

# Opportunities for U.S. Leadership at Its Moment of Reckoning on Global HIV

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## Executive Summary

Over the course of 15 years, the United States has generated exceptional experience, tools, and knowledge as the leader in the global fight against HIV. However, **THIS TREMENDOUS EXAMPLE OF U.S. LEADERSHIP IS IN JEOPARDY**. In its FY 2018 budget proposal to Congress, the Trump administration's proposed \$2 billion-plus in cuts to global health funding includes a \$1.1 billion reduction in international HIV/AIDS programs. This 18 percent reduction to the President's Emergency Plan for AIDS Relief (PEPFAR) and its companion financing partner, the Global Fund to Fight AIDS, Tuberculosis and Malaria, would put millions of lives at risk and raise the possibility that the pandemic will reignite, threatening both U.S. and global health security. A reduction in U.S. leadership would come at an unfortunate time. Global donor funding for HIV has declined in the last two years, just as experts advise that the world is within reach of bringing the HIV epidemic under control—even without a vaccine or cure. To succeed, countries affected by HIV will need to accelerate treatment initiation, increase support to keep those already on treatment virally suppressed, and recommit to expanding access to proven HIV prevention interventions. With 17 million people living with HIV worldwide still in need of treatment and 1.7 million more newly infected each year, **NOW IS NOT THE TIME FOR U.S. LEADERSHIP ON GLOBAL HIV TO WANE**.

Three key considerations should guide the Trump administration, Congress, and others in this period of significant change and heightened uncertainty:

- 1. U.S. leadership on HIV continues to advance U.S. national interests.** HIV/AIDS remains a worldwide health security threat that requires sustained U.S. engagement. When President Bush supported the creation of the Global Fund in 2002 and launched PEPFAR in 2003, the United States made a profound historic commitment to control global HIV/AIDS driven by American compassion and a moral obligation to care for those who were dying and share the treatment that had become available in the United States. The decision was also driven by U.S. national interests and international security. **PROTECTING AMERICANS AT HOME BY ANSWERING DANGEROUS HEALTH SECURITY THREATS ABROAD REMAINS RELEVANT TODAY**—U.S. commitment to combating HIV successfully confronts head-on the genuine threat that a runaway HIV epidemic in eastern and southern Africa will gut these societies and economies and spread instability. By investing to stabilize and control the epidemics in this region, the United States advanced its own interests by creating markets for U.S. products and good will toward the United States. While recent UNAIDS data shows that eastern and southern Africa has made exceptional progress in recent years largely due to focused effort from PEPFAR, the Global Fund, and others, the scenario is not as rosy in other places. New infections and deaths are rising in eastern Europe and central Asia—the only region where this is occurring worldwide. **THE FAILURE TO SEIZE THE OPPORTUNITY TO CONTROL THE EPIDEMICS IN ANY OF THESE COUNTRIES COULD SEE THEM SPIRAL OUT OF CONTROL.**
- 2. U.S. leadership centers on a proven formula for success.** The U.S. HIV/AIDS effort has been driven by sustained leadership by Presidents Bush and Obama; bipartisan congressional support; relatively stable

multiyear funding; the requirement that U.S. investments in the Global Fund be matched two-to-one from other donors; synergies in planning and implementation between PEPFAR and the Global Fund; a centralized decision-making structure; clear, concrete, measurable goals; and empowered and engaged ambassadors and country teams that harness the technical expertise of multiple U.S. government agencies and nongovernmental partners. Since the beginning, the United States has insisted on evidence-based programmatic and scientific rigor, programmatic accountability, and strong partnerships with host governments, combined with the steady achievement of efficiencies and lower commodity prices that have come from increasing scale. U.S. HIV programs draw systematically from American innovation, public health expertise, and scientific achievements largely attributed to public, private, and philanthropic investments in research and development (R&D). **THE EXCEPTIONAL BIPARTISAN BASE OF SUPPORT IN CONGRESS FOR GLOBAL HIV PROGRAMS IS BACKED BY A DIVERSE COALITION OF THE FAITH COMMUNITY, BUSINESSES, SECURITY EXPERTS, FOUNDATIONS, UNIVERSITIES, NGO IMPLEMENTERS, CIVIL SOCIETY GROUPS, AND ADVOCATES.** Deft diplomacy brings forward financial investments from partner governments, other donors, and private corporations. This formula for success remains as valid today as it was in 2003.

**3. We know what needs to happen next and we know what is at risk.** A strong consensus exists in the United States on the priorities of HIV/AIDS programs for the next four years: deploying new testing approaches to identify those who are not yet diagnosed and get them on treatment to suppress their viral load, while working to prevent new infections. New tools, such as self-testing and pre-exposure prophylaxis (PrEP), are already showing an impact, while vaginal rings and injectable HIV drugs offer promise. Implementing these measures and developing additional new tools will require financial and political investment, but they are feasible and affordable and will deliver concrete results.

In February 2017, the CSIS Global Health Policy Center convened an expert working group on HIV to discuss critical issues affecting continued U.S. leadership and progress toward control of the pandemic. The group's recommendations to the Trump administration and Congress are provided in several papers, including the policy brief "A Moment of Reckoning for U.S. Leadership on Global HIV"<sup>2</sup> issued in June 2017 and companion papers focused on the Global Fund, adolescent girls and young women, and sustainability and country ownership, the content of which is briefly cited in this paper.<sup>3</sup> This paper, "Opportunities for U.S. Leadership at Its Moment of Reckoning on Global HIV," is written for a nontechnical policy audience to demonstrate how HIV remains a relevant policy priority for the U.S. government.

## Recommendations

**THE TRUMP ADMINISTRATION AND CONGRESS SHOULD FOCUS THEIR GLOBAL HIV/AIDS EFFORTS ON THE FOLLOWING SIX PRIORITIZED, FUTURE-ORIENTED GOALS.** They respond to the emerging challenge of better leveraging the U.S. government's HIV investments to success in controlling HIV and continuing with successful implementation even with tight budgetary constraints, which will require disciplined managerial capacities and innovative program execution.

**1. Protect the U.S. approach to global HIV:** The multifaceted U.S. approach to fighting HIV through investments in PEPFAR, the Global Fund, and research has been a tremendous success, and should be maintained. PEPFAR was uniquely designed to apply the exceptional, diverse expertise of seven U.S. government departments and agencies<sup>4</sup> and capitalize effectively on the resources of other health, development, diplomacy, and defense activities

and the leadership role of ambassadors in each country. This whole-of-government approach should continue to underpin the work of the U.S. global AIDS coordinator at the Department of State, which oversees the PEPFAR program. In addition, the United States should sustain its investments in the Global Fund and in the National Institutes of Health (NIH), which enable the U.S. government to fight HIV more comprehensively from multiple fronts and with the most effective and efficient interventions. PEPFAR and the Global Fund work in tandem in countries to support the national response; activities are complementary, additive, and intertwined. The U.S.-supported research agenda has led to numerous innovations in tools and approaches that have provided the incredible opportunity to achieve epidemic control<sup>5</sup> in many hard-hit countries.

**2. Achieve HIV epidemic control:** PEPFAR data shows that epidemic control is possible in the near-term in at least 13 partner countries<sup>6</sup> in sub-Saharan Africa.

The key priority for the U.S. government should be achieving the epidemic control goal in those countries by scaling PEPFAR-supported services up strategically, in partnership with the Global Fund, the host government, and other partners.

### **3. Sustain investments to prevent backsliding:**

While focused effort to achieve epidemic control will be resource intensive in the 13 countries, HIV prevention and treatment scale-up should continue to the extent financially and programmatically feasible in the other 50 PEPFAR countries that are not yet near epidemic control. It would be foolish to risk epidemic rebound in the other countries just to ensure epidemic control in those closest to achieving it. Smart investments are needed to keep the countries with longer timelines to epidemic control on a positive trajectory even if that trajectory is slower paced than in the 13 countries targeted for near-term epidemic control.

### **4. Invest in programs for adolescent girls/young women:**

In many parts of east and southern Africa, areas that continue to have the highest numbers of people living with HIV, adolescent girls and young women face substantially higher risk of HIV infection than do males their age. This difference stems from social and economic factors and is exacerbated by the historic rise in the youth population. To be successful, the United States should continue to concentrate on preventing HIV in adolescent girls and young women while simultaneously reaching their 15- to 35-year-old male partners with HIV treatment and prevention services.

### **5. Incentivize partner country self-reliance:**

No country or regional program should be ended abruptly. The United States should consider how to 1) accelerate the orderly transition of several middle-income partner countries to self-reliance in HIV control, aided by continued U.S. technical expertise, and 2) support countries to increase domestic resources for health in settings that continue to have large U.S. service delivery investments. This transition will require a transparent strategy with strong benchmarks that establishes a comanagement relationship with partner governments; focused high-level U.S. diplomatic outreach to heads of state and finance ministers, the World Bank and regional banks, the private sector, and others; and clear metrics to monitor continued progress and avoid backsliding. Transitions must be managed in a way that protects those most vulnerable in the HIV epidemic.

### **6. Maintain HIV vaccine and cure research:**

U.S. scientific and research institutions have been instrumental in developing many of the tools that have

led to success in fighting HIV. While focused investment toward epidemic control is essential, the United States should also continue its research toward identifying an HIV vaccine and cure.

## **HIV at the Turn of the Millennium: U.S. Leadership on HIV Advances U.S. National Interests**

In 2000, there were 34.3 million people living with HIV worldwide and 18.8 million had already died.<sup>7</sup> An estimated 15.6 million children were projected to have lost their mothers or both of their parents in 23 countries heavily affected by HIV/AIDS.<sup>8</sup> Southern Africa was particularly hard-hit; in several countries, approximately a quarter of the population was living with HIV. In Botswana, 35.8 percent of the population was living with HIV.<sup>9</sup>

In January 2000, the National Intelligence Council issued a National Intelligence Estimate, entitled “The Global Infectious Disease Threat and Its Implications for the United States,” in which it concluded that “persistent infectious disease burden is likely to aggravate and, in some cases, may even provoke economic decay, social fragmentation, and political destabilization in the countries.”<sup>10</sup> It predicted reductions in life expectancy by as much as 30 years or more in heavily affected countries by 2010.<sup>11</sup>

*At least some of the hardest hit countries, initially in Sub-Saharan Africa and later in other regions, will face a demographic catastrophe as HIV/AIDS and associated diseases reduce human life expectancy dramatically and kill up to a quarter of their populations [by 2010]. This will further impoverish the poor and often the middle class and produce a huge and impoverished orphan cohort unable to cope and vulnerable to exploitation and radicalization.*<sup>12</sup>

## **U.S. Leadership Centers on a Proven Formula for Success**

It is easy to forget that fighting HIV/AIDS, especially in sub-Saharan Africa, was once seen by some as a lost cause. Effective antiretroviral treatment (ART) started becoming available in the United States and other countries in 1996. For those in sub-Saharan Africa, ART was locally available in only a couple of countries; as a result, only 50,000 Africans were on ART in 2000. Some worried that Africans could not take medication on a set time regimen when they did not have clocks or watches. Unless you could afford to travel to the United States or another country where treatment was available, HIV was seen as a death sentence, taking its toll on the continent.

While still trying to manage the HIV epidemics in their own countries, the magnitude of the AIDS crisis around the world, particularly in Africa, was resonating in Washington and other capitals (see Appendix: HIV Action before the Game Changers for more background). However, most of the efforts by the United States and other governments were small in scale and resources relative to the scope and breadth of the numbers of affected countries and people. President Bill Clinton's Leadership and Investment in Fighting an Epidemic (LIFE) initiative, announced in July 1999 to address the global AIDS pandemic, increased U.S. support for sub-Saharan African countries and India by \$100 million in the FY 2000 budget.<sup>13</sup>

Following the publication of the January 2000 National Intelligence Estimate, the United States began steadily increasing resources for global HIV efforts. In FY 2002, it provided \$988 million—a 36 percent increase over FY 2001. In 2002, President George W. Bush launched the two-year, \$500 million International Mother and Child HIV Prevention (PMTCT) initiative designed to reduce mother-to-child transmission by increasing testing, counseling, and prevention for pregnant women, delivering ART to the mothers and infants, and building healthcare delivery systems to reach women with care<sup>14</sup> in 12<sup>15</sup> African countries and the Caribbean.<sup>16</sup> In his FY 2003 Budget, President Bush proposed \$1.1 billion in global HIV/AIDS assistance—a 13 percent increase.<sup>17,18</sup>

## Game Changers

The global game changers came in 2002 and 2003. First, in January 2002, the United States joined with France, the United Kingdom, the Bill & Melinda Gates Foundation, and other donors to establish the Global Fund,<sup>19</sup> a financing mechanism aimed at directing resources to fight HIV, tuberculosis, and malaria. The United States also made the founding pledge to the Global Fund. The fund was unique in bringing together governments, foundations, private-sector companies, multilateral organizations such as the United Nations, faith-based and other nongovernmental organizations, and people living with the diseases. This composition of stakeholders is evident at the headquarters level in the board and committees as well as at the country level in the Country Coordinating Mechanisms (CCMs), which are responsible for developing grant proposals, selecting organizations to serve as principal recipients (PRs), and monitoring implementation. As a financing mechanism, the Global Fund relies on PRs to implement the grants in country and local funding agents (LFAs) to “monitor program implementation, ensure financial

accountability, and provide funding recommendations to the Secretariat.”<sup>20</sup> Since 2002, the fund has worked in more than 120 countries,<sup>21</sup> with 405 active grants in more than 100 countries.<sup>22</sup> As of August 2017, the fund had disbursed \$35.1 billion in grant disbursements across all three diseases and in support of health systems.<sup>23</sup>

Second, in his January 2003 State of the Union message, President Bush recognized a calling for the United States to make the world better not just safer:

*Ladies and gentlemen, **seldom has history offered a greater opportunity to do so much for so many.** We have confronted, and will continue to confront, HIV/AIDS in our own country. And to meet a severe and urgent crisis abroad, **tonight I propose the Emergency Plan for AIDS Relief, a work of mercy beyond all current international efforts to help the people of Africa.** This comprehensive plan will prevent 7 million new AIDS infections, treat at least 2 million people with life-extending drugs and provide humane care for millions of people suffering from AIDS and for children orphaned by AIDS. I ask the Congress to commit \$15 billion over the next five years, including nearly \$10 billion in new money, to turn the tide against AIDS in the most afflicted nations of Africa and the Caribbean.*

Congress quickly passed the United States Leadership Against Global HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (P.L. 108-25) authorizing creation of the President's Emergency Plan for AIDS Relief (PEPFAR). On May 27, 2003, President Bush signed the bill into law. The initial strategy targeted 14 countries, which accounted for more than half of the world's HIV cases at the time: Botswana, Côte d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia.<sup>24</sup> Vietnam was added as the 15th country in June 2004. Some countries were already implementing PMTCT activities upon which PEPFAR would build, but implementation under PEPFAR began in 2004. PEPFAR has subsequently been reauthorized twice, in 2008 and 2013. PEPFAR now supports programs in more than 60 countries with planning and reporting requirements for any country or regional programs receiving more than \$5 million in U.S. investment annually.<sup>25</sup>

During his administration, President Barack Obama called for PEPFAR to work toward an AIDS-free generation and increasing its annual programmatic targets.

Since 2002, U.S. engagement on HIV—through both PEPFAR and the Global Fund—has rested on an exceptional bipartisan base of support in Congress,

backed by a diverse coalition of the faith community, the private sector, security experts, foundations, universities, NGO implementers, civil society groups, and advocates. Fighting HIV is a special place in our politics where Democrats and Republicans, liberals and conservatives, have found common ground. Deft diplomacy has brought forward financial investments from partner governments, other donors, and private corporations. This formula for success remains as valid today as it was in 2003.

## **U.S. Investment in Global HIV**

Since FY 2004, the United States has invested nearly \$73 billion toward global HIV through bilateral PEPFAR and TB funding and the Global Fund.<sup>26</sup> The majority (\$57 billion) has been directed through bilateral PEPFAR programs; of that amount, approximately 80 percent has been allocated to high burden countries in sub-Saharan Africa. Per the 2013 authorizing legislation, 50 percent of annual funding must go to treatment-related activities and 10 percent to orphans and vulnerable children programs.<sup>27</sup> For FY 2017, Congress appropriated \$5.220 billion to PEPFAR for HIV.<sup>28</sup> The majority is appropriated through the State and Foreign Operations bill to the Department of State for management by the U.S. global AIDS coordinator. Smaller amounts are appropriated to the U.S. Agency for International Development (USAID), Centers for Disease Control and Prevention (CDC), and NIH.

The United States contributes approximately one-third of Global Fund's annual resources. The first U.S. contribution was in FY 2001 through annual appropriations bills. Of the \$15.3 billion congressionally appropriated to the Global Fund through FY 2017, the United States had disbursed over \$12.9 billion to the Fund as of June 30, 2017.<sup>29</sup> For the current three-year Global Fund funding cycle (2017–2019), the United States pledged a total of \$4.3 billion out of \$12.9 billion committed by all global actors.<sup>30</sup> In the original authorizing legislation for PEPFAR, Congress required that annual U.S. contributions to the Global Fund not exceed 33 percent of total contributions from all donors. With its strict 2:1 matching requirement, the U.S. investment has leveraged an additional \$25 billion from other donors, as well as significant and growing coinvestments by countries receiving Global Fund grants.

Funding for bilateral PEPFAR programs increased exponentially over the first six years of the program (2004–2009). However, since a peak of \$5.574 million in 2010, U.S. funding for global HIV decreased to \$4.709 million in FY 2013 and then slightly recovered and plateaued at around \$5.2 million per year.<sup>31</sup> In an era of budget constraints, some see the plateau as a success.

PEPFAR has been able to continue to increase new numbers of people on treatment despite these trends. An accumulated pipeline of resources funded the scale-up between 2011 and 2014. Addressing “inefficiencies and ineffectiveness” allowed PEPFAR to increase treatment by 50 percent in the last three years despite a flat budget.<sup>32</sup>

President Trump's FY 2018 budget proposal signals a potential major reversal in U.S. leadership on global HIV. The Trump administration's proposed \$2 billion-plus in cuts to global health in its FY 2018 budget, including \$1.1 billion from international HIV/AIDS programs, which is an 18 percent reduction to PEPFAR and the Global Fund. The proposal also calls for a 23 percent cut to the National Institutes of Health's National Institute of Allergy and Infectious Diseases (NIH/NIAID), which supports HIV research. The full House Committee on Appropriations counterbalanced the president by approving flat-lined PEPFAR bilateral funding in the FY 2018 State and Foreign Operations (SFOPs) bill.<sup>33</sup> If approved in the final budget legislation, PEPFAR bilateral funding would stay at the FY 2017 level at \$4.650 million, which is \$800 million above the president's FY 2018 request.<sup>34</sup> However, it is unclear what the final FY 2018 levels will be at the time of this report's publication.

Despite a stated expectation that other donors increase their commitments, reductions in U.S. investment would come at a time of significant concern over the levels of funding for global HIV activities. In recent years, many other donor governments have eliminated or significantly downgraded their bilateral HIV programs in affected countries, opting in some cases for greater investment in the Global Fund or to redirect to other development priorities. From a peak of \$8.6 billion in donor government disbursements for HIV in 2014, the amount fell in 2015 to \$7.5 billion.<sup>35</sup> In 2016, total HIV disbursements further decreased by a net of \$108 million; 11 out of 14 donors' disbursements decreased, while 3 increased or remained flat.<sup>36</sup> France, the United Kingdom, the Netherlands, and Germany remain among the top donor governments. According to UNAIDS estimates, \$26.2 billion a year will be needed by 2020 to meet the global targets to end AIDS by 2030. The gap between the 2016 HIV funding disbursements of \$7.0 billion and the global need in 2020 is thus \$19.2 billion—a sizable gap, which could potentially grow if the Trump administration continues to push for reduced U.S. contribution.

## **U.S. Global HIV Approach: Departure from Traditional Development Programs**

The United States has maximized its investment in HIV over the last 15 years by investing in health

infrastructure and research; directing resources bilaterally and multilaterally through PEPFAR and the Global Fund; utilizing a whole-of-government approach both centrally and in the field; demanding data use and accountability; learning from new science and mistakes; and use of public-private partnerships.

**Health Infrastructure Investments**

When PEPFAR first started, health systems to address the care and treatment needs of the millions of people living with HIV in the 15 focus countries were either nonexistent or completely severely under-equipped to address the care and treatment needs of the millions of people living with HIV in the 15 focus countries. The United States had to invest in the rehabilitation or construction of health facilities, train healthcare workers, create data and supply chain management systems, and build its own public health, development, diplomatic, and defense operational platforms to get activities started and drugs moving. U.S. programmatic interventions have been supported by ongoing research and scientific advancements that have delivered new drug combinations, prevention tools, and insights, which have led to efficiencies in cost and service delivery.

**Use of Bilateral and Multilateral Channels**

U.S. investment is directed through two different but complementary channels, which allows the United States to fight HIV more comprehensively from multiple fronts. PEPFAR and the Global Fund complement each other because they utilize very different approaches that together support both immediate acceleration of HIV programs as well as longer-term, and perhaps more sustainable, development of national capacity and commitment by affected countries.

PEPFAR and the Global Fund work in tandem in countries to support the national response; activities have been de-duplicated at country level to ensure they are complementary and additive.<sup>37</sup> They are fundamentally intertwined at the headquarters and country levels, which means any funding reductions in one undermines the potential of the other to achieve the U.S. government’s HIV goals. See the companion piece “The Global Fund and PEPFAR: Complementary, Successful, and Under Threat” for more information on how the two work together.

**Whole of Government**

PEPFAR was uniquely designed to apply the exceptional, diverse expertise of seven U.S. government departments and agencies<sup>38</sup> and effectively capitalize on the resources

of other health, development, diplomacy, and defense activities and the leadership role of ambassadors in each country. Its power is in the collective planning, implementation, and evaluation at headquarters and in the field to ensure the best approaches are utilized. The approach allows PEPFAR to intervene and have impact at various levels (national, district, local governments, and community). Implementation in the field utilizes the technical expertise and procurement mechanisms of multiple agencies.

Department or Agency	Sub-Entity
Department of State	Office of the Global AIDS Coordinator and Global Health Diplomacy; Bureau of Population, Refugees, and Migration; regional bureaus and embassies
U.S. Agency for International Development	Bureau for Global Health; Bureau for Economic Growth, Education, and Environment; Youth Power; Bureau for Food Security; Senior Coordinator for Gender Equality and Women’s Empowerment; Bureau for Democracy, Conflict, and Humanitarian Assistance
Department of Health and Human Services	Office of Global Affairs, Centers for Disease Control and Prevention, Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration, National Institutes of Health, domestic U.S. government national and state AIDS programs
Department of Defense	Navy HIV/AIDS Prevention Program and Walter Reed Army Institute of Research
Peace Corps	
Department of Treasury	
Department of Labor	

The U.S. global AIDS coordinator is an ambassador-level position based at the U.S. Department of State with authority over the all U.S. global HIV resources. The position was uniquely created by statute to ensure a whole-of-government approach to managing PEPFAR. At headquarters, the global AIDS coordinator works in close coordination with the other departments and agencies through various management and technical entities. Maintaining centralized budget and planning control has been essential to PEPFAR's success by ensuring consistency across multiple agencies and country and regional programs. At the country level, the U.S. ambassador leads the program often with day-to-day support from a country coordinator and the agencies present in country, which may include USAID, CDC, Peace Corps, Department of Defense (DoD), and Department of State. In some countries, a Department of Treasury representative is imbedded at the Ministry of Finance to provide technical assistance related to financial planning, systems, and accountability.

PEPFAR-funded activities take many shapes and are largely delivered in country by USAID and CDC through implementing partners or direct technical assistance to host government ministries. Together these two agencies account for upwards of 94 percent<sup>39</sup> of PEPFAR resources directed through annual Country Operational Plans (COPs), which detail how congressionally appropriated funds will be spent and to how activities will deliver on specific targets and goals. U.S. country teams must allocate resources according to annual programmatic and technical guidance from the Office of the Global AIDS Coordinator on all areas of treatment, prevention, and care, as well as health systems, surveillance, and monitoring and evaluation.

In addition to the two largest PEPFAR implementing agencies, Peace Corps volunteers work with local communities and implement small grants largely focused on HIV awareness and prevention. DoD's Department of Navy HIV/AIDS Prevention Program (DHAPP) works with uniformed services, their families, and surrounding communities, and the Department of Army's Walter Reed Institute of Research (WRAIR) conducts vital HIV research and provides direct service delivery in some instances. NIH also conducts research in several countries that informs new HIV diagnostic, prevention, and treatment approaches.

PEPFAR also has been successful because it leveraged existing programs including a legacy of USAID programs targeting maternal, newborn, and child health; family planning and reproductive health; and orphans and

vulnerable children; DoD and HHS research projects; and U.S. domestic experience from HHS's Health Services and Resources Administration (HRSA). Over the years, PEPFAR has actively worked to leverage these other efforts, which are now captured in each annual COP's Strategic Direction Summary Table 2.2.3.

## Partnerships

Beyond the internal U.S. government program leveraging, PEPFAR has partnered with other governments, private sector, civil society, donors, multilaterals, and foundations to advance its work and goals against HIV. Public-private partnerships (PPPs) enable multiple entities to contribute monetary and in-kind resources toward a common objective. PEPFAR has engaged in many PPPs since its inception, such as Saving Mothers, Giving Life; Pink Ribbon, Red Ribbon; Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe (DREAMS) women; and the Accelerating Children's HIV/AIDS Treatment (ACT) initiative.<sup>40</sup> See the companion piece "The Next Frontier" for more information on DREAMS.<sup>41</sup>

Governments themselves have been increasing their own contributions to their national HIV responses. Domestic investment amounts to nearly 60 percent of HIV spending in low- and middle-income countries and increased by an average of 11 percent a year from 2006 to 2016.<sup>42,43</sup> India pays for more than 80 percent of its national HIV program, while South Africa pays for 77 percent of its response.<sup>44</sup> In 2016, the Global Fund strengthened cofinancing requirements and incentives for country partners to help accelerate the contributions by governments.<sup>45</sup> The U.S. Treasury is helping countries improve public financial management of their health resources, facilitate communication between health and finance ministries, and produce sustainable plans for increasing domestic resource allocations for HIV.<sup>46</sup> See the companion piece "Advancing Country Partnerships on HIV/AIDS" for more information on local government financing.<sup>47</sup>

## Emphasis on Data and Accountability

Both PEPFAR and the Global Fund were developed in an era where skepticism of foreign assistance and multilateralism was especially high. They were explicitly designed from the outset to be different from, and somewhat independent of, other longstanding global health initiatives by being more accountable, transparent, and results-focused. PEPFAR's ability to demonstrate progress and results against targets has been critical in persuading Congress to continue robustly funding the program. In recent years, PEPFAR has put even greater emphasis on data, accountability, and transparency

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## U.S.-LED SCIENTIFIC ADVANCEMENT

U.S. research institutions, for example, NIAID, CDC, DoD, and universities, have shaped the global scientific HIV/AIDS response. Networks of laboratories, clinics, and collaborators within the United States and throughout the world have enabled them to advance our basic understanding of HIV, develop prevention and treatment tools, and work toward finding a cure.

For example, a NIAID study was the first to establish efficacy of PrEP, by demonstrating that taking a daily pill significantly reduces the risk of HIV acquisition among high-risk groups. CDC collaborated with the Bangkok Metropolitan Administration and Thailand Ministry of Public Health to complete the first study of PrEP use among people who inject drugs. The so-called Bangkok Tenofovir Study showed that taking daily tenofovir reduces HIV infection by 49 percent among all trial participants and 74 percent among consistent users. NIAID also supports basic research into microbicides<sup>51</sup> as a tool to reduce the risk of infection as well as clinical trials of other tools, including the large, multinational ASPIRE trial that showed efficacy of a vaginal ring in protecting women against HIV.

In addition, U.S.-based groups continue to search for an effective vaccine to prevent HIV, the gold standard of prevention. Jointly with the Royal Thai government, the U.S. government conducted the RV144 trial, the first HIV vaccine regimen to show some efficacy against HIV. The vaccine showed 60 percent efficacy one year after vaccination and 31.2 percent after 3.5 years. This trial has informed and inspired more vaccine research. Most notably, the HVTN 100 vaccine trial, funded by NIH, was based off the RV144 vaccine but modified to address the HIV subtype in South Africa. This smaller vaccine trial was a promising precursor to the ongoing, larger HVTN 702 trial, funded by NIAID. U.S. scientists not only contributed to the development of these promising vaccine candidates but also continue to generate and test new preventative vaccine ideas.

NIAID's research precipitated several antiretroviral drugs, and it continues to work to improve the efficacy of ART. Beyond treatment, NIAID and others are working to develop a cure by sustaining viral remission (functional cure) or eradicating the virus.<sup>52</sup> Stem cell transplantation and gene therapy are being explored as promising methods for cure development.

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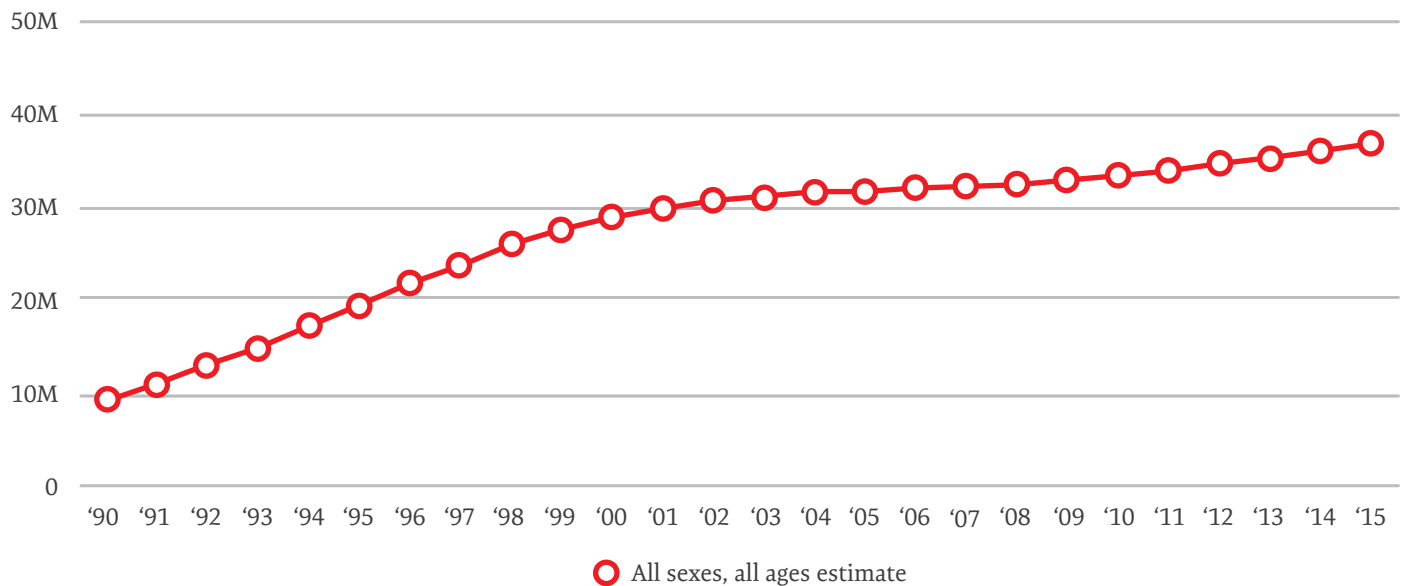
as pillars of the PEPFAR 3.0 approach outlined in the "PEPFAR Blueprint: Creating an AIDS-Free Generation" issued in 2012.<sup>48</sup> It has introduced the PEPFAR Dashboards to make data publicly available.

### Using Data to Inform Learning and Change

Both PEPFAR and Global Fund have moved away from emergency responses in order to build greater sustainability and achieve long-term epidemic control. This shift has been fueled by science and implementation lessons from the United States. Over the past 15 years, PEPFAR and Global Fund have adopted new approaches and tools, often a direct result of U.S. supported research, advanced by researchers and programmatic partners. For example, PEPFAR began requiring voluntary medical male circumcision (VMMC) be integrated into programs as a key prevention tool after research demonstrated that VMMC reduces the risk of female-to-male sexual transmission of HIV by approximately 60 percent.<sup>49</sup> Similarly, PEPFAR has begun utilizing PrEP for high-risk groups following research indicating that taking daily, oral ART can prevent HIV infection if taken as directed. Further, research also demonstrated that people living with HIV who take their ART consistently can reduce their viral load to undetectable levels that mean they will not pass on the virus.<sup>50</sup> It is possible that adoption of other new technologies that have demonstrated promise, such as vaginal rings or injectable ART for life-long treatment and for PrEP, could create efficiencies and lower costs of HIV prevention and treatment in addition to saving lives. These efficiencies should be quantified with projected impact modeled to inform future programmatic decisions.

New HIV approaches also have been informed by surveillance and 10 years of program data. Since 2014, PEPFAR has employed a more targeted approach to reach populations and geographies not only hardest hit by HIV and AIDS but also with the largest concentration of new infections. By collecting and analyzing data at the facility and community site level, PEPFAR has been able to make more targeted decisions about where to direct financial and human resource investments to have the most impact on the epidemic. Coupled with the scientific advancements detailed above, this new approach gives PEPFAR the ability to get the most people onto treatment and prevent new HIV infections.

**Figure 1: Annual Numbers of People Living with HIV (All Ages) Worldwide<sup>58</sup>**



## What U.S. Investments Have Achieved

### Protected U.S. National Security

Fundamentally, PEPFAR was designed to protect Americans at home by answering dangerous health security threats abroad. This remains relevant today—U.S. commitment successfully confronts head-on the genuine threat that a runaway HIV epidemic in eastern and southern Africa will gut these societies and economies and spread instability. Since its inception, PEPFAR has served the interests of the United States through the economic stabilization and growth of the countries with PEPFAR investments and the broader reductions in insecurity. ART has enabled HIV-positive teachers, entrepreneurs, government officials, and others to live, work, and contribute to their economies, which has created markets for U.S. goods and opportunities for U.S. private-sector investment. In 10 sub-Saharan African countries, PEPFAR funding was associated with a 13 percent increase in employment among males, which translates into economic benefits equaling one half of the money spent on PEPFAR.<sup>53</sup> In addition, countries with PEPFAR programs have experienced a 40 percent reduction in political instability and violent activity compared to a 3 percent reduction in those without a PEPFAR program in the same region.<sup>54</sup> Further, from 2007 to 2011, the approval rating of U.S. leadership is 68 percent in PEPFAR countries compared to the global average of 46 percent.<sup>55</sup>

### Transformational Impact on the Pandemic

The U.S. contribution to overall accomplishments against

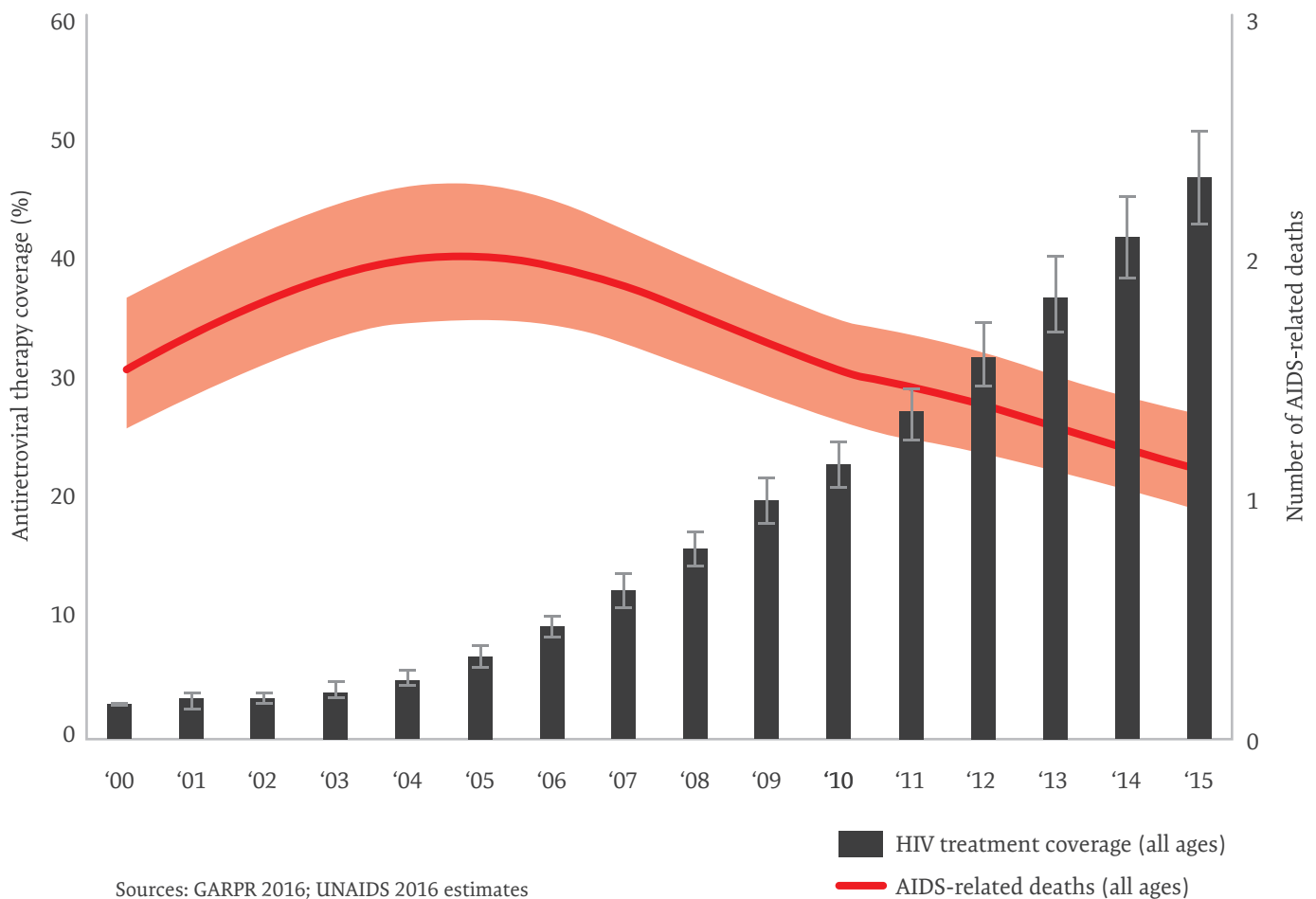
HIV cannot be overstated. In July 2017, UNAIDS released its 2017 Annual Report, which provided a status update on the pandemic as of the end of 2016 based on data submitted by 168 countries. The report highlighted some very good news on the impact of U.S. and other investment on the numbers of people on treatment, annual deaths, and progress toward the 90-90-90 goals.

In 2016, an estimated 36.7 million people worldwide were living with HIV; 94 percent are adults 15 years or older.<sup>56</sup> The numbers of people living with HIV increased rapidly through the 1990s until the mid-2000s when U.S. investment through Global Fund and PEPFAR started (see Figure 1). Since then, the rates have been largely steady until the last few years. The clear majority of people living with HIV, approximately 25.5 million, continue to live in sub-Saharan Africa, with 19 million in East and Southern Africa.<sup>57 58</sup>

For the first time in 2016, more than half of all people living with HIV—53 percent—were on ART, which equates to more than 19.5 million (Figure 2). As HIV treatment has expanded, deaths have also come down. There has been a 42 percent decline in deaths since 2010. New infections also have declined since 2010: by an estimated 11 percent among adults (from 1.9 million per year to 1.7 million) and by 47 percent among children (from 300,000 to 160,000 per year).<sup>59</sup>

**Of those on treatment worldwide, 63 percent are supported by U.S. investment.** As of March 31, 2017, U.S. support through PEPFAR and the Global Fund contributes to ART for 12.3 million people living with

**Figure 2: Antiretroviral Therapy Coverage and Number of AIDS-related Deaths, Global, 2000–2015**



HIV out of the 19.5 million on treatment worldwide.<sup>60</sup> Nearly 2 million babies have been born free of HIV due to PEPFAR support of PMTCT programs. PEPFAR has supported more than 12.5 million VMMC for prevention. PEPFAR’s work has averted an estimated 11.3 million HIV infections<sup>61</sup> and contributed to a 43 percent reduction in AIDS-related deaths since 2000.<sup>62</sup>

At a country level, U.S. investment has substantially changed the epidemics as illustrated in Table 1 showing the change in each of the original 15 PEPFAR focus countries. The greatest degree of progress has occurred in eastern and southern Africa where U.S. investment has been targeted since 2003. In addition to annual COP investments, PEPFAR also has targeted many central initiatives toward the region including ACT and DREAMS. As a result, 79 percent of those who know their status are on treatment and AIDS-related deaths have been cut nearly in half in six years.<sup>63 64</sup>

## We Know What Needs to Happen Next

### Epidemic Control

U.S. investment and its resulting accomplishments have transformed countries and “bent the curve” of the pandemic, which has presented a tremendous moment of opportunity. Data and modeling indicate that with accelerated HIV treatment initiation and resulting viral suppression, along with intensified prevention efforts to stop new infections, by 2020, there is the opportunity to “break” the epidemic, but the window is very small. With accelerated action now, UNAIDS predicts 28 million new HIV infections could be averted, which would save millions of lives but also make fighting the pandemic more manageable in terms of numbers of affected and cost. That acceleration requires intensified political leadership and financial investment. The level of investment needed, as noted earlier in the financing section, is \$26 billion annually by 2030, but achieving the goals would result in a 15-fold return on investment.<sup>66</sup> Without it, modeling<sup>67</sup> shows that HIV

**Table 1: Impact of U.S. Investment in the Original 15 PEPFAR Focus Countries<sup>64</sup>**

Country	2003		2015	
	New infections per year <i>all ages</i>	% of pop. living with HIV <i>ages 15-49</i>	New infections per year <i>all ages</i>	% of pop. living with HIV <i>ages 15-49</i>
<b>Botswana</b>	19,000	25.7	10,000	21.9
<b>Côte d'Ivoire</b>	43,000	5.6	20,000	2.7
<b>Ethiopia</b>	44,000	2.7	30,000	1.1
<b>Guyana</b>	<1,000	1.1	<100	1.6
<b>Haiti</b>	11,000	2.5	7,900	2.1
<b>Kenya</b>	95,000	8.4	62,000	5.4
<b>Mozambique</b>	180,000	12.9	83,000	12.3
<b>Namibia</b>	15,000	15.7	9,600	13.8
<b>Nigeria</b>	290,000	4.1	220,000	2.9
<b>Rwanda</b>	16,000	4.5	7,500	3.1
<b>South Africa</b>	520,000	16.4	270,000	18.9
<b>Tanzania</b>	100,000	7.9	55,000	4.7
<b>Uganda</b>	100,000	8.2	52,000	6.5
<b>Vietnam</b>	27,000	0.3	11,000	0.4
<b>Zambia</b>	74,000	14.3	59,000	12.4

rates will rebound and grow, especially given the size of the youth populations in many highly affected countries, beyond the world's collective ability to rein it in again.

The good news is that Public Health Impact Assessments (PHIAs) in Malawi, Zimbabwe, and Zambia, released in 2016, show that with aggressive treatment scale-up epidemic control at country-level is possible and in reach. Since the start of PEPFAR, new HIV infections have declined by 76 percent, 67 percent, and 51 percent respectively, and all three countries are on the path to achieving UNAIDS's 90-90-90 goals. On July 24, 2017, PEPFAR released the results of the fourth PHIA conducted in Swaziland, which like Malawi and Zimbabwe was also supported by the Global Fund, indicating coverage of ART among adults at more than 80 percent.<sup>68</sup> In addition, since 2011, new HIV infections were nearly halved and HIV viral load suppression has doubled.

## 90-90-90

In 2014, UNAIDS unveiled its Fast Track targets to end HIV as a public health threat by 2030. The targets include 1) achieving “90-90-90” goals for HIV diagnosis, treatment, and viral suppression and a reduction in new infections in adults to 500,000 a year by 2020 and 2) achieving “95-95-95” and a reduction to 200,000 new adult infections annually by 2030.<sup>65</sup> The targets have been adopted by countries and cities for their national responses, as well as by PEPFAR and the Global Fund. The numbers refer to the treatment cascade. The first number in the sequence is the target number of people living with HIV who have been tested and know their status. The second is the proportion of those who know their status who are taking ART. Of those on ART, the third target is the proportion who have achieved viral suppression. Viral suppression is key because studies have shown that consistent use of ART can lower the levels of the virus in someone's blood to undetectable levels, which then lowers the chance of passing on the virus to a very small chance. Undetectable means untransmissible. Progress toward control of the epidemic is being measured against these goals. Fully achieving 90-90-90 equates to 73 percent of all people living with HIV being virally suppressed. Already 7 countries have achieved or exceed this goal as of 2016 and 11 countries are very close. A handful of countries are already eyeing 95-95-95, such as Cambodia, which would equate to virtual elimination of the virus in their countries.

*The global community decided to move forward on this. No one ever thought that you could control a pandemic without a vaccine or a cure, but we are actually shrinking the pandemic in the future by decreasing the number of new infections. . . . And we are doing that without a vaccine or a cure.—Ambassador Deborah Birx, the U.S. Global AIDS Coordinator and Special Representative for Global Health Diplomacy<sup>69</sup>*

## **HIV Is Not Over Yet**

Behind the rosy topline numbers presented in the 2017 UNAIDS report and in the PEPFAR PHIA data, there are some stark realities for certain populations. First, despite the history-making ART numbers, there are still approximately 17 million people living with HIV in need of treatment and an estimated 30 percent do not know their HIV status. Second, while there has been a drop in new infections in children since 2010, it has proven more difficult to diagnose and treat children. Only 43 percent of children living with HIV have access to ART in 2016, compared to 54 percent of adults. Children are also more likely to be diagnosed late and start treatment with advanced immunodeficiency (as many as two thirds of children under two years old), resulting in a high mortality rate.

Third, compared to the 2020 goal of 73 percent of all people living with HIV being virally suppressed, only 44 percent had achieved viral suppression in 2016—leaving a huge gap that affects their own health but also leaves them vulnerable to passing on the virus. Preventing new infections is still a major hurdle with 1.8 million new infections each year driven by increases in Eastern Europe and Central Asia and North Africa. The new infection rate must decrease exponentially to be truly success against the pandemic.

## **Containing Micro-epidemics Key to Success**

Addressing these challenges and achieving UNAIDS's 90-90-90 goals and control of the pandemic requires targeted interventions at the most granular levels of society to find those most at risk and get them access to services. HIV is an opportunistic disease that affects populations in vastly divergent ways even within a generalized epidemic.

The availability now of site-level data allows for better targeting of “micro-epidemics” where new HIV infections are occurring and addressing the sub-populations that are most at risk. These groups, usually referred to as key populations, often face cultural, societal, and other challenges that not only put them at greater risk but make access to services more difficult. In many countries, their risk of acquiring HIV is exponentially higher than

the general population; the key population group most affected varies from region to region.

Across the world, lesbian, gay, bisexual, transgender, and intersex (LGBTI) populations are particularly vulnerable to HIV because of fear, repression, and denial of rights and protections. “Men who have sex with men . . . are 24 times more likely to acquire HIV, [and] transgender people . . . are 49 times more likely to be living with HIV.”<sup>70</sup> In some countries, LGBTI also are involved in sex work that increases their risk. In others, stigma and discrimination drive LGBTI to drugs, which also increase risk.

*Adolescent Girls and Young Women:* In sub-Saharan Africa, nearly 7,500 adolescent girls and young women are infected with HIV every week, representing almost 75 percent of infections among adolescents and 25 percent of all new infections. Most new HIV infections in this population are connected to gender-based violence and rape,<sup>71</sup> barriers to health services and education, poverty and lack of access to resources, and harmful cultural practices such as child marriage.<sup>72</sup> Higher infection rates among young women are due to a pattern of transmission in which older men (23–35 years old) transmit the virus to adolescent girls and young women (16–23). Later, these young women infect their longer-term partners (young men 24–29) who are not yet living with HIV.<sup>73</sup> See the companion piece “The Next Frontier” for more information on the need to address this important population.<sup>74</sup>

*Youth Bulge:* Complicating efforts to fight HIV, especially among adolescent girls and young women, is the increase in youth in sub-Saharan Africa since the start of the pandemic, largely attributed to the success of U.S. leadership and investments in reducing early childhood deaths through PMTCT, as well as U.S. support for vaccinations and malaria programs. The youth population ages 15–24 has nearly doubled in sub-Saharan Africa since 1990 and is predicted to increase by an additional 30 percent by 2030.<sup>75</sup> Contributing to the youth bulge is high unmet need for family planning, which contributes to high fertility rates in many countries hard-hit by the epidemic. The 15- to 30-year-old age group will continue to grow for decades.<sup>76</sup> Program and PHIA data show that this age cohort in general is less likely to know their HIV status. Less than half of men under 35 years old do not know their status and are not on treatment, which is fueling the epidemic in the 15- to 24-year-old adolescent girls and young women.<sup>77</sup> More effort is needed to reach this age band with HIV prevention, testing, and treatment services, while simultaneously addressing societal norms and other factors that put girls at risk.

## Treatment Isn't Everything

Treatment alone will not ensure achievement of the UNAIDS goals. More investment is needed for aggressive HIV prevention strategies, which include biomedical interventions such as VMMC and PrEP, as well as primary prevention approaches that educate about the risks of HIV. In sub-Saharan Africa in particular, with upwards of 50 percent of many countries' populations under the age of 15, the youth do not remember the heyday of HIV when everyone was sick and/or dying. Continued research into new communication approaches and tools is necessary to keep up with and get ahead of the virus.

Recent study data out of Uganda and Kenya also show that a more holistic health-centered approach has huge value and impact on HIV rates. The SEARCH (Sustainable East Africa Research in Community Health) study is using a streamlined care delivery system in 32 rural communities of roughly 10,000 persons each, in Uganda and Kenya, to quantify the impact of early HIV diagnosis and immediate ART initiation. The goal is to "improve the entire continuum of care, to reduce structural barriers for all populations including those most 'at risk' and build upon evidence based prevention interventions."<sup>78</sup> The study, which began in 2013 and will run until 2020, has already demonstrated significant impact on HIV rates by going beyond HIV to facilitate linkage to care for people who need treatment for diseases, such as malaria, tuberculosis, hypertension, chronic kidney disease, and diabetes. After only two years of service delivery, the communities met the 90-90-90 diagnosis, treatment, and viral suppression targets; most notably, the communities increased viral suppression to 80 percent.<sup>79</sup> Further, the approach had positive results in reaching men and youth with men doubling viral suppression to 76 percent from 39 percent at the baseline. These results indicate that a more integrated health systems approach that address wider health needs of communities may be a better way to do business and have impact on the pandemic.

Further, HIV programs can only be successful if there is a health system in which to deliver services. U.S. investment has greatly increased the capacity of local health systems in countries over the last 15 years—from building or rehabilitating health clinics and laboratories, training health care workers, and strengthening data collection. If the goal is to work the United States out of its role as a leading provider of assistance on health, continuing investments in health systems is essential. A country's capacity to lead its national HIV response goes well beyond funding alone. It must have the technical and administrative capacity as well as the infrastructure and human resources to manage the response.

## Proposed Funding and Programmatic Priority Changes

U.S. leadership on global HIV has been instrumental in achieving huge progress in the battle against HIV. No one would have imagined that 15 years on from the announcement of the Global Fund and PEPFAR would come the opportunity to break the pandemic even without a vaccine or cure. The Trump administration has the opportunity to lead the effort to achieve the 90-90-90 goals by 2020, but it must maintain the fight against HIV as a political priority and commit to concerted programmatic and diplomatic efforts to push it forward. It was the sense of a moral obligation, humanitarian concerns, and national security interests that drove the bipartisan coalition back in 2002 and 2003 to establish the Global Fund and PEPFAR, respectively, even in the face of significant skepticism about the value of foreign aid. That same urgency exists today. With increasing youth populations in many countries and stagnated infection rates, the possibility of HIV reigniting and spinning out of control is real. If that were to occur, the National Intelligence Estimate's predication of "economic decay, social fragmentation, and political destabilization in the hardest hit countries" could become reality. Continuing the fight and win against HIV remains the right thing to do and in America's national interest. Only the United States has the science, tools, knowledge, experience, and wealth to do just that.

The Trump administration's proposal to significantly reduce U.S. investment in global HIV comes at the wrong time. The budgetary pressures on the U.S. government do not reduce the demand for resources needed to achieve the reversal of the epidemic, which is within our grasp. There is a clear case to sustain, if not increase, U.S. investment in HIV, given the success of programming to date and the very real opportunity to achieve epidemic control in numerous countries in the next few years.<sup>80</sup> However, in July 2017, PEPFAR proposed redirecting its efforts toward 13 high-burden countries that have the opportunity for epidemic control in the next few years. The countries include Cameroon, Côte d'Ivoire, Ethiopia, Kenya, Lesotho, Malawi, Namibia, Rwanda, Uganda, Swaziland, Tanzania, Zambia, and Zimbabwe. In these countries, PEPFAR plans to expand HIV prevention and treatment services through "increased performance, efficiency gains, and shared responsibility of all partners"; however, it is unclear what additional efficiencies are left to be found in the program that would enable significant scale-up. Assuming flat or reduced funding levels, the resources to support HIV treatment scale-up would also come from capping treatment initiation in the other 50 countries PEPFAR supports and

redirecting those resources toward the 13. Given that the 13 countries are those closest to epidemic control, they are not the countries that are seeing dramatic increases in new infections. Countries like Mozambique, South Africa, the Democratic Republic of Congo, Nigeria, Ukraine, and the Central Asia regional program are left off the list, which raises concerns about what will happen to those epidemics without concerted HIV prevention and treatment services.

It is unreasonable to ask the United States to fill the resource gap alone, thus increased investments by major donors as part of the Global Fund's 2016 replenishment are welcome. Other donor countries must do their part, and additional partnerships must be formed that can harness the collective academic, civil society, and private-sector knowledge toward the goals. DREAMS offers lessons about how to form and implement PPPs that maximize the equity of each partner, and more can be done to use those lessons to engage local business in highly affected countries and get them involved in the national HIV responses.

While partner countries have been stepping up politically and financially in recent years, most are not ready to assume full responsibility for the national HIV response. If there are decisions to significantly reduce or eliminate funding in the future, those decisions should be made in a well-planned manner that is appropriate for the epidemic in each country. The United States must plan for transition to country ownership transparently and collaboratively with those countries and help them plan for success to ensure that the achievements of America's investments through PEPFAR and the Global Fund are sustained. Cutting funding for HIV programs without a transition plan that ensures patients continue to get their treatment is irresponsible and immoral.

There also have been proposals as part of the ongoing debate surrounding reorganization of the U.S. foreign affairs and assistance apparatus about whether ownership of PEPFAR should remain at the State Department. As noted earlier, PEPFAR was uniquely designed to apply the exceptional, diverse expertise of seven U.S. government departments and agencies. The U.S. global AIDS coordinator position was uniquely created by statute and intentionally ensconced at State to ensure a whole-of-government approach to managing PEPFAR and minimize the competition between the agencies. This whole-of-government of approach should be maintained under the leadership of the U.S. global AIDS coordinator at the Department of State.

## Recommendations

### **THE TRUMP ADMINISTRATION AND CONGRESS SHOULD FOCUS THEIR GLOBAL HIV/AIDS EFFORTS ON THE FOLLOWING SIX PRIORITIZED, FUTURE-ORIENTED GOALS.**

They respond to the emerging challenge of better leveraging the U.S. government's HIV investments to success in controlling HIV and continuing with successful implementation even with tight budgetary constraints, which will require disciplined managerial capacities and innovative program execution.

**1. Protect the U.S. approach to global HIV:** The multifaceted U.S. approach to fighting HIV through investments in PEPFAR, the Global Fund, and research has been a tremendous success, and should be maintained. PEPFAR was uniquely designed to apply the exceptional, diverse expertise of seven U.S. government departments and agencies<sup>81</sup> and capitalize effectively on the resources of other health, development, diplomacy, and defense activities and the leadership role of ambassadors in each country. This whole-of-government approach should continue to underpin the work of the U.S. global AIDS coordinator at the Department of State, which oversees the PEPFAR program. In addition, the United States should sustain its investments to the Global Fund and to the National Institutes of Health, which enable the U.S. government to fight HIV more comprehensively from multiple fronts and with the most effective and efficient interventions. PEPFAR and the Global Fund work in tandem in countries to support the national response; activities are complementary, additive, and intertwined. The U.S.-supported research agenda has led to numerous innovations in tools and approaches that have provided the incredible opportunity to achieve epidemic control<sup>82</sup> in many hard-hit countries.

**2. Achieve HIV epidemic control:** PEPFAR data shows that epidemic control is possible in the near-term in at least 13 partner countries<sup>83</sup> in sub-Saharan Africa. The key priority for the U.S. government should be achieving the epidemic control goal in those countries by scaling PEPFAR-supported services up strategically, in partnership with the Global Fund, the host government, and other partners.

**3. Sustain investments to prevent backsliding:** While focused effort to achieve epidemic control will be resource intensive in the 13 countries, HIV prevention and treatment scale-up should continue to the extent financially and programmatically feasible in the other 50 PEPFAR countries that are not yet near epidemic control. It would be foolish to risk epidemic rebound in the other countries just to ensure epidemic control in those closest to achieving

it. Smart investments are needed to keep the countries with longer timelines to epidemic control on a positive trajectory even if that trajectory is slower paced than the 13 countries targeted for near-term epidemic control.

#### **4. Invest in programs for adolescent girls/young women:**

In many parts of east and southern Africa, areas that continue to have the highest numbers of people living with HIV, adolescent girls and young women face substantially higher risk of HIV infection than males their age. This difference stems from social and economic factors and is exacerbated by the historic rise in the youth population. To be successful, the United States should continue to concentrate on preventing HIV in adolescent girls and young women while simultaneously reaching their 15- to 35-year-old male partners with HIV treatment and prevention services.

#### **5. Incentivize partner country self-reliance:**

No country or regional program should be ended abruptly. The United States should consider how to 1) accelerate the orderly transition of several middle-income partner countries to self-reliance in HIV control, aided by continued U.S. technical expertise, and 2) support countries to increase domestic resources for health in settings that continue to have large U.S. service delivery investments. This transition will require a transparent strategy with strong benchmarks that establishes a comanagement relationship with partner governments; focused high-level U.S. diplomatic outreach to heads of state and finance ministers, the World Bank and regional banks, the private sector, and others; and clear metrics to monitor continued progress and avoid backsliding. Transitions must be managed in a way that protects those most vulnerable in the HIV epidemic.

#### **6. Maintain HIV vaccine and cure research:**

U.S. scientific and research institutions have been instrumental in developing many of the tools that have led to success in fighting HIV. While focused investment toward epidemic control is essential, the United States should also continue its research toward identifying an HIV vaccine and cure.

## Appendix

### HIV Action before the Game Changers

In 1994 the UN Economic and Social Council issued a resolution establishing the Joint United Nations Programme on HIV and AIDS (UNAIDS), which was formally launched in January 1996. UNAIDS takes the lead role in driving accelerated, comprehensive, and coordinated global action on the HIV/AIDS pandemic.

In June 1996, President Bill Clinton issued a Presidential Decision Directive calling for a more focused U.S. policy on infectious disease. On July 19, 1999, President Clinton announced the Leadership and Investment in Fighting an Epidemic (LIFE) initiative to address the global AIDS pandemic and Congress funded his request to increase U.S. support for sub-Saharan African countries and India by \$100 million in the FY 2000 budget.<sup>84</sup>

In 2000, 12-year-old South African Nkosi Johnson addressed the International AIDS Society conference in Durban. He challenged the denialism permeating his government and implored the congregation to bring ART to the continent.

In January 2000, the National Intelligence Council issued a National Intelligence Estimate, entitled “The Global Infectious Disease Threat and Its Implications for the United States,” in which it concluded that “persistent infectious disease burden is likely to aggravate and, in some cases, may even provoke economic decay, social fragmentation, and political destabilization in the hardest hit countries.”<sup>85</sup>

From June 25–27, 2001, the United Nations General Assembly held a special assembly and issued a declaration of commitment on HIV/AIDS “Global Crisis–Global Action” in which member states acknowledged deep concern about the scale and impact of the pandemic, particularly in developing countries, and committed to secure a global commitment to review and address the problem of HIV/AIDS in all its aspects as well as to secure a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat it in a comprehensive manner.<sup>86</sup>

In 2002, President George W. Bush launched the two-year, \$500 million International Mother and Child HIV Prevention (PMTCT) initiative designed to prevent mother-to-child transmission. The goals were to increase testing, counseling, and prevention for pregnant women, deliver ART to the mothers and infants, and build healthcare delivery systems to reach women with care.<sup>87</sup> The initiative aimed to reach up to 1 million women

annually and reduce mother-to-child transmission by 40 percent within five years or less in 12<sup>88</sup> African countries and the Caribbean.<sup>89</sup> In his remarks introducing the initiative, President Bush stated that “The United States already contributes approximately a billion dollars a year to international efforts to combat HIV/AIDS. In addition, we plan to spend more than \$2.5 billion on research and development for new drugs and new treatments. We’ve committed \$500 million to the Global Fund to Fight AIDS and other infectious diseases, and we stand ready to commit more as this fund demonstrates its success.”<sup>90</sup>

The global game changers came in 2002 and 2003. First, in January 2002, the United States joined with France, the United Kingdom, the Bill & Melinda Gates Foundation, and other donors to establish the Global Fund,<sup>91</sup> a financing mechanism aimed at directing resources as fighting HIV, tuberculosis, and malaria. The fund was unique in bringing together governments, foundations, private-sector companies, multilateral organizations such as the United Nations, faith-based and other nongovernmental organizations, and people living with the diseases. This composition of stakeholders is evident at the headquarters level in the board and committees as well as at the country level in the Country Coordinating Mechanisms (CCMs), which are responsible for developing grant proposals and monitoring implementation. As a financing mechanism, the Global Fund relies on principal recipients (PRs) to implement the grants in country and local funding agents (LFAs) to “monitor program implementation, ensure financial accountability, and provide funding recommendations to the Secretariat.”<sup>92</sup> Since 2002, the fund has worked in more than 120 countries,<sup>93</sup> with 408 active grants in more than 100 countries.<sup>94</sup> As of July 2016, the fund had disbursed \$30.7 billion in grant disbursements.<sup>95</sup>

In June 2002, CSIS convened a Task Force on HIV/AIDS chaired by Senators Bill Frist (R-TN) and John Kerry (D-MA). In its Call to Action, the task force called for “strategic, forward-looking U.S. leadership to combat the global HIV/AIDS pandemic. The United States plays a leading role on global health issues, has vast institutional expertise in development, public health policy, and scientific research, and has at its disposal unmatched resources and global influence. For these reasons, U.S. leadership is essential to the present and future global response to the HIV/AIDS pandemic. To be most effective, the United States will need to use its economic and human resources, influence, and public diplomacy skillfully to empower the world community to work together to combat HIV/AIDS.”<sup>96</sup>

President Bush took up the call and, in his January 2003 State of the Union message, recognized a calling for the United States to make the world better not just safer. “Ladies and gentlemen, seldom has history offered a greater opportunity to do so much for so many. We have confronted, and will continue to confront, HIV/AIDS in our own country. And to meet a severe and urgent crisis abroad, tonight I propose the Emergency Plan for AIDS Relief, a work of mercy beyond all current international efforts to help the people of Africa. This comprehensive plan will prevent 7 million new AIDS infections, treat at least 2 million people with life-extending drugs and provide humane care for millions of people suffering from AIDS and for children orphaned by AIDS. I ask the Congress to commit \$15 billion over the next five years, including nearly \$10 billion in new money, to turn the tide against AIDS in the most afflicted nations of Africa and the Caribbean.”

Building off the momentum generated by the CSIS Task Force, Congress quickly passed the United States Leadership Against Global HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (P.L.

108-25) authorizing creation of the President’s Emergency Plan for AIDS Relief (PEPFAR). On May 27, 2003, President Bush signed the bill into law. The initial strategy targeted 14 countries, which accounted for more than half of the world’s HIV cases at the time: Botswana, Côte d’Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia.<sup>97</sup> Vietnam was added as the 15th country in June 2004. Although some countries had ongoing PMTCT activities upon which to build, PEPFAR implementation began in 2004. PEPFAR has subsequently been reauthorized twice in 2008 and 2013.

In 2010, the Obama administration put forth the first ever National HIV/AIDS Strategy. In November 2011, Secretary of State Hillary Clinton announced that an AIDS-free generation is “within reach,” and set ambitious HIV treatment and prevention goals, including 12.9 million men, women, and children on ART by the end of 2017. Over the course of President Obama’s administration, PEPFAR increased its numbers of people living with HIV on ART more than fourfold to 9.5 million.<sup>98</sup>

## Notes

1. Sara M. Allinder is deputy director and senior fellow of the CSIS Global Health Policy Center. This paper grew out of a CSIS Global Health Policy Center working group on HIV and the work of one of its sub-groups on the evolution and sustainability of the U.S. response. The members of the sub-group included the following (organizations listed for identification purposes only): Chris Beyrer, Johns Hopkins University; Catherine Connor, Elizabeth Glaser Pediatric AIDS Foundation; Lillian Dattilo, CSIS; Reuben Granich, International Association of Providers of AIDS Care; Charles Holmes, Johns Hopkins University; Ronald MacInnis, Palladium Group; Carolyn Reynolds, PATH; Tyler Smith, CooperSmith; Jeffrey L. Sturchio, Rabin Martin; Taylor Wilkerson, LMI; Jason Wright, Management Sciences for Health. See CSIS, “HIV Working Group,” <https://www.csis.org/programs/global-health-policy-center/hivaids/hiv-working-group>, for a full list of working group and sub-group members.
2. Sara M. Allinder and J. Stephen Morrison, “A Moment of Reckoning for U.S. Leadership on Global HIV,” CSIS, June 21, 2017, <https://www.csis.org/analysis/moment-reckoning-us-leadership-global-hiv>.
3. CSIS HIV Working Group webpage with all papers: <https://www.csis.org/programs/global-health-policy-center/hivaids/hiv-working-group>.
4. PEPFAR, “About Us,” accessed August 7, 2017, <https://www.pepfar.gov/about/270968.htm>.
5. Epidemic control is defined as the point in which new HIV infections fall below the number of HIV-related deaths.
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