Ambassador Deborah Birx, M.D.
U.S. Global AIDS Coordinator
Department of State
Washington, DC

May 23, 2014

Dear Ambassador Birx,

Congratulations, once again, on your confirmation. We write as independent civil society, professional, and advocacy groups to urge you to use the 2014 Country Operational Plan process to increase the impact of PEPFAR funding on the AIDS epidemic and set the tone for further investments in 2015.

Thank you for your recent statement that noted, “Around the world, progress has been greatest when a nationally-tailored combination of high-impact HIV inventions is brought to scale and sustained,” and promised a thorough process to align program portfolios with highest impact. We strongly support this process as a top priority for the Obama Administration, and suggest here some specific priorities for this year that we believe are necessary to achieve this goal.

The PEPFAR Blueprint, which we applauded, lays out a clear vision of a portfolio structured for maximum impact—focused on rapid scale up of core interventions and smart prioritization of funding. While the program has had huge impact on the epidemic, there is still a significant disconnect in many countries between the portfolio of PEPFAR-funded programs and evidence-supported interventions with the highest impact.

We know that this year, perhaps more than any other, the COPS/ROPS process will require difficult decisions about prioritization. We also know that the evidence on high impact interventions suggests that programs move in new directions. That is why it is critical to increase the impact of every U.S. global AIDS dollar. We have followed the process closely this year, gathering input from civil society and clinician partners in PEPFAR countries, and make the following recommendations. While some country plans have addressed these issues well, we believe many countries need greater attention to the following areas:

A. Scale up of ART and clinical services: As you know well, ARV treatment that leads to sustained virologic suppression not only saves lives, but is also among the most effective prevention interventions and belongs in every combination prevention portfolio. Continuing treatment expansion in all PEPFAR countries, at least in line with new WHO guidelines and with room for countries that move toward immediate initiation in their guidelines, coupled with routine viral load monitoring, are critical priorities. We note this is even more urgent where the newly released Global Fund allocations are insufficient to allow real scale up—early versions of some COPS do not reflect this reality, and will need adjustment.

PEPFAR support varies on this front: in several countries the critical task is maintaining at minimum the current (2013-2014) pace of treatment scale up (e.g. Uganda). Intensification is needed in others countries like Kenya, where treatment initiation decreased during 2012-2013. A third set of countries such as Malawi and Zimbabwe are set to leap ahead, but PEPFAR has historically invested insufficiently in direct treatment services. Doing so this year could enable substantial uptick in the pace of scale up at a critical moment.

Finally, a group of countries face substantial problems in coverage (including Cameroon, DRC, Burundi, South Sudan), and urgently need investments reminiscent of early PEPFAR efforts in building direct-service capacity and delivering life-saving services.

Moreover many countries have not yet fully implemented lifetime treatment for HIV positive pregnant women. Expansion of programs targeting treatment for most at risk populations is also crucial, requiring innovative efforts to reach isolated and criminalized groups.
We urge you to invest as much as possible in services that directly reach people living with HIV and those at greatest risk for HIV acquisition. The next few years of scale up will be critical to the long-term success of the global AIDS response.

**B. Clinical program quality:** As PEPFAR countries move to implement earlier treatment for more patient populations, minimum standards of program quality are required in order to ensure maximum clinical and prevention benefit for all. Unfortunately, not all countries are rolling out service delivery models consistent with evidence of what works to maximize viral suppression, adherence, patient ownership and empowerment, and to minimize loss to follow up. Instead, a patchwork of approaches between countries and between implementing partners within countries characterize some programs—creating unnecessary risk of poor quality outcomes, inefficiency and waste. The FY14 COPs should include a specific focus on quality, and resource allocations to match that focus.

We strongly recommend consistent minimum standards that should be expected to feature in every COP/ROP:

- Nurse and midwife initiation and maintenance of patients on ART;
- Option B+ programs should be the priority where PEPFAR is providing support;
- Trained, supervised and compensated community health workers are needed to bring essential services outside the clinic and into the community; including Option B+ programs that rely on HIV positive mentor mothers;
- Expanded use of self-help groups of stable ART patients who can improve retention and reduce travel and clinic burden through group ART pick up and distribution;
- Rapid HIV testing being done by lay health workers in the community, including door-to-door and workplace settings.

We also **strongly** urge you to directly support monitoring and advocacy efforts by community-based activists and NGOs—whose ability to watch-dog services and budgets will make a long-term difference in quality of the response.

**C. Additional high impact HIV prevention interventions:** We know more about what works in prevention than we did just a few years ago—and evidence is strong that a combination prevention approach can drive down incidence. We are concerned that the PEPFAR portfolio is still under-investing in proven high-impact programs and, at least in some countries, over-investing in marginally effective efforts. The PEPFAR Blueprint provides an important starting point— with scale up of community based- and provider-initiated testing, male and female condoms, VMMC, and the supportive community-based programming surrounding each of these critical priorities.

*We want to make clear our strong support for scaling up, not back, the core sexual prevention efforts described in the Blueprint.* Doing so means a focus on **coverage** of a nationally-appropriate basket of high-impact interventions. Yet we still see too many examples of countries that have not reached saturation of these interventions despite substantial PEPFAR budgets.

Meanwhile, **real efficiencies** are needed in the prevention and the health system strengthening portfolios to ensure the budgets for each of these important areas is used to maximal effect to reach the most people. Prevention, testing and treatment programs all need to be designed to maximize impact and efficiency. Methodologies that have been used to re-design treatment and VMMC programs to optimize impact and cost savings need to be adapted for all interventions, such as testing (where both cost per test and cost per new HIV infection identified need to be evaluated.) High-impact prevention packages need to be linked to concrete indicators of success. Efficiencies and impact may be gained through innovation such as community-driven program approaches, task-shifting, and service delivery models that reach more people
at high risk of sero-conversion with highest impact interventions. Determining appropriate target unit costs and calibrating the portfolio in countries on such evidence is an urgent priority.

D. **Key populations:** People who use drugs, sex workers, sexual minorities and other priority populations that are criminalized and excluded are uniquely vulnerable to HIV infection or rapid disease progression if HIV positive. The COP 2014 process must be leveraged to expand stigma-free service delivery, and to commit to subpopulation targets for prevention and treatment, along with training and capacity building implementers so that partners are able to perform against standards.

E. **Transparency in Counting:** We note that under the new legislation PEPFAR has been asked to clarify what counts as a “direct” provision. We believe this is essential and ask that you clarify this in COP 2014. In most countries it is disingenuous for PEPFAR to claim credit for the results of the entire national AIDS response, as is occurring in some countries—doing so undermines PEPFAR credibility.

**COPS review processes and civil society engagement**

In addition to the above priorities, as you move toward the annual PEPFAR meeting in a few weeks, we also hope you can provide some important feedback on the process by which the COPS were generated this year. We acknowledge and appreciate a commitment by OGAC to engage civil society meaningfully in review of the COPs following the release of the Blueprint for an AIDS-free Generation. As a matter of basic democratic practice, affected people have a right to know and guide how PEPFAR is investing in their communities and have a right to a say in the priorities PEPFAR addresses. However, some countries seem to have been unable to make progress in implementing this requirement in its letter or spirit.

Based on our experiences with those countries that did have success, we recommend the following:

- Invite a broad section of civil society, including but not limited to ‘leaders’ and formal representatives (eg such as CCM members). Hand picking civil society representatives through which PEPFAR Country Teams will ‘operate’ is harmful and inconsistent with the nature of robust and meaningful engagement.
- Operate on a principle of transparency—very little about what PEPFAR is doing would not be appropriate to share quite publicly, and so the operating assumption and practice should be that reports, progress, targets, and spending patterns will be shared with all civil society who are interested.
- Make performance review data available to civil society on request and in advance of any meeting, to ensure high quality review, inputs and analyses. Without opportunities to review in advance, civil society cannot prepare to meaningfully participate.
- Include in presentations **granular** and **specific** information about the COP: strategies, targets, budgets and partners. Describe what might change between years, and why.
- Focus on soliciting concrete assessments and strategic recommendations, not general feedback.
- Share all communication from OGAC, such as the 2014 country letters that accompanied the global COP 2014 guidance.
- Plan for multiple meetings—at least before, during and after COP submission—in order to systematically address inputs by civil society.
- Solicit written feedback and recommendations by civil society throughout the COPs drafting and review processes. Describe in writing how those recommendations were or were not addressed, and why.
- Commit to ongoing engagement with civil society, even outside the COPs review process and timeline.
- Emphasize participation by civil society members that do not have funding relationships with PEPFAR.
- Specifically reach out to key populations networks, in particular networks of criminalized groups.
We are glad to hear that, albeit under difficult circumstances, PEPFAR is conducting a careful review of COPS this year. We hope you will consider this feedback in that process. We also hope that you will bring some of our feedback to this year’s annual meeting next month.

Many thanks for your work to end the AIDS crisis.

Sincerely,

Matthew Kavanagh, Health GAP (Global Access Project)
Greg Millet, AmFAR: the foundation for AIDS research
Christine Lubinski, Infectious Disease Society of America, Center for Global Health Policy
Mitchell Warren, AVAC: Global Advocacy for HIV Prevention
Kenyon Farrow, Treatment Action Group