals FY09-FY13	**$ 142,698,573**	**$ 108,051,260**	**$ 126,802,243**	**$ 31,723,647**	**$ 17,081,342**	**$ 7,387,239**	**$63,089,667**	**$ 146,316,033**	**$ 643,150,004**
2015 (est)	Kenya									**$ 85,971,780**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, 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.

Key populations will remain a large focus in PEPFAR's prevention program in Kenya for FY 2015. Female sex workers (FSW) and men who have sex with men (MSM) will be targeted with interventions including health education, provision of condoms, HIV counseling and testing (HCT), sexually transmitted infection (STI) screening, and linkages to care and treatment. In addition to strengthening the policy environment, activities for people who inject drugs (PWID) will include HCT. Training and capacity building will focus on both service providers and the community in order to develop comprehensive approaches for supporting injecting drug users (IDU). A close collaboration will be fostered with other non-PEPFAR partners to leverage support for needle and syringe exchange program (NSP), and condom procurement and distribution for PWID and sexual partners. The HIV prevention interventions targeting the military populations in the country will include HCT and condom provision scale up to increase PEPFAR's impact.

PEPFAR Kenya will continue to prioritize HIV HTC for couples that lack knowledge of their HIV status key populations, and in high prevalence and burden areas. HCT in health facilities, a low-cost model, will be scaled-up and home-based testing and counseling and outreach services will be provided in regions of high HIV prevalence and with poor access to services. The program will strengthen linkage of clients testing HIV positive to care and treatment. Innovative strategies will be encouraged including but not limited to physical escort of the client, attaching client to a community health worker who will support the client and ensure access to and enrolment into care and treatment services is achieved. In order to strengthen linkage from HCT to care and treatment, having quarterly review meetings in specific regions will enhance communication between the HCT providers and care and treatment staff. Both the HCT and care and treatment services will be expected to keep proper records of the linkages. Specifically the program will maintain cohort records for key populations and maintain periodic testing as per the national guidelines.

In FY 2015, 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. The program will use a number of strategies: increase the number of males who are circumcised for HIV prevention through demand creation strategies in low VMMC coverage focusing on non-circumcising communities, scale-up of adult, adolescent and infant circumcision strategies and advocacy plans with evaluation of new devices, continue to gain efficiencies through task shifting to nurses allowing them to perform the procedure, and use of combination prevention strategies including HCT, linking those identified as HIV positive to care and treatment, and promoting behavior change aimed at consistent condom use and avoidance of multiple sexual partnerships.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Kenya	$ 5,935,585	$ 73,774,826	$ 9,156,589	**$ 88,867,000**
	Totals FY09-FY13	**$ 244,994,685**	**$ 407,317,106**	**$ 53,705,925**	**$ 706,017,716**
2015 (est)	Kenya				**$ 142,324,049**

*Totals include planned funding for all accounts.
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In FY 2015, 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 therapy (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, and increasing access of ART to key populations.

PEPFAR has aligned its prevention of Mother-to-Child transmission of HIV (PMTCT) programs to the Kenyan government's plan for the elimination of MTCT (eMTCT) and 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. Under the eMTCT framework for Kenya PEPFAR will support the government by: providing technical assistance through capacity building, implementation of highly active antiretroviral therapy (HAART) for pregnant and breastfeeding HIV+ women by supporting dissemination of the new guidelines using the National Harmonized HIV training curriculum and provision of ART, integration of PMTCT into the broader maternal, newborn, and child health (MNCH) services, especially linkages to safe delivery and strengthening the delivery of a quality comprehensive package of MNCH services including retention of mother and infant pairs, and strengthening linkages and referrals between facility and community.

PEPFAR will also continue supporting blood safety and injection safety programs to ensure elimination of HIV transmission in healthcare settings.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Kenya	$ 13,444,830	$ 2,130,225	$ 10,389,241	$ 22,961,521	**$ 48,925,817**
	Totals FY09-FY13	**$ 161,101,740**	**$ 20,151,696**	**$ 77,197,323**	**$ 193,814,997**	**$ 452,265,756**
2015 (est)	Kenya					**$ 91,918,332**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR Kenya has made tremendous progress in delivering HIV care and support services. In FY 2015, 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 will also continue to support community activities that directly influence effective linkages to treatment and retention in HIV medical care.

PEPFAR Kenya will increase support to orphans and vulnerable children (OVC) in Kenya with emphasis on improved quality of care and will prioritize household economic strengthening, vocational training and linkage to national social safety net programs. PEPFAR OVC partners will also support the continuum of response through HCT coverage and linkage of HIV-infected OVC to care. PEPFAR 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.

HIV service implementation will continue to be transitioned to local organizations to increase coverage, efficiency, and country ownership for long-term sustainability. In FY 2015, PEPFAR will work closely with the Kenyan government and other development partners to ensure support, such as the Global Fund and UNICEF, are fully leveraged to maximize competencies, synergies and sustainability across care services, particularly for community-based services. Efficiencies will be emphasized through partner quarterly and portfolio reviews to assess achievements against targets and budgets.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Kenya	$ 13,876,507	$ 14,964,165	$ 5,697,667	$ 10,566,451	**$ 45,104,790**
	Totals FY09-FY13	**$ 104,020,859**	**$ 93,034,307**	**$ 54,235,428**	**$ 112,676,822**	**$ 363,967,416**
2015 (est)	Kenya					**$ 51,465,839**

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Since the March 2013 elections, Kenyans have observed a restructuring of government. The transition has simultaneously included the transfer of power and resources from the center to the sub-national level and a re-organization of local government, including the creation of 47 new county systems. Within the past year, restructuring of the Ministry of Health (MOH) included the merger of the two former health ministries, with changes in staffing and key directorates. Counties assumed responsibility for health service delivery, although this mandate has been exercised to varying degrees across the counties.

In FY 2015, PEPFAR Kenya will continue to work with the Kenyan government to strengthen governance structures, provide better access to training at the county level to increase production of key staff cadres and expand the capacity of training institutions. The PEPFAR program will also assist the new Health Ministry to finalize key policies and guidelines stemming from the new Constitution thus ensuring a smooth transition to a devolved health sector.

The human resources for health systems strengthening activities in FY 2015 will continue to focus on HIV /AIDS prevention interventions in the country. Health workforce hiring on contract to work in the underserved regions at both the facility and community levels, has seen great achievement in reaching out to larger and especially underserved populations. Many contracted health workers have been transitioned to the government payroll in the last financial year and this has contributed towards sustainability of the program.

In FY 2015, PEPFAR will continue address supply chain needs so counties can procure medical products. PEPFAR will also assist with mainstreaming HIV/AIDS issues in county governments to help shape policy; clarify responsibilities and ensure alignment with national objectives; strengthen coordination of government and partner efforts as an input to county strategic planning/budget process; and facilitate access of key staff to relevant leadership, management and governance trainings.

PEPFAR will continue to 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.

Country Engagement

PEPFAR activities are planned and coordinated within the context of Kenya's National AIDS Strategic Plan (KNASP). As it relates to the HIV/AIDS response, a review of the Kenya National AIDS Strategic Plan (KNASPIII) was undertaken in 2013 and a position paper developed to assess the implications of the changing policy and governance arrangements under devolution. The Ministry of Health and the National AIDS Control Committee continue to navigate the HIV/AIDS program through the many reforms envisioned under the devolved government, and are leading the development of both a new KNASP IV and a longer term HIV Investment Plan. Sustainability and transition planning remain the hallmark of PEPFAR programs, including deliberate efforts to strengthen policy and governance at national and county levels; integrate parallel supply chains within the national system; build institutional capacity and systems for producing qualified health workers; and increase domestic financing for HIV through health financing reforms and private sector engagement.

The Global Fund continues to play an important role in support of HIV treatment in Kenya. Global Fund financing supports ARV drugs, condoms 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.

PEPFAR, jointly with the Ministry of Health (MOH), Global Fund and other stakeholders including UNICEF will accelerate and support antiretroviral therapy (ART) scale up. The Kenya HIV Program is well coordinated by the MOH through the National AIDS and STI Control Program (NASCOP). The National ART Task Force, which is led by NASCOP and includes stakeholders from development and implementing partners, provides leadership and oversight for planning and implementation of the ART program. Through joint planning and collaboration, the use of Government of Kenya, Global Fund and PEPFAR resources is coordinated to avoid duplication and improve efficiency.

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. PEPFAR 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 agriculture 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 one of the highest HIV prevalence in the world at just over 23 percent, 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, aged 0-14. At least two percent of people who need treatment are not accessing it. New infections dropped from 27,000 to 23,000 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. In FY 2013, the Government of Lesotho reviewed and revised their National Strategic Plan for HIV and AIDS 2011/12 – 2015/16. The revision included resource mapping, costing and gap analysis of prioritized activities. 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.

The Lesotho PEPFAR Team undertook an exhaustive re-alignment process and evidence-based priority setting exercise in FY 2013. The PEPFAR Focus in FY 2014 will be to support rapid scale up of programs as detailed in the National Strategic Plan through:

1. Strengthening the national continuum of response to reach a "tipping point" ration of less than 1 by FY 2015 and sustain it over the next three years while increasing national antiretroviral treatment (ART) coverage to at least 80 percent;

2. Focus on linkages, retention and quality assurance of services to strengthen the continuum of response;
3. Focus on the prevention portfolio on clinical service demand creation;
4. Improving the quality of Ante Natal Care (ANC) and delivery services to increase and expand the pool of women and infants accessing PMTCT and pediatric services; and
5. Fostering increased sustainability within the PEPFAR long-term strategy approach by increasing capabilities and capacity of health systems to manage the growing workload.

Below is a table 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
2013	$ 14,590,452	43%	$ 8,224,498	24%	$ 2,376,552	7%	$ 9,008,498	26%	$ 34,200,000
Total 2009-2013	**$ 53,190,962**	**37%**	**$ 34,615,153**	**24%**	**$ 6,163,266**	**4%**	**$ 48,725,619**	**34%**	**$ 142,695,000**
2015 (est)	**$ 9,604,542**	**29%**	**$ 10,163,438**	**30%**	**$ 8,823,427**	**26%**	**$ 5,096,593**	**15%**	**$ 33,688,000**

*Totals include planned funding for all accounts.
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Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Lesotho	$ 3,094,466	$ 54,173	$ 2,454,041	$ 811,119	$ 15,916	$ -	$ 4,679,687	$ 3,481,050	**$ 14,590,452**
	Totals FY09-FY13	**$ 13,519,172**	**$ 5,285,696**	**$ 7,914,429**	**$ 3,346,771**	**$ 27,773**	**$ -**	**$10,904,536**	**$ 12,192,585**	**$ 53,190,962**
2015 (est)	Lesotho									**$ 9,604,542**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, PEPFAR will continue to support the Government of Lesotho to implement the National Strategic Plan (NSP) with the goal of acceleration and intensification of HIV prevention in order to reduce new annual HIV infections by 50 percent by 2015. Building on the COP 13 review and prevention technical working group visit, the COP 14 prevention portfolio has reinforced People Living with HIV (PLHIV) as a priority population to link to clinical services. Core multi-channel communication activities will limit mass media investments and elevate and segment, condom programming to high risk key populations including sex workers and men who have sex with men. HIV testing and counseling remains the key entry point to clinical services

and COP 14 has re-balanced community and provider initiated HIV testing and counseling to leverage better yields while maintaining early identification of HIV positive Basotho.

The Ministry of Health (MOH) launched its Voluntary Medical Male Circumcision (VMMC) program in February 2012. Over 40,000 VMMCs have been conducted which is more than 95 percent of the total national target. Early infant male circumcision (EIMC) services were introduced in 2013. PEPFAR supports activities to reach the VMMC primary audience including school mobilization, workplace mobilization, a toll-free hotline, and radio programs to engage men about VMMC.

PEPFAR Lesotho will continue to support the national PMTCT program. In April 2013, Lesotho moved to nationwide implementation of Option B+ (lifelong treatment for pregnant women). This shift comes with a whole cascade of activities to strengthen the national, district, and local health systems in quality improvement, strategic information, surveillance, provider-initiated testing and counseling (PITC), improved (evidence based and measurable) community-based approaches, and human resources for health. Building on the current PMTCT acceleration plan, in FY 2015 PEPFAR will closely monitor HIV positive mother-infant pairs to ensure HIV-free survival of HIV exposed infants.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Lesotho	$ -	$ 1,340,444	$ 1,036,108	**$ 2,376,552**
	Totals FY09-FY13	**$ -**	**$ 3,392,677**	**$ 2,770,589**	**$ 6,163,266**
2015 (est)	Lesotho				**$ 8,823,427**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 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.

The MOH has adapted their ART guidelines to conform to 2013 WHO guidelines. Adult and pediatric treatment budget allocations will increase in FY 2015 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 and support the supply chain office to forecast for an increase in patients as a consequence of B+ and the new CD4 cutoff. At the core of the approach is the building of local capacity of the district health management teams to manage quality health services.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Lesotho	$ 1,135,944	$ 399,651	$ 4,158,658	$ 2,530,245	**$ 8,224,498**
	Totals FY09-FY13	**$ 6,003,650**	**$ 3,042,124**	**$ 15,010,661**	**$ 10,558,718**	**$ 34,615,153**
2015 (est)	Lesotho					**$ 10,163,438**

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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.

Identified priorities for FY 2015 for care and support focus on early identification of HIV-infected children and adults, linkage to national care packages, ensuring retention in treatment, increasing coverage, and improving quality. In addition, PEPFAR is supporting the improvement of early diagnosis of TB among people living with HIV (PLHIV) including the expansion of access to rapid diagnostics.

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 - FY13) & FY15 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**
2013	Lesotho	$ 1,867,891	$ 2,622,168	$ 2,279,824	$ 2,238,615	**$ 9,008,498**
	Totals FY09-FY13	**$ 7,435,294**	**$ 7,920,402**	**$ 17,492,430**	**$ 15,877,493**	**$ 48,725,619**
2015 (est)	Lesotho					**$ 5,096,593**

*Totals include planned funding for all accounts.
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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 rollout 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. U.S. government supports MOH to address human resource development in the laboratory setting by supporting in-service training using customized and standardized training modules for HIV diagnosis and monitoring tests, quality management, logistics management information systems (LMIS), and supply

management. 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.

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. PEPFAR will support the MOH rollout the Pharmaceutical Management Information System (PMIS) and the (LMIS) to all service delivery sites, DHMT, and the MOH SCM Unit through an implementing partner. To enhance quality assurance and supervision; PEPFAR will continue to second 8 staff to the MOH through an implementing partner to implement the Supportive Supervision and Mentorship program (SSM) in all 10 districts including MOH headquarters and the NDSO.

Country Engagement

Lesotho is one of PEPFAR's long-term strategy countries and falls in the Global Fund 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 Partnership Framework. 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 make more financial planning decisions in guiding the PEPFAR support. In turn, the PEPFAR Lesotho program will be able to focus increasingly on discrete 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). The 2012 UNAIDS Report estimates the prevalence at 10.8 percent for adults aged 15-49 years. Demographic Health Survey (DHS) data (2010) show significant variations in HIV prevalence, which is highest in the southern and central regions, in urban areas, and in females across all settings and ages.

The Republic of Malawi has a population of over 16 million people in an area of 45,747 square miles. Although the economy has grown considerably over the past five years, Malawi is still one of the poorest countries in the world, ranked 170 out of 187 on the UN Human Development Index. The National AIDS Commission (NAC) reports 1.1 million Malawians living with HIV, with an estimated 46,000 HIV-related deaths in 2012, contributing to Malawi's low life expectancy of 54 years. Malawi has one of the highest Total Fertility Rates in the world at 5.7 and the population is expected to triple by 2040. Malawi is well known in the region for its innovations in streamlining 'the public health approach' to service delivery, which has contributed to the remarkable success of Antiretroviral Therapy (ART) scale-up.

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. In 2011, Malawi switched to Option B+, which placed all HIV-positive pregnant and breastfeeding women on ART for life regardless of CD4 count or clinical staging. Option B+ has provided a platform to aggressively scale-up ART access under a programmatically sustainable approach with the number of sites providing ART increasing from just over 350 in 2011 to 675 in 2013. As of September 2013, 459,261 patients of the 602,000 estimated in need (74 percent) were reported alive and on antiretroviral treatment (ART.) In FY 2013 it is estimated that 66,000 people were newly infected and 103,421 people were newly enrolled on ART, providing a tipping point ratio of less than 1.0 (66,000/103,421 = 0.64), which is a positive metric of progress in the treatment program.

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 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 Global Fund 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.

PEPFAR Malawi has five major areas of focus. 1) Continue scale-up of Option B+ along with integration of services as part of a standard comprehensive package. The focus will be on the quality of HIV care and treatment services with improved retention and adherence, and standardizing linkages with other services. 2) Accelerate momentum of the Voluntary Medical Male Circumcision (VMMC) program. 3) Address the health worker shortage, strengthen laboratory services, undertake infrastructure upgrades, and improve management of supply chains and the security of HIV commodities. 4) Strengthen intentional integration of the community based care and support platform with the facility based care and treatment platform, and expand family planning-HIV prevention, care, and treatment programming for adolescents through public and private sector approaches. 5) As a follow on to the successful Partnership Framework (PF), work with the Government of Malawi civil society organization (CSOs), UNAIDS and the Global Fund ATM to establish a new framework and sustainability plan for collaboration and shared responsibility.

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
2013	$ 29,372,000	39%	$ 10,791,802	14%	$ 10,990,664	15%	$ 23,845,534	32%	$ 75,000,000
Total 2009-2013	**$ 136,101,153**	**44%**	**$ 45,893,789**	**15%**	**$ 24,619,683**	**8%**	**$ 104,360,375**	**34%**	**$ 310,975,000**
2015 (est)	**$ 21,119,637**	**25%**	**$ 17,773,873**	**21%**	**$ 30,904,232**	**37%**	**$ 13,690,258**	**16%**	**$ 83,488,000**

*Totals include planned funding for all accounts.
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Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Malawi	$ 11,986,926	$ 1,686,556	$ 3,887,293	$ 1,112,375	$ 3,814	$ -	$ 7,173,204	$ 3,521,832	**$ 29,372,000**
	Totals FY09-FY13	**$ 49,278,899**	**$ 20,513,586**	**$ 18,023,201**	**$ 4,816,284**	**$ 587,274**	**$ -**	**$ 26,137,314**	**$ 16,744,595**	**$ 136,101,153**
2015 (est)	Malawi									**$ 21,119,637**

*Totals include planned funding for all accounts.
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PEPFAR support wraps around Global Fund investments through delivery of quality services in all districts, and constitutes the majority of prevention funds available nationally. 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 strengthening the quality and targeting of all HIV counseling and testing (HCT) services, strengthening the Option B+ program, ensuring HIV-negative men are referred to VMMC services, targeting high risk and vulnerable groups through community interventions, increasing condom access and utilization, and linking HIV- positive people to care and treatment services.

Historically, PEPFAR has been the main funder of HIV prevention activities in Malawi, although the Global Fund has funded condom procurement and programs for young people. Access and acceptance of male and female condoms will be expanded through continued condom social marketing and expansion of outlets and branded marketing to ensure adequate condom availability. PEPFAR Malawi will continue to scale up VMMC as a U.S. government priority by collaborating with religious leaders, civil society and the MoH in creating demand and providing services in static and outreach sites, utilizing efficient high-volume service-delivery models.

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. FY 2015 PEPFAR priorities for PMTCT will be on quality of services and retention in care. HIV counseling and testing (HTC) programming will continue to address the quality of testing by strengthening the competency of HTC counselors and improving the security of the HIV test kit supply chain. PEPFAR will increase use of standardized Positive Health Dignity and Prevention (PHDP) toolkits by a network of expert clients, mother care, adolescent and support groups to facilitate disclosure, encourage partner testing, support adherence and risk reduction. 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 - FY13) & FY15 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**
2013	Malawi	$ -	$ 9,146,222	$ 1,844,442	**$ 10,990,664**
	Totals FY09-FY13	**$ 388,000**	**$ 18,575,794**	**$ 5,655,889**	**$ 24,619,683**
2015 (est)	Malawi				**$ 30,904,232**

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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 Global Fund funds core elements of the ART program, including ARV and other commodities. PEPFAR programs are designed to complement the Global Fund Global Fund elements and will support ART service delivery in all 28 districts, prioritizing sites with high patient volumes where HIV services are provided for children, adolescents and adults through an integrated service delivery model.

PEPFAR will continue support for a pediatric HIV program evaluation. PEPFAR will continue to provide technical assistance for the implementation of revised national HIV clinical guidelines to increase ART coverage, including support to trainings on the new guidelines and clinical mentoring of service providers. 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 provides support to the National TB Control Program (NTP) to strengthen NTP's capacity to implement, supervise and monitor a comprehensive TB program. PEPFAR will undertake routine review of partner activities aimed at strengthening HIV service delivery quality. These include quality assurance activities for HIV diagnostics (HTC and GeneXpert). PEPFAR will continue to support implementation of Provider Initiated Testing and Counseling (PITC) among those who are suspected of having TB. Family members and contacts of TB patients will be offered HTC and linked to follow-up services as necessary. At facility level, PEPFAR will continue to build capacity of health workers and facility managers to continually address infection control gaps

Care

CARE (FY09 - FY13) & FY15 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**
2013	Malawi	$ 2,822,618	$ 965,584	$ 2,227,460	$ 4,776,140	**$ 10,791,802**
	Totals FY09-FY13	**$ 11,613,660**	**$ 2,669,770**	**$ 8,285,082**	**$ 23,325,277**	**$ 45,893,789**
2015 (est)	Malawi					**$ 17,773,873**

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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.

Malawi has adopted the universal test-and-treat approach for HIV+ children under five years. Through clinical supervision and mentorship, PEPFAR will support MoH in the implementation of the new treatment eligibility criteria. Partners supported by PEPFAR will intensify active case finding through provider initiated testing and counseling in pediatric in-patient wards, Nutrition Rehabilitation Units and under-five clinics. Expert clients and other lay workers will link HIV-infected children with care and treatment services. Care services include community led complementary feeding and learning sessions, household economic strengthening, secondary school support, early childhood development (ECD), child protection, birth registration and Community Integrated Management of Childhood Illnesses (C-IMCI).

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Malawi	$ 3,135,729	$ 4,174,741	$ 8,722,720	$ 7,812,344	**$ 23,845,534**
	Totals FY09-FY13	**$ 13,605,040**	**$ 15,201,024**	**$ 42,225,489**	**$ 33,328,822**	**$ 104,360,375**
2015 (est)	Malawi					**$ 13,690,258**

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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 investments in capacity building are largely focused on front-line HIV service providers through pre- and in-service activities. At the district level, PEPFAR will continue to support training in financial management, resource leveraging and coordination. PEPFAR will also continue to support the MoH to strengthen supervision of health services including mobile technology based integrated supportive supervision systems. PEPFAR will continue to strengthen referral, feedback and patient tracking systems to improve the facilitation of patient access to a continuum of HIV services in clinics and communities and reduce loss to follow-up by using care group models such as mother infant pairs to facilitate early infant diagnosis (EID), referrals and adherence.

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 provides technical and financial support to the Health Management Information Systems, national electronic medical record systems, vital registration, and surveys, surveillance, and M&E activities at the national and district levels. PEPFAR Malawi will continue to support construction and renovations at high volume sites in selected districts.

PEPFAR will continue to prioritize laboratory workforce training, strengthening laboratory infrastructure and improving laboratory management through accreditation processes. To improve availability of services for (EID), viral load, GeneXpert and CD4, PEPFAR will support expansion of the sample transportation network to all districts in Malawi.

PEPFAR will support healthcare training, specimen transportation, laboratory information management systems (LMIS) and SMS technology to increase uptake of EID and reduce the turn-around time of the results and appropriate care interventions.

Country Engagement

The Government of Malawi has made progress in expanding both the scale and quality of its national response to HIV/AIDS, maximizing donor investments to improve health and bolster the health system in the near-term while making long-term systems strengthening investments. These successes are due to the MOH coordinated health sector and a willingness to use scientific evidence to introduce and evaluate innovative new policies and service delivery programs. The U.S. government has aligned its programming to address Malawi's health and development goals in an integrated manner through participation in the design of the Malawi 2011-2016 Health Sector Strategic Plan (HSSP).

Malawi maintains a well-coordinated health donor environment, under the leadership of the MOH. Like many countries, Malawi also has a NAC that coordinates a multi-sectorial response to the epidemic. PEPFAR and other donors coordinate closely on the national HIV response through the HIV/AIDS and the Health Donor Groups. The U.S. government serves as the chairs of both donor groups. These two donor groups are effective forums to coordinate donor and government inputs, ensure awareness of critical political developments, and address pressing issues. The PEPFAR Malawi team also actively participates in all national health technical work groups convened by the government of Malawi.

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. According to the 2013 National AIDS Spending Assessment (NASA), approximately 95% of the national HIV response is funded by donors, and 4.9% and 0.2% is covered by Government of Malawi and private sector funds respectively. Approximately 80% of the Government of Malawi's overall health program is supported 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 PEPFAR country to sign a Partnership Framework (PF) in 2009. The Malawi PF has been a useful guide and reference in the achievement of the primary purpose to fully align the PEPFAR program with Government of Malawi national health and HIV strategic plans. This has been successful as there is one national response and no parallel PEPFAR programs, activities, or facilities. The PF expired at the end of 2013, but the principles of collaboration enshrined in it continue.

Mozambique

Country Context

Mozambique is a rural country of approximately 25 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 11.1 percent (2012 UNAIDS report), 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 740,000 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 2015, the PEPFAR program will continue to support 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 antiretroviral (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
2013	$ 67,024,377	26%	$ 53,423,192	20%	$ 83,837,104	32%	$ 57,678,540	22%	$ 261,963,213
Total 2009-2013	**$ 373,688,515**	**29%**	**$ 208,003,349**	**16%**	**$ 332,511,468**	**26%**	**$ 369,593,295**	**29%**	**$1,283,796,627**
2015 (est)	**$ 64,516,610**	**24%**	**$ 53,195,846**	**19%**	**$ 117,564,717**	**43%**	**$ 38,723,826**	**14%**	**$ 274,001,000**

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Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Mozambique	$ 23,949,580	$ 1,509,869	$ 7,635,099	$ 998,327	$ 761,908	$ 389,276	$21,999,001	$ 9,781,317	**$ 67,024,377**
	Totals FY09-FY13	**$ 142,039,225**	**$ 49,277,827**	**$ 59,301,580**	**$ 9,282,749**	**$ 11,831,851**	**$ 1,412,150**	**$46,782,275**	**$ 53,760,858**	**$ 373,688,515**
2015 (est)	Mozambique									**$ 64,516,610**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Mozambique has endorsed the Global Initiative for the elimination of mother-to-child transmission (EMTCT) and PMTCT Option B+ (lifelong ART), with the intent to reduce MTCT to less than 5 percent by 2015. In FY 2015 PEPFAR Mozambique will continue to support the Ministry of Health (MOH) in scaling-up PMTCT activities to improve and maintain maternal health, and to prevent sexual transmission to partners. In a phased approach, PEPFAR Mozambique has supported the MOH in Option B+ implementation with immediate initiation upon diagnosis (test and treat lifelong ART) for pregnant women at 423 priority sites with co-located ART and PMTCT services (target 707 by 2015). PEPFAR Mozambique will continue to support partner testing and initiation of ART among HIV-infected men in sero-discordant couples, initiate broader FP/HIV integration, commence treatment for pregnant, postpartum and lactating women, and HIV-exposed infants. In FY 2015, community adherence support group (CASG) strategies that have been established in adult ART programs will be piloted in PMTCT settings and resources, a new Option B+ evaluation will be supported and additional funds will be allocated for intensified peer educator support for case management and individual attention to prevent loss-to-follow-up.

The PEPFAR voluntary medical male circumcision (VMMC) program in Mozambique supports the national VMMC Strategy, which aims to achieve 80 percent coverage by 2017, by performing two million procedures within key provinces that have high prevalence of HIV and low prevalence of MC (10-49 year old males). Currently, PEPFAR supports 33 fixed sites for VMMC, plus two mobile units with two beds each. In FY 2015, PEPFAR will expand to nine more sites and expand transport networks to provide access to established fixed sites that have saturated demand within the local community. As well, two additional prefab units will be installed, and we anticipate an additional 22 fixed sites will be renovated and prepared for VMMS service delivery. Advocacy to introduce surgical field hospitals will continue. As VMMC is scaled up, so will efforts to increase male uptake of treatment and care services.

Mozambique's FY 2015 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 MSM and CSW populations and efforts will be made to coordinate activities with principal recipients of the Global Fund, 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 - FY13) & FY15 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**
2013	Mozambique	$ 39,674,459	$ 36,733,605	$ 7,429,040	**$ 83,837,104**
	Totals FY09-FY13	**$ 116,140,648**	**$ 175,818,989**	**$ 40,551,831**	**$ 332,511,468**
2015 (est)	Mozambique				**$ 117,564,717**

*Totals include planned funding for all accounts.
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In FY 2015, PEPFAR Mozambique will increase its overall treatment budget to expand clinical services and availability of ART. Additional resources will be used to support universal ART for HIV-infected TB patients by expanding a one stop integrated model to 160 priority districts, support active index case finding, mobile clinics in two provinces, community ARV drug distribution in four provinces, ART site expansion to 51 new sites in 2015, and access to early treatment through pre-ART and clinical training. Retention remains a significant problem in Mozambique. Treatment retention has remained virtually static at 72 percent at 12 months and dropping to 52 percent after 36 months on ART. In FY 2015, new activities to improve retention will include: roll-out of peer educators to all ART sites to manage patient defaulter tracking

systems, expansion of the Community Adherence and Support Groups from 5 percent to 20 percent community distribution of ARV drugs in four provinces, and quarterly ARV drug prescriptions for patients stable on ART.

PEPFAR Mozambique will continue to support task shifting from clinics to nurses and lower cadres, expand early infant diagnosis and universal pediatric ART to age five and engage gender advisors who will develop action plans to ensure that more men access HIV services.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Mozambique	$ 21,848,788	$ 6,010,109	$ 5,179,319	$ 20,384,976	**$ 53,423,192**
	Totals FY09-FY13	**$ 60,569,140**	**$ 6,798,332**	**$ 20,514,226**	**$ 66,698,459**	**$ 154,580,157**
2015 (est)	Mozambique					**$ 53,195,846**

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FY 2015 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 2015 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 (CHW) who serve as primary interlocutors between MOH facilities and the community. By standardizing the roles of official and unofficial CHW in all PEPFAR-supported health

facilities, CHW will be better placed to support bidirectional referral systems for positive prevention, nutritional counseling and OVC services.

In FY 2015, 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 - FY13) & FY15 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**
2013	Mozambique	$ 6,661,900	$ 8,676,342	$ 20,124,279	$ 22,216,019	**$ 57,678,540**
	Totals FY09-FY13	**$ 47,378,638**	**$ 34,229,268**	**$ 181,009,040**	**$ 106,976,349**	**$ 369,593,295**
2015 (est)	Mozambique					**$ 38,723,826**

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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 2015, 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 The U.S. government human resources for health (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 FY 2015, PEPFAR will continue to support decentralization planning and management to 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 AIDS-free Generation targets in the National Acceleration Plan, as well as, the PF and GHI strategy. PEPFAR Mozambique will maintain funding levels for HIV commodities and increase support to strengthen the supply chain system. Ensuring procured medicines reach patients via the national supply chain system continues to be a top priority in 2015. Supply chain funds will focus on: national forecasting, quantification, supply planning and resource coordination, implementation of the national supply chain strategic plan (PELF), improving supply chain operations and infrastructure, and strengthening pharmaceutical quality assurance and quality control. It is expected that investments made in the supply chain system will lead to more effective public sector health commodity procurements, improved public sector warehousing and distribution at all levels, improved quality of logistics data, and more effective pharmaceutical services. Additionally, PEPFAR Mozambique will continue to prioritize technical assistance to the national, provincial, and district levels to strengthen data systems, forecasting and 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 Global Fund. Coordination of support to the HIV response is facilitated by the HIV Partners Forum which engages the National AIDS Control Program (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 Global Fund Country Coordination Mechanism (CCM).

Country Engagement

Mozambique's government has been actively confronting challenges in the health sector and HIV response. While Mozambique public revenue is significantly increasing and financial investments in health have increased from 4 percent in 2009 to 9.1percent in FY 2014, the HIV response remains largely dependent on external donor resources. Despite challenges, the MOH has been successful in its implementation of the National HIV Acceleration Plan and has maintained efforts to absorb a greater number of previously donor funded employees (non-U.S. government funded) into its permanent staff, paying their wages with internal funds. In 2015, 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 2015, 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 projected 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 care (ANC) survey reports HIV prevalence among pregnant women attending ANC 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 2015, PEPFAR Namibia is prioritizing activities that reflect the program's transition. 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 2015 activities will continue shifting to a collaborative technical assistance model. Most notably, in FY 2015, PEPFAR Namibia will no longer purchase condoms, rapid test kits, nutritional food supplementation, or fund healthcare worker salaries. 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
2013	$ 7,561,651	22%	$ 6,979,699	20%	$ 6,142,819	18%	$ 13,564,724	40%	$ 34,248,893
Total 2009-2013	**$ 126,532,609**	**29%**	**$ 90,501,377**	**21%**	**$ 86,687,272**	**20%**	**$ 133,873,972**	**31%**	**$ 437,595,230**
2015 (est)	**$ 8,593,552**	**20%**	**$ 10,195,140**	**23%**	**$ 10,271,226**	**24%**	**$ 14,453,082**	**33%**	**$ 43,513,000**

*Totals include planned funding for all accounts.
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Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Namibia	$ 2,102,159	$ -	$ 2,604,591	$ -	$ -	$ -	$ 13,744	$ 2,841,157	**$ 7,561,651**
	Totals FY09-FY13	**$ 19,715,845**	**$ 23,776,521**	**$ 29,184,808**	**$ 4,517,678**	**$ 2,375,000**	**$ -**	**$ 11,942,692**	**$ 35,020,065**	**$ 126,532,609**
2015 (est)	Namibia									**$ 8,593,552**

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In FY 2015, PEPFAR Namibia will support the Namibian government's Combination Prevention Strategy through activities that build country capacity to expand access to services, promote increased utilization of high impact prevention services and behaviors, and strengthen the policies, systems and human capacities needed to support Namibia's prevention goals. In addition, PEPFAR Namibia will directly support targeted prevention activities for key populations (KP) and strengthen country strategic information systems.

Related to voluntary testing and counseling, PEPFAR Namibia will support the implementation of programs at Ministry of Health and Social Services (MOHSS) facilities, Ministry of Defense (MOD) clinics, faith-based hospitals, and at the community level through training, mentoring, supportive supervision, the promotion of quality assurance and strengthening referrals. Activities will also build the capacity of civil society to support testing and counseling among KP and other risk groups.

The PEPFAR team will also support implementation of the National Emergency Mother to Child Transmission Strategy. PEPFAR will also facilitate ongoing review and adaptation of national guidelines, and enhance country systems and capacities to increase access to these services through MOHSS facilities and private sector mobile clinics, outreach interventions and community system strengthening activities.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Namibia	$ -	$ 5,099,826	$ 1,042,993	**$ 6,142,819**
	Totals FY09-FY13	**$ 4,034,718**	**$ 64,490,341**	**$ 12,019,394**	**$ 80,544,453**
2015 (est)	Namibia				**$ 10,271,226**

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Namibia continues to make remarkable progress toward the goal of providing universal access to high quality comprehensive HIV treatment services, and in 2011 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 February 2014 the MOHSS launched new HIV treatment guidelines that expand ART eligibility, including universal eligibility for pregnant women, children less than 15 years of age, tuberculosis or hepatitis co-infected patients, and sero-positive individuals in sero-discordant relationships. Additionally, general eligibility for those not included in the aforementioned groups will be eligible at a CD4 cell count threshold of 500. These changes will substantially increase the number of persons on ART requiring an array of both facility- and community-based care services.

In FY 2015, PEPFAR Namibia will support the national treatment program by providing technical support to enable Namibia to expand access to and coverage of services, assist the MOHSS to improve quality and oversight of treatment programs, advance the efficient delivery of national treatment services, and strengthen linkages between community-based services and treatment programs. PEPFAR Namibia will use modeling, operational, and financial data to assist the MOHSS in developing costed national and regional level implementation plans. Also, PEPFAR will assist in developing estimates projected program resource needs for comprehensive treatment programming.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Namibia	$ 1,447,374	$ 477,464	$ 2,373,936	$ 2,680,925	**$ 6,979,699**
	Totals FY09-FY13	**$ 27,512,010**	**$ 11,698,649**	**$ 16,294,718**	**$ 34,996,000**	**$ 90,501,377**
2015 (est)	Namibia					**$ 10,195,140**

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In FY 2015, PEPFAR will support activities that strengthen, systematize, and institutionalize community-based, community-centric care and support programs that support national program goals. With a priority on providing a continuum of integrated services, PEPFAR programs will deepen the Namibian government and civil society's leadership and capacity to expand access to and quality of facility and community-based care and support services. To this end, PEPFAR Namibia will assist country institutions and community organizations to operationalize national, standardized HIV care and treatment guidelines, with particular attention to building the capacity of the Namibian government and civil society to collaboratively implement and monitor a family-centered model of community-and home-based care. Support for the health extension worker program will be central to this effort.

For pediatric care and support, PEPFAR Namibia will support the MOHSS to implement the new guidelines supporting universal access for children less than 15 years of age through assistance for training, quality assurance, supervision and mentorship, as well as monitoring and evaluation. The PEPFAR team will continue to provide training for healthcare workers in early infant diagnosis. PEPFAR support for OVC programs will focus on enabling family, community and governments to address the socio-economic needs of OVC by increasing access to and utilization of services that increase child resilience to HIV/AIDS. PEPFAR will work with the Namibian government and civil society to implement national policies and standards for OVC, specifically those which support activities to link childhood victims of sexual violence with support and services.

PEPFAR will also support MOHSS efforts to improve TB/HIV services including, HIV testing of TB patients, "Three I's" with emphasis on scale up TB infection control efforts through training, the development of infection control plans, the drafting of TB IC education materials, and timely provision of ART to all TB co-infected patients.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Namibia	$ 456,878	$ 3,621,711	$ 6,368,562	$ 3,117,573	**$ 13,564,724**
	Totals FY09-FY13	**$ 8,025,370**	**$ 26,399,170**	**$ 45,351,129**	**$ 54,098,303**	**$ 133,873,972**
2015 (est)	Namibia					**$ 14,453,082**

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With FY 2015 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. Key activities will include analyses of the 2013 DHS data (including the first-ever HIV biomarker), implementation of the tuberculosis drug resistance survey and HIV drug resistance surveys, launch of an HIV incidence sentinel surveillance system, operational research on community- and facility-based services, and assistance to the MOHSS to develop a country-wide program for regional-level HIV clinical data reviews.

Country Engagement

Namibia's selection as one of the first three PEPFAR countries to develop a Country Health Partnership is reflective of the high level of host country ownership of the national HIV/AIDS response. The Namibian government's strong political, administrative, and financial leadership has resulted in Namibia having impressively high coverage levels for treatment and prevention of mother-to child transmission, rapidly adopting new international guidelines and best practices, and increasing domestic financing for HIV programming. As a result, new HIV infections and HIV/AIDS-related mortality in Namibia have declined substantially.

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. Over 27 percent of the Namibian national budget is for health, and the government covers 60 percent of the total HIV budget in Namibia. The National Strategic Framework commits the Namibian government to increasing its financial contribution to the HIV/AIDS response to 70 percent by 2015.

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 3.4 million HIV-positive individuals and constitutes the second greatest burden of HIV/AIDS care and treatment worldwide. Adding to this burden are the estimated 2.2 million children orphaned by HIV/AIDS. Nigeria also has one of the highest tuberculosis (TB) burdens in the world (161 /100,000 population prevalence), 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 3.1 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 PEPFAR programmatic approach for FY 2015 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. PEPFAR 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 PEPFAR agencies will work towards fulfilling the 2015 partnership framework (PF) and PFIP goals in FY 2015:

- 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 therapy (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
2013	$ 96,661,141	21%	$ 75,706,668	17%	$ 182,558,249	40%	$ 103,688,223	23%	$ 458,614,281
Total 2009-2013	**$ 427,626,899**	**18%**	**$ 459,465,237**	**20%**	**$ 840,903,494**	**36%**	**$ 599,303,550**	**26%**	**$2,327,299,179**
2015 (est)	**$ 90,181,468**	**20%**	**$ 82,216,491**	**18%**	**$ 206,968,183**	**45%**	**$ 77,285,858**	**17%**	**$ 456,652,000**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Nigeria	$ 49,076,084	$ 1,582,790	$ 16,858,181	$ 3,086,023	$ 1,896,688	$ -	$ -	$ 24,161,375	**$ 96,661,141**
	Totals FY09-FY13	**$ 163,964,741**	**$ 56,716,831**	**$ 99,977,836**	**$ 30,491,474**	**$ 13,031,466**	**$ -**	**$ 40,000**	**$ 63,404,551**	**$ 427,626,899**
2015 (est)	Nigeria									**$ 90,181,468**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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.

PEPFAR 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. PEPFAR 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 PEPFAR and the Global Fund occurred during preparation of the 2013 Country Operational Plan (COP) and will continue in the 2014 COP. PEPFAR 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 PEPFAR, 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 2015, the PEPFAR 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 2015, PEPFAR 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 2015, PEPFAR 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 20154 targets will extend to 6 million people.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Nigeria	$ 88,089,255	$ 82,174,352	$ 12,294,642	**$ 182,558,249**
	Totals FY09-FY13	**$ 413,613,529**	**$ 378,693,800**	**$ 48,596,165**	**$ 840,903,494**
2015 (est)	Nigeria				**$ 206,968,183**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Treatment activities in FY 2015 include the provision of ARVs and services to eligible patients and laboratory support for the diagnosis and monitoring of HIV-positive patients identified through PEPFAR activities and in-line with goals and strategies of the Nigerian government National Strategic Framework (NSF) and the PFIP. In FY 2015, PEPFAR 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.

PEPFAR 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, PEPFAR 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 2015. To support this goal, PEPFAR 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 2015, PEPFAR 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. PEPFAR 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 a high burden of TB in Africa. The TB prevalence in Nigeria (WHO 2012 report) is 270/ 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 2015. PEPFAR 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, PEPFAR will continue provider-initiated routine HIV testing. In FY 2015, PEPFAR 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 - FY13) & FY15 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**
2013	Nigeria	$ 27,959,191	$ 4,538,378	$ 7,516,204	$ 35,692,895	**$ 75,706,668**
	Totals FY09-FY13	**$ 181,739,317**	**$ 24,919,050**	**$ 51,318,888**	**$ 201,487,981**	**$ 459,465,237**
2015 (est)	Nigeria					**$ 82,216,491**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 2015, care services will be provided to all HIV-positive patients identified in PEPFAR 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. PEPFAR will promote access to community home-based care and strengthen networks of health care personnel and community health workers. PEPFAR 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. PEPFAR 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. PEPFAR 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 2015 PEPFAR will provide support to over 1.6 million OVC.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Nigeria	$ 40,694,788	$ 11,373,050	$ 20,432,662	$ 31,187,723	**$ 103,688,223**
	Totals FY09-FY13	**$ 202,853,519**	**$ 84,647,967**	**$ 157,907,001**	**$ 153,895,063**	**$ 599,303,550**
2015 (est)	Nigeria					**$ 77,285,858**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR 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 PEPFAR GHI Strategy and the PF have also identified HRH as a critical element of health programming in Nigeria. PEPFAR will improve the availability, distribution, and utilization of adequately skilled HRH. PEPFAR, 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.

PEPFAR'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. PEPFAR will also work to strengthen coordination mechanisms at all levels. With FY 2013 funds, PEPFAR implemented a lead IP strategy and will continue to consolidate and strengthen the system in FY 2015. PEPFAR 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. PEPFAR'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 PEPFAR supported sites for reporting routine data from the health facilities through LGAs to the state and then to the national level. PEPFAR 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 overlapping 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 2015 will reflect the objectives outlined in the Nigerian government National Strategic Framework 2 and the Nigerian government NSHDP. FY 2015 activities will specifically follow the commitments agreed upon by PEPFAR, 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 PEPFAR 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, PEPFAR 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. PEPFAR 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, PEPFAR has commenced efforts to decentralize service delivery which will allow for a more manageable program at the local level. PEPFAR 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

Located in central Africa, Rwanda is one of the smallest mainland countries on the continent and is bordered by Uganda, Tanzania, Burundi and the Democratic Republic of Congo. Rwanda has made remarkable economic and social development progress since the tragedy of the 1994 genocide, with real income per capita in 2012 nearly 50 percent higher than the pre-genocide level. Economic performance has been particularly strong over the last decade, with a 5.4 percent compound annual growth rate of real GDP per capita. However, Rwanda remains one of the world's poorest countries. According to the 2011 household survey, 45 percent of the population lives below the national poverty line of $1.30 per day.

Rwanda faces a multitude of health and development challenges. An estimated 2.9 percent of the population aged 15-49 (UNAIDS 2013) are infected with HIV (3.7 percent of women and 2.2 percent of males), HIV prevalence has stabilized since 2005. Out of Rwanda's population of 11.5 million, about 190,000 adults and 20,000 children are estimated to be living with HIV. The repercussions of the 1994 genocide, in which up to a million Rwandan citizens were killed, combined with HIV, resulted in more than a million orphans and vulnerable children. The annual deaths due to HIV-related illness are estimated to be 5,600 and there is an estimated 100,000 AIDS orphans. Rwanda's epidemic is primarily driven by heterosexual contact (95 percent) with 5 percent attributed to MSM. Populations at higher risk for HIV infection include women, youth, commercial sex works (CSW), men who have sex with men (MSM), mobile populations, and discordant couples. The Rwandan government has been committed to fighting HIV/AIDS and takes a proactive role in prevention, care, and treatment (with national ART coverage at 94 percent of adults and 50 percent of children in need).

FY 2015 priorities include:

- Support for the sustainable transition of activities to national ownership, continued decline in the incidence rate while maintaining the gains made in treatment and PMTCT coverage with an increase in pediatric treatment and care;
- Direct funding to civil society organizations and the Ministry of Health (MOH),
- Improved targeting and services for key populations;
- Strengthening the supply chain management system, and;
- Maintaining the military-to-military and Peace Corps programs, while providing support to the Human Resources for Health (HRH) Program.

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
2013	$ 14,996,427	16%	$ 15,800,660	17%	$ 24,532,262	26%	$ 40,099,029	42%	$ 95,428,378
Total 2009-2013	**$ 119,418,373**	**20%**	**$ 130,751,286**	**22%**	**$ 153,145,544**	**26%**	**$ 192,064,557**	**32%**	**$ 595,379,760**
2015 (est)	**$ 8,809,480**	**11%**	**$ 14,963,279**	**19%**	**$ 30,211,346**	**38%**	**$ 24,574,894**	**31%**	**$ 78,559,000**

*Totals include planned funding for all accounts.
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Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Rwanda	$ 3,694,315	$ -	$ 3,062,796	$ 2,334,710	$ 192,341	$ -	$ 825,051	$ 4,887,214	**$ 14,996,427**
	Totals FY09-FY13	**$ 25,494,068**	**$ 11,318,879**	**$ 25,566,209**	**$ 16,734,736**	**$ 5,045,930**	**$ -**	**$ 6,196,542**	**$ 29,062,009**	**$ 119,418,373**
2015 (est)	Rwanda									**$ 8,809,480**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, there will continue to be an overall shift in prevention programming from a focus on the general population to an emphasis on key populations, including 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 Ministry of Heath (MOH), will place a greater emphasis on targeted HIV prevention. The Government of Rwanda and PEPFAR will continue to provide key populations with a combination prevention approach to HIV/AIDS prevention. This approach involves biomedical, behavioral and structural interventions working together to complement and reinforce one another.

In FY 2015, Rwanda's PMTCT program will provide a comprehensive package including 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 (FP) 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.

PEPFAR will continue to support existing HCT sites with clinical and non-clinical partners, assist the Government of Rwanda to roll-out finger prick sample collection and support approaches to HIV testing such as provider initiated testing (PITC) in all health facilities and a focus on services availability to key populations. PEPFAR's programs support mentorship and implementation of quality assurance for finger prick sample collection and processes. PEPFAR will monitor and evaluate this initiative, support prevention activities for HIV negative partners in discordant relationships, and support follow-up activities for discordant couples.

With FY 2015 resources, PEPFAR will support Rwanda's voluntary medical made circumcision (VMMC) strategy. PEPFAR will work with the national program to ensure uniformity of national VMMC guidance and build the capacity of healthcare providers to deliver safe quality services. PEPFAR will continue to support VMMC activities in military health facilities and their catchment areas by building capacity, creating demand, and emphasizing quality assurance and monitoring and evaluation.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Rwanda	$ 13,152,583	$ 8,811,005	$ 2,568,674	**$ 24,532,262**
	Totals FY09-FY13	**$ 53,272,202**	**$ 88,108,745**	**$ 11,764,597**	**$ 153,145,544**
2015 (est)	Rwanda				**$ 30,211,346**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, treatment will remain a priority focus for PEPFAR support. PEPFAR resources will continue to support treatment services in health facilities in 27 of Rwanda's 30 districts and increase coverage for children. The Government of Rwanda, PEPFAR, and the Global Fund will ensure that antiretroviral drugs (ARV) and associated lab commodities requirements are met. Over time, PEPFAR will shift a greater share of ARVs and commodities to the Government of Rwanda and the Global Fund. The Government of Rwanda has adopted prevention of mother-to-child transmission (PMTCT) Option B+, and plans to treat all discordant couples, key populations, and people with co-infections (TB, Hepatitis B, and Hepatitis C) regardless of CD4

cell count. PEPFAR will support the Government of Rwanda in decentralizing antiretroviral therapy (ART) from central level institutions to community level health facilities.

As Rwanda shifts from the 350 CD4 cells/mm^3 threshold for initiating ART to 500 CD4 cells/mm^3 in FY 2015, the current ART coverage levels will decrease to 80 percent from 90 percent levels. To address this, PEPFAR will support the MOH in enhancing timely identification, enrollment and retention into care and treatment all eligible clients.

Rwanda has also adopted the new WHO Option B+ PMTCT recommendations. Pregnant women found to be HIV-positive are enrolled on lifelong ART regardless of CD4 count. With the NSP's focus on key or high-risk populations, testing services will target high-risk groups who have been identified as potential reservoirs for new HIV infections. PEPFAR will continue to support an integrated care services model including screening and treating HIV+ patients co-infected with TB and Hepatitis B. PEPFAR will also support the MOH in increasing clinician's abilities to link PLHIV to other available support services such as PEPFAR's OVC programs, where possible.

With PEPFAR technical and financial support, Rwanda has been able to efficiently procure and distribute drugs and commodities in a timely fashion under the Coordinated Procurement and Distribution System (CPDS). PEPFAR will continue to fund technical assistance (technical assistance) and support staff at the central level to improve quantification and forecasting of HIV commodities. PEPFAR will also continue to support the national treatment program as it transitions to a combined single pill regimen, and promote efficiencies through targeted and integrated trainings of healthcare workers. PEPFAR will support the MOH and National Reference Labs in continuing to develop quality testing and immunological follow up facilities to support the treatment program.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Rwanda	$ 5,203,235	$ 2,089,215	$ 2,912,126	$ 5,596,084	**$ 15,800,660**
	Totals FY09-FY13	**$ 49,665,164**	**$ 11,921,309**	**$ 21,779,424**	**$ 47,385,389**	**$ 130,751,286**
2015 (est)	Rwanda					**$ 14,963,279**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, PEPFAR will continue to support a comprehensive package for adult and pediatric care at PEPFAR-supported sites. The support provided by PEPFAR 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 PEPFAR 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.

In FY 2015, care and support for OVC will remain a priority, with 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.

In line with National HIV/AIDS Strategic Plan (NSP) priorities, the support provided by PEPFAR is aimed at testing and providing linkage to care for PLHIV, keeping PLHIV healthy, reducing transmission of HIV, and assessing ART eligibility. To protect the health of PLHIV and reduce the chances of transmission, PEPFAR will support the implementation of positive health dignity prevention (PHDP).

In FY 2015, PEPFAR will continue to strengthen clinical services including regular clinical follow-up; CD4 cell count testing; HIV-1 viral load evaluations; screening, diagnosis and treatment of common opportunistic infections (OIs); support adherence; tracing lost-to-follow-up clients; and cervical cancer screening for HIV positive women. PEPFAR will also continue to support integration of mental health into HIV services. PLHIV will receive psychosocial support and mental health screenings and referral to therapy, as needed. Patients with mental health problems will receive home visits for adherence support.

PEPFAR will also continue to procure basic care commodities in coordination with the Government of Rwanda's central procurement agency, the Medical Production, Procurement and Distribution Division (MPPD). These supplies include: drugs for the prevention and treatment of OIs and laboratory and diagnostic kits for improved and expanded OI diagnosis. PEPFAR will also continue to support community health insurance for eligible HIV patients

and their families to enable them to access broad primary healthcare services, to support patients' transportation costs, and promote income generating activities through PLHIV associations.

As children represent only 6 percent of PLHIV on ART, pediatric case finding will be a major priority in FY 2015. In alignment with the NSP, PITC will be systematically implemented especially among malnourished, hospitalized children or children who have a parent or sibling that is HIV+. PEPFAR partners will continue to strengthen the existing linkages and sensitization campaigns at all levels. Additionally, through task shifting, nurses will be trained to prescribe ART for children. In FY 2015, PEPFAR will also support systematic reviews of program data to ascertain retention rates, loss to follow-up, and adherence.

All HIV+ patients are and will continue to be screened for TB co-infection and vice versa, with those testing positive for HIV enrolled in ART. During FY 2015, PEPFAR will continue to align its programs with Government of Rwanda priorities and focus on strengthening the existing TB/HIV activities at PEPFAR clinical sites. Key strategies will include systematic screening for TB among HIV+ patients at all entry points such as HCT, PMTCT, ANC, ART, pediatric and nutrition services, prisons, boarding schools, refugee camps; systematic screening for HIV among TB patients in all TB clinics; and early initiation of ART for HIV patients co-infected with TB regardless of their CD4 cell counts and WHO clinical stages.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Rwanda	$ 11,190,792	$ 3,518,725	$ 15,345,145	$ 10,044,367	**$ 40,099,029**
	Totals FY09-FY13	**$ 39,700,843**	**$ 28,346,089**	**$ 71,875,254**	**$ 52,142,371**	**$ 192,064,557**
2015 (est)	Rwanda					**$ 24,574,894**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, PEPFAR Rwanda will continue to support institutional and human capacity building in the Rwandan government from the central to the community level. 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.

With support from PEPFAR and other partners, Rwanda has made tremendous progress in its capacity to collect, manage, and integrate data from different sources for monitoring, evaluating, planning, and program management. PEPFAR also supports the electronic medical records system which hosts HIV patient data and allows information sharing within facilities, patient follow-up, and linkages to other services in 124 health facilities. PEPFAR will continue to support scale up of the system to additional facilities.

PEPFAR 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. Assistance will continue to support the implementation of Rwanda's National e-Health Strategic Plan and National HIV/AIDS Monitoring and Evaluation (monitoring & evaluation) Policy and Strategy.

In FY 2015, PEPFAR 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, PEPFAR 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.

In FY 2015, PEPFAR 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, PEPFAR 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, PEPFAR, other donors, civil society, and implementing partners to establish technical priorities and share information about the PEPFAR Country Operational Planning (COP) process,

following which, PEPFAR and the Government of Rwanda jointly develop Country Operational Plans.

In 2013 a new National HIV/AIDS Strategic Plan (2013-18) (NSP) was developed with broad stakeholder participation and an international Joint Assessment of National Health Strategies review. A two-year rolling NSP Operational Plan (OP) is also being developed. PEPFAR remains the largest bilateral funding source for Rwanda's national HIV and AIDS program. In 2013 the Global Fund developed a new results based financing (RBF) pilot grant agreement for Rwanda, which is based on six HIV indicators that are part of the NSP. The agreement was signed in February 2014, and provides two years of funding (July 2013-June 2015) to support the NSP. Coordinated planning of all activities is to be through the OP. The OP will also provide a visual of what sources are funding each intervention as well as unfunded interventions. The plan will be reviewed at the Global Fund Country Coordinating Mechanism (CCM) and PEPFAR Steering Committee (PSC). In practice, the OP will help to find efficiencies as the overall donor funding envelope continues to decline and Rwanda increases funding of its HIV program towards the realization of Vision 2020. The OP will also provide a management tool to help Rwanda meet its NSP objectives and the realization of an AIDS-free Generation. Increasingly PEPFAR Rwanda collaborates with the Global Fund. Other donors supporting Rwanda's HIV/AIDS program include: UN agencies, health-focused non-governmental organizations (NGOs) include Partners in Health, the Clinton Health Access Initiative, and other international NGOs.

South Africa

Country Context

South Africa has a population of nearly 52 million and the largest HIV epidemic in the world, with approximately 6.1 million people living with HIV (UNAIDS 2012 Report). 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 17.9 percent, with an estimated HIV incidence reported by UNAIDS as 1.37%. However, recent results from the 2012 South Africa National HIV, Behavior and Health Survey (a population-based household survey led by Human Science Research Council) estimates the incidence to be 1.72%, 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 54 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 857 new infections per 100,000 people in 2013 (WHO estimate). While the TB cure rate increased to 74 percent in 2011 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 11,046 confirmed MDR-TB cases among new pulmonary TB cases in 2012. 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 August 2012, reflects a mutual intent to shift financial and implementation responsibilities for clinical care and treatment services into the South African government public health system by 2017. In FY 2015, 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 provision of HIV treatment 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
2013	$ 140,770,041	29%	$ 128,987,645	27%	$ 144,963,713	30%	$ 69,278,601	14%	$ 484,000,000
Total 2009-2013	**$ 769,680,677**	**29%**	**$ 658,259,247**	**25%**	**$ 893,676,795**	**33%**	**$ 356,933,890**	**13%**	**$2,678,550,609**
2015 (est)	**$ 104,953,540**	**26%**	**$ 117,725,321**	**29%**	**$ 129,646,240**	**32%**	**$ 57,224,899**	**14%**	**$ 409,550,000**

*Totals include planned funding for all accounts.
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Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	South Africa	$ 36,614,803	$ 15,825,325	$ 32,248,974	$ 7,044	$ 5,865	$ 12,854	$ 36,807,723	$ 19,247,453	**$ 140,770,041**
	Totals FY09-FY13	**$ 207,253,364**	**$ 107,684,437**	**$ 156,626,625**	**$ 3,767,044**	**$ 1,335,685**	**$ 12,854**	**$157,282,916**	**$ 135,717,752**	**$ 769,680,677**
2015 (est)	South Africa									**$ 104,953,540**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 2015, 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 2015, 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 2015 program will increase focus on follow-up of mother-baby pairs post-delivery (after 6 weeks) and infant feeding to ensure durable PMTCT outcomes as well as a special focus on 18-month PICT for infants and mothers. 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 2015, services will include treatment and prevention packages for SWs involving public-private partnership linkages.

Since 2009, PEPFAR has been focusing 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 development and targeting the education sector more broadly with technical assistance at the policy level. Targeted support to women and girls will address findings of the HSRC study which show a sharp increase in national prevalence from five percent in females ages 15-19 to 18 percent among those ages 20-24. PEPFAR South Africa's

youth prevention programs focus on girls' education to increase their retention in schools and completion of education.

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 - FY13) & FY15 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**
2013	South Africa	$ 2,976,812	$ 113,962,533	$ 28,024,368	**$ 144,963,713**
	Totals FY09-FY13	**$ 96,689,655**	**$ 679,809,636**	**$ 117,177,504**	**$ 893,676,795**
2015 (est)	South Africa				**$ 129,646,240**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 transitioning 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: quality improvement for HIV and TB clinical services; TB/HIV coordination and integration of services; pediatric and adolescent services; linkages and continuity of care.

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 and TB 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;
- Increasing access to treatment for key and vulnerable populations (e.g., sex workers, MSM, people who inject drugs, and prisoners);
- Strengthening supply chain management (SCM) to overcome challenges in public sector.

Care

CARE (FY09 - FY13) & FY15 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**
2013	South Africa	$ 35,799,993	$ 8,731,335	$ 41,553,194	$ 42,903,123	**$ 128,987,645**
	Totals FY09-FY13	**$ 201,958,619**	**$ 36,427,454**	**$ 185,466,053**	**$ 234,407,121**	**$ 658,259,247**
2015 (est)	South Africa					**$ 117,725,321**

*Totals include planned funding for all accounts.
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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 nutrition assessment, counseling, and support (NACS) as a routine and integral part of HIV care and support;
- Recognizing the lag in pediatric testing and treatment, PEPFAR will sort the Department of Health to increase the testing and retention of children once in treatment
- 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 caseload, 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 nurse-initiated management of MDR-TB through the NDOH.

The restructured 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 Department of Social Development (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 - FY13) & FY15 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**
2013	South Africa	$ 5,437,637	$ 17,188,084	$ 28,513,052	$ 18,139,828	**$ 69,278,601**
	Totals FY09-FY13	**$ 30,112,911**	**$ 83,220,795**	**$ 117,247,744**	**$ 126,352,440**	**$ 356,933,890**
2015 (est)	South Africa					**$ 57,224,899**

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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. 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 2015 the PEPFAR team will focus on implementing the revised M&E framework from OGAC (MER). PEPFAR South Africa will also work with the South African government and civil society to improve the integration of information systems, data quality and date use for evidence-based management of HIV programs across national, provincial, district, and facility levels. In addition, the program will support activities to strengthen the scale-up of the three-tiered information system for ART, in collaboration with the Department of Health.

In FY 2015, PEPFAR South Africa will continue to support the 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 at the district and facility-levels to this new information system and thereby improve timely access to test results. This support

will be expanded in FY 2015 to include implementation of electronic gate keeping aimed at reducing unnecessary ordering of tests to create significant cost savings. The implementation of the GeneXpert has greatly reduced the TB turnaround time especially for MDR-TB.

Country Engagement

South Africa is well on its way to realizing the PEPFAR Country Health Partnerships (CHP) vision through structures and mechanisms established under the vigorously negotiated PEPFAR Partnership Framework Implementation Plan (PFIP), signed by the U.S. and South African governments in August 2012. The existing PFIP Steering Committee—co-chaired by the Minister of Health and the U.S. Ambassador— functions as the high-level oversight board envisioned under a CHP.

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 implementation 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 more than 2.4 million people on treatment in 2013 making it the world's largest ART program; improvement in the TB cure rate to 77 percent; The NSP has 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 Treasury has allocated over $3 billion from 2013 through 2015, which has allowed South Africa to begin to absorb treatment costs for HIV patients and health care workforce currently funded by PEPFAR.

South Sudan

Country Context

After decades of war and conflict, South Sudan faces a severe shortage of health care providers, weak health institutions, poor health infrastructure, and severe poverty. These conditions were exacerbated by conflict that erupted in December 2013 in the capital of Juba and spread across the country, destabilizing an already weak and fragile health system. Continued peace talks offer the country hope, but a lasting peace is crucial for stabilizing the health system. The PEPFAR South Sudan team established contingency plans based on different scenarios, and has planned for continuing activities in FY 2015 with the assumption that stability will return to the areas where PEPFAR works. The PEPFAR South Sudan team will continue to work closely with headquarters to shared updated information and ensure continuity of services during the crisis.

South Sudan has a generalized HIV epidemic with geographic areas of hyperendimicity. States report HIV seroprevalence rates ranging from 0.3 percent (Northern Bahr El-Ghazal) to 6.8 percent (Western Equatoria). Existing data suggest that military personnel are similar to the general population in terms of HIV risk in South Sudan. An estimated 150,000 South Sudanese adults and children are living with HIV, with 62,000 in need of anti-retroviral therapy (ART).

HIV transmission in South Sudan is driven by heterosexual practices, including multiple and concurrent sexual partnerships and 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.

In FY 2015, it is expected that the overall focus will be continued improvement of the vital linkages between prevention, care, and treatment services.

FY 2015 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;
- Improving access to ART services for pregnant mothers through targeted technical assistance for basic ART service delivery at high yield prevention of mother-to-child transmission (PMTCT) and HIV counseling and testing (HCT) sites;
- Prioritizing pediatric HIV testing, care and treatment;
- Expanding HCT at existing HIV treatment sites to increase the number of people living with HIV (PLHIV) who know their status and are linked to treatment and care services;
- Strengthening the national supply chain in order to improve coordination and distribution of HIV commodities;
- Strengthening surveillance, strategic information, monitoring and evaluation, and laboratory systems;
- Supporting human resource capacity building;
- Building national institutional capacity in governance, leadership, and policy; and

- A geographical focus on the highest burden states (Western Equatoria, Central Equatoria, and Eastern Equatoria).

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
2013	$ 7,001,535	43%	$ 1,958,095	12%	$ 1,888,091	12%	$ 5,248,279	33%	$ 16,096,000
Total 2009-2013	**$ 29,200,276**	**62%**	**$ 8,067,343**	**17%**	**$ 3,570,203**	**8%**	**$ 20,845,087**	**44%**	**$ 47,475,000**
2015 (est)	**$ 6,493,093**	**47%**	**$ 1,824,133**	**13%**	**$ 1,390,247**	**10%**	**$ 4,092,527**	**30%**	**$ 13,800,000**

*Totals include planned funding for all accounts.
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Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	South Sudan	$ 1,856,704	$ 503,359	$ 1,892,582	$ 104,000	$ -	$ -	$ -	$ 2,644,890	**$ 7,001,535**
	Totals FY09-FY13	**$ 6,292,447**	**$ 3,836,395**	**$ 9,022,568**	**$ 481,891**	**$ -**	**$ -**	**$ -**	**$ 9,566,975**	**$ 29,200,276**
2015 (est)	South Sudan									**$ 6,493,093**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, PEPFAR South Sudan will continue to focus on strengthening facility-based prevention services through established comprehensive facility-based service providers and will prioritize an intensified communication-based strategy that fosters intensified support for key populations. The priority areas in prevention include HCT, PMTCT, condom promotion, behavior change communication (BCC), targeting key and priority populations, and blood transfusion safety.

In FY 2015, HCT sites will continue to serve as a key entry point for services within the continuum of care with a continued emphasis on implementing provider-initiated counseling and testing (PICT) at existing treatment sites to facilitate earlier identification of HIV-infected persons. PEPFAR South Sudan will also work with the Ministry of Health (MOH) to roll out a nationwide PICT program. HCT will also be provided through targeted outreach services and mobile 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 will continue to strengthen quality control of HCT services through quality assurance activities and program monitoring activities.

PEPFAR currently provides support in twenty PMTCT sites while the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) provides support in thirty-seven facilities. In FY 2015, the focus of PEPFAR's PMTCT activities will be to identify, treat, and retain HIV-positive pregnant women, their exposed infants, and families, and continuing expansion of the World Health Organization (WHO)-recommended expansion of Option B+ (ART throughout pregnancy and breastfeeding for affected women). In FY 2015, PEPFAR technical assistance will be expanded at the 22 ART facilities to support the PMTCT sites co-located at those facilities to continue transition to Option B+, and technical assistance will be provided to primary health care centers in the Equatoria states to provide a more basic package of ART services. PEPFAR South Sudan intends to support Option B+ at 41 facilities by the end of FY 2015. PEPFAR will work closely with the MOH and the Global Fund to ensure that the national program can support Option B+ moving forward.

BCC will address 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 will also provide full and accurate information about correct and consistent condom use. PEPFAR South Sudan has been shifting the BCC program to target those key populations more at risk for HIV. This focus will continue in FY 2015, with prevention focused on key populations and other vulnerable groups using BCC strategies, as well as a focus on linkages to family planning, HIV care and treatment, and adherence support.

The coverage of post-exposure prophylaxis (PEP) remains very low, and has been provided through Global Fund support in limited facilities, largely for occupational exposure. Victims of sexual violence seeking PEP are required to obtain a police form to access PEP. PEPFAR South Sudan will work to address this policy constraint through advocacy with the South Sudan government and support to community-based organizations (CBOs).

In FY 2015, Positive Health, Dignity, and Prevention (PHDP) interventions will be integrated into routine care for PLHIV as a core component of prevention services.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	South Sudan	$ -	$ 1,888,091	$ -	**$ 1,888,091**
	Totals FY09-FY13	**$ -**	**$ -**	**$ -**	**$ -**
2015 (est)	South Sudan				**$ 1,390,247**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2014 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, PEPFAR will provide critical complementary support to the Global Fund, who should again be the core funder of the South Sudan treatment response. It is expected that PEPFAR's provision of commodities for treatment under the treatment bridge, which was developed as a two-year gap program to address Global Fund treatment limitations, will phase out in FY 2014 as Global Fund increases treatment funding to South Sudan.

During FY 2015, PEPFAR will continue providing technical assistance to 22 ART sites 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 standardized, routine mentorship and supportive site supervision, including on-site training and mentoring and improving site drug supply management. In FY 2015, the majority of technical assistance will continue to focus on the three Equatoria state (Western, Central, and Eastern) where the HIV burden is the highest.

In FY 2015, fifteen of the primary health care centers supported by PEPFAR will receive resources to start providing full ART services, and PEPFAR will expand the supportive supervision and mentoring to these additional 15 sites.

Care

CARE (FY09 - FY13) & FY15 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**
2013	South Sudan	$ 1,351,284	$ -	$ 110,096	$ 496,715	**$ 1,958,095**
	Totals FY09-FY13	**$ 5,844,748**	**$ -**	**$ 264,500**	**$ -**	**$ 6,109,248**
2015 (est)	South Sudan					**$ 1,824,133**

*Totals include planned funding for all accounts.
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Care activities in FY 2015 will continue to focus on health maintenance of PLHIV and their families, and retention and linkage of HIV-infected clients across the continuum of care from prevention to treatment. In FY 2015, focus will extend to increased coverage of ART for PLHIV, improving rates of pre-ART retention in care, and providing capacity building for care and support. As described earlier, PEPFAR support will concentrate primarily in the three Equatoria states, with limited technical assistance support to ART sites outside of the Equatorias.

Key activities include:

- Provision of technical assistance to treatment sites to increase retention of all HIV positive persons, particularly pregnant women and their exposed infants, and improved linkages for patients at TB and antenatal clinic (ANC) sites;
- Continuing to implement the basic care package of clinical staging for ART eligibility (including obtaining specimens for CD4 cell counts), including cotrimoxazole (CTX) provision, TB screening and referral, condom provision, linkages to PLHIV support groups, and treatment of opportunistic infections;
- 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;
- Improving integration of the Positive Health, Dignity, and Prevention (PHDP) 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;
- Supporting collaboration between the national TB and HIV programs to ensure that all HIV patients are routinely screened for TB, and those who are HIV-positive are linked to treatment and care;
- Continuing to work with community PLHIV support groups 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 2015, PEPFAR South Sudan will continue to support the MOH to update care and treatment guidelines (per WHO 2013 guidelines) and support training of healthcare workers to implement these guidelines.

PEPFAR has supported the government to increase the number of ART sites with CD4 testing machines, and has provided training and mentorship on the use of point-of-care CD4 cell testing machines. In FY 2015, PEPFAR will continue to provide support to procure reagents and support testing quality assurance.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	South Sudan	$ 811,807	$ 2,132,353	$ 623,996	$ 1,680,123	**$ 5,248,279**
	Totals FY09-FY13	**$ 2,603,447**	**$ 7,054,569**	**$ 2,825,775**	**$ 8,361,296**	**$ 20,845,087**
2015 (est)	South Sudan					**$ 4,092,527**

*Totals include planned funding for all accounts.
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In FY 2015, PEPFAR South Sudan will continue to work in partnership with the MOH to strengthen its capacity in governance, leadership, policy, and finance, including development of country-led strategic plans. 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. PEPFAR will continue to provide technical support to the MOH in developing strategic plans, policies, guidelines, and roadmaps to improve leadership and governance.

PEPFAR resources will support improved surveillance of the HIV epidemic. 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. PEPFAR South Sudan will continue to provide technical support for surveillance, monitoring & evaluation, data quality assessments, and indicator harmonization.

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, including a number of SI data collection and surveillance activities. PEPFAR South Sudan will continue to provide technical support to the MOH to implement the

surveillance strategic plan and HIV monitoring & evaluation strategy, the development of which PEPFAR supported.

In FY 2015, PEPFAR South Sudan will provide lab capacity building and training, help establish a comprehensive Quality Management System, improve overall clinical laboratory testing, and strengthen the lab supply chain management system.

PEPFAR will continue to support overall strengthening of supply chain management through technical assistance at both the MOH and warehouses, and working closely with the MOH, Global Fund, and other stakeholders to ensure that supply chain and logistics systems are implemented that are responsive to country needs.

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 engaged in a collaborative process with the Government of the Republic of South Sudan, UNAIDS, and other donors in providing technical assistance on the 2013 South Sudan National Strategic Plan for HIV/AIDS for 2013-2017, and remains committed to assisting the government in successfully implementing it. The South Sudan AIDS Commission (SSAC) and the MOH lead the coordination of HIV development and technical partners. PEPFAR will continue to collaborate closely with the MOH, SSAC, and other partners, including the WHO, Global Fund, and United Nations implementing bodies, to provide coordinated technical and financial assistance in rolling out this long-term strategy. PEPFAR will also continue to provide technical support for policy and guidelines.

Swaziland

Country Context

Swaziland is a landlocked kingdom with the world's highest prevalence of HIV and tuberculosis (TB). Economic growth and development are stagnated by HIV/AIDS and related health issues, which are enormous burdens on the economy, health system, and related 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, women 30-34 have the highest prevalence of 54 percent, and a staggering 41 percent of pregnant women attending antenatal care (ANC) facilities are HIV positive.

In FY 2015, PEPFAR investments address the most up to date epidemiological needs, as well as the broader social, cultural and gender dynamics of the HIV/AIDS epidemic in Swaziland. All proposed activities were designed in consultation with the government of the Kingdom of Swaziland, civil society organizations, faith based organizations, and key populations groups. Key priorities during FY 2015 include:

- Strengthening integration and coordination of HIV and TB clinical care services to improve access and quality;
- Strengthening social behavior and change communication coverage, quality and dose across the continuum of the HIV response to increase uptake of high impact services;
- Implementation of targeted combination prevention programming; and
- Health systems strengthening including quality management, health management information systems, targeted support for human resources for health, social welfare, and epidemiology capacity.

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
2013	$ 2,537,766	9%	$ 10,430,979	39%	$ 4,892,101	18%	$ 8,939,154	33%	$ 26,800,000
Total 2009-2013	**$ 56,289,303**	**30%**	**$ 41,713,170**	**22%**	**$ 28,657,259**	**15%**	**$ 63,459,409**	**33%**	**$ 190,119,141**
2015 (est)	**$ 12,666,064**	**29%**	**$ 15,527,699**	**36%**	**$ 10,794,692**	**25%**	**$ 4,324,545**	**10%**	**$ 43,313,000**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Swaziland	$ 187,107	$ 547,815	$ 745,815	$ 500,000	$ -	$ -	$ 187,107	$ 369,922	**$ 2,537,766**
	Totals FY09-FY13	**$ 14,974,023**	**$ 5,946,686**	**$ 4,938,516**	**$ 2,365,000**	**$ -**	**$ -**	**$21,381,400**	**$ 6,683,678**	**$ 56,289,303**
2015 (est)	Swaziland									**$ 12,666,064**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR is the largest donor supporting prevention interventions in Swaziland and collaborates closely with civil society partners, the National Emergency Response Council on HIV and AIDS (NERCHA), and the Ministry of Health (MOH) in the implementation of the national program. In FY 2015, there are several strategic shifts in the prevention portfolio including a robust focus on attaining coverage of priority populations with a minimum package of interventions and high impact services. In FY 2015, PEPFAR Swaziland will introduce a new activity to strengthen community systems for prevention of mother-to-child transmission (PMTCT) and support the Swaziland government in the roll out of Option B+ for PMTCT. Community stakeholders will be empowered to address socio-cultural and gender norms contributing to barriers in accessing HIV/AIDS services.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Swaziland	$ 59,961	$ 3,144,828	$ 1,687,312	**$ 4,892,101**
	Totals FY09-FY13	**$ 6,078,655**	**$ 18,058,322**	**$ 4,520,282**	**$ 28,657,259**
2015 (est)	Swaziland				**$ 10,794,692**

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The PEPFAR Swaziland treatment program is responding to the government of the Kingdom of Swaziland's aspiration to treat all HIV-infected patients, adults and children, with antiretroviral treatment (ART) with a CD4 count of less than 500. In 2015, PEPFAR will continue to support the scale-up of treatment services 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. In FY 2015, the program will also support National goals to improve pediatric treatment coverage from 70 percent to 90 percent by the end of 2015. Activities will focus strengthening case finding, communications strategies and interventions to improve ART uptake, building nurse capacity for phlebotomy on infants, and strengthening adolescent adherence and retention. Regarding key populations, PEPFAR will also increase its emphasis for counseling and testing for female sex workers and men who have sex with men to increase uptake and referral to care and treatment.

PEPFAR Swaziland and implementing partners established Regional Clinical Mentoring Teams (RCMT) in FY 2013. RCMT continue to provide on-site clinical mentoring, as well as leadership for decentralization of HIV and TB services. RCMT also promotes task-shifting of antiretroviral treatment (ART) initiation from doctors to nurses. In FY 2015, PEPFAR will build upon this success with a regionalized approach to clinical services to maximize efficiencies and strengthen integration across the continuum of the response. A new program will establish and monitor performance standards for HIV care and treatment services develop guidelines, policies, and training materials in respective regions.

The Swaziland government funds 100 percent of the country's ARVs and lab commodities. In FY 2015, PEPFAR will provide supply chain technical assistance focused on capacity building, and advocating for new legislation that will lead to a Medicines and Regulatory Authority and licensing of pharmacy professionals. PEPFAR Swaziland will continue to collaborate with the Global Fund in these areas, and also meet quarterly with the Clinton Health Access Initiative (CHAI), Médecins sans Frontières (MSF), and the MOH to monitor supplies and identify gaps in procurement.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Swaziland	$ 2,739,846	$ 1,307,313	$ 3,053,236	$ 3,330,584	**$ 10,430,979**
	Totals FY09-FY13	**$ 13,547,764**	**$ 4,141,283**	**$ 11,721,423**	**$ 12,302,700**	**$ 41,713,170**
2015 (est)	Swaziland					**$ 15,527,699**

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In FY 2015, PEPFAR Swaziland will support improvements in the initiation of co-infected TB patients on ART, expanding positive prevention messaging, nutrition counseling and related referrals, and strengthening social welfare systems to improve service delivery for orphans and vulnerable children (OVC).

PEPFAR Swaziland made significant strides in improving strategic information and the overall quality of TB/HIV integrated care and services provided to HIV positive individuals. In FY 2015, PEPFAR will continue to provide support for the implementation of services across the TB/HIV confection continuum at the facility level, with a focus on rapid expansion of isoniazid preventative therapy and increasing the amount of co-infected TB patients initiated on ART. A new program will help establish and monitor performance standards, as well as support the development of guidelines, policies, training materials, and implementation science research for TB/HIV.

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. PEPFAR has strategic investments to balance the need for long-term, sustainable systems strengthening support and service delivery to OVC. A new program will have specific focus on prevention interventions that target the most vulnerable children, including adolescent girls. The program will focus on evidence-based interventions, supporting integrated HIV prevention and OVC interventions (with linkages to testing, care and treatment) targeting adolescents, and organizational development and capacity building of civil society organizations with the comparative advantage to deliver these services in Swaziland.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Swaziland	$ 1,419,809	$ 1,263,031	$ 3,027,019	$ 3,229,295	**$ 8,939,154**
	Totals FY09-FY13	**$ 7,249,205**	**$ 27,599,835**	**$ 13,576,679**	**$ 15,033,690**	**$ 63,459,409**
2015 (est)	Swaziland					**$ 4,324,545**

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Strengthening national institutions is a cross-cutting focus of all PEPFAR Swaziland investments. PEPFAR Swaziland works closely with partners and the Swazi government to ensure that all components of a comprehensive health system are strengthened and coordinated effectively to deliver a sustainable national response to HIV/AIDS. In FY 2015, PEPFAR will focus support in strengthening and finding efficiencies in service delivery, supply chain, laboratory, strategic information, and governance. In the area of governance, PEPFAR

Swaziland will support a new program with the MOH dedicated to improving leadership and governance through the introduction of quality management systems.

The program will accomplish this objective by providing support to the ministry to finalize the mentoring and supervision framework, as well as clearly define performance indicators and targets for treatment, care, and support. Additionally, PEPFAR Swaziland will support program evaluations in the areas of linkage to care, ART programmatic outcomes, costing, and PMTCT to enhance data utilization for program improvement.

Country Engagement

Despite being a lower-middle income country, Swaziland manages to finance over 40 percent of its HIV response. The Swazi 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 received 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. Even as the country adopts the CD4 count threshold of 500 in 2014, the Swazi government maintains they will fully fund ARVs.

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 will continue to closely engage with NERCHA and the MOH to prepare for the New Funding Model, discuss long-term human resource management challenges, and improve CCM governance.

Tanzania

Country Context

According to the 2013 UNAIDS Report on the Global AIDS Epidemic, adult HIV prevalence in Tanzania is estimated at 5.1 percent, with an estimated 1.5 million Tanzanians living with HIV and 1.2 million orphans and vulnerable children (OVC). An estimated 80,000 AIDS-related deaths occur in Tanzanian each year. The 2011-12 Tanzania HIV and AIDS and Malaria Indicator Survey (THMIS) shows that the epidemic varies significantly by region, with the highest prevalence region estimated at 14.8 percent (Njombe) and the lowest at 0.1 percent (Kaskazini Unguja, Zanzibar). There is a significant difference in the prevalence between urban (7.2 percent) and rural (4.3 percent) areas. The data also reveal significant sex differentials in HIV prevalence, with male prevalence at 3.8 percent, and female prevalence nearly twice as high, at 6.2 percent. Girls acquire HIV at a younger age. Key populations also play a critical role in HIV transmission dynamics. Data indicate that injection drug use, specifically heroin use, is on the rise in urban Tanzania and Zanzibar. Studies in Dar es Salaam estimate that the HIV prevalence is 42 percent among people who inject drugs (2007) and 31.4 percent among sex workers (2010), while unpublished data for men who have sex with men estimates prevalence over 30 percent (2012).

Since 2004, PEPFAR Tanzania has been working closely with the Government of Tanzania, the Global Fund, and other donors 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+ (ART throughout pregnancy and breastfeeding for affected women), scaling up both adult and pediatric treatment coverage on antiretroviral therapy (ART), and increasing access to and uptake of voluntary medical male circumcision (VMMC), HIV counseling and testing (HCT), and condoms. In addition, PEPFAR Tanzania will work to reduce new infections and accelerate epidemic control in Tanzania by targeting high prevalence, high-burden geographic areas.

Below is a 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
2013	$ 111,626,043	32%	$ 67,452,716	19%	$ 116,756,829	34%	$ 52,142,096	15%	$ 347,977,684
Total 2009-2013	**$ 502,792,313**	**29%**	**$ 349,518,350**	**20%**	**$ 529,950,897**	**31%**	**$ 331,600,450**	**19%**	**$ 1,713,862,010**
2015 (est)	**$ 104,385,853**	**28%**	**$ 88,314,166**	**24%**	**$ 141,618,419**	**38%**	**$ 38,062,562**	**10%**	**$ 372,381,000**

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Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Tanzania	$ 43,317,060	$ 2,071,261	$ 19,019,409	$ 5,138,211	$ 1,058,047	$ 2,510,811	$22,152,312	$ 16,358,932	**$ 111,626,043**
	Totals FY09-FY13	**$ 174,068,078**	**$ 60,709,933**	**$ 89,158,039**	**$ 27,464,407**	**$ 10,069,327**	**$ 13,121,985**	**$50,484,002**	**$ 77,716,542**	**$ 502,792,313**
2015 (est)	Tanzania									**$ 104,385,853**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR Tanzania will continue to shift its prevention portfolio toward high impact, evidence-based HIV prevention services and will seek to increase the adoption of protective social and gender norms and behaviors in an effort to reduce HIV incidence. This combination approach, which includes behavioral, biomedical, and structural interventions, focuses on targeted 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.

In FY 2015, the HCT portfolio will heighten its focus on provider-initiated testing and counseling (PITC) as a priority modality while adopting a high-yield approach to HCT by strategically working in regions with high HIV prevalence and higher known density of key populations and other large at-risk sub-populations. The program will also more closely collaborate with the care and treatment services, including PMTCT, with a view toward better integration into the clinical care cascade. PEPFAR Tanzania will establish standardized referral/linkages and tracking systems between points of testing and care and treatment centers (CTCs). PEPFAR Tanzania will also continue to strengthen lab quality assurance of HCT services through internal Quality Assurance, proficiency testing, and test kit validation. The

program will continue to strengthen the monitoring & evaluation system and data utilization to inform program implementation and policy formulation.

The VMMC program will continue to scale up services. Its approaches will include working with the Government of Tanzania to integrate VMMC services within existing activities and increasing the involvement of the private sector and faith-based-supported facilities in the national program.

The PMTCT strategy for FY 2015 focuses on supporting Tanzania in the continued roll out of Option B+, initiated in October 2013. The goals of Option B+ in Tanzania are to increase access to PMTCT, Early Infant Diagnosis (EID), and nutrition services and to increase the number of pregnant and lactating women on ART. The approach decentralizes ART provision to all existing PMTCT sites in country and increases the uptake of EID services in all PMTCT sites. PEPFAR Tanzania will scale up integrated maternal and child services and encourage coordination between partners and programs in the regions to increase linkages from facility to community. PEPFAR Tanzania also will continue to focus on high prevalence, high burden regions and sites.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Tanzania	$ 15,226,915	$ 90,777,103	$ 10,752,811	**$ 116,756,829**
	Totals FY09-FY13	**$ 83,421,711**	**$ 397,034,019**	**$ 49,495,167**	**$ 529,950,897**
2015 (est)	Tanzania				**$ 141,618,419**

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PEPFAR Tanzania will continue to expand ART services for adults, pregnant and lactating women, HIV/Tuberculosis (TB) patients, and children. The PEPFAR Tanzania treatment 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, high adherence levels, and retention of patients in care and treatment. PEPFAR Tanzania will support the Tanzanian government in its efforts to scale-up treatment services and maximize efficiencies by focusing on high prevalence, high burden regions and sites, evaluating the availability of quality services and commodities, and strengthening systems to link patients in need of care and treatment services.

PEPFAR Tanzania has prioritized a substantial increase in Pediatric ART coverage. This will be supported by linkage and retention improvement strategies to maximize use of OVC community programs. The team will seek to build on the PMTCT Option B+ implementation to intensify efforts to strengthen EID services and better identify, enroll and retain children in care and treatment. In addition to PMTCT, PEPFAR Tanzania will continue to expand pediatric ART services in parallel with adult ART services. PEPFAR will seek to maximize PITC at all high yield pediatric entry points such as clinics for pediatric in-patients, children under five, TB clinics, malnutrition wards and children of adults being seen in care and treatment centers. The team will also coordinate with PMTCT and supply chain teams to ensure uninterrupted testing reagents and strengthen the blood sample transportation system.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Tanzania	$ 24,416,165	$ 3,527,640	$ 9,192,238	$ 30,316,673	**$ 67,452,716**
	Totals FY09-FY13	**$ 154,699,836**	**$ 11,795,686**	**$ 39,706,372**	**$ 143,316,456**	**$ 349,518,350**
2015 (est)	Tanzania					**$ 88,314,166**

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Despite increasing numbers of PLHIV on ART, there are still high rates of loss to follow up, with up to 26 percent of care and treatment center 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. To address the rates of loss to follow up, PEPFAR Tanzania is making strategic changes in the Community Services and Clinical Services platforms to strengthen linkages in the continuum of care from the point of diagnosis through enrollment, staging, pre-ART care, ART initiation, and treatment adherence.

With more PLHIV receiving ART and living longer, the portfolio has shifted away from palliative care to address other essential care and support services to better respond to the changing needs of PLHIV and households affected by AIDS. These strategic changes include health promotion and linkages to social services, as HIV becomes a chronic illness. PEPFAR Tanzania will focus on linkage and retention in community care, and improved coordination between community and facility level care. PEPFAR Tanzania will continue to strengthen community-based and sub-national structures to protect and support vulnerable populations through PLHIV networks, civil society organizations (CSOs), and faith-based organizations (FBOs).

Related activities that included in the PEPFAR Tanzania program include community savings, lending, and other micro-insurance activities, and approaches to help vulnerable households prevent, mitigate, and cope with social-economical and health shocks. PEPFAR Tanzania will seek to build the capacity of caregivers through mentoring/coaching and training on child care, savings, and money management. The care portfolio will also include building the capacity and national and sub-national level to oversee the implementation of social-economic empowerment activities that contribute to health and other health related development outcomes.

The care portfolio will also focus on health systems strengthening aspects such as improving data use for decision making, learning and quality of services, promotion of community-based human resources to provide supportive care to vulnerable populations, and support for the implementation of national and sub-national policies and legal frameworks for health and social services.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Tanzania	$ 7,794,401	$ 8,546,575	$ 23,710,835	$ 12,090,285	**$ 52,142,096**
	Totals FY09-FY13	**$ 43,255,224**	**$ 43,312,434**	**$ 158,329,971**	**$ 86,702,821**	**$ 331,600,450**
2015 (est)	Tanzania					**$ 38,062,562**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

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. In FY 2015, PEPFAR Tanzania will prioritize human resources for health (HRH) within system strengthening.

PEPFAR Tanzania will continue to strengthen the workforce by supporting the full health care worker (HCW) continuum including production, recruitment and retention. The team will continue to support implementation of the National HRH Strategic Plan through specific interventions focused on increasing the quantity and quality of social and health care workers, including at the community level.

PEPFAR Tanzania will continue to work closely with the Medical Stores Department and the Global Fund to ensure that the supply chain is well coordinated. The PEPFAR Tanzania team continues to ensure that quality health commodities and equipment are procured according to the Ministry of Health and Social Welfare (MOHSW) procurement plan and associated schedules

and are maintained in working order. The strengthened logistic management systems will provide a sustainable and secure health commodity supply chain that will support the health management of patients throughout the public health system. PEPFAR Tanzania will also support physical and systems infrastructure to increase capacity and efficiencies within the public supply chain system.

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, reducing new infections, and accelerating epidemic control in Tanzania require strong government systems that are efficiently implementing Global Fund grants, the adoption of necessary policy changes, and utilizing data effectively to make informed decisions on the epidemic. The Tanzania government recently approved the creation of an AIDS Trust Fund (ATF), which should increase the public funding of Tanzania's own response to HIV and AIDS, and is currently pending approval by Parliament. Tanzania Commission for AIDS projects an initial Government of Tanzania contribution of US$190 million, with funding tapering down in subsequent years.

In FY 2015, PEPFAR Tanzania will work with the Tanzanian government, the Global Fund and other development partners to develop guiding documents for the three major funding sources in country:

- Concept Note for the Global Fund
- Sustainability Plan for PEPFAR in Tanzania; and
- Governance structure for the AIDS Trust Fund.

The Third National Multi-Sectoral Strategic Framework for HIV and AIDS and the Tanzania Health Sector Strategic Plan NMSF III will provide the foundation for these documents. PEPFAR Tanzania will collaborate with the Tanzanian government and Global Fund to plan the full HIV and AIDS response and develop a collaborative division of responsibility.

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. Increases in the prevalence were most significant among women and uncircumcised men, fishing communities and key populations.

HIV is predominantly heterosexually transmitted, accounting for 75-80 percent of new infections (18 percent vertical transmission; less than 1 percent blood borne and other modes). Those most affected, the risk factors, and drivers of HIV infections have evolved in recent years. Studies show an HIV prevalence of 1.2 percent in university students, 15-40 percent in fishing communities, 37 percent among SW, 18 percent in the partners of SWs, and 13 percent in the group of men with a history of having sex with men (MSM). Strikingly, 35 percent of new infections occur amongst self-reported monogamous individuals, raising concerns regarding rising multiple concurrent partnerships, extra-marital relations, and transactional, early, and cross-generational sex. HIV transmission involving SW networks bridging to the general population accounts for approximately 10 percent of new HIV infections. As a result of these trends, the peak of the epidemic has shifted from unmarried younger individuals to 30 to 39-years-old individuals, who are more likely to be married or in long-term relationships (2011 Uganda AIDS Indicator Survey).

In FY 2015 PEPFAR Uganda has selected programmatic strategies that include:

- Achieving full coverage to eliminate mother-to-child transmission; 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;
- Improving outreach and service delivery to populations most at risk MSM, sex workers, and fisherfolk;
- Improving access to ART and support the government of Uganda in adopting new WHO guidelines including raising initiation to CD4 500, and test and treat for all pediatric patients;
- Building health systems including labs, human resources for health (HRH) and data; and

- Continued scale up of treatment for HIV positive pregnant women through PMTCT Option B+.

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
2013	$ 75,344,771	23%	$ 72,014,086	22%	$ 122,631,032	38%	$ 53,398,483	17%	$ 323,388,372
Total 2009-2013	**$ 386,527,426**	**25%**	**$ 327,940,557**	**22%**	**$ 509,450,178**	**34%**	**$ 294,619,061**	**19%**	**$1,518,537,222**
2015 (est)	**$ 53,027,540**	**17%**	**$ 48,255,619**	**15%**	**$ 165,898,152**	**52%**	**$ 52,994,689**	**17%**	**$ 320,176,000**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Uganda	$22,975,506	$ 780,250	$ 13,428,600	$ 2,026,197	$ 310,478	$ -	$21,366,161	$ 14,457,579	**$ 75,344,771**
	Totals FY09-FY13	**$99,488,365**	**$ 49,228,024**	**$ 67,551,213**	**$ 15,153,386**	**$ 2,877,978**	**$ -**	**$71,313,442**	**$ 80,915,018**	**$ 386,527,426**
2015 (est)	Uganda									**$ 53,027,540**

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Implementation of evidence based, combination HIV prevention approaches led to a decrease in incidence between 2011 and 2012; however, incidence remains high. The overall increase in prevalence can be attributed to previous interventions not being scaled up enough to make a significant impact; prevention interventions not being aligned to sources of new infections; and widespread risky sexual behavior with low levels of prevention knowledge and risk perception in the population.

PEPFAR has shifted its prevention activities away from stand-alone behavioral interventions to combination approaches that integrate appropriate prevention messaging and condom promotion with biomedical interventions such as PMTCT and VMMC. PEPFAR continues to refine its behavioral prevention portfolio to better target key populations and prioritize proven biomedical and structural interventions. In FY 2015, PEPFAR will prioritize continued VMMC scale up; ensuring a balanced portfolio that addresses prevention needs across generational subgroups; eliminating bottlenecks that impede condom access and use; and targeting key populations with tailored

programs. PEPFAR will continue its support for blood safety, medical infection, post exposure prophylaxis (PEP), and sexually transmitted infection (STI) management.

In FY 2015, the PEPFAR Uganda prevention program will continue to focus on Option B+ for PMTCT, scaling-up provider-initiated testing and counseling (PITC), targeted testing for key high risk groups, and VMMC.

In September 2012, Uganda launched treatment for life for HIV positive pregnant women (Option B+). In FY 2015, PEPFAR will continue to scale-up Option B+ coverage and roll out the Mother Baby Care Point service delivery model to improve retention and linkage to pediatric care and treatment by better integrating services for HIV-positive mothers and HIV exposed children, which has previously been fractured between antenatal clinics (ANC) and early infant diagnosis (EID) care points. PEPFAR will support universal Option B+ coverage by testing 80 percent of pregnant women for HIV, providing ARVs to 85 percent of identified HIV-positive pregnant women, and ensuring early testing to 65 percent of HIV-exposed infants.

The 2011 Uganda AIDS Indicator Survey (UAIS) results indicate a reduction in condom use in those engaged in high-risk sex (47 percent to 29 percent for women; 53 percent to 38 percent for men). PEPFAR will support implementation of the MOH's condom strategy and coordination mechanisms to ensure comprehensive condom programming. Under the Global Fund interim application, the Global Fund and United Nations Population Fund (UNFPA) will provide male and female condoms while PEPFAR will support distribution and messaging. Key activities include increasing distribution outlets at facilities, community level, fishing landing sites, and hard to reach areas (primarily rural); strengthening national coordination through the MOH's Condom Coordinating Unit to plan condom procurement and monitor availability; undertaking diplomacy and advocacy activities to de-stigmatize condoms; social marketing of condoms in the private sector and tertiary institutions; engagement with the hospitality industry, bars, and hotels; and supporting advocacy efforts among religious and political leaders. Deliberate efforts will be made to promote condom use among key populations, sero-discordant couples, and multiple concurrent partnerships.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Uganda	$ 70,493,790	$ 46,041,225	$ 6,096,017	**$ 122,631,032**
	Totals FY09-FY13	**$ 263,190,951**	**$ 199,754,358**	**$ 46,504,869**	**$ 509,450,178**
2015 (est)	Uganda				**$ 165,898,152**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2014 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, 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 Government of Uganda in adopting new WHO guidelines including raising initiation to CD4 500, and test and treat for all pediatric patients;
- 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 - FY13) & FY15 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**
2013	Uganda	$ 34,633,478	$ 2,300,812	$ 7,938,790	$ 27,141,006	**$ 72,014,086**
	Totals FY09-FY13	**$ 135,475,072**	**$ 20,769,865**	**$ 43,127,820**	**$ 128,567,800**	**$ 327,940,557**
2015 (est)	Uganda					**$ 48,255,619**

* Totals include planned funding for all accounts. .
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 2015, 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 2015 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 through 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 and expanding TB/HIV activities to increase coverage of HIV testing among TB patients from 80 percent to 90 percent and increase access to and uptake of ART in TB clinics from 61 percent to 80 percent; 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 - FY13) & FY15 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**
2013	Uganda	$ 15,258,756	$ 13,403,380	$ 9,614,473	$ 15,121,874	**$ 53,398,483**
	Totals FY09-FY13	**$ 82,494,326**	**$ 68,084,544**	**$ 53,003,096**	**$ 91,037,095**	**$ 294,619,061**
2015 (est)	Uganda					**$ 52,994,689**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In 2014, PEPFAR had notable improvements in governance and systems strengthening, including stimulating Government of Uganda leadership, particularly for Option B+ and lab services expansion, as well as the recruitment of more than 1,500 health workers. In FY 2015, PEPFAR will continue to shift from vertical emergency approaches to working through, and supporting, the Ugandan health system.

PEPFAR will strengthen its efforts across institutions and individuals to build capacity for health sector leadership and improved governance. At the central level, technical assistance will support key line ministries with strategic planning, policy and guideline development and standardization of tools and processes to assist in planning, monitoring, and quality improvement (QI).

Strengthening governance, technical capacity, performance, and accountability to improve service delivery systems at the unit of implementation will have an impact on key HIV performance parameters and on health systems well beyond HIV/AIDS.

Through PEPFAR technical support, the HRH information system will be expanded to cover all 112 districts; staffing levels at districts will gradually increase; health training institutions and professional associations will receive resource inputs and capacity building to ensure that production of critical cadres through pre-service institutions remains on track, contributing 3,000 health workers. PEPFAR will support the MOH and Ministry of Education and Sports (MOES) to establish and complete their information system on in-service training and pre service training, which will improve forecasting and planning, as well as accreditation, coordination, and regulation of all in service training events in the country. PEPFAR will continue to build capacity within district and local governments and district health teams to strengthen work environments, performance, and management. In addition, PEPFAR will support the MOH and districts in implementing the retention and motivation plan and support staff motivation and accommodation in hard-to- reach and remote districts with low staffing levels and high patient load.

PEPFAR will support pre-service training institutions to generate key cadres, enhance the quality of trainers/tutors, upgrade training facilities/equipment, and standardize national training curricula. PEPFAR will continue to support universities and health training institutions through 1) the Medical Education Partnership Initiative (MEPI) support to medical training, MPH and leadership fellowships, and scholarships for poor students from hard to reach areas and 2) the Global Health Service Partnership (GHSP), and PEPFAR, that will continue to provide valuable teaching and mentorship of medical school professors and students through the placement of American doctors and nurses in Ugandan schools.

PEPFAR will remain an important technical assistance provider to the MOH for supply chain system strengthening. PEPFAR builds capacity of local institutions to manage all components of the supply chain system effectively and will continue to focus on strengthening the national supply chain management system and building on past investments. In partnership with the Global Fund and other partners, and under the leadership of the Government of Uganda, the key short-term priorities are 1) increasing warehousing and distribution capacity to deliver the large volumes of condoms needed for effective prevention activities; 2) ensuring standardized logistics manual, paper based data collection tools are available at all levels for all health commodities; 3) developing standards for electronic logistics management information systems and ensuring they are interoperable with the national HMIS; 4) rolling out electronic inventory management systems for stock management at high volume facilities; 5) ensuring logistics management data are available for tracer HIV products to report on PEPFAR indicators; and 6) reinforcing lab logistics through capacity-building interventions.

PEPFAR Uganda will continue to focus on strengthening family planning (FP)/HIV integration and ensure it available in every PEPFAR supported site.

Country Engagement

The Ministry of Health (MOH) through its AIDS Control Program (ACP) and the Uganda AIDS Commission (UAC) under the office of the President lead the national HIV response. The MOH is responsible for coordination and technical guidance; the ACP coordinates service delivery in public and private facilities and other public health programs. The UAC provides oversight of nationwide HIV efforts, including coordination of policy development, planning, resource mobilization and allocation, as well as monitoring and reporting on progress. Over the last year, coordination between the UAC and MOH has improved under the leadership of the UAC Board Chairman and the new Minister of Health appointed in May 2013.

The Government of Uganda continues to increase investments in the health sector. Overall health sector spending increased between 2001 and 2013 but declined from 9 percent to 7.9 percent as a percentage of total national budget. The Government of Uganda's percentage contribution of total national HIV expenditures increased from 5 percent to 12 percent. Ugandan households contribute substantially towards the national response. Out-of-pocket spending by households on HIV/AIDS and related conditions not only accounts for more than one-fifth of annual expenditures but is also twice the amount contributed by the Government of Uganda.

In 2014, the Government of Uganda demonstrated increased leadership in the national HIV response. The UAC shepherded the national HIV investment case dialogue and the MOH and UAC jointly led development of the interim application to the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund). Through these processes, they have better coordinated national stakeholders; articulated national testing, treatment, care, and circumcision targets; and set the tone for increased collaboration in 2015.

PEPFAR, led by the Ambassador, has raised the political profile of health with the President of Uganda and the executive and legislative branches of government. PEPFAR is an active member on the Global Fund (Global Fund) Country Coordinating Mechanism (CCM) in Uganda, and PEPFAR agencies are active members of the Health Development Partner and AIDS Development Partner groups, as well as the Health Policy Advisory Committee. The PEPFAR team has regular planning and strategic meetings with the Global Fund's Fund Portfolio Manager and country coordination mechanism (CCM) members on a range of key issues for the HIV response, which includes an active partnership on commodities supply.

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 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 2015 include:

- Biomedical interventions including continued scale-up of adult treatment, support for PMTCT and the implementation of Option B+ for the elimination of MTCT, scale-up of voluntary medical male circumcision (VMMC), and increased focus on pediatric treatment;
- Improved quality of services and data quality;
- Strengthening of the health system, including:
    - Integration of HIV programs with other health programs, with specific attention to HIV-family planning integration;
    - Ensuring commodity security;
    - Improved governance;
    - Focus on geographic coverage;
- Improved access to and quality of services for key populations; and
- A focus on youth and the importance of demand creation at the community level.

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
2013	$ 90,913,498	30%	$ 55,249,696	18%	$ 78,077,659	25%	$ 82,218,513	27%	$ 306,459,366
Total 2009-2013	**$ 404,400,409**	**29%**	**$ 278,093,675**	**20%**	**$ 365,403,851**	**26%**	**$ 362,766,712**	**26%**	**$1,410,664,647**
2015 (est)	**$ 67,248,481**	**22%**	**$ 56,937,380**	**19%**	**$ 121,614,286**	**40%**	**$ 58,481,853**	**19%**	**$ 304,282,000**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Zambia	$ 24,543,289	$ 8,594,789	$ 13,387,436	$ 1,499,500	$ -	$ -	$18,227,294	$ 24,661,190	**$ 90,913,498**
	Totals FY09-FY13	**$ 104,805,584**	**$ 61,833,566**	**$ 69,679,206**	**$ 12,320,839**	**$ 350,000**	**$ -**	**$47,434,720**	**$ 107,976,494**	**$ 404,400,409**
2015 (est)	Zambia									**$ 67,248,481**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, the Zambian and U.S. governments will focus on scaling up effective combination HIV prevention strategies, including VMMC and prevention of mother-to-child transmission (PMTCT). 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.

In FY 2014, PEPFAR Zambia implemented a robust plan to increase both the supply and demand of the VMMC program and more than double the clients reached during FY 2013. The program focused scale up to new and hard-to-reach areas to increase access to quality-assured VMMC services by leveraging 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. This collaboration continues to involve the Gates Foundation, the Clinton Health Access Initiative (CHAI) and the Government of the Republic of Zambia on VMMC scale-up, although PEPFAR supports the large majority of VMMC service delivery in Zambia. In FY 2015, PEPFAR will continue to

scale-up effective and efficient models of VMMC to support the national goal of circumcising 1.9 million by 2015. The innovative campaign using traditional leaders as champions of change for VMMC will roll out to ten chiefdoms in FY 2015.

The PEPFAR Zambia PMTCT program will support the Ministry of Health (MOH) as the country initiates the planned implementation 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 also continue to strengthen linkages and services in early infant diagnosis (EID) and follow-up of HIV-exposed children for treatment. Stronger linkages with PMTCT will improve pediatric treatment coverage for children infected with HIV.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Zambia	$ 38,978,729	$ 28,854,555	$ 10,244,375	**$ 78,077,659**
	Totals FY09-FY13	**$ 169,957,685**	**$ 154,997,541**	**$ 40,448,625**	**$ 365,403,851**
2015 (est)	Zambia				**$ 121,614,286**

*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, adults and children, with ART regardless of CD4 count. In 2015, treatment services will continue to 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 support of improved pediatric treatment services in FY 2015, PEPFAR Zambia will prevent the emergence and spread of HIV drug resistance, expand access to viral load testing, scale-up early initiation of treatment for infants and adolescents, and develop a robust plan to measure the performance of the program.

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 CHAI supports drug access and laboratory systems strengthening.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Zambia	$ 15,249,829	$ 7,298,808	$ 10,262,322	$ 22,438,737	**$ 55,249,696**
	Totals FY09-FY13	**$ 94,119,031**	**$ 33,008,347**	**$ 50,892,083**	**$ 100,074,214**	**$ 278,093,675**
2015 (est)	Zambia					**$ 56,937,380**

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In FY 2015, 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 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 is currently supporting 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 expand, and to inform improved practices in OVC programming.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Zambia	$ 31,634,934	$ 14,951,436	$ 25,592,681	$ 10,039,462	**$ 82,218,513**
	Totals FY09-FY13	**$ 113,009,721**	**$ 68,007,635**	**$ 121,440,626**	**$ 60,308,730**	**$ 362,766,712**
2015 (est)	Zambia					**$ 58,481,853**

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Improved surveillance, data collection, and data quality is a priority in FY 2015 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 2015, there is also an enhanced focus on data use and quality in program planning and review, including robust evaluations to inform decision making and to ensure standardized quality of services across partners. In FY 2015, 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.

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 *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 the Ministry of Community Development, Mother and Child Health (MOCDMCH) participated in FY 2015 PEPFAR consultations, along with civil society stakeholders and other donor partners. Consultations with the MOH and MOCDMCH on PEPFAR's FY 2015 program led to increased PEPFAR support for family planning-HIV integration activities, increased focus on geographic coverage of services, strengthened evidence generation and surveillance activities, and mutual scale-up of treatment and PMTCT services.

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.

Zimbabwe

Country Context

The Zimbabwe Demographic Health Survey (DHS) 2010-2011 defined adult prevalence at 15 percent, one of the highest in the world. Zimbabwe's population is 13 million (2012 National Census) with an estimated 1.3 million individuals living with HIV. An estimated 60,607 individuals were newly infected with HIV in 2013. HIV is the leading cause of death among adults and accounts for approximately 29,494 adult and 7,660 child deaths each year. HIV accounts for over 27 percent of all deaths among mothers and infants. The estimated number of orphans and vulnerable children (OVC) is 1.6 million. The 2010 DHS found that six in ten children under age 18 were not living with both parents, and that 20percent of children under age 18 were orphaned—one or both parents were dead. 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) incidence rate (562 per 100,000) is one of the highest in the world (WHO Global TB Report 2013). The TB epidemic in Zimbabwe is largely HIV driven with a very high TB/HIV co-infection rate (at 70 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 2015 remain 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
2013	$ 32,469,389	34%	$ 11,166,291	12%	$ 32,039,869	34%	$ 19,324,451	20%	$ 95,000,000
Total 2009-2013	**$ 110,544,480**	**32%**	**$ 46,322,741**	**13%**	**$ 97,226,172**	**28%**	**$ 90,097,432**	**26%**	**$ 344,190,825**
2015 (est)	**$ 30,236,113**	**32%**	**$ 13,213,469**	**14%**	**$ 40,692,767**	**43%**	**$ 9,607,651**	**10%**	**$ 93,750,000**

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Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Zimbabwe	$ 6,926,298	$ 360,556	$ 1,676,190	$ 500,000	$ 100,000	$ -	$ 20,180,445	$ 2,725,900	**$ 32,469,389**
	Totals FY09-FY13	**$ 30,268,907**	**$ 5,912,077**	**$ 7,580,270**	**$ 4,725,000**	**$ 300,000**	**$ -**	**$ 49,849,668**	**$ 11,908,558**	**$ 110,544,480**
2015 (est)	Zimbabwe									**$ 30,236,113**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR Zimbabwe's 2015 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 continue to decline resources for VMMC will increase in FY 2015 as the program accelerates efforts to increase coverage to 80 percent of all males. New partners have been brought on board to expand service delivery in both rural and urban districts, increase demand creation schemes, and integrate male circumcision services for HIV prevention into routine clinical care. In FY 2014, the Ministry of Health and Child Care (MOHCC) approved a task-shifting policy allowing for nurses to perform medical circumcision. In FY 2015, PEPFAR Zimbabwe will allocate additional resources for training in order to expedite the number of nurses skilled in VMMC.

The PEPFAR program continues to support a robust provider initiated testing and counseling (PITC) while also maintaining a core set of client initiated testing and counseling (CITC) centers in urban areas, with increased mobile outreach to rural and vulnerable populations. In FY 2015, PEPFAR Zimbabwe will support a pilot to increase opt-out testing rates at select facilities and increase the proportion of men and women accessing HTC as at static sites in both urban and rural areas. Additionally, PEPFAR Zimbabwe will continue to strengthen the MOHCC's capacity for implementation of infection prevention and control (IPC) activities in health care facilities nation-wide. FY 2015 funding will be used to disseminate the national IPC policy, establish hospital IPC committees and policies, trainings, education and communication activities among health workers and clients and strengthen the provision of post-exposure prophylaxis (PEP) through improving monitoring and reporting of occupational injuries and strengthening the PEP drug supply chain.

In FY 2015, 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 2015 activities will support injection safety activities including trainings for healthcare workers and strengthening of the post-exposure prophylaxis drug supply chain.

In FY 2015, PEPFAR Zimbabwe will increase effort to take gender-specific vulnerabilities into consideration during program implementation in order to promote improved health outcomes for women and girls. FY 2015 activities include: targeted gender-based violence (GBV) prevention messages to reach in and out-of-school children; initiating Family Support Groups that target men and women and address gender-related roles within the household; expanding school-based clubs that equip adolescent girls and boys with HIV prevention information and skills to prevent sexual abuse and exploitation.

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, 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 - FY13) & FY15 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**
2013	Zimbabwe	$ 19,689,348	$ 10,442,404	$ 1,908,117	**$ 32,039,869**
	Totals FY09-FY13	**$ 61,470,880**	**$ 29,731,911**	**$ 6,023,381**	**$ 97,226,172**
2015 (est)	Zimbabwe				**$ 40,692,767**

*Totals include planned funding for all accounts.
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The PEPFAR program in Zimbabwe works closely with the MOCC to strengthen ART services within the existing health delivery system. The MOHCC, 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 supports 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). In FY 2015, PEPFAR Zimbabwe will strengthen continuum of response by increasing the number of facilities providing opportunistic infection (OI)/ART services. In FY 2015, PEPFAR will improve and expand the HIV/AIDS prevention and care capacity in health facilities in all eight provinces of the country. Additionally, COP15 funding will be used to support an early warning indicators survey and cross-sectional survey that will monitor drug resistance acquired during treatment at various time intervals To help alleviate severe space constraints in ART clinics, PEPFAR will also procure 100 prefabricated three-room clinics for distribution to MOHCC facilities nationwide.

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, Global Fund and MOHCC to support national quantification efforts to ensure availability of supply. Additionally, in FY 2015, the U.S. government team will expand support for provincial "super-laboratories" which will serve networks of OI clinic conducting regular laboratory monitoring for ART patients.

Under the leadership of the MOHCC 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 MOHCC AIDS & TB Program: the National ART Coordinator, Deputy National ART Coordinator for Quality Assurance, and Assistant National ART Coordinator. FY 2015 resources will continue to support the funding of site readiness assessments and site supervision aimed at enhancing the MOHCC's ART scale-up activities, national quality of care initiative, and decentralization of ARV treatment.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Zimbabwe	$ 444,939	$ 601,732	$ 2,564,696	$ 7,554,924	**$ 11,166,291**
	Totals FY09-FY13	**$ 4,396,959**	**$ 3,423,347**	**$ 14,085,848**	**$ 24,416,587**	**$ 46,322,741**
2015 (est)	Zimbabwe					**$ 13,213,469**

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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 2015 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.

In FY 2015, the U.S. government will continue to support MOHCC 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 and support will be maintained for the National Microbiology Reference Laboratory in Harare and the TB Reference Laboratory in Bulawayo 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, technical assistance and training to people living with HIV/AIDS (PLHIV) and workplace-based support groups.

In FY 2015, 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. In FY 2015, there will be a transition of international awards to three local organizations that are currently sub-partners of World Education International (WEI).

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Zimbabwe	$ 3,377,517	$ 3,315,320	$ 7,299,756	$ 5,331,858	**$ 19,324,451**
	Totals FY09-FY13	**$ 13,047,469**	**$ 14,842,407**	**$ 36,599,309**	**$ 25,608,247**	**$ 90,097,432**
2015 (est)	Zimbabwe					**$ 9,607,651**

*Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, the U.S. government, through the Zimbabwe National Quality Assurance Program, 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 2015, the PEPFAR Zimbabwe team will continue to assist the MOHCC as it establishes a Laboratory Management Information System (LMIS) 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 MOHCC by working closely to build the capacity of both the MOHCC'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 laboratory management and information system. In FY 2015, the U.S. government 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 2015 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 MOHCC and once completed, will be implemented using PEPFAR and other donor resources. 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 MOHCC 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 MOHCC is high in terms of technical direction and policy setting, the capacity for implementation continues to be limited. For the MOHCC, low capacity is largely an outcome of limited national resources for programming. This impacts 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 Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria (Global Fund) remains the largest source of support to the national response. In FY14, Zimbabwe was one of six countries to pioneer the New Funding Model (NFM) and was awarded a three-year $311 million grant to support Global Fund OVC activities, TB, VMMC, treatment, capacity building, and other care and support services. The PEPFAR Global Fund Liaison supports the continuous collaboration and coordination of PEPFAR and Global Fund funded work in Zimbabwe.

The focus of PEPFAR in Zimbabwe has historically been to enhance the capacity of government facilities 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). At the end of 2012, UNAIDS estimated the HIV prevalence among the adult (15 – 49 year old) age group was 0.9 percent and Ukraine had 230,000 people living with HIV (PLHIV). UNAIDS also estimated that there are 5,100 children (0 – 14) living with HIV and there were 18,000 deaths from HIV/AIDS (AIDS Info, UNAIDS, 2013). The reported cumulative number of clients registered with the national AIDS Centers on January 1, 2014, was 139,573. Of these, 75,301 (54 percent) were male and 64,272 (46 percent) were female.

The HIV epidemic in Ukraine continues to be driven by unsafe drug injection and sexual practices, and remains concentrated among key populations, including people who inject drugs (PWID), female sex workers (FSW), men who have sex with men (MSM), and other vulnerable groups such as the sexual partners of these key populations and prisoners. In 2012, 63 percent of 16,677 new adult/adolescent HIV cases were attributed to heterosexual transmission, and 36 percent to PWID. Since 2007, the reported primary mode of HIV transmission has shifted from intravenous drug use (IDU) to sexual transmission underlining the need to focus prevention efforts increasingly on changing sexual behaviors of key populations while continuing to scale up harm reduction activities for PWID.

The U.S. government is Ukraine's largest bilateral partner in HIV/AIDS, though the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) is the largest overall donor for the HIV response in Ukraine. The U.S. government 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 a five-year HIV/AIDS Partnership Framework was signed by the Government of Ukraine and the U.S. government. The Partnership Framework 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
2013	$ 5,065,418	34%	$ 2,046,555	14%	$ 898,544	6%	$ 6,989,483	47%	$ 15,000,000
Total 2009-2013	**$ 19,845,612**	**37%**	**$ 7,384,441**	**14%**	**$ 1,324,368**	**2%**	**$ 40,382,579**	**75%**	**$ 53,937,000**
2015 (est)	**$ 7,455,907**	**30%**	**$ 4,267,261**	**17%**	**$ 1,189,561**	**5%**	**$ 11,602,271**	**47%**	**$ 24,515,000**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Ukraine	$ -	$ 20,196	$ 1,284,951	$ 749,762	$ -	$ 2,673,638	$ -	$ 336,871	**$ 5,065,418**
	Totals FY09-FY13	**$ -**	**$ 112,390**	**$ 6,294,873**	**$ 2,283,454**	**$ 250,000**	**$ 9,529,728**	**$ -**	**$ 1,375,167**	**$ 19,845,612**
2015 (est)	Ukraine									**$ 7,455,907**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR's prevention work is fully aligned with the 2014-2018 National AIDS Program (NAP) goals in prevention which endeavor to substantially decrease new HIV infections among general population and key populations and enroll key populations into medicine assisted therapy (MAT) and rehabilitation programs (MAT target 20,000).

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 2015 largely continue the approaches taken in FY 2014, with PEPFAR Ukraine continuing to provide technical assistance (TA) to strengthen the overall quality and outcomes of Global Fund and Government of Ukraine programs. PEPFAR's prevention program is carefully designed to complement and leverage these other, larger resources.

Size estimations of the various KP subgroups inform PEPFAR's prevention activities. PWID continue to be the most affected group and contribute disproportionately to current HIV incidence. An estimated 300,000 Ukrainians inject drugs, amounting to 0.8 percent of the total

adult population (aged 15 and up). A 2011 Integrated Biological and Behavioral Surveillance (IBBS) survey found a 21.6 percent HIV prevalence among PWID (20.5 percent in males and 25.1 percent in females). Prevalence among young PWID (aged 25 and younger) progressively declined from 29.9 percent in 2004 to 7.2 percent in 2011. Opioids remain predominant (83 percent) although stimulants are also injected by 37 percent of users (20 percent inject both). In 2011, only 8 percent reported sharing a needle/syringe within the last 30 days; however, a majority inject with syringes prefilled by others.

The estimated population size of FSW is 65,000 - 90,000. Many FSW are also PWID although the proportion is declining. Sixteen percent of FSW surveyed in 2011 reported current drug use, 58 percent of whom reported current injecting drug use. HIV prevalence was 10 percent overall: 41 percent among FSW reporting injecting drug use and 6 percent among non-PWID. In 2011, 92 percent of FSW reported condom usage with their last commercial partner. The estimated MSM population size is 95,000 - 230,000. HIV prevalence in 2011 was 6 percent, data that appears to support the misclassification of MSM in case reporting and a significant though modest contribution to the epidemic.

To support the reduction of HIV transmission among key populations per the first goal of the Partnership Framework, PEPFAR will continue to provide TA to the Ukrainian government, principal recipients, and local civil society organizations (CSOs) to enhance their HIV prevention programming to at-risk populations. This technical assistance will help ensure that GFATM and Government of Ukraine programs are evidence-driven, high quality, efficient, and impactful in the nine focal oblasts most affected by the epidemic. Targeted populations include PWID, MSM, FSWs, most-at-risk adolescents (MARA), PLHIV, and sexual partners of these key populations.

The PEPFAR Ukraine program has evolved from the provision of direct service delivery to the provision of technical assistance to support sustainable capacity and systems with the Government of Ukraine and Global Fund principal recipients (PRs). The U.S. government will continue to build national support for services targeted to key populations, such as MAT, and advocacy for the removal of legal and policy barriers, including conflicting public health and drug control policies. Prevention activities will support the strengthening of public sector and civil society service delivery capacity. PEPFAR Ukraine will also continue to support the inclusion of law enforcement and military agencies in the national HIV/AIDS response. Additional TA will support blood safety, the reduction of stigma and discrimination among health professionals, and greater linkage between prevention and other HIV services. Anticipated efficiency gains include strengthened Ukrainian government ownership, including increased publicly-provided key populations prevention services, and integrated services efficiencies, as feasible within an inherently vertical health care system.

While anticipated efficiency gains in FY 2015 may be jeopardized by the volatility in Ukraine's political climate, the PEPFAR Ukraine program remains committed to protecting the gains already achieved in the HIV response and will continue to collaborate closely with the appropriate Ukrainian government counterparts to maintain prevention activities.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Ukraine	$ -	$ 898,544	$ -	**$ 898,544**
	Totals FY09-FY13	**$ 25,824**	**$ 1,298,544**	**$ -**	**$ 1,324,368**
2015 (est)	Ukraine				**$ 1,189,561**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The most significant achievement of the national treatment program is a rapid increase in anti-retroviral therapy (ART) coverage between 2010 and 2013. As of October 1, 2010, the national program supported 25,865 ART patients. The number of patients on ART more than doubled by the end of 2013 to 55,784 patients. In 2013, the Ukrainian government funded 79 percent of anti-retroviral drug (ARV) procurement and the Global Fund funded 21 percent. At the end of 2013, ART coverage remains sub-optimal at approximately 50 percent coverage of adults who need treatment, per the national treatment threshold of CD4<350. PEPFAR Ukraine does not directly support ART therapy or procure ARVs. However, PEPFAR Ukraine engages in strategic TA to the Ukrainian government and to Global Fund PRs to improve the scale up and quality of treatment and support services. Under the 2014-2018 NAP, ART will expand rapidly to 118,000 individuals by 2018, representing approximately 84 percent of the anticipated need (CD4<350).

The goal of PEPFAR Ukraine's treatment program relates mainly to Partnership Framework Goal 2: to improve the quality and cost effectiveness of care and treatment services for key populations. In FY 2015, technical priorities continue to be:

- Scaling up comprehensive treatment services to key populations;
- Enhancing evidence-based approaches for HIV diagnostics and treatment, including strengthening quality assurance throughout the laboratory system; and
- Increasing the efficiency of the national ART system through improved ART monitoring, evaluation, procurement, and supply management, as well as strengthened provider capacity to actively monitor adverse drug events.

These priorities build on the incremental gains achieved to date in treatment expansion and evidence-based HIV treatment. As the agency responsible for the technical guidance, implementation, monitoring, surveillance, and epidemiologic research of the national AIDS and

TB programs and a Global Fund PR, the Ukrainian Center for Socially Dangerous Disease Control (U-CDC) will continue to receive extensive support from PEPFAR Ukraine.
In FY 2015, PEPFAR Ukraine will provide TA to help remove regulatory and operational barriers to treatment, as well as to support treatment providers' ability to forecast and quantify treatment commodities. PEPFAR will also intensify support for the roll out of national HIV/AIDS treatment protocols and human resource allocation; the scale up of integrated treatment models that look comprehensively at HIV, MAT, and tuberculosis); and an analysis of the cost-effectiveness of various ART models. Anticipated efficiency gains include strengthened Ukrainian government ownership and better integrated treatment services.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Ukraine	$ 100,000	$ -	$ 1,646,555	$ 300,000	**$ 2,046,555**
	Totals FY09-FY13	**$ 403,211**	**$ -**	**$ 5,405,168**	**$ 1,576,062**	**$ 7,384,441**
2015 (est)	Ukraine					**$ 4,267,261**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, 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. The goal of PEPFAR Ukraine's care program relates mainly to Partnership Framework Goal 2: to improve the quality and cost effectiveness of care and treatment services for key populations. In FY 2015, 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).

HIV/AIDS care and support services for key populations are primarily provided by civil society organizations (CSOs) through the Global Fund, with limited Ukrainian government support. Approximately 47 percent of officially registered HIV-positive adults are estimated to have accessed at least one care and support service in 2013. Care and support services available to PLHIV include: screening and prevention of TB and viral hepatitis; nutritional assessment;

counseling and psychosocial support; economic strengthening and legal services; and PLHIV support groups.

In the approach to TB/HIV co-infection, PEPFAR's focus in FY 2015 will be to build on initial achievements in strengthening the Ukrainian government's national HIV/AIDS TB response, including screening, referrals, treatment, services integration, and monitoring and evaluation (M&E), particularly given the country's alarming increases in multi-drug resistant (MDR) and extremely drug resistant (XDR) TB.

Only half of people in need of ART receive treatment, and there are service disruptions between testing and treatment. Similarly, only half of registered HIV-positive patients receive care and support services. PEPFAR's care activities will also, therefore, strengthen existing referral systems to ensure that HIV positive individuals are linked to care and treatment services in a timely manner, minimizing those who are lost in the follow up.

Anticipated efficiency gains include strengthened Ukrainian government ownership, increased publicly-provided KP HIV care services, and programmatic and cost efficiencies from integrated prevention, care, and treatment services.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Ukraine	$ 451,740	$ 1,335,929	$ 4,149,476	$ 1,052,338	**$ 6,989,483**
	Totals FY09-FY13	**$ 5,216,951**	**$ 5,917,869**	**$ 21,354,380**	**$ 7,893,379**	**$ 40,382,579**
2015 (est)	Ukraine					**$ 11,602,271**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 2015 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 Global Fund PRs, and building civil society capacity.

Structural and systemic impediments to HIV services include a) fragmented and uneven government leadership and governance, b) unsatisfactory capacity to plan and implement HIV services at national and sub-national levels, c) highly vertical, hospital-centered health services

with inadequate laboratory and pharmaceutical management systems, d) vertical and duplicative health information systems, and e) lack of performance-based budgeting and funding.

Despite constraints that affect the entire health system, Ukraine has recently made progress in addressing its HIV epidemic. The 2014-2018 NAP has been drafted, costed, and is undergoing Parliamentary review. The NAP addresses program sustainability and, for the first time, allocates state funds for activities beyond treatment

The main technical priorities for FY 2015 include support and coordination with the Ukrainian government, Global Fund, and PRs as the current Global Fund HIV grant is implemented. PEPFAR Ukraine will also provide TA to strengthen national and regional laboratory and M&E systems; procurement and supply chain management; and financing for the HIV response. Further TA will increase Ukrainian government capacity for key populations surveillance, unifying what will be a national M&E system with data for decision making in the public domain. PEPFAR will also provide TA to the decentralized laboratory system in Ukraine, with emphasis on quality improvement and control for HIV and TB diagnostics, and procurement and supply management. Assistance in human resources for health will focus on strengthening adult treatment training and mentoring, and updating pre-training curricula. PEPFAR will co-fund an efficiency survey to look at harm reduction, MAT, ART, and integrated care.

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 Ministry of Health (MOH) is legally responsible for coordinating the national HIV/AIDS response, the details of which are laid out in the 2014-2018 National AIDS Program. The MOH chairs the National Council for HIV/AIDS and TB that acts as the Country Coordination Mechanism (CCM) for the Global Fund. The PEPFAR program in Ukraine leverages the considerable resources provided by the Global Fund for HIV/AIDS prevention, care, and treatment activities for key populations and TB/HIV co-infection.

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 PF that deepens cooperation, strengthens coordination, and enhances collaboration on programming of technical and financial resources in concerted support with other donors, primarily the Global Fund. 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 2015, 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 Global Fund resources, and the delivery of measurable, value-adding TA 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 focus on the HIV responses in China, Laos, and Thailand. The unrivaled 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, migrants and refugees, and rural ethnic minorities. 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 2012, 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 2015. 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 to Fight AIDS, Tuberculosis and Malaria (Global Fund).

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	$ -
2013	$ 6,074,516	N/A	$ 2,182,173	N/A	$ 539,732	N/A	$ 7,733,579	N/A	$ 16,530,000
Total 2009-2013	**$ 6,074,516**	**N/A**	**$ 2,182,173**	**N/A**	**$ 539,732**	**N/A**	**$ 7,733,579**	**N/A**	**$ 16,530,000**
2015 (est)	**$ 3,401,168**	**27%**	**$ 1,632,451**	**13%**	**$ 646,501**	**5%**	**$ 6,732,880**	**54%**	**$ 12,413,000**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY13) & FY15 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	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2013	Asia Regional	$ 315,488	$ -	$ 3,727,009	$ 35,775	$ -	$ 336,083	$ -	$ 1,660,161	**$ 6,074,516**
	Totals FY09-FY13	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
2015 (est)	Asia Regional									**$ 3,401,168**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

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 counseling and testing, 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, the development of monitoring and evaluation (M&E) guidelines, and support for piloting effective service delivery models. A small portion of funding will also go to strengthening the capacity of local civil society organizations to improve treatment adherence and retention, identify PLHIV in discordant couples, and increase accessibility for key populations.

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 PEPFAR 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 2015 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

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 - FY13) & FY15 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	$ -	$ -	$ -	**$ -**
2013	Asia Regional	$ -	$ 361,662	$ 178,070	**$ 539,732**
	Totals FY09-FY13	**$ -**	**$ 361,662**	**$ 178,070**	**$ 539,732**
2015 (est)	Asia Regional				**$ 646,501**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 2015, PEPFAR ARP will continue to promote and indirectly support increased and accelerated access to treatment for PLHIV in the region.

China

China is the first country to establish treatment as prevention (TasP) as a national ART strategy. Under this strategy, clinicians can prescribe ART for PLHIV regardless of CD4 count (original treatment eligibility threshold was 350 cell/µl). In FY 2015, PEPFAR ARP will continue to provide TA to China for model development and scale-up to increase treatment coverage and quality of treatment services for PLHIV, with a focus on key populations and those at higher-risk. Additionally, PEPFAR ARP will conduct a pilot program for the management of HIV/HCV co-infections; strengthen data analysis utilization for the National Free ARV Treatment Program; and build the capacity of physicians for ART management at the county-level in HIV high-risk provinces and minority areas. PEPFAR ARP will also support adherence activities through the training of lay counselors to deliver treatment literacy education and counseling.

Laos

In FY 2015, PEPFAR ARP will focus on providing TA to strengthen existing care and treatment services with an aim to increase ART coverage of eligible PLHIV, increase the quality of services, improve early access to ART, and improve retention in care along the treatment cascade. Additionally, PEPFAR ART will support mathematical modeling and cost analysis, using care and treatment program monitoring data and other epidemiological evidence, to demonstrate resource needs and benefits to be gained from policy decisions. PEPFAR ARP will advocate for increased national financing for ART as the Global Fund contribution declines.

Thailand

In FY 2015, PEPFAR ARP will continue to work closely with the Royal Thai Government to improve data quality for policy work on ART guidelines, increase retention along the treatment and care continuum, continue to implement rapid testing models and combination prevention programs with the Royal Thai Government, and work toward the elimination of mother to child transmission. Additionally, PEPFAR ARP will provide TA for the design, demonstration, scale-up, and integration of programs and policies to improve identification of HIV-positive cases, initiation of treatment, and retention; and will strengthen the government and non-governmental sector capacities to maximize and sustain the response. PEPFAR ARP's activities will primarily focus on key populations, including FSW, migrant workers, MSM, PWID, prisoners, and TG as these populations are disproportionately affected by the epidemic.

Care

CARE (FY09 - FY13) & FY15 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	$ -	$ -	$ -	$ -	**$ -**
2013	Asia Regional	$ 1,700,494	$ 325,834	$ 155,845	$ -	**$ 2,182,173**
	Totals FY09-FY13	**$ 1,700,494**	**$ 325,834**	**$ 155,845**	**$ -**	**$ 2,182,173**
2015 (est)	Asia Regional					**$ 1,632,451**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, PEPFAR ARP will continue to maximize access to high-quality HIV care in China, Laos, and Thailand by focusing on programs, services, and policies that address the epidemic among key populations. PEPFAR ARP will continue to build sustainable national capacity to support health care and service delivery systems, while strengthening the cascade of prevention, care, and treatment in the region.

China

PEPFAR ARP programs are well integrated with the Government of China's policies. The "Four Frees and One Care policy" provides free voluntary HIV counseling and testing (VCT), ART, PMTCT, and education for children orphaned by AIDS. The "Circular on Further Strengthening AIDS Notifications" prioritizes strengthening PLHIV care and support (C&S) (e.g., palliative care, poverty alleviation, anti-discrimination). In FY 2015, PEPFAR ARP will support national and sub-national partners to increase coverage and efficiency of C&S services to key populations; build clinical capacity of county-level health care workers (HCWs) via scaling up community and home-based care; estimate prevalence of HIV infection to help budgeting for care services/products, and provide quality improvement (QI) and linkage to C&S for foreign PLHIV living in China.

Laos

In FY 2015, PEPFAR ARP TA will continue to focus on developing guidelines, curricula, and standard operating procedures (SOPs) for capacity building of health care providers. The 2011–2015 national strategic and action plan focuses on the major goals of increasing the coverage and quality of 1) HIV treatment, care, and support services; 2) HTC; 3) ARV and OI management; 4) home and community-based care for people infected with and affected by HIV; and 5) positive health. PEPFAR ARP TA will build capacity at national and provincial levels to realize these goals.

Thailand

In FY 2015, PEPFAR ARP will help address key gaps in the PMTCT system by working with the MOPH, 4 pediatric HIV quality care training sites, and networks in every Thailand province to establish an Active Case Management Network for elimination of MTCT. This will identify HIV-infected infants, link them to HIV care programs, and initiate ART as quickly as national guidelines allow. Mothers and babies will be followed along the treatment and care cascade. Other key priorities include support for: client-centered and appropriate high-quality services for care and treatment of MSM and TG PLHIV; updated HIV/AIDS Adult and Pediatric Treatment Guidelines; improved information systems; and quality improvement programs for care services.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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	$ -	$ -	$ -	$ -	**$ -**
2013	Asia Regional	$ 696,423	$ 2,042,194	$ 890,187	$ 4,104,775	**$ 7,733,579**
	Totals FY09-FY13	**$ 696,423**	**$ 2,042,194**	**$ 890,187**	**$ 4,104,775**	**$ 7,733,579**
2015 (est)	Asia Regional					**$ 6,732,880**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, PEPFAR ARP will continue to collaborate with national stakeholders to strengthen health systems and support country-led and managed HIV responses. PEPFAR ARP expedites sustainable, measurable progress towards zero new HIV infections, zero discrimination, and zero HIV-related deaths (the "Three Zeroes") through TA to enhance host-country capacity and leadership, and investments in high-impact, cost-efficient, and sustainable responses to HIV/AIDS.

China

PEPFAR ARP will continue to strengthen country-owned responses by providing TA for developing models and strategic information (SI) systems that will inform policy and national guidelines, and to improve data analysis and utilization. Additionally, PEPFAR ARP will continue to build the national systems needed to ensure the quality of national HIV/AIDS services in lower levels of the healthcare system, particularly in rural areas. Assistance will be provided to improve integration and communication between vertical health systems that manage and provide different HIV interventions and PLHIV services in order to increase retention rates and continuity of services between testing, diagnosis, treatment, and care.

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 2015, PEPFAR ARP will continue to strengthen the government's ability to use evidence for priority setting and policy decisions in ways that proactively promote improvements to current evidence-based programs. A key focus will be to strengthen national health and M&E

systems to assess and monitor HIV-related risk behaviors and epidemiological trends as well as to increase the HIV and TB research capacity of national and local research institutions.

Thailand

In FY 2015, PEPFAR ARP will continue to engage with and provide TA to support the MOPH, the National Health Security Office (NHSO), and other bodies governing. Additionally it will coordinate the HIV response in Thailand, as well as continue to support Global Fund 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), to strengthen the management and quality of laboratory services throughout the region. In 2015, 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.

Although SI capacity in the region has been strengthened in recent years, barriers still exist that limit the effectiveness of the national program. In FY 2015, PEPFAR ARP will continue to assist the MOPH to strengthen the quality of M&E data particularly among key populations, and to build the capacity at national and provincial levels to undertake projection and estimation modeling and increase the utilization of this data for decision making.

Country Engagement

In 2011, several countries in the region adopted ambitious targets associated with their commitment to realize the "Three Zeros" 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 CCMs in China, Laos, and Thailand. 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 and Thailand use domestic resources to fund the bulk of their HIV responses, Laos continues to rely heavily on donor funding (such as from PEPFAR and the Global Fund) 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

Burma is emerging from decades of isolation which has greatly impacted the country's health sector. Chronically low expenditures on health, inadequate infrastructure, active and on-going sectarian/communal conflict, and a shortage of health personnel at all levels contribute to poor health outcomes, including a substantial caseload of HIV/AIDS. The Government of Burma and its development partners are working together closely to carefully adapt to this rapidly changing, dynamic environment to help transform the Burma health sector and more specifically, scale-up programming for HIV prevention, care, support, and treatment.

The HIV epidemic in Burma is concentrated, with HIV transmission primarily occurring among key populations, including sex workers, their clients, men who have sex with men (MSM), and the sexual partners of these sub-populations. There is also a high level of HIV transmission among people who inject drugs (PWID) through use of contaminated injecting equipment, with subsequent transmission to their sexual partners. Reported HIV prevalence from sentinel surveillance sites of these key populations is 9.6 percent in female sex workers (FSW), 7.8 percent in MSM, and 21.9 percent in male PWID.

An estimated 216,000 people were living with HIV/AIDS (PLHIV) in Burma in 2011, of which 36 percent were female. In the same year, 18,000 people died of AIDS-related illness. Incidence was estimated at well above 8,000 new infections in 2011. By the end of 2012, the number of adults and children receiving ART was 52,586. According to the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and UNAIDS, only an estimated 42 percent of individuals in need of anti-retroviral treatment (ART) were receiving it, using the CD4+ lymphocyte cell count threshold of 350. An estimated 125,000 adults are in need of ART at the 350 threshold. However, major HIV treatment implementers in Burma have deliberately initiated ARV rationing in which the ART initiation threshold is lowered to CD4 <150 to conserve ARV drugs and address the limited service capacity.

The PEPFAR Burma program supports the national plan and response by working closely with the Government of Burma, development partners, and other donors (UN, Global Fund, international NGOs). The majority of the response is being funded by the Global Fund, implemented through the Government of Burma. PEPFAR's role in Burma is to support the implementation of Global Fund grants, and build the capacity of the Government and civil society to lead the national response. Specifically, PEPFAR Burma activities focus on improving the quality and representativeness of surveillance data; assessing and improving the quality of laboratory HIV testing and clinical monitoring measures; and continuing the key populations service-delivery platform focused on addressing critical gaps in the national program.

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 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.
*** Burma did not complete a Country Operational Plan until FY 2013.

FY 2015 resources will continue to support targeted gaps in HIV services for key populations through ongoing support for 19 Targeted Outreach Program (TOP) Drop-In Centers throughout the country. These activities reach FSW, men who have sex with men and transgendered people (MSM/TG), and people who inject drug (PWID), and their partners. Services at these centers include prevention, care and support programs, and ensure beneficiaries receive the essential package of prevention services. Activities promote voluntary HIV testing and counseling services and, if found to be HIV infected, link patients to care, support, and treatment 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	Burma	$ -	$ -	$ -	$ -	**$ -**
2010	Burma	$ -	$ -	$ -	$ -	**$ -**
2011	Burma	$ -	$ -	$ -	$ -	**$ -**
2012	Burma	$ -	$ -	$ -	$ -	**$ -**
	Totals FY09-FY12	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
2014 (est)	Burma					**$ 1,040,576**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 Burma 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 is provided through private, public, and donor-funded activities. PEPFAR Burma does support some care and support services directly through the TOPs Drop-In centers, which target key populations in 19 villages and towns across the country.

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 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 Global Fund and other donors. PEPFAR Burma's focus is to build the capacity within the Ministry of Health help coordinate donor activities and set clinical guidelines. With FY 2015 funds, PEPFAR Burma will provide targeted technical assistance (TA) to the Government of Burma and the Global Fund to support an antiretroviral (ARV) treatment program reporting system and development of HIV ARV drug resistance surveillance. In addition, PEPFAR Burma will continue to support 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 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 Burma's primary mission is to build the capacity of the Ministry of Health and civil society to lead and implement the national response to HIV in Burma. As such, the bulk of PEPFAR Burma's work in country focuses on governance and systems. FY 2015 funds will be used to continue to support the MOH's efforts to coordinate the donor response, and improve commodities procurement processes and the logistics and supply chain. Resources will also be used to focus on supporting and building the capacity of Civil Society organizations (CSOs) to reach key populations at the community level.

FY 2015 resources will also continue to support the collection, analysis, interpretation, and use of improved quality strategic information to better monitor trends of the HIV epidemic in collaboration with the Global Fund, the national government, and international partners. Developing the government and Global Fund routine program monitoring capacity with an emphasis on data use and improved data quality will be central to PEPFAR Burma support.

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 Burmese MOH is in a strong position to lead the response, but have capacity identified gaps in areas of donor coordination and strategic information, which PEPFAR is helping address. The team also works closely to coordinate with Global Fund activities. PEPFAR's FY 2015 resources in Burma are shifting from supporting short and intermediate term activities to supporting longer term strategic HIV and health priority needs of the country. These long term goals include sustaining success of Global Fund activities in Burma and strengthening country ownership for HIV/AIDS programs.

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. Per UNAIDS data, 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 make up the largest key population group in Cambodia and in 2011 had an estimated HIV prevalence of 3.1 percent. Prevalence was nearly triple that (10.8 percent) among female entertainment workers with eight or more partners per week.
Men who have sex with men (MSM) make up the second largest key population group in Cambodia. The highest HIV prevalence of 2.2 percent was found among men who had sex with both men and women, indicating a potentially important bridging population.
Transgender women (individuals born as male who self-identify as female) are the third largest key population group in Cambodia and in 2012 were reported to have an HIV prevalence of 4.1 percent. The smallest key population group in Cambodia is people who inject drugs (PWID). PWID are especially vulnerable to HIV with prevalence estimated at 26 percent in 2012.

Over the past two years, PEPFAR Cambodia has been transitioning out of direct service delivery activities and focusing on providing technical assistance to the Cambodian government and local non-governmental and civil society partners as they deliver prevention, clinical and non-clinical care, and anti-retroviral treatment (ART) services. This transition has unfolded due to the evolution of the HIV epidemic and the progress of the response. The Cambodian government has always been the lead implementer of Cambodia's clinical care and treatment service delivery through the Cambodian public-health sector, and the PEPFAR Cambodia program did not establish a parallel HIV-care and treatment service delivery system. Nonetheless, the transition away from direct service delivery toward the provision of technical assistance has been gradual and moderate in order to preserve the gains already achieved in Cambodia, particularly in the area of prevention, since until 2013, PEPFAR supported approximately 90 percent of the direct service delivery of prevention activities for key populations.

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
2013	$ 5,172,368	34%	$ 3,086,516	21%	$ 1,078,651	7%	$ 5,662,465	38%	$ 15,000,000
Total 2009-2013	**$ 37,282,696**	**44%**	**$ 14,247,137**	**17%**	**$ 5,077,470**	**6%**	**$ 28,392,697**	**33%**	**$ 85,000,000**
2015 (est)	**$ 4,640,212**	**33%**	**$ 1,436,669**	**10%**	**$ 880,018**	**6%**	**$ 7,165,101**	**51%**	**$ 14,122,000**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Cambodia	$ 592,785	$ -	$ 2,799,016	$ 193,168	$ -	$ 249,058	$ -	$ 1,338,341	**$ 5,172,368**
	Totals FY09-FY13	**$ 3,958,862**	**$ 1,330,314**	**$ 24,068,055**	**$ 1,815,980**	**$ -**	**$ 2,138,381**	**$ -**	**$ 3,971,104**	**$ 37,282,696**
2015 (est)	Cambodia									**$ 4,640,212**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR Cambodia's FY 2015 prevention program will help Cambodia to more efficiently, effectively, and independently achieve its overarching national HIV/AIDS goal of virtually eliminating new HIV infections by 2020. Through scaled, targeted prevention activities focused on key populations, pregnant women, and their HIV-exposed infants, the PEPFAR prevention program will build upon prior success by identifying the right people to receive the right package of services to address their HIV and sexually transmitted infection (STI) prevention needs in the most cost-efficient way possible.

Specifically, PEPFAR Cambodia's prevention strategy will focus its prevention efforts on key populations, prevention of mother-to-child transmission (PMTCT), and blood safety. This approach was developed in response to a number of variables, including ensuring PEPFAR Cambodia support of and alignment with the PEPFAR Blueprint; responding to important gaps in the national HIV program; and the ongoing transition to a technical assistance platform focused on enhancing the impacts and reducing the costs of the national response.

Eliminating new infections in Cambodia with limited resources calls for prevention activities tightly focused on key populations, including female entertainment workers, MSM, transgender women, and PWID. Achieving saturation coverage of these difficult-to-reach key populations with a set of core prevention services is expected to decrease new HIV and STI infections and accelerate progress towards achieving the goal of eliminating new infections.
PEPFAR Cambodia's prevention investments aim to:

- Support the operationalization of treatment-as-prevention to sero-discordant couples and high-risk populations;
- Improve the quality and impact of the essential package of prevention services for key populations, with studies to assess and improve effectiveness and targeting of interventions;
- Assure the quality and effectiveness of implementation of the continuum of prevention, care, and treatment through intensified case finding and delivery of HIV-prevention and counseling and testing services to key populations at highest risk of HIV infection and/or transmission;
- Enable reduced costs and more effective implementation of HIV and AIDS intervention programs in Cambodia through collection, interpretation, and use of information regarding population size, overlapping risk behaviors, hotspots, and other venues where key populations are found;
- Promote "condom plus" (dual protection from HIV infection and unplanned pregnancies) and increase access of female entertainment workers and other vulnerable populations to an array of contraceptive methods by integrating family planning/reproductive health services into HIV-related services for entertainment workers and other high-risk women through outreach as well as at antenatal clinics, methadone maintenance sites, and adult HIV/AIDS care and treatment clinics;
- Address a recent plateau in consistent condom use by entertainment workers by a) increasing condom availability in high-risk venues and clinical sites serving most-at-risk populations and people living with HIV and b) developing a for-profit condom market and commercial-sector distribution channels to improve national condom sustainability;
- Reduce perinatal HIV infection and loss of pregnant women and HIV-exposed infants from the PMTCT service cascade through improved quality of care for life-long ART through technical assistance to the National HIV/AIDS and the Maternal Child Health program; and
- Ensure safe blood is available to all Cambodians by strengthening the capacity of the National Blood Transfusion Center to lead and implement the national strategy effectively, including developing national policies, improving blood management and quality systems, improving donor recruitment, and coordinating effectively.

Prevention programming will continue to change in FY 2015, moving away from direct service delivery and emphasizing technical assistance. Rather than providing the requisite prevention 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 Global Fund, 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.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Cambodia	$ 1,321	$ 852,593	$ 224,737	**$ 1,078,651**
	Totals FY09-FY13	**$ 51,538**	**$ 3,831,634**	**$ 1,194,298**	**$ 5,077,470**
2015 (est)	Cambodia				**$ 880,018**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Cambodia has made remarkable progress in providing treatment services to people living with HIV. The continuum of prevention, care, and treatment (continuum model), established with U.S. government support, is being implemented nationwide. In 2013, 69 percent of the estimated 73,000 adults living with HIV in Cambodia were receiving facility-based HIV care and support. Home and community-based care services introduced with PEPFAR resources are active nationally. By the end of September 2013, more than 50,000 HIV-positive individuals were enrolled in clinical care and treatment services. Only four sites are run by the private sector or non-governmental organizations (NGOs), but these sites receive anti-retroviral drugs from the Ministry of Health with Global Fund financing. The number and percent in care, but not yet eligible to receive ART based on current clinical criteria, fell by over half after new clinical care guidelines were introduced in 2011, raising the eligibility for treatment to a CD4 count of 350 cells/mm3 or less.

Of an estimated 72,159 HIV-infected adults in Cambodia, 57,438 are forecast to be in need of ART in 2014 based on the revised clinical criterion. By the end of September 2013, 46,134 people were receiving ART at 61 HIV-treatment sites across 20 of Cambodia's 24 provinces, accounting for roughly 82 percent of those estimated in need. At PEPFAR-supported sites, 8,767 adult patients were on ART at the end of September 2013, of whom 56 percent were women

Despite this progress, challenges remain, including:

- Low adherence to ART and the possible link to anti-retroviral resistance;
- Late initiation of treatment, despite the increase in the CD4 eligibility threshold for initiation of treatment;
- Low diagnosis of treatment failure and subsequent switch to second line treatment;
- Inconsistent implementation of quality improvement systems for care and treatment across the country;
- Lack of coordination and management of the various HIV care and treatment services across facilities;
- Difficulty maintaining high-quality, motivated human resources for health; and
- Long-term sustainability of HIV treatment in the context of declining donor funding.

In FY 2014, the PEPFAR Cambodia treatment program will support efforts to overcome these challenges. PEPFAR Cambodia will continue to support the development of new, cost-effective models to improve access, retention, and adherence to ART to reduce both mortality and the spread of HIV. The priority will be on strengthening national and provincial systems, quality of services, piloting and evaluating new models of care and treatment, and use of information to improve and maintain the reach and quality of treatment services.

Part of the Cambodian government's HIV/AIDS strategy is to provide expanded access to HIV care and treatment services. In 2013, the national HIV program, supported by PEPFAR Cambodia, developed comprehensive, "boosted" packages of services for people living with HIV to address HIV case finding, retention in care, and lifelong adherence to ART. The "Boosted Continuum of Prevention, Care, and Treatment" is a network of services coordinated at the district level and delivered in healthcare facilities, communities, and homes. Health services include new point-of-care HIV counseling and testing and new case-management approaches to ensure retention between services such as HIV counseling and testing, TB screening, antenatal care, and ART. Community-based support groups and self-help groups provide counseling, education, and psycho-social support to HIV-infected individuals to improve retention in care and adherence to treatment.

In FY 2014 and FY 2015, these ambitious new models will be piloted with funding and technical support from PEPFAR and are expected subsequently to be expanded nationally with funding from other partners, primarily the Global Fund. PEPFAR Cambodia's technical assistance will enhance the quality and cost-effectiveness of the implementation of Cambodia's ambitious plans.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Cambodia	$ 917,020	$ 2,087,791	$ 947,277	$ 1,710,377	**$ 5,662,465**
	Totals FY09-FY13	**$ 3,176,293**	**$ 6,637,143**	**$ 6,138,275**	**$ 12,440,986**	**$ 28,392,697**
2015 (est)	Cambodia					**$ 7,165,101**

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Despite improvements over the last decade, Cambodia faces many challenges in delivering quality public-health services to those in need. Health delivery systems are characterized by limited governance and leadership, inadequate human and institutional capacity, low quality of services, and corruption. Extremely low host-country government spending threatens the sustainability of already weak health and social services. While the government's percentage of the HIV-sector budget has increased since 2010, this has not been a result of increased spending among all contributors, which plateaued at $5.7 million, but rather due to a reduction in UN and PEPFAR contributions.

The health sector features an underpaid and poorly motivated public-sector work force, limited and poor-quality public infrastructure and services, and excessive reliance on foreign donor assistance to carry out critical surveillance and service-delivery functions. There is an acute shortage of adequately trained and experienced mid- and upper-level health professionals. Those who are trained often juggle multiple jobs to supplement their meager civil servant salaries. As a result, public health authorities have faced challenges strengthening the public health system as a whole. Pervasive systemic and governance issues have negatively impact the HIV national response. In 2013, a number of stock-outs of essential drugs and laboratory supplies occurred. These stock-outs resulted in reduced numbers of individuals tested and required HIV-positive individuals to visit treatment centers frequently to obtain their medication, overburdening both clients and providers.

PEPFAR Cambodia is addressing these challenges by investing in more impactful, integrated, and efficient service delivery systems and building local capacity to use data to improve the strategic allocation of available resources. Without critical PEPFAR investments in a more effective and efficient response to HIV, Cambodia will lack the health-systems infrastructure and technical ability needed to maintain vital coverage of prevention, care, and treatment services, particularly in light of Cambodia's HIV elimination strategy.

The national Health Strategic Plan 2008-2015 serves as a framework for PEPFAR Cambodia project planning and activity management. In FY 2015, PEPFAR will support cross-cutting elements through the following key activities:

- Building local capacity to use existing and new data to inform resource allocation (health information systems);
- Enhancing local capacity, leadership, and systems to improve quality and sustainability of services (health systems governance; human resources for health);
- Improving program impact for those populations at greatest risk (health service delivery); and
- Reducing program costs through efforts to promote integration and efficiency, reduce financial barriers for marginalized populations, and support performance-based incentive schemes (healthcare financing).

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, primarily through its National Center for HIV/AIDS, Dermatology and Sexually Transmitted Infections (NCHADS), 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 Global Fund, and the Royal Government of Cambodia.

While the United States is by far the largest *bilateral* donor to the HIV/AIDS response in Cambodia, the Global Fund is now the largest donor in the HIV sector on an annual basis contributing more than 40 percent of the overall resources for HIV. In Cambodia, the national HIV/AIDS program uses the Global Fund resources to procure all anti-retroviral medications, support facility-level service delivery for the majority of individuals on treatment and in pre-ART care, and undertake a portion of the prevention activities related to HIV/AIDS. Delays in procurement or distribution of pharmaceuticals and other key HIV-related commodities and clinical supplies supported by the Global Fund result in programmatic concerns for all parties engaged in the HIV response. The Global Fund, lacking an in-country technical or management presence, depends upon the Country Coordinating Committee (CCC) that is responsible for oversight and proposal development. The PEPFAR Cambodia program and team contribute

significant assistance to the Global Fund program through active engagement in the CCC and the technical working groups, support to develop and fund pilot programs prior to national scale-up, and assistance in ongoing monitoring of the national program.

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 2013 prevalence of 2.3 percent.

With treatment and care services for HIV/AIDS in Indonesia fully supported by the Government of Indonesia and the Global Fund, 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), the Global Fund, and the Indonesia government, PEPFAR Indonesia is also improving access to key prevention and treatment services in Papua, where the epidemic is most severe. In FY 2015, the PEPFAR team will continue to build the capacity of key Indonesian government partners to monitor, evaluate, and analyze strategic information on the HIV epidemic 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
2013	$ 3,883,580	49%	$ 215,813	3%	$ 20,000	0%	$ 3,880,607	49%	$ 8,000,000
Total 2009-2013	**$ 24,488,640**	**50%**	**$ 3,048,719**	**6%**	**$ 538,323**	**1%**	**$ 20,674,318**	**42%**	**$ 48,750,000**
2015 (est)	**$ 3,277,178**	**41%**	**$ 1,043,563**	**13%**	**$ 981,781**	**12%**	**$ 2,697,478**	**34%**	**$ 8,000,000**

* Totals include planned funding for all accounts.
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Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Indonesia	$ 429,874	$ -	$ 3,029,329	$ -	$ -	$ 282,824	$ -	$ 141,553	**$ 3,883,580**
	Totals FY09-FY13	**$ 650,716**	**$ -**	**$ 20,996,101**	**$ -**	**$ -**	**$ 783,404**	**$ 84,138**	**$ 1,974,281**	**$ 24,488,640**
2015 (est)	Indonesia									**$ 3,277,178**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR Indonesia's priorities for FY 2015 build on the incremental gains made in previous fiscal years which included close coordination with UNAIDS, the World Health Organization (WHO) and the Global Fund.

PEPFAR 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 (TB) 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 2015. PEPFAR will collaborate with the Global Fund and Indonesian government to support the nationwide condom marketing strategy.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Indonesia	$ -	$ 20,000	$ -	**$ 20,000**
	Totals FY09-FY13	**$ -**	**$ 538,323**	**$ -**	**$ 538,323**
2015 (est)	Indonesia				**$ 981,781**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 Global Fund. PEPFAR Indonesia, in turn, focuses its treatment program on building the capacity of local civil society organizations (CSOs), which include Global Fund sub-recipients, in the following areas: access to services for opportunistic infection prevention, treatment, and diagnosis; 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 2015 is a continuation of what was done in FY 2014.

While the Global Fund supplies much of the funding for treatment in Indonesia, AusAID has worked closely with the MOH and partners in Papua to improve antiretroviral 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 - FY13) & FY15 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**
2013	Indonesia	$ 215,813	$ -	$ -	$ -	**$ 215,813**
	Totals FY09-FY13	**$ 2,445,323**	**$ -**	**$ 603,396**	**$ -**	**$ 3,048,719**
2015 (est)	Indonesia					**$ 1,043,563**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 Global Fund. 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 2015, this work will continue to be done in direct partnership and collaboration with the MOH, the Global Fund, and local CSOs.

In FY 2015, 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 Global Fund grantees, and UN partners. In Papua in particular, AusAID supports substantial programs in care and treatment for HIV/AIDS patients and the work PEPFAR Indonesia complements these programs.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Indonesia	$ -	$ 1,479,106	$ 1,850,944	$ 550,557	**$ 3,880,607**
	Totals FY09-FY13	**$ 342,823**	**$ 3,860,491**	**$ 12,213,566**	**$ 4,257,438**	**$ 20,674,318**
2015 (est)	Indonesia					**$ 2,697,478**

* Totals include planned funding for all accounts.
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Given investments in HIV/AIDS from the Global Fund 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 2015, PEPFAR Indonesia will continue its FY 2014 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

In 2014 Indonesia's National AIDS Commission (NAC) will lead the preparation of a new strategic plan for 2015-2019. Completion of a new national strategy is a requirement for application for new Global Fund grants and PEPFAR Indonesia will provide technical assistance and input to support its development.

Based on a recent analysis of the epidemiological situation, PEPFAR Indonesia continues to focus its bilateral assistance and partnership with the Government of Indonesia on activities that will prevent sexual transmission among key populations and expanding the reach of CSOs that target the at-risk populations and local governments.

PEPFAR Indonesia will calibrate its program objectives, interventions, and benchmarks to continue to align with, and operate in support of the new 2015-2019 strategic plan, and will continue to work in close partnership with the National AIDS Commission, MOH, and Indonesian Armed Forces. In addition, PEPFAR Indonesia works closely with Global Fund principal recipients and the Global Fund Country Coordination Mechanism to ensure effective coordination.

Decentralization remains an important consideration for the HIV response in Indonesia. 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 2015, PEPFAR will continue to 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.

Papua New Guinea

Country Context

Papua New Guinea 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. Papua New Guinea is a diverse country with 85 percent living in rural areas, and more than 700 languages. 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.

Papua New Guinea 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 Papua New Guinea 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 Papua New Guinea.

While much is still unknown about the current and future status of the HIV epidemic in Papua New Guinea, 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, 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 Papua New Guinea's low health status. The lack of skilled human resources and the Government of Papua New Guinea'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.

Below is a table of PEPFAR Papua New Guinea'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	$ -
2013	$ 1,601,179	32.0%	$ 484,885	9.7%	$ 240,851	4.8%	$ 2,673,085	53.5%	$ 5,000,000
Total 2009-2013	**$ 1,601,179**	**N/A**	**$ 484,885**	**N/A**	**$ 240,851**	**N/A**	**$ 2,673,085**	**N/A**	**$ -**
2015 (est)	**$ 2,109,196**	**34%**	**$ 865,973**	**14%**	**$ 457,063**	**7%**	**$ 2,767,768**	**45%**	**$ 6,200,000**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 - FY13) & FY15 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	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2013	Papua New Guinea	$ 20,000	$ -	$ 1,304,067	$ -	$ -	$ -	$ -	$ 277,112	$ 1,601,179
	Totals FY09-FY13	**$ 20,000**	**$ -**	**$ 1,304,067**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 277,112**	**$ 1,601,179**
2015 (est)	Papua New Guinea									**$ 2,109,196**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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.

PEPFAR Papua New Guinea's prevention program focuses on addressing key populations (KP), including FSW, MSM, and transgendered persons, to more effectively target HIV services" to those who most need it. In FY 2015, PEPFAR Papua New Guinea will intensify technical assistance (TA) and mentoring support to the Government of Papua New Guinea and local partners to strengthen the delivery of a Comprehensive Prevention Package (CPP). The package includes Social and Behavior Change Communication (SBCC), condom/lube distributions, testing and counseling, sexually transmitted infection screening and treatment, and referrals to clinical and other support services.

Additionally, gender-based violence (GBV) interventions continue to be an important part of the HIV response in Papua New Guinea. PEPFAR Papua New Guinea's focus during FY 2015 will be to fully integrate and operationalize GBV services in the five PEPFAR-supported facilities. Referral for survivors of GBV will continue to be part of the training and the day-to-day interventions. Health care providers in all clinics and family support units will provide trauma

counseling that will focus on the psychological needs of GBV survivors and provision of post-exposure prophylaxis (PEP). PEPFAR Papua New Guinea advocacy will include an assessment of media (print, TV, and radio) reporting on gender issues including GBV and HIV. Training will be developed for media personnel on appropriate and consistent reporting on issues of gender, HIV, and women's rights based on the analysis of the assessment.

Treatment

TREATMENT (FY09 - FY13) & FY15 Estimate					
Fiscal Year	**Operating Unit**	**HTXD: ARV Drugs**	**HTXS: Adult Treatment**	**PDTX: Pediatric Treatment**	**Total, Treatment**
2009	Papua New Guinea	$ -	$ -	$ -	**$ -**
2010	Papua New Guinea	$ -	$ -	$ -	**$ -**
2011	Papua New Guinea	$ -	$ -	$ -	**$ -**
2012	Papua New Guinea	$ -	$ -	$ -	**$ -**
2013	Papua New Guinea	$ -	$ 223,351	$ 17,500	**$ 240,851**
	Totals FY09-FY13	**$ -**	**$ 223,351**	**$ 17,500**	**$ 240,851**
2015 (est)	Papua New Guinea				**$ 457,063**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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.

PEPFAR Papua New Guinea's treatment strategy is to provide TA to address health system issues that impact effective delivery of HIV treatment. TA is focused on supporting effective models for improving treatment at the facility level for PLHIV, with a focus on key populations; improving the national monitoring and evaluation (M&E) system to improve the quality and reliability of HIV treatment data; strengthening laboratory services; and developing policies and guidelines.

Care

CARE (FY09 - FY13) & FY15 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	$ -	$ -	$ -	$ -	**$ -**
2013	Papua New Guinea	$ 343,229	$ 15,000	$ 126,656	$ -	**$ 484,885**
	Totals FY09-FY13	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
2015 (est)	Papua New Guinea					**$ 865,973**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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.

PEPFAR Papua New Guinea supports a continuum of prevention, care, and treatment (CoPCT) model in Papua New Guinea that combines outreach, clinical and community care, and support services in a holistic model to provide the best quality of care for those most at risk of becoming infected with or affected by HIV and AIDS. In 2012, UNAIDS cited the CoPCT model for case management teams in Papua New Guinea as a "best practice." An independent mid-term review of Papua New Guinea's National HIV Strategy for 2011-2015 identified the CoPCT model as a high impact HIV strategy and called for the model's replication nationally – but with an intensified focus on key populations.

In addition to support for current CoPCT clinics, in FY 2015 PEPFAR Papua New Guinea will assist in the planning and scale up of HIV services under the CoPCT in Papua New Guinea by modeling, piloting, evaluating, and costing core service packages appropriate to high prevalence provincial HIV epidemics. Key program outcome indicators will be included that are attached to staffing and budget norms. This process will require analysis of provincial and district led data and program analysis to aid efficient planning of what HIV services need to be provided, where, and by whom.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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	$ -	$ -	$ -	$ -	**$ -**
2013	Papua New Guinea	$ 204,977	$ 413,595	$ 1,248,817	$ 805,696	**$ 2,673,085**
	Totals FY09-FY13	**$ 204,977**	**$ 413,595**	**$ 1,248,817**	**$ 805,696**	**$ 2,673,085**
2015 (est)	Papua New Guinea					**$ 2,767,768**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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.

The general health system in Papua New Guinea is weak. As the National Department of Health (NDoH) and donors implement HIV programs, a large gap remains to ensure quality programs and the ability for managers to understand basic M&E of the quality of services that are being provided.

In FY 2015 PEPFAR Papua New Guinea will continue to support health system strengthening to the NDoH and provincial health offices in the following areas: laboratory quality systems; care and treatment quality systems using HIVQUALContinuous Quality Program, sponsored by HRSA, for enhanced performance measurement and quality improvement; M&E systems; and HIV surveillance. Additionally, PEPFAR Papua New Guinea supports training and capacity building with governmental partners at the provincial health office in Madang and with local non-governmental organizations.

Country Engagement

PEPFAR Papua New Guinea has developed and refined its strategies and implementation plans in close consultation with the Government of Papua New Guinea 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 Papua New Guinea in resource allocation decisions. The PEPFAR country platform in Papua New Guinea 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 260,000 people living with HIV in Vietnam as of 2014. Approximately 14,000 new infections were reported in 2013 compared to 16,000 new infections reported annually from 2010-2012. 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.

While the national HIV prevalence rate is 0.45 percent for ages 15-49, 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 (HCMC) (48 percent), Hai Phong (48 percent), Dien Bien (56 percent), and Quanh Ninh (56 percent). In recent years there has been greater recognition of the HIV epidemic among MSM in Vietnam.

The estimated MSM population ranges from 160,000 to 482,000 and available data indicate a growing epidemic in Hanoi and HCMC, with HIV prevalence estimated to be up to 16 percent in these urban centers. There are an estimated 65,000 FSW (range: 29,000-101,000) in Vietnam and HIV prevalence among FSW indicates a slightly increasing trend among female sex workers with large variation by province, exceeding 10 percent in Hanoi, Hai, Phong, Can Tho, and HCMC.

Since its launch in 2005, PEPFAR Vietnam has been the major contributor to HIV prevention, care, and treatment in Vietnam. PEPFAR Vietnam is transitioning from a direct service delivery model to one with greater focus on technical assistance (TA). While the Partnership Framework signed by the U.S. government and Government of Vietnam is valid through 2015, its goals have been updated to reflect transition priorities. The first goal is to improve and sustain the quality and coverage of HIV services, focusing on accessing key populations and increasing the reach and retention of clients in services. The second goal is to enhance program cost-effectiveness and build affordable models of care that can be supported by domestic financing. The third goal is to increase domestic financing, including the transition of human resources for health (HRH) and essential commodities. The final goal is to build enduring institutions, ensuring that civil society is engaged in shaping policy and delivering services; the public sector has the capacity to maintain health systems and the training to deliver services; laboratories are accredited according to international standards; and national stakeholders are able to use program monitoring and surveillance data to improve programs. 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
2013	$ 19,962,538	29%	$ 9,130,705	13%	$ 20,287,870	29%	$ 20,452,055	29%	$ 69,833,168
Total 2009-2013	**$ 122,648,333**	**30%**	**$ 70,146,645**	**17%**	**$ 85,033,601**	**21%**	**$ 134,357,261**	**33%**	**$ 412,185,840**
2015 (est)	**$ 12,611,309**	**22%**	**$ 8,318,407**	**14%**	**$ 16,794,175**	**29%**	**$ 20,418,109**	**35%**	**$ 58,142,000**

* Totals include planned funding for all accounts.
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Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Vietnam	$ 1,161,472	$ -	$ 4,973,892	$ -	$ -	$ 10,054,443	$ -	$ 3,772,731	**$ 19,962,538**
	Totals FY09-FY13	**$ 13,063,825**	**$ 3,368,944**	**$ 35,619,772**	**$ 1,190,900**	**$ 949,358**	**$ 46,372,064**	**$ -**	**$ 22,083,470**	**$ 122,648,333**
2015 (est)	Vietnam									**$ 12,611,309**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 key populations, in FY 2015 PEPFAR Vietnam will continue to provide technical support to the Government of Vietnam to ensure the continued quality and coverage of patients on antiretroviral (ARV) treatment; core prevention services including methadone maintenance treatment (MMT) and HIV counseling and testing (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 financial responsibility for 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.

In FY 2015, PEPFAR Vietnam's flagship MMT program will continue and the transfer of MMT service delivery to the Government of Vietnam will begin per the 2010 PEPFAR Vietnam decision to exclusively support the opening of new MMT sites where provincial authorities could commit to assuming full responsibility within three years PEPFAR Vietnam will continue a three-pronged approach to support MMT in Vietnam: capacity building through training and mentoring at medical universities and mental health institutions; strengthening the methadone supply chain; and 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.

The Government of Vietnam's November 2012 adoption of a new medication assisted therapy (MAT) decree has expanded 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 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. Like most policies and decisions in Vietnam, the enforcement of this decree has depended upon the government's political and financial commitment at both central and provincial levels.

Treatment

PEPFAR Vietnam's contribution to ART meets approximately 60 percent of the treatment need. The Government of Vietnam set a target of 105,000 patients on ART by 2015, based on the estimated need and CD4 threshold of CD4= 350. The target will not be achieved unless the continuum of prevention, care, and treatment (CoPCT) is improved and funding for the response, including ART, is ensured. PEPFAR supports the Government of Vietnam to increase treatment coverage for all eligible HIV-infected people. The goal is to achieve a tipping point – to bring the number of annual new HIV infections below the annual increase in patients on ART. Vietnam's tipping point, as of 2013, is 0.9.

TREATMENT (FY09 - FY13) & FY15 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**
2013	Vietnam	$ 11,575,620	$ 7,646,227	$ 1,066,023	**$ 20,287,870**
	Totals FY09-FY13	**$ 44,705,620**	**$ 35,312,941**	**$ 5,015,040**	**$ 85,033,601**
2015 (est)	Vietnam				**$ 16,794,175**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

To support ART scale-up, PEPFAR works with the Government of Vietnam to diversify treatment models to include mobile care and treatment services for mountainous provinces, decentralization of treatment, and HTC, MAT, and outpatient clinic (OPC) integration to increase service linkage and reduce loss-to-follow up.

In FY 2015, PEPFAR Vietnam will continue active transfer of clinics and patients to the Government of Vietnam. 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 PEPFAR will not be able to continue its 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. support this effort, PEPFAR plans to shift HRH 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 OPCs. Another approach will be to strengthen counseling quality. Peer educator counseling training within the voluntary counseling and testing (VCT) program will be revised to increase referrals to the treatment system. At the OPC level, people living with HIV (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 - FY13) & FY15 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**
2013	Vietnam	$ 5,295,577	$ 556,020	$ 2,700,912	$ 578,196	**$ 9,130,705**
	Totals FY09-FY13	**$ 41,822,279**	**$ 5,547,560**	**$ 13,083,835**	**$ 9,692,971**	**$ 70,146,645**
2015 (est)	Vietnam					**$ 8,318,407**

* Totals include planned funding for all accounts.
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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 to Fight AIDS, Tuberculosis and Malaria (Global Fund) support. Where possible, PEPFAR Vietnam promotes integration of facility-based services like ART, MMT, and VCT, with community-based services.

In FY 2015, 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. 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 orphans and vulnerable children (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 - FY13) & FY15 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**
2013	Vietnam	$ 3,981,265	$ 5,253,985	$ 2,702,822	$ 8,513,983	**$ 20,452,055**
	Totals FY09-FY13	**$ 24,271,365**	**$ 29,043,783**	**$ 20,565,518**	**$ 60,476,595**	**$ 134,357,261**
2015 (est)	Vietnam					**$ 20,418,109**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In line with PEPFAR's third and fourth Partnership Framework goals 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 Vietnam AIDS Administration Control (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.

In FY 2015, the PEPFAR Vietnam team remains 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 the VAAC and 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

At the end of 2012, Vietnam updated its National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030, which primarily illustrates Vietnam's commitment to the "Three Zeros"- zero new infections, zero discrimination, and zero AIDS-related deaths. In recognition of declining external resources, the Government of Vietnam is currently making efforts for closer cooperation with development partners to develop a transition 'roadmap' to sustain progress toward the targets set out in the strategy. The roadmap will address the gradual shift from donor support of services to a national HIV program that harnesses technical assistance from donors but is managed and funded by Vietnam. National and sub-national processes and systems must be strengthened to enable this sustainable response in the long-term.

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 2015.

Concurrent with significant decreases in available PEPFAR resources since FY 2010 and the ongoing, incremental transition of service delivery sites to the Government of Vietnam, the U.S. government has taken an aggressive role to improve harmonization of all available HIV/AIDS resources in Vietnam. Harmonization will support a sustainable national HIV/AIDS response that is embedded within the broader healthcare and social work system; it is a key part of the sustainability planning process.

Country engagement and ownership of the HIV response in Vietnam must also encompass civil society and the private sector. The Government of Vietnam, however, warily receives civil society implementers, given a fear that these groups will engage in politics in addition to programs. The PEPFAR team has identified Vietnamese CSOs that are ready and capable of receiving U.S. government funding directly to deliver community-based prevention and care services. Three direct grants to local CSOs have been negotiated and will be implemented in FY

2015. The meaningful engagement of civil society remains a cornerstone for broad country ownership in Vietnam, especially as the Government of Vietnam is not expected to invest heavily in HIV prevention for these key populations whose behavior is still referred to as “social evils.”

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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 highest HIV prevalence in the region is found among the estimated 174,000 people who inject drugs (PWID) in the region and most registered HIV cases are found among young, unemployed males aged 20-39. Results of a recent integrated bio-behavioral surveillance (IBBS) reveal HIV prevalence among PWID is up to 13.5 percent in Tajikistan, 12.4 percent in the Kyrgyz Republic, and ranges in different sentinel sites from 3.4 to 18 percent in Kazakhstan and from 1 to 39 percent in Uzbekistan (data are not available for Turkmenistan).

The United Nations Office on Drugs and Crime (UNODC) estimates that 20 percent of heroin shipped from Afghanistan passes through drug corridors in Tajikistan, Turkmenistan, Uzbekistan, the Kyrgyz Republic, and Kazakhstan. Approximately 11 metric tons of heroin per year are consumed in the region, where PWID constitute up to 1 percent of the adult population.

Surveillance data and other strategic information is often unavailable, incomplete, or inaccurate in the region due to the sensitivity of HIV/AIDS issues in the respective Ministries of Health. Notwithstanding, there is evidence that HIV prevalence among sexual partners of PWID and sex workers (SW), women, prisoners and men who have sex with men (MSM) is increasing. In 2013 the proportion of sexually transmitted new HIV cases grew to 61 percent in Kazakhstan, 57.5 percent in Tajikistan, and 48 percent in the Kyrgyz Republic. These trends should be further studied and verified, as a major proportion (38 percent) of the population tested for HIV is pregnant women in all countries in the region; testing among PWID remains very low, at 1.6 percent. Ministry of Health (MOH) data shows a substantial proportion of people living with HIV/AIDS (PLHIV) are women in the region – 47.5 percent in Uzbekistan, 34.9 percent in Tajikistan, and 30.7 percent in the Kyrgyz Republic. In addition, IBBS shows high prevalence among sexual partners of PWID – 4.8 percent in the Kyrgz Republic and 7.5 percent in Kazakhstan. Condom use is inconsistent and varies significantly by gender; in the Kyrgyz Republic, condom use at last higher-risk sexual encounter is reported by 83.8 percent of males but only 50.6 percent of females. HIV prevalence among another key population (KP), prisoners, is reported to be 8.4 percent in Tajikistan, 8 percent in the Kyrgyz Republic, and 3 percent in Kazakhstan.

Given the epidemiology and the progress of the response in the region, in FY 2015, PEPFAR will continue to prioritize the following objectives, outlined in the Central Asia PEPFAR 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 Central Asia Region (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
2013	$ 5,938,013	42%	$ 574,576	4%	$ 494,479	4%	$ 6,992,932	50%	$ 14,000,000
Total 2009-2013	**$ 23,508,996**	**64%**	**$ 2,058,432**	**6%**	**$ 1,143,621**	**3%**	**$ 24,079,366**	**65%**	**$ 36,790,415**
2015 (est)	**$ 5,613,565**	**42%**	**$ 1,827,840**	**14%**	**$ 486,994**	**4%**	**$ 5,565,601**	**41%**	**$ 13,494,000**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 - FY13) & FY15 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**
2013	Central Asia Regional	$ -	$ -	$ 1,227,624	$ 190,289	$ 50,289	$ 4,161,602	$ -	$ 308,209	**$ 5,938,013**
	Totals FY09-FY13	**$ -**	**$ -**	**$ 4,575,897**	**$ 555,818**	**$ 301,266**	**$ 10,543,533**	**$ -**	**$ 1,594,469**	**$ 17,570,983**
2015 (est)	Central Asia Regional									**$ 5,613,565**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 2015, 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, the Kyrgyz Republic, 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 - FY13) & FY15 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**
2013	Central Asia Regional	$ -	$ 494,479	$ -	**$ 494,479**
	Totals FY09-FY13	**$ -**	**$ 1,143,621**	**$ -**	**$ 1,143,621**
2015 (est)	Central Asia Regional				**$ 486,994**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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, the Kyrgyz Republic, 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 CAR 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 the Kyrgyz Republic, 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 CAR 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 (Global Fund) Project Implementation Units to develop and implement effective systems for forecasting and stocking laboratory supplies.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Central Asia Regional	$ 574,576	$ -	$ -	$ -	**$ 574,576**
	Totals FY09-FY13	**$ 2,058,432**	**$ -**	**$ -**	**$ -**	**$ 2,058,432**
2015 (est)	Central Asia Regional					**$ 1,827,840**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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.

Through NGO-based outreach activities and in selected service delivery sites in Kazakhstan, the Kyrgyz Republic, 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 - FY13) & FY15 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**
2013	Central Asia Regional	$ 1,247,010	$ 954,748	$ 4,069,416	$ 721,758	**$ 6,992,932**
	Totals FY09-FY13	**$ 3,973,346**	**$ 3,596,743**	**$ 6,384,721**	**$ 10,124,556**	**$ 24,079,366**
2015 (est)	Central Asia Regional					**$ 5,565,601**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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.

Countries in the region confront a number of contextual and structural difficulties that affect HIV transmission. First and foremost, the region is situated along the main northern drug trade route out of Afghanistan, which allows for easy access to heroin and makes cheap, illicit drugs widely available in the region. In some countries, syringes are more expensive than a dose of heroin, resulting in sharing of needles and fueling HIV transmission among PWID. Second, the legacy of a Soviet health care system means that all the countries in Central Asia have highly siloed, vertical, centralized medical systems that are focused on curative, facility-based care for specific diseases. As a result, comprehensive and integrated health sector policies and structures do not exist, making it extremely challenging to link key populations along the continuum of prevention, care, and treatment services. HIV/AIDS, TB, infectious diseases (such as hepatitis), drug abuse, sexually transmitted infections, and mental health illness are all provided by separate facilities in a fragmented and uncoordinated manner. Without an explicit and deliberate strategy to generate demand for HIV prevention services and without adequate referrals and linkages for HIV positive individuals, HIV transmission continues to rise (particularly by PWID, their partners, SW, and MSM).

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, despite the inherent challenges of the existing vertical health care delivery system in the region. PEPFAR CAR 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 team will address the legislative, regulatory, and attitudinal barriers that constrain key populations' access to services. Finally, PEPFAR CAR will prioritize information systems needed to measure accessibility, effectiveness, and efficiency of HIV/AIDS services.

In developing and implementing FY 2015 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 CAR 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 Global Fund, the largest HIV donor in the region. The PEPFAR CAR team follows a three-pronged approach with the Global Fund: provision of expertise to help Global Fund-funded programs function more effectively; assistance to recipient countries to become and remain eligible to receive future Global Fund grants; and partnership with implementing partners of Global Fund 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, Kyrgyz Republic, and Tajikistan. Kazakhstan, for example, has significant financial resources. However, policies to support evidence-based approaches, such as social contracting of non-governmental organizations (NGOs) and expansion of services, have not led to the scale up of targeted services for key populations. Tajikistan and the Kyrgyz Republic are entirely dependent on donor resources in HIV/AIDS, with 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. 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 Global Fund 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.

The U.S. government is engaging in country discussions to support CAR country transition to the Global Fund's new funding model. The new funding model puts greater emphasis on strategic investments in HIV; therefore, PEPFAR has also initiated a new partnership with UNAIDS to assist in the implementation of country level Investment Framework planning in Tajikistan, the Kyrgyz Republic, 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 Centers for Disease Control and Prevention (CDC) 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 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 to Fight AIDS, Tuberculosis and Malaria (Global Fund) providing significant funding for prevention of mother-to-child transmission (PMTCT), HIV care and support, and antiretroviral treatment (ART) drug procurement, PEPFAR India's focus remains the provision of technical assistance to maximize Global Fund grant performance.

PEPFAR India's key priorities for FY 2015 include:

- Support the continued roll-out of the fourth phase of the NACP (NACP-IV) and comprehensive HIV services among key populations and infected migrants with high-level technical assistance;
- Support the Indian government to identify, assess, prioritize, and implement better integration with other health programs;
- Support improved health financing decisions by using Expenditure Analysis data;
- Expand private sector engagement in India's HIV response by continuing to encourage Public-Private Partnerships;
- Continue to strengthen the role of civil society in advocating for and engaging with policy issues around the HIV national response; and
- Promote South-to-South technical exchanges between India and African and Asian countries, facilitating bi-directional technical knowledge transfers and adoption of best practices.

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
2013	$ 1,474,026	17%	$ -	0%	$ 305,733	3%	$ 6,977,691	80%	$ 8,757,450
Total 2009-2013	**$ 31,753,540**	**24%**	**$ 11,663,505**	**9%**	**$ 3,672,470**	**3%**	**$ 86,117,935**	**65%**	**$ 133,207,450**
2015 (est)	**$ 6,443,000**	**25%**	**$ 2,330,797**	**9%**	**$ 725,379**	**3%**	**$ 16,500,823**	**63%**	**$ 26,000,000**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	India	$ -	$ -	$ -	$ 1,474,026	$ -	$ -	$ -	$ -	**$ 1,474,026**
	Totals FY09-FY13	**$ 5,095,699**	**$ 3,104,485**	**$ 17,713,848**	**$ 1,474,026**	**$ 10,000**	**$ 300,000**	**$ -**	**$ 4,055,482**	**$ 31,753,540**
2015 (est)	India									**$ 6,443,000**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 (STI) 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 - FY13) & FY15 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**
2013	India	$ -	$ 305,733	$ -	**$ 305,733**
	Totals FY09-FY13	**$ -**	**$ 3,555,470**	**$ 117,000**	**$ 3,672,470**
2015 (est)	India				**$ 725,379**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 antiretroviral treatment (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 - FY13) & FY15 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**
2013	India	$ -	$ -	$ -	$ -	**$ -**
	Totals FY09-FY13	**$ 6,590,779**	**$ 551,307**	**$ 671,475**	**$ 3,849,944**	**$ 11,663,505**
2015 (est)	India					**$ 2,330,797**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 2015, 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 - FY13) & FY15 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**
2013	India	$ 509,559	$ 2,565,821	$ 1,436,098	$ 2,466,213	**$ 6,977,691**
	Totals FY09-FY13	**$ 3,360,557**	**$ 22,087,957**	**$ 45,661,203**	**$ 15,008,218**	**$ 86,117,935**
2015 (est)	India					**$ 16,500,823**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

U. S. government investments in FY 2015 will support NACO's 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 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 Global Fund 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 Global Fund Country Coordinating Mechanism, overseeing India's large Global Fund 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 Global Fund, 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 program focuses on increasing and improving HIV-related prevention, care and treatment services for key populations (men who have sex with men (MSM) and sex workers (SW)), across the clinical cascade.

Resource allocation across the region is made based on a balance of epidemiology/disease burden, and resource needs, with an eye on where PEPFAR resources can have a lasting impact to reduce the impact of HIV/AIDS in the region.

The Caribbean has higher HIV rates than any region outside of sub-Saharan Africa. The adult HIV prevalence of 1.0 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. In the countries with data, however, 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.

Overall in the region HIV incidence has been declining, however, much work needs to be done to improve outcomes for key populations. Men who have sex with men (MSM) and female sex workers (FSW) continue to be disproportionately affected. The HIV prevalence among MSM in the Caribbean is among the highest documented in the world. MSM prevalence varies from 6.7 percent in Suriname to 32.8 percent in Jamaica. A comprehensive review of HIV disease burden among MSM worldwide found that pooled HIV prevalence ranged from a low of 3 percent in the Middle East and North Africa to a high of 25.4 percent of MSM in the Caribbean. FSW prevalence is reported to be as high as 24 percent in Suriname.

Jamaica and the countries in the OECS (Antigua and Barbuda, Dominica, Grenada, St. Kitts and Nevis, St. Lucia, St. Vincent, and the Grenadines) rely more heavily on donor support for the National AIDS Program, and antiretroviral (ARV) drug costs are covered almost 100 percent by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). The Bahamas,

Suriname, and Trinidad and Tobago programs are supported much more financially by their national governments. In both cases, PEPFAR supports those countries where there may be gaps in prevention, care, and treatment focusing on key populations.

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
2013	$ 7,021,053	30%	$ 669,236	3%	$ 439,500	2%	$ 15,170,184	65%	$ 23,299,973
Total 2009-2013	**$ 35,343,418**	**32%**	**$ 4,664,997**	**4%**	**$ 1,603,892**	**1%**	**$ 69,479,066**	**63%**	**$ 111,091,373**
2015 (est)	**$ 3,939,961**	**18%**	**$ 338,633**	**2%**	**$ 440,872**	**2%**	**$ 17,561,534**	**79%**	**$ 22,281,000**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Caribbean Regional	$ -	$ -	$ 6,185,088	$ -	$ -	$ -	$ -	$ 835,965	**$ 7,021,053**
	Totals FY09-FY13	**$ 438,000**	**$ 302,474**	**$ 30,527,763**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 4,075,181**	**$ 35,343,418**
2015 (est)	Caribbean Regional									**$ 3,939,961**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

To reduce the number of new HIV infections in the region, the Caribbean Region prevention approach is focused on supporting the continuum of prevention, care and treatment (CoPCT) targeted at key populations, including HIV positive individuals. To accomplish this, prevention efforts focus on the following interconnected strategies: (1) Providing technical assistance to improve partners' technical competency in program design and management targeting key populations; (2) Strengthening the enabling environment for key populations' HIV/AIDS programming; and (3) Strengthening Quality Assurance/Quality Improvement and Monitoring and Evaluation systems throughout the CoPCT. This approach builds on ongoing regional support focused on increasing access to quality HIV prevention, care, and support services for key populations. These efforts will complement and leverage efforts by national governments and other donors and will generate quality data for evidence-based programming.

The regional landscape faces religious, cultural, policy, and legal challenges that hinder effective HIV responses. As important social and structural drivers of the epidemic, these marginalizing factors affect the morale and personal self-worth of key populations, driving them underground, and limiting their access to appropriate and client-acceptable services. PEPFAR's prevention response in the Caribbean continues to focus on key populations because of the concentrated nature of the epidemic and the persistent contextual and structural factors (e.g. stigma and discrimination) that contribute to the epidemic.

PEPFAR Caribbean Region's technical assistance will continue to support prevention models that address critical gaps within the CoPCT aimed at linking individuals to facility and community interventions. To achieve greater country ownership and sustainability, government and local health systems will receive support to strengthen their networks of coordinated and effective interventions. Additionally, the PEPFAR team will continue to advocate for an enabling environment to ensure availability and access to quality, crucial HIV/AIDS services to key populations.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Caribbean Regional	$ -	$ 439,500	$ -	**$ 439,500**
	Totals FY09-FY13	**$ -**	**$ 1,603,892**	**$ -**	**$ 1,603,892**
2015 (est)	Caribbean Regional				**$ 440,872**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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 national government funds. PEPFAR's role in supporting antiretroviral treatment (ART) in the Caribbean is to help governments address barriers to increasing treatment coverage and improving the quality of treatment services for key populations.

PEPFAR and UNAIDS also work 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 ARV costs are paid by the national governments.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Caribbean Regional	$ 627,289	$ -	$ 41,974	$ -	**$ 669,263**
	Totals FY09-FY12	**$ 4,082,290**	**$ -**	**$ 82,734**	**$ 500,000**	**$ 4,665,024**
2015 (est)	Caribbean Regional					**$ 338,633**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The overall U.S. government strategy in FY 2015 will focus on care of key populations and people living with HIV (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 - FY13) & FY15 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**
2013	Caribbean Regional	$ 3,035,974	$ 2,763,646	$ 6,269,011	$ 3,101,553	**$ 15,170,184**
	Totals FY09-FY13	**$ 12,117,728**	**$ 16,106,578**	**$ 24,209,246**	**$ 17,045,514**	**$ 69,479,066**
2015 (est)	Caribbean Regional					**$ 17,561,534**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The main challenges for the Caribbean Program as it relates to health systems strengthening are weak or uncertain leadership, human resources for health (HRH) shortages, lack of sustainable financing, and poor management. There is also a shortage of strategic information and an inherent culture of not using evidence for decision-making.

Currently there is insufficient capacity in the health systems throughout the region to meet the HIV prevention, care, and treatment needs. The strategies and activities for FY 2015 will continue to address identified gaps, especially where they affect key population's access to services in these areas and work towards sustainability of the programs.
The PEPFAR Caribbean Regional program has been prioritizing integration of services and the advancement of health efficiency and financing components as the islands move closer towards country ownership and sustainability. The involvement of the non-governmental organization (NGO) and civil society organization (CSO) communities has been very slow but the Program will move to strategically integrate NGOs and private sector organizations to participate in the development of country work plans and strategic forums. PEPFAR Caribbean Region will continue to work with sub-awardees and other government and CSOs to build capacity to plan for and achieve results in HIV prevention programs targeting key populations.

Towards the goal of sustainability, PEPFAR will continue to work closely with UNAIDS to roll out the new investment framework within the Caribbean region. The program held two regional meetings, one in Jamaica and the other in St. Lucia, to discuss HIV investments and the sustainability of the HIV responses in the Caribbean. The overall goal of these meetings was to advance the dialogue that encourages Caribbean countries to invest in HIV and health in order to improve efficiency and optimize the achievement of sustainable results, and to understand the role of shared responsibility and country ownership in the context of sustaining the HIV response. Using the Jamaica investment case as a model, the countries all agreed on the need for them to establish their own in-country task forces which will focus on and timetable their various sustainability planning needs, identifying all of the gaps which exist with a view of then articulating to the PEPFAR team any specific TA needs to achieve their sustainability goals.

The Strategic Information (SI) work of the PEPFAR Caribbean Regional program is made up of three components: surveillance, monitoring and evaluation (M&E), and health information system (HIS). The goal of SI is to improve the capacity of national governments and regional public health organizations to collect quality data that will help determine the characteristics of the HIV epidemic and use the data to plan and prioritize health interventions.

PEPFAR Caribbean Region recently used available data to come up with coverage and gaps of HIV intervention in key populations. This undertaking showed that the HIV epidemic in most of the countries in the region is concentrated and key populations are an important source of HIV transmission. According to available data, prevention activities are reaching about 20 percent of key populations and counseling and testing is reaching only 15 percent.

PEPFAR Caribbean Region is supporting countries to conduct biological and behavioral surveys with appropriate methodologies and the data generated will be used for planning of prevention interventions to reach most key populations. Another SI task in FY 2015 is to continue supporting countries to expand the implementation of case-based surveillance and produce continuum of care analyses, an important analytical method to identify gaps in the health care system where patients are lost from health care. Such analyses will help prioritize interventions so that patients are maintained in care, have quality lives, and reduce transmission through prevention activities. Plans are in place to continue supporting cost effective studies in FY 2015 to help countries make informed decisions about initiating early treatment.

Country Engagement

Across the eleven countries in the Caribbean region, each government's capacity and engagement varies. On the whole, governments are strongly engaged as the lead implementers of HIV-related treatment and care services. However, the ability to finance the national responses varies. Some rely heavily on Global Fund resources for HIV treatment, while others have moved to fund all HIV services with national resources.

Regional organizations are particularly important in the region. Organizations like the Pan-Caribbean HIV-AIDS Program (PANCAP) are critical in strengthening the region's ability to respond to the epidemic.

The PEPFAR Caribbean Regional Program has enhanced countries' abilities to manage their HIV programs and resources through training and technical assistance 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 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. The region, however, 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.

According to the 2013 UNAIDS Global Report, HIV prevalence in adults in Central America is highest in Belize (1.4 percent), followed by Panama (0.7 percent), Guatemala (0.7 percent), El Salvador (0.6 percent), Honduras (0.5 percent), Costa Rica (0.3 percent), and Nicaragua (0.3 percent). 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 2015, the Central America Regional U.S. government team will continue to be guided by the Regional Partnership Framework (PF) with a clear commitment to country ownership. The U.S. government will redouble the PF focus on key populations (as defined by PEPFAR/UNAIDS) and on providing targeted technical assistance to strengthen the continuum of prevention, care, and treatment for key populations.

For FY 2015, the U.S. government team will continue to use the results of the Prevention Reach Model which estimated the reach into key populations in each country as a tool to better

understand the gaps in current investments in the region. The U.S. government team has critically analyzed evidence coming from U.S. government supported studies to further investigate what sub-populations are driving the epidemic. The recent country level Behavioral Surveillance Study (BSS+) studies show an extraordinarily high prevalence among transgender women and, while considered MSM for epidemiological purposes, their context and gender identity require specifically tailored interventions and services. The U.S. government is providing technical leadership for the region in supporting these kinds of customized evidence-based activities.

In addition, PEPFAR Central America will continue supporting activities 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).

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
2013	$ 6,138,996	28%	$ 2,493,387	12%	$ -	0%	$ 12,981,617	60%	$ 21,614,000
Total 2009-2013	**$ 18,954,553**	**28%**	**$ 6,038,000**	**9%**	**$ -**	**0%**	**$ 43,409,447**	**63%**	**$ 68,402,000**
2015 (est)	**$ 5,271,079**	**25%**	**$ 4,521,291**	**22%**	**$ -**	**0%**	**$ 11,199,630**	**53%**	**$ 20,992,000**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 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
2013	Central America Regional			$ 4,242,359					$ 1,896,637	$ 6,138,996
	Totals FY09-FY13	$ -	$ -	$ 13,735,215	$ -	$ -	$ -	$ -	$ 5,219,338	$ 18,954,553
2015 (est)	Central America Regional									$ 5,271,079

* Totals include planned funding for all accounts.
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With FY 2015 funds, PEPFAR Central America will continue to fill gaps identified through the Prevention Reach Model, which was used to estimate the reach of prevention to key populations

in each country. PEPFAR Central America will also focus on strengthening prevention efforts in high prevalence hot spots, focused on MSM, FSW, and transgender women a minimum prevention package uniquely tailored to each group. Gender will also be included as a crosscutting theme in PEPFAR's work with key populations in the Central America region. Positive Health, Dignity, and Prevention (PHDP) will continue to be a strategic priority for PEPFAR Central America in FY 2015. In FY 2014, the U.S. government, in collaboration with the regional network of people living with HIV (PLHIV), began assisting all seven countries in the region in the development of a regional and national PHDP strategy. In FY 2015, the U.S. government will continue finalizing these strategies, and provide trainings on the minimum package of prevention services as defined in each country's national PHDP plans. 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 surveillance information system. VICITS activities in FY 2015 continue to 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 - FY13) & FY15 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	$ -	$ -	$ -	**$ -**
2013	Central America Regional	$ -	$ -	$ -	**$ -**
	Totals FY09-FY13	**$ -**	**$ -**	**$ -**	**$ -**
2015 (est)	Central America Regional				**$ -**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

To respond to the region's concentrated epidemic, the PEPFAR Central America team supports the continuum of prevention, care, and treatment (CoPCT) for key populations through targeted technical assistance. The U.S. government team does not have any funding in the treatment area but works to support and strengthen the linkages to treatment for key populations.

With funding provided by host country governments and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), access to anti-retroviral treatment (ART) has increased over the past two years. With these resources covering all the direct costs for adult and pediatric ART in Central America, PEPFAR does not provide any support for treatment related service delivery or procurement of ARVs, but the U.S. government plays a critical role in assisting Central American governments in curbing their concentrated epidemic by supporting crossing cutting areas that focus on key populations to: a) increase retention in care and treatment services, b) ensure access to treatment, c) increase treatment adherence, and d) strengthen supply chain management. U.S. government assistance will also focus on promoting the quality of services with an emphasis on key populations, strengthening the quality of laboratory diagnosis for effective patient care, and promoting the CoPCT through community networks and Ministry of Health (MOH) supported clinical facilities for an enhanced package of services.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Central America Regional	$ 1,754,477	$ -	$ 738,910	$ -	**$ 2,493,387**
	Totals FY09-FY13	**$ 4,157,954**	**$ -**	**$ 1,880,046**	**$ -**	**$ 6,038,000**
2015 (est)	Central America Regional					**$ 4,521,291**

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** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

As a targeted technical assistance program in a concentrated epidemic, PEPFAR Central America provides support to improve the CoPCT for key populations. U.S. government technical assistance emphasizes building national capacity to provide quality care services through strengthening human resources and laboratories, improving tuberculosis (TB)/HIV services, and by developing and strengthening linkages between both facilities and communities and the public and non-governmental organization sectors for a comprehensive CoPCT. PEPFAR Central America programs build the capacity of public sector institutions and civil society organizations that have complete ownership and leadership of their care programs.

In FY 2015, the U.S. government will continue to focus on the Adult Care and Support and TB/HIV program areas.

In Adult Care and Support, the U.S. government focuses on improving the referral and linkages for key populations within the CoPCT. U.S. government technical assistance works to improve the quality of care for key populations through performance improvement and the establishment of multi-sector networks that link PLHIV, community groups, and clinical sites to improve

accountability and overall quality. The U.S. government also provides technical support for PHDP programs for PLHIV.

U.S. government activities are organized around three objectives:

1. To improve the quality of services in selected facilities, including hospitals with HIV care centers and STI clinics for key populations.
2. To strengthen the capacity of health personnel to provide quality services.
3. To increase PLHIV retention in quality care and treatment services and improve adherence to ART.

In the area of TB/HIV and fungal co-infections, the U.S. government provides technical assistance to MOH staff at targeted high burden TB/HIV districts in three main areas:

1. Improvement of TB/HIV care by intensifying TB case finding among PLHIV, improving access of HIV testing among TB patients, conducting TB infection control assessments in HIV clinics and improving linkages to care across TB and HIV clinics.
2. Strengthening of laboratories in the region by providing trainings to MOH staff on diagnosis of TB and fungal opportunistic infections (OI).
3. Strengthening of health information systems and surveillance departments within all Ministries of Health including surveillance of fungal OIs among PLHIV.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Central America Regional	$ 280,091	$ 3,065,827	$ 7,845,581	$ 1,790,118	**$ 12,981,617**
	Totals FY09-FY12	**$ 1,514,927**	**$ 11,259,616**	**$ 23,103,037**	**$ 7,531,867**	**$ 43,409,447**
2015 (est)	Central America Regional					**$ 11,199,630**

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In FY 2015, the U.S. government will continue working with more than 90 hospitals and 27 community networks across six countries in the Central America region to improve the quality of the CoPCT services for PLHIV and other key populations.
Training in stigma, 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 2015, the U.S. government is planning to continue these activities with hospitals and community networks and to support the institutionalization of the strategy across various countries in the region.

In FY 2015, 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 2015, the U.S. government will continue to support the establishment of a regional lab network for HIV, STI, Mycotic Infections and 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 National AIDS Spending Assessment (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

The seven governments in Central America all play strong leadership roles in their respective national responses to HIV and AIDS. Governments are always the lead implementers, and often the primary funders for services. Continuing to strengthen and support each country's ownership of their HIV response is at the heart of the Central America Regional program.

PEPFAR-funded partners are working to improve the quality of HIV related services at public hospitals and building the capacity of key populations-focused NGOs.

Across the region, PEPFAR Central America has played a key role in supporting the development of strategic plans that better reflect the reality of the region's concentrated epidemic.

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 2015 planning, the U.S. government held a series of meetings across the region to assess the advances and challenges in each country in implementing the partnership framework.

Dominican Republic

Country Context

The Dominican Republic 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.

Below is a table of PEPFAR Dominican Republic'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
2013	$ 8,360,625	58%	$ 533,367	4%	$ 62,802	0%	$ 5,543,206	38%	$ 14,500,000
Total 2009-2013	**$ 34,786,187**	**45%**	**$ 9,696,990**	**13%**	**$ 2,355,941**	**3%**	**$ 30,077,816**	**39%**	**$ 76,916,934**
2015 (est)	**$ 4,755,593**	**34%**	**$ 2,431,841**	**17%**	**$ 140,877**	**1%**	**$ 6,784,688**	**48%**	**$ 14,112,999**

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Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Dominican Republic	$ 1,240,599	$ 264,435	$ 5,422,304	$ 148,671	$ -	$ -	$ 146	$ 1,284,470	**$ 8,360,625**
	Totals FY09-FY13	**$ 6,486,898**	**$ 2,375,221**	**$ 18,919,408**	**$ 3,170,595**	**$ -**	**$ -**	**$ 230**	**$ 3,833,835**	**$ 34,786,187**
2015 (est)	Dominican Republic									**$ 4,755,593**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, PEPFAR Dominican Republic's program will continue to focus on prevention interventions among key populations, implementation of the Government of Dominican Republic's prevention of mother-to-child transmission (PMTCT) strategic plan (PSP), NGO and health systems strengthening, and continued support to the Dominican government's procurement procedures.

In addition to PEPFAR Dominican Republic's focus on key populations, primarily men who have sex with men (MSM), and sex workers (SW), PEPFAR will continue to work with other vulnerable groups, including non-injecting drug users, mobile populations, residents of Bateyes, military, and at-risk youth. A few key prevention interventions are outlined below.

PEPFAR Dominican Republic will continue to support high-risk youth and gender programs by delivering HIV prevention messages through peer educators and training for Dominican leaders who will guarantee the sustainability of these programs. Positive gender norms and behaviors are emphasized in PEPFAR Dominican Republic's prevention programs.

Studies suggest that soldiers deployed near the Dominican Republic -Haiti border engage in risky sexual behaviors placing them at a high risk for HIV infection. To address this risk, PEPFAR Dominican Republic will provide testing, counseling, and clinical services in health units on military bases and to troops deployed along the border. Activities include prevention messaging and access to condoms.

In FY 2015, PEPFAR Dominican Republic will also help identify and address the health and wellness issues affecting out-of-school youth, in particular those behaviors which place them at increased risk of HIV infection. Programs focused on youth prevention will be implemented in Dominican Republic's major urban centers. Since FY 2013, the Ministry of Education has taken full ownership of the sexual education program for youth and PEPFAR will no longer provide support for this specific activity.

High rates of stigma, discrimination, and gender-based violence (GBV) are "critical enablers" of the HIV epidemic. In FY 2015, PEPFAR Dominican Republic will provide technical and policy assistance to reduce stigma, discrimination, and GBV directed at key populations, persons living with HIV, women, and girls. Additionally, PEPFAR Dominican Republic will support the institutional strengthening of two local organizations to ensure the sustainability of these efforts and link with local government counterparts to address policy and regulatory issues related to stigma.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Dominican Republic	$ -	$ 7,585	$ 55,217	**$ 62,802**
	Totals FY09-FY13	**$ 148,986**	**$ 1,570,699**	**$ 636,256**	**$ 2,355,941**
2015 (est)	Dominican Republic				**$ 140,877**

* Totals include planned funding for all accounts.
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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 2015 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. The expectation is that the PEPFAR DR program and other donors will indirectly support treatment programs through technical assistance (TA) activities to the Government of DR to improve data quality and utilization, as well as supportive site supervision at the point of service delivery. As a middle-income country, the Dominican Republic has continued to increase its financial contribution for ARV procurement along with Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) support.

In FY 2015, PMTCT remains a priority for PEPFAR Dominican Republic. Since FY 2012, the PEPFAR team has worked closely with the MOH to develop a National Strategy focused on 16 high-volume hospitals. Since more than 80% of deliveries in the public sector take place at these facilities, U.S. government programming already supports improved and expanded HIV counseling and testing in the PMTCT setting, same-day delivery of results through improved laboratory services, and the encouragement of male partners to access counseling and testing services. PEPFAR Dominican Republic also provides supportive site supervision as a means to strengthen the quality of PMTCT and other care services. PEPFAR Dominican Republic will also provide TA to the MOH to move towards compliance with World Health Organization B and B+ options, which include placing women who are found to be HIV positive on a lifetime ARV regimen.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Dominican Republic	$ 228,664	$ -	$ 304,703	$ -	**$ 533,367**
	Totals FY09-FY13	**$ 2,854,443**	**$ 1,202,469**	**$ 2,447,691**	**$ 3,192,387**	**$ 9,696,990**
2015 (est)	Dominican Republic					**$ 2,431,841**

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PEPFAR will continue to support the Dominican government to ensure that a comprehensive package of effective care and support services is available, accessible, and sustainable, through the promotion and support of the continuum of prevention, care, and treatment for all people living with HIV, with a focus on key populations and other vulnerable populations. The goals include improving linkages across the continuum, improving the enabling environment for key populations, expanding the evidence base, and using information for action.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Dominican Republic	$ 609,773	$ 1,630,739	$ 1,942,547	$ 1,360,147	**$ 5,543,206**
	Totals FY09-FY13	**$ 6,308,061**	**$ 6,632,489**	**$ 8,118,153**	**$ 9,019,113**	**$ 30,077,816**
2015 (est)	Dominican Republic					**$ 6,784,688**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR Dominican Republic aligns its support with the National Strategic Plan (NSP) for HIV and coordinates with the Global Fund. Many PEPFAR-supported activities are designed and implemented directly by the MOH, such as the PMTCT program, HIV service provision, the Tuberculosis (TB) Control Program, and epidemiology functions. PEPFAR DR supports a large number of Technical Working Groups that are chaired by the MOH, including: HIV clinical care, PMTCT, HIV laboratories, TB laboratories, HIV/TB co-infection, Blood Safety, Field Epidemiology Training Program (FETP), and supply chain management.

PEPFAR Dominican Republic's ongoing TA and support to MOH systems, especially in training and program protocols, promote the various dimensions of country ownership. In laboratories, for example, PEPFAR Dominican Republic has provided valuable TA in helping the Dominican government develop protocols of quality assurance, training of staff and supervisors, and provision of equipment. These underscore the development of institutional ownership and capabilities. Similarly, in the procurement/logistics system, TA has resulted in procedures that provide antiretroviral (ARVs) drugs efficiently and at (lower) international prices. For two years now the MOH has budgeted its own resources to procure ARVs, a strong step towards financial accountability.

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 Dominican Republic 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 that informed and ensured the alignment of U.S. government programs with national priorities.

PEPFAR Dominican Republic 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 people living with HIV. 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.

Guyana

Country Context

The number of new HIV infections in Guyana has progressively decreased among the general population over the last six years. In 2012, UNAIDS estimated Guyana's HIV prevalence to be at 1.3 percent, with approximately 7,200 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 key populations, including men who have sex with men (MSM) (21.2 percent, 2005; 19.4 percent, 2009) and female 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 Guyana 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 2015, 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
2013	$ 1,868,468	20%	$ 1,368,773	14%	$ 1,184,156	13%	$ 5,044,607	53%	$ 9,466,004
Total 2009-2013	**$ 19,210,593**	**26%**	**$ 10,783,367**	**14%**	**$ 15,292,880**	**20%**	**$ 29,655,464**	**40%**	**$ 74,942,304**
2015 (est)	**$ 1,008,603**	**15%**	**$ 460,311**	**7%**	**$ 1,110,351**	**17%**	**$ 4,056,735**	**61%**	**$ 6,636,000**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Guyana	$ 193,696	$ -	$ 860,792	$ 157,419	$ 19,733	$ 12,233	$ 13,233	$ 611,362	**$ 1,868,468**
	Totals FY09-FY13	**$ 2,576,244**	**$ 2,015,361**	**$ 7,206,807**	**$ 2,674,050**	**$ 532,090**	**$ 21,944**	**$ 23,040**	**$ 4,161,057**	**$ 19,210,593**
2015 (est)	Guyana									**$ 1,008,603**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Averting new HIV infections across all groups is the goal of the National Response, outlined in *HIVision 2020*. PEPFAR prevention strategies align with Guyana's national priorities and strive to ensure that U.S. government contributions to the national HIV response reflect the needs of the host country during the transition to the Government of Guyana.

In FY 2015, the PEPFAR Guyana prevention strategy will focus on evidence-based, combination prevention activities. PEPFAR Guyana will support prevention programming to reduce new infections, providing long-term impact through dollars saved on the cost of care and management of people living with HIV/AIDS (PLWHA). Key activities will include i) targeted surveillance and strategic information gathering for key and priority populations; ii) expanding key populations-based programming to interrupt ongoing transmission and reduce HIV incidence over time; iii) increasing access to testing and counseling where necessary; and iv) developing implementation plans for integrating HIV testing and care services into other systems of care.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Guyana	$ 459,493	$ 606,866	$ 117,797	**$ 1,184,156**
	Totals FY09-FY13	**$ 6,186,508**	**$ 8,798,192**	**$ 308,180**	**$ 15,292,880**
2015 (est)	Guyana				**$ 1,206,480**

* Totals include planned funding for all accounts.
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PEPFAR Guyana provides both direct support and technical assistance to the national treatment program, which includes infants and children. PEPFAR Guyana directly supports three treatment centers that collectively service 85 percent of all HIV-infected persons (including children) on antiretroviral treatment (ART). In addition, PEPFAR Guyana provides supply chain management support for the procurement of all pediatric drugs in FY 2015.

In FY 2015, PEPFAR Guyana will support expansion of pediatric and adolescent HIV treatment using an evidence-based approach to re-programming. This will be achieved through continued case tracking of infants and young children in care and improved linkage to care and support services aimed at improving patient retention. PEPFAR Guyana will support the Ministry of Health (MOH) in closer monitoring of pediatric and adolescent clinical outcomes and survival assessment, using the site-level patient monitoring system (PMS).

PEPFAR Guyana will also continue support for decentralization and integration of HIV treatment into other systems of care. The final product will be uniform training for physicians and MEDEX staff who work in the Health Care system across all regions. This will assure countrywide coverage of treatment services. Furthermore, PEPFAR Guyana will intensify technical assistance for integrating HIV care into the general primary care system (e.g. maternal child health, chronic disease clinics, internal medicine). This will promote reductions in stigma and discrimination associated with HIV treatment sites, thus improving patient linkage and retention in treatment programs.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Guyana	$ 817,406	$ 71,611	$ 190,870	$ 288,886	**$ 1,368,773**
	Totals FY09-FY13	**$ 5,643,922**	**$ 170,373**	**$ 1,302,480**	**$ 3,666,592**	**$ 10,783,367**
2015 (est)	Guyana					**$ 460,311**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, PEPFAR Guyana's care and support portfolio's primary objective is to optimize the continuum of care for PLHIV. This is particularly important to support the scale up of the national HIV treatment program and ensure retention in care and treatment from diagnosis through long-term ART administration. PEPFAR Guyana will bridge key gaps in direct service delivery and provide capacity building for local NGOs and treatment site clinicians to prevent disruptions in patient care. While continuing to transition aspects of the care and treatment portfolio to the MOH, partnerships with community-based organizations and clinical health care

providers will be designed to improve HIV-related patient outcomes. This will be done through effective coordination and linkage to comprehensive facility-based clinical and other supportive services.

Additionally, care and support partnerships will target specific populations including orphans and vulnerable children, pediatrics, and key populations, prioritizing care components through partnerships with seven community-based NGOs covering eight regions. Key populations targeted include commercial sex workers and MSM, as well as outreach services to partners of key populations. PEPFAR Guyana will also support critical areas in which the MOH's National AIDS Program has requested support. PEPFAR Guyana strategies will also pay particular attention to improving linkage and retention in care and treatment, increased stakeholder collaboration with clinical health professionals, and supportive staff based at treatment sites.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Guyana	$ 280,304	$ 423,227	$ 2,580,000	$ 1,761,076	**$ 5,044,607**
	Totals FY09-FY13	**$ 3,182,538**	**$ 4,404,493**	**$ 11,119,502**	**$ 10,948,931**	**$ 29,655,464**
2015 (est)	Guyana					**$ 4,056,735**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The PEPFAR Guyana team will continue to actively advance the transition of direct services to the Government of Guyana and support systems strengthening through technical assistance to ensure that the quality of the HIV response is sustained. PEPFAR Guyana will also continue its role in supporting donor coordination through the Health Donor Coordination Group and continue actively engaging all stakeholders: donors, civil society, faith based, PLHIV, key populations, and the private sector. PEPFAR Guyana has made considerable investments in the development of the public health laboratory system in Guyana, supporting infrastructure development, equipment, commodities and supplies, human resources for health salaries, and capacity building. In FY 2015, PEPFAR Guyana will continue its investment in laboratory strengthening with a focus on quality. Additionally, PEPFAR Guyana will continue supporting the development of a comprehensive national quality assurance program through the Stepwise Laboratory Improvement Process towards Accreditation (SLIPTA). This will include rollout of SLIPTA, standardization of HIV rapid testing logbooks, and rollout of the dried tube specimen proficiency testing to all testing and counseling sites. PEPFAR Guyana will also provide technical assistance in the lab's expansion of HIV services to resistance testing – a currently outsourced service for persons failing therapy.

Country Engagement

Guyana has strong ownership of 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 Guyana team; and has been very adept at generating resources from the international community, including PEPFAR and the Global Fund. 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, there are still areas requiring further strengthening and support from the U.S. government.

Transition of the PEPFAR Guyana portfolio towards a technical assistance model remains a priority for the U.S. government team. To ensure that the transition is both responsible and realistic, the U.S. government team engaged in a comprehensive portfolio review process to examine all aspects of currently funded programs and activities as well as their stage in transition. This review, along with the experiences of the transition process thus far, will be included in the revision of the transition plan. The PEPFAR team will continue to actively advance the transition of direct services to the Government of Guyana and support systems strengthening through technical assistance to ensure that the quality of the HIV response is sustained.

Haiti

Country Context

Haiti's estimated 150,000 people living with HIV (PLHIV) constitutes 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 sex workers (SW) 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, over 70 percent of PLHIV eligible to receive antiretroviral treatment (ART) were receiving it and 71 percent of all pregnant women were tested for HIV as of December 2013. 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 2015, universal access and country ownership through health systems strengthening underpin major shifts and important advances in the PEPFAR Haiti portfolio and are reflected throughout the program. The PEPFAR program is in the midst of an in-depth analysis to identify core and non-core activities which will inform strategic shifts needed to accelerate progress towards controlling the HIV epidemic in light of the present constrained budget environment.

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
2013	$ 28,278,912	20%	$ 29,127,147	20%	$ 27,431,443	19%	$ 57,462,946	40%	$ 142,300,448
Total 2009-2013	**$ 139,953,863**	**19%**	**$ 163,529,190**	**22%**	**$ 168,108,354**	**23%**	**$ 267,422,048**	**36%**	**$ 739,013,455**
2015 (est)	**$ 21,786,684**	**18%**	**$ 30,783,158**	**25%**	**$ 42,369,274**	**34%**	**$ 29,073,883**	**23%**	**$ 124,013,000**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

Prevention

PREVENTION (FY09 - FY13) & FY15 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**
2013	Haiti	$ 8,428,151	$ 2,212,107	$ 4,716,507	$ 4,948,025	$ 1,082,652	$ -	$ -	$ 6,891,470	**$ 28,278,912**
	Totals FY09-FY13	**$ 36,629,699**	**$ 14,317,662**	**$ 26,326,750**	**$ 24,459,442**	**$ 4,915,716**	**$ -**	**$ -**	**$ 33,304,594**	**$ 139,953,863**
2015 (est)	Haiti									**$ 21,786,684**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

PEPFAR Haiti is committed to implementing prevention programming that is aimed at the drivers of new infections in Haiti. Haiti has already reached the 'tipping point' with the number of adults on treatment exceeding the estimated number of new adult infections. Preventing new infections is an important way to further reduce this ratio and is a critical component to the overall PEPFAR strategy in Haiti. In FY 2015, the PEPFAR Haiti prevention portfolio includes prevention of mother-to-child transmission (PMTCT) in the sites with the highest yield, interventions to change behavior and prevent sexual transmission with a focus on key populations, and biomedical prevention. PEPFAR Haiti will leverage the strong political will within the Government of Haiti at the highest levels to continue to raise awareness and promote safe sex and encourage people to know their status.

Treatment

TREATMENT (FY09 - FY13) & FY15 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**
2013	Haiti	$ 4,011,133	$ 18,456,371	$ 4,963,939	**$ 27,431,443**
	Totals FY09-FY13	**$ 27,136,982**	**$ 119,274,935**	**$ 21,696,437**	**$ 168,108,354**
2015 (est)	Haiti				**$ 42,369,274**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In line with the PEPFAR Blueprint, the Haiti PEPFAR program is committed to increasing access to antiretroviral (ARV) care and treatment services to PLHIV, improving the quality of these services and delivering them as sustainably as possible. To this end, increasing testing and counseling in adult populations and expanding the use of Polymerase Chain Reaction (PCR) in pediatric populations will help identify more eligible patients given new treatment guidelines.

More targeted testing in departments/districts with the highest yield of HIV per site will be accelerated to hasten the cost-effective identification of persons eligible for ART. Data-driven programming will also focus on departments with lower coverage rates to close gaps and increase the trajectory to epidemic control. The expanded network of sites will also foster adherence over time by allowing clients to receive drugs at access points closer to their homes.

Care

CARE (FY09 - FY13) & FY15 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**
2013	Haiti	$ 11,088,581	$ 3,911,413	$ 5,968,387	$ 8,158,766	**$ 29,127,147**
	Totals FY09-FY13	**$ 59,555,479**	**$ 19,935,320**	**$ 29,460,233**	**$ 54,578,158**	**$ 163,529,190**
2015 (est)	Haiti					**$ 30,783,158**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

In FY 2015, PEPFAR Haiti aims to sustain the expansion of HIV care and support in order to bring services closer to the population while improving the quality of these services. Specifically, PEPFAR Haiti will support the following priority activities: integration of HIV into primary care services with a particular focus on a complete integration of HIV and tuberculosis (TB) services and on sustaining the quality of services; scale-up of interventions such as early infant diagnosis to improve the PMTCT cascade and favor the enrollment of all HIV exposed infants in care; expansion of viral load testing, TB testing, and multidrug-resistant TB MDR-TB surveillance; livelihood support for orphans and vulnerable children (OVC) and nutritional support for vulnerable infants and young children infected or affected by HIV, particularly those moderately or severely malnourished; and re-establishment of strong community support with formal operational linkages at the institutional level.

Governance and Systems

GOVERNANCE AND SYSTEMS (FY09 - FY13) & FY15 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**
2013	Haiti	$ 10,964,026	$ 17,283,221	$ 22,621,907	$ 6,593,792	**$ 57,462,946**
	Totals FY09-FY13	**$ 61,001,627**	**$ 51,133,202**	**$ 119,810,982**	**$ 35,476,237**	**$ 267,422,048**
2015 (est)	Haiti					**$ 29,073,883**

* Totals include planned funding for all accounts.
** FY 2014 programmatic funding levels are "To Be Determined" pending approval of all Country Operational Plans. Upon approval of the FY 2014 Country Operational Plans, a detailed FY 2015 PEPFAR Operational Plan will be issued that details each country's programmatic allocations.

The U.S. government Haiti strategy focuses on three main areas in health systems strengthening:

- Increasing support to the 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.

PEPFAR Haiti intends to reinforce the foundation of the overall health system in Haiti, which will facilitate improvements across the entire health sector, including HIV/AIDS. PEPFAR Haiti will continue to assist the MOH to respond to broader health needs, including those impacting affected communities and to play a larger role in the design, financing, implementation, and oversight of the National HIV program in Haiti. PEPFAR Haiti Health Systems Strengthening (HSS) support intends to reinforce the foundation of the Haitian health system across all six building blocks: 1) human resources for health, 2) service delivery, 3) leadership and governance, 4) health financing, 5) supply chain, and 6) health information systems.

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 the 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 to Fight AIDS, Tuberculosis and Malaria resource mapping and data verification exercises to achieve lower service costs and validate results.

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SECTION V: HEADQUARTERS OPERATIONAL PLAN

Headquarters Operational Plan Executive Summary

	GHP-State					
	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2015 Request
S/GAC Oversight/Management	**$127,407,692**	**$145,838,332**	**$172,153,634**	**$174,096,000**	**$154,961,364**	**$152,669,000**
Other Agency Costs	$113,407,692	$131,838,332	$158,181,634	$159,846,000	$141,410,524	$135,169,000
OGAC Administrative Costs	$14,000,000	$14,000,000	$13,972,000	$14,250,000	$13,550,840	$17,500,000

*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) and FY 2009 – 2013, and FY 2015 estimate.

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 Technical Oversight and Management 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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