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AN ASSESSMENT OF PEPFAR PARTNERSHIP FRAMEWORKS AND PARTNERSHIP FRAMEWORK IMPLEMENTATION PLANS: SYNTHESIS REPORT

PEPFAR

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The Health Finance and Governance Project
The United States Agency for International Development's (USAID's) Health Finance and Governance (HFG) project is helping to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team will work with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. As a result, this five-year, $209 million global project will increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG will support countries as they navigate the economic transitions needed to achieve universal health care.

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ACRONYMS

ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
C&S	Care and Support
CHW	Community Health Worker
COP	Country Operational Plan
CBO	Community Based Organization
CSO	Civil Society Organization
DHIS	District Health Information System
HMIS	Health Management Information System
HRH	Human Resources for Health
HRIS	Human Resource Information System
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NGO	Non-Governmental Organization
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PF	Partnership Framework
PFIP	Partnership Framework Implementation Plan
PLHIV	People Living With HIV
PMTCT	Prevention of Mother-To-Child Transmission
SID	Sustainability Index Dashboard
STI	Sexually Transmitted Infection
TA	Technical Assistance
USG	United States Government
VMMC	Voluntary Male Medical Circumcision

EXECUTIVE SUMMARY

In 2003, President George W. Bush supported the launch of the largest effort ever to combat a single disease—the President's Emergency Plan for AIDS Relief (PEPFAR). The world was facing a significant health security crisis. Nearly one-third of the population of many sub-Saharan African countries had contracted HIV, and approximately 20 million people had died. In some countries companies were hiring five employees to complete the work of one, because they anticipated four would die an AIDS-related death. AIDS-related deaths had nearly eradicated a generation, and in its path left approximately 14 million orphans and vulnerable children (OVCs). Moreover, there were almost no prevention, care, or treatment services in the countries that needed them most.

In five years, PEPFAR, the Global Fund, partner governments, and countless organizations around the world changed this landscape. Prevention, care, and treatment began to reach those who needed them most in Africa, Latin America, and Asia. Across the globe, over two million people were accessing anti-retroviral therapy (ART), over 10 million people infected or affected were receiving care, and over seven million new infections were averted (PEPFAR WAD 2008). PEPFAR was subsequently renewed for another eight years by the Lantos and Hyde Act on Global Leadership Against HIV/AIDS, Tuberculosis and Malaria. This reauthorization also initiated a focus on developing partnerships to ensure a sustainable approach for combating HIV. Accordingly, PEPFAR developed Partnership Frameworks (PFs) and in some cases Partnership Framework Implementation Plans (PFIPs). These acted as strategic agreements between PEPFAR and partner governments to implement a sustainable approach for achieving an AIDS Free Generation. In total, PEPFAR drafted and signed 22 PFs between 2009 and 2012 in Angola, Botswana, the Democratic Republic of Congo, the Dominican Republic, Ethiopia, Ghana, Haiti, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Ukraine, Vietnam, Zambia, the Caribbean Region, and the Central America Region.

These agreements represented a new era of partnership and joint decision making between PEPFAR and country governments. They established joint strategic road maps, and their implementation created the space for advanced dialogue with partner governments. Undoubtedly, PFs/PFIPs represented a significant shift in the way PEPFAR was conducting business with a new era of sustainable partnerships. However, did the PFs/PFIPs succeed in improving partnerships between PEPFAR and partner governments, and did they help promote country-led, country-financed, and strategically executed HIV/AIDS responses?

There has been no global assessment of the PFs and PFIPs to date. This study assesses the development and impact of the PFs and PFIPS based on the agreements themselves, Country Operational Plans (COPs), Mid-Term Assessments, and other related documentation. The study considers 12 countries that had both a PF and a PFIP, and four countries that had a PF and a draft PFIP. The study's findings are presented in two groupings: (1) a review of the process to create and implement a PF/PFIP; and (2) the impact across the domains of sustainability as defined by the PEPFAR Sustainability Index Dashboard (SID) 2.0 (2015).

The findings of this study demonstrate that overall the PFs/PFIPs did indeed advance partnership dialogue and partnerships between PEPFAR and governments. The process of development epitomized the spirit of country ownership with the active engagement of a wide array of partners and stakeholders. In addition, the PFs/PFIPs engendered greater alignment between United States Government (USG) mandates and national priorities. The agreements positively impacted on the sustained scale-up of high impact HIV interventions, notably expansion and scale up of ART, and the rollout of Prevention of Mother-to-Child Transmission (PMTCT) and Voluntary Male Medical Circumcision (VMMC). The process also helped identify a focus on critical systems issues impacting

on HIV care and treatment—notably related to supply chain, domestic financing, and human resources for health. Even with these successes, the PFs/PFIPs had shortcomings. The implementation of PFIPs failed to sustain continued high level oversight and did not provide a way of holding stakeholders accountable through the implementation process. Most lacked standard indicators and/or had monitoring and evaluation plans that were not fully implemented. Lastly, they were not treated as living documents—as economies grew or shrank, epidemics evolved, and new research and policies became available, there was no systematic process to re-evaluate or revise the documents. As a result, the commitments in the agreements were no longer as relevant.

Today, PEPFAR and partner governments face the challenge of delivering the promise of an AIDS Free Generation in the context of stagnant and in some cases declining donor funding. No country or donor can achieve this goal alone.

1. INTRODUCTION

The 2008 Lantos and Hyde Act on Global Leadership Against HIV and AIDS, Tuberculosis, and Malaria reauthorized up to $48 billion in spending for five years (FY2009–FY2013) for HIV and AIDS, including support to the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund) through PEPFAR. This reauthorization promoted a sustainable approach to tackling HIV and AIDS, and placed a higher value on country leadership, ownership, and strengthening country capacity. The development of PFs was the primary expression of this ambition to strengthen country ownership of HIV and AIDS activities. PEPFAR intended PFs to be five-year, high-level, strategic agreements between the USG and partner governments of selected countries. PFs were designed to articulate the nature of cooperation for HIV policy reforms, program funding and alignment, and improved coordination and integration of service delivery strategies.

PEPFAR guidelines issued in September 2009 identified the process for developing PFs, and outlined the nature of PFIPs. This guidance distinguished PFs as joint strategic frameworks for PEPFAR and partner country governments, and PFIPs as specific implementation plans of this partnership. Additional PEPFAR funding was provided to incentivize countries to develop and sign PFs. In the period from 2009 to 2012, 22 countries or regions that received support from PEPFAR completed PF agreements. Sixteen countries initiated the development of PFIPs (completed by 12 countries) to further articulate how USG and other local stakeholders would carry out the vision articulated in the PFs (see Annex 1).

One of the requirements of the 2013 Reauthorization of PEPFAR was the review of PFs and PFIPs. Secretary of State John Kerry renewed emphasis on partnerships with host country governments and sustainability with the creation of Country Health Partnerships, announced in September 2013. Country Health Partnership agreements between PEPFAR and local stakeholders and sustainability-related programming were designed to build on the experience of PFs and PFIPs, furthering the partnership between PEPFAR and each respective country. Although Country Health Partnerships were announced in 2013, none have been finalized to date. PEPFAR 3.0 (2014) emphasizes five key agenda areas—impact, efficiency, human rights, sustainability, and partnerships. To advance the sustainability agenda, PEPFAR also introduced the Sustainability Index Dashboard (SID) tool in 2014 to be used by PEPFAR teams and country partners to evaluate the sustainability of the HIV response. Now in its second iteration, the SID 2.0 tool is composed of a series of indicators in four domains—(A) Governance, Leadership, and Accountability, (B) National Health System and Service Delivery, (C) Strategic Investments, Efficiency, and Sustainable Financing, and (D) Strategic Information.

2. OBJECTIVES AND RESEARCH METHODS

While there is anecdotal evidence that some PFs/PFIPs influenced the nature of collaboration between USG and partner countries, to date no global systematic assessment has been conducted concerning their evolution or their implications for collaboration and country ownership of HIV and AIDS programming. Other analysts (e.g., Judice et al. 2012, Verani 2010) have undertaken documentary reviews investigating the planned policy interventions contained in PFs. A recent study of AIDS financing and expenditures in 12 PEPFAR countries explored sustainability issues but without an explicit focus on the effects of PFs on country ownership and sustainable planning for national HIV responses (Resch et al. 2015). Five countries conducted mid-term or final assessments of their PFs/PFIPs, as detailed in Table 2.

HFG conducted a systematic desk assessment of the development of PFs and PFIPs and their impact on increasing sustainability and country-led partnerships for HIV. This assessment considers the successes of PFs/PFIPs in strengthening partnerships between PEPFAR and local country stakeholders (including government, civil society, and the private sector) to promote a country-led, country-financed, and strategically allocated HIV and AIDS response. The assessment explored specific research questions related to three key phases of the PFIP/PF process: (i) development, (ii) implementation, and (iii) monitoring. In investigating these three aspects, HFG focused specifically on the four domains of relevance to PEPFAR as defined within the PEPFAR SID 2.0 (see Table 1).[1]

2.1 Documentary Analysis

This report consists of a documentary analysis alone. For each of the 16 countries that developed and signed PF agreements and subsequently developed PFIPs, we collected all available formal documentation regarding the agreements. The original PF agreements were available from PEPFAR.gov, and HFG sought to access the 16 draft and/or completed PFIPs to obtain more in-depth information on development and implementation. Analysis of these documents was generally complemented by a review of: (i) PEPFAR COPs, typically for one year preceding and for all years after the PF/PFIP (until COP 2014); (ii) National HIV Strategic Plans or similar country HIV strategy documents, and, when possible, (iii) other publicly available documents (e.g., PFIP evaluations, UNAIDS progress reports) that described the country's HIV strategy or commented/reflected on the PF/PFIP. In reviewing the COPs, HFG sought to trace specific commitments made in PFs and PFIPs, the extent to which those commitments were delivered (by PEPFAR, local governments, or others), whether delays had occurred, and if so, why. Information was also extracted from COPs regarding evaluations of the PFIP. Investigators did not approach individual country missions or other national stakeholders for additional information.

HFG sought to extract information from the available documentation related to: (i) the process of developing and implementing the PF/PFIP, specifically seeking to understand how the PF/PFIP related to ongoing country planning processes, the actors involved, and the level of commitment to implementing the PF/PFIP; (ii) the four key domains identified above and explained in more detail in Table 1; and (iii) the progress and advances to date in these areas.

[1] HFG's research was conducted during the creation and finalization of the SID 1.0 and 2.0 tools. For the purpose of this report, we have outlined our findings per the SID 2.0, and identified SID 2.0 as the primary tool even though the research was coordinated under frameworks that preceded SID 2.0.

Table 1 Domains for Data Extraction

SID 2.0 Domains and Related Elements	Description of Parameters
Domain A. Governance, Leadership, and Accountability • Public Access to Information • Civil Society Engagement • Private Sector Engagement • Policies and Governance • Planning and Coordination	• Models for joint planning and decision making between PEPFAR and host governments, including: formal structures for ongoing, regular information meetings for sharing (programmatic and budget) and decision making • Standard operating procedures for how information is shared and decisions made; inter and intra-ministerial membership; and roles/responsibilities to elucidate core policymaking, financing, program development, implementation, or monitoring roles/activities between relevant stakeholders, including the private sector • Aligning PEPFAR and host government business processes, including: annual HIV and AIDS planning (such as national strategic plans and COPs); monitoring and sharing achievements/weaknesses to inform program realignment; and budget cycles (host government and PEPFAR) • Approaches to providing transparency of USG resources (program and budgetary) to host governments and vice versa; approaches to establishing practices/procedures to improve public access to information and increase transparency and accountability of HIV investments and impacts for non-governmental organizations (NGOs), civil society members, and affected communities
Domain B. National Health System and Service Delivery • Service Delivery • Human Resources for Health • Commodity Security and Supply Chain • Quality Management • Laboratory	• Promoting the use of local institutions, including: models that nationalize the use of non-governmental and private providers, for expanding access and coverage, and improving the quality HIV prevention, care, and treatment programs • Approaches to establishing publicly funded private providers for HIV • Approaches to strengthening health systems including human resources, commodity security and supply chains, quality management, and laboratory systems • Budget government-to-government funding, including: examples and approaches to establish on-budget support to Ministry of Finance and Ministry of Health (MOH) for USG funds; and other models that allow greater flexibility in access to PEPFAR funding by partner governments (e.g., modifications to existing Cooperative Agreements)
Domain C. Strategic Investments, Efficiency, and Sustainable Financing • Domestic Resource Mobilization • Technical and Allocative Efficiencies	• Strategies to increase domestic investments in national HIV programs and to increase the efficient use of available funds, including models for incentivizing or promoting increased domestic resources by partner governments • Strategies for promoting approaches to increase domestic resource mobilization opportunities • Models to promote partner government abilities; determining the efficient use of resources and applying ongoing planning and allocation decisions • Methods to catalyze the use of innovative financing mechanisms to support the national HIV response

Domain D: Strategic Information • Epidemiological and Health Data • Financial and Economic Data • Performance Data	• Strategic information on allocation of resources (financial, human resources, and others) • Methods for improving the use of strategic information/data systems, including surveillance, health, and expenditure data, to strategically target and align ongoing resource investments to maximize impact and efficiencies • Models for applying strategic information to determine "value for money" in targeting limited funds to ensure maximum performance and impact

Data was extracted for the 16 countries included in this study using a standard Excel template. The HFG study team met shortly after starting data extraction to compare notes and standardize approaches, and then again near the completion of data extraction to discuss emerging themes. Annex 2 captures the number and types of documents reviewed and abstracted for this activity. All of the data presented in the findings section was sourced directly from the PFs/PFIPs, COPs, and evaluations of PFIPs, unless noted otherwise.

3. FINDINGS FROM PROCESSES AND ACROSS DOMAINS

3.1 Overview

Table 2 lists the countries reviewed, the PF/PFIP dates, and whether or not a mid-term review and/or evaluation of the PFIP had been undertaken. In many countries, the PFs/PFIPs were developed around the same time as a national HIV planning or strategy document—the two documents frequently appeared to have been developed with close consultation between their respective authors, and there was common cross-referencing between the two. The table therefore also indicates which government document the PF was related to, if any.

Of the 33 PEPFAR Operating Units (either country or regional PEPFAR programs),[2] 22 had completed a PF and 16 had completed both a PF and either drafted or finalized a PFIP. Eleven out of the 33 Operating Units did not complete PFs or PFIPs.[3] Out of the 22 units that developed a PF, six did not have a PFIP: Central Asia Regional, Democratic Republic of Congo, Ethiopia, Haiti, Namibia, and Tanzania. Although the 16 countries listed in Table 2 were selected on the basis that they had a PFIP, in practice, not every country had a finalized PFIP. In Angola and the Ukraine, for example, documents reference the PFIP the PFIP but these were not finalized and/or executed. The PFIP from the Dominican Republic remained in draft and the Kenyan PFIP was undated. This review explores the details of the 16 countries that had both a PF and PFIP (either finalized or drafted).

Table 2 Countries and PFs/PFIPs in this Study

	PF Signing Date	PFIP Date of Completion	Period Covered	Related Government Document	Mid-Term Review or Evaluation of PF/PFIP
Angola	Aug 2009	Not completed	2009–2013	HIV national strategic framework, which expired in 2010	No
Caribbean Regional Program	April 2010	May 2010	2010–2014	Pan Caribbean Partnership against HIV and AIDS	Yes, mid-term review
Central America Regional Program	March 2010	Oct 2010	2010–2014	Multiple regional/national reports	Yes, mid-term review, 2013
Dominican Republic	Nov 2010	In draft Jan 2010, not finalized	2009–2013	National Strategic Plan 2007–2015	No
Ghana	Nov 2009	Aug 2010	2009–2013	National HIV and AIDS strategy 2006–2010	No
Kenya	Dec 2009	Undated, but other documents indicate 2010	2010–2013	Kenya National AIDS Strategic Plan 2010–2013	No

[2] This represents the Operating Units that are listed as active by PEPFAR.

[3] Of the 33 PEPFAR Operating Units listed as active, only 22 completed a PF. There was no available evidence on the development of a PF for the remaining 11units. These are: Asia Regional, Burundi, Cambodia, Cameroon, Cote D'Ivoire, Guyana, India, Indonesia, Namibia, Uganda, and South Sudan.

	PF Signing Date	PFIP Date of Completion	Period Covered	Related Government Document	Mid-Term Review or Evaluation of PF/PFIP
Lesotho	Aug 2009	Aug 2009	2009–2014	National HIV and AIDS Strategic Plan 2006–2011	Yes, mid-term review
Malawi	May 2009	May 2010	2009–2013	Government of Malawi National Action Framework for HIV and AIDS 2010–2012 revision	Yes, mid-term review Jan 2012
Mozambique	Aug 2010	Dated 2011, finalized March 2012	2010–2013	National HIV and AIDS Strategic Plan expired during year PF/PFIP were developed	No
Nigeria	Aug 2010	Dec 2011	2010–2015	National Strategic Framework for Control of HIV and AIDS 2010–2015	No
Rwanda	June 2010	June 2010	2009–2012	HIV and AIDS National Strategic Plan 2009–12	No
South Africa	Dec 2010	Aug 2012	2012/13–2016/17	National Strategic Plan for HIV, STIs, and TB 2012–16	No
Swaziland	June 2009	Feb 2010	2009–2013	None	Yes, evaluation complete 2014
Ukraine	Feb 2011	Not completed	N/A	Ukraine National Program for the Prevention of HIV Infection, Treatment, Care, and Support for People with HIV and AIDS 2009–2013	No
Vietnam	July 2010	Dec 2010	2010–2015	National HIV Strategy was under development at time of PFIP	No
Zambia	Nov 2010	Feb 2011	2011–2015	National AIDS Strategic Framework 2011–2015	No

3.2 PF and PFIP Development, Implementation, and Monitoring

3.2.1 Development

In countries with both PFs and PFIPs, these agreements were documented as developed inclusively, involving multiple stakeholders, such as in-country USG PEPFAR staff and representatives from multiple ministries, PEPFAR implementing partners, other donors, and civil society. In some cases (e.g., Lesotho and Rwanda) the PF and PFIP were produced simultaneously, while in other countries a long time elapsed between production of the two documents. For example, 12 months or more elapsed between development of the PF and the PFIP in South Africa, Malawi, Nigeria, and Mozambique. The reasons for this were not specified and could not be deduced from the available information. Country government signatories to the PF/PFIP tended to be very high-level, including the Prime Minister of Swaziland, the Deputy Prime Minister and Minister of Finance in Kenya, the

Cabinet Minister in Ukraine, and a number of different ministers in the Dominican Republic. Within the USG, most PFs were signed by ambassadors and a few by U.S. Secretary of State Hillary Clinton, notably for South Africa.

In some cases (Kenya, Malawi, Nigeria, Rwanda, and Zambia), the PF and PFIP were very closely linked to and developed in conjunction with a new HIV and AIDS National Strategic Plan. These PFs/PFIPs aligned their timing, built upon the broader national planning processes, and sought not to replicate existing in-country processes. In contrast, when the PF/PFIP development process was not aligned to the timing of national plans, countries appear to have struggled to gain traction around the PF/PFIP process. In Mozambique, for example, the expiration of the national plan coincided with the start of the PF, which appeared to result in a less integrated approach.

The process of PF/PFIP development was considerably more complex for the Regional PFs/PFIPs (Central America and Caribbean), which involved a multitude of local partners as well as multiple national HIV and AIDS strategies. In both cases, USG worked with regional authorities to develop the PFs/PFIPs, and focused on strengthening coordination across countries. However, this approach resulted in national-level tension in the Caribbean and a lack of buy-in, since the agreements did not necessarily reflect national-level priorities and needs, and it was not clear how to reconcile these differences. These tensions were clearly articulated in the Caribbean Region's mid-term evaluation of the PFIP:

> "Many key country representatives remarked that they felt the scope of the PFIP was largely predetermined by PEPFAR, and they did not feel that its objectives always coincided with national priorities." (Franco et al. 2013, pg. 8)

Based on available documentation, this tension seemed to be less explicit in Central America. However, this may be due partly to existing bilateral agreements for HIV in four out of the seven countries.

3.2.2 Implementation

Many PFIPs required extensive and often complicated governance mechanisms to provide oversight for their implementation. For example, the Malawi PF suggested that: PEPFAR would provide technical oversight of the PF; joint meetings between the Malawi government and pooled partners would provide strategic oversight; PEPFAR and the government would incorporate the PF into the existing Global Fund Country Coordinating Mechanism structure to provide oversight to the Global Fund grant and to monitor PF progress; and high-level government oversight to the PF would be provided via meetings with officials, such as the president of the Republic of Malawi, officials from the Ministry of Finance and MOH, Chief Secretary to the President and Cabinet, and the U.S. Ambassador to Malawi. The three out of four mid-term reviews of PFIPs on which we have information (Malawi, Caribbean, Central America) stressed the need to revitalize governance and stakeholder structures.

We could not discern from available documents the extent to which the PFs/PFIPs were truly living documents that continued to guide work in-country. In some cases (e.g., Malawi and Rwanda), there were frequent references to the PFs/PFIPs in later COPs in addition to the COP-required PF summary section. In other contexts (e.g., Angola and Nigeria), there were very limited subsequent references to the PFs/PFIPs. In Nigeria, the PF was viewed as a document that underpinned other strategies by articulating the relationship between participating organizations. The PF may have been valuable for this reason, but it did not appear to be a living and evolving document. As discussed, four of the 16 PFs/PFIPs had mid-term reviews—Central America Region, Malawi, the Caribbean

Region, and Lesotho.[4] Mid-term reviews were most likely to be conducted in countries where the PFIPs remained active and living documents.

3.2.3 Monitoring and Evaluation

While the PFIPs present detailed monitoring and evaluation (M&E) frameworks, typically these appear to be derived from or linked to existing strategy documents (such as the national HIV and AIDS strategy or PEPFAR indicators). Accordingly, the majority of PFIP M&E indicators focus on service coverage and delivery. Very few present clear indicators to track progress in domains such as accountability and transparency, and indicators presented for domestic financing are often vague.

As policy tracking was an existing PEPFAR priority and a requirement in COP submissions, indicators for tracking policy change are an exception. Several PFs/PFIPs (e.g., Kenya, Lesotho, Malawi, Swaziland, and Zambia) employ a relatively sophisticated and standardized policy tracking process. These identify six different phases of policy development and track priority policies across these different stages. However, specific policies were not consistently tracked during the PFIP period across all countries.

3.3 Key Domains Reviewed

3.3.1 Governance, Leadership, and Accountability

The PFIPs were intended to improve both PEPFAR and partner country government transparency and accountability by engaging USG, partner country governments, local civil society, and other stakeholders in key ways. These included promoting an enabling policy and legal environment, ensuring good stewardship of HIV and AIDS resources, engaging civil society actors, and meeting commitments for the HIV response. The elements or subthemes covered in this section are therefore Policies and Governance, Planning and Coordination, Civil Society Engagement, and Public Access to Information. Following the narrative below are a series of tables outlining the implementation strategies and impact for those countries included in this study.

Policies and Governance

At the time the PFs and PFIPs were written, many of the governments already had national AIDS strategic plans and had created national AIDS councils. The national strategic plans and AIDS councils—or their equivalents—existed in all 16 of the countries considered.

Fourteen out of the 16 PFs/PFIPs outlined strategies to address policies, laws, and regulations. These were primarily aimed at advocating for or supporting development and enforcement of policies, laws, and regulations for HIV service delivery, health systems, and a positive political environment for HIV prevention and control efforts.

Twelve countries had policy goals related to service delivery, including: developing or revising national plans and strategies for HIV and AIDS; introducing or expanding services such as HIV counseling and testing, services for OVCs, and VMMC; and addressing service integration. Of these, only Swaziland did not include goals for policies, laws, and regulation changes related to service delivery.

[4] Only the Swaziland and Caribbean region mid-term reviews were available, but the COPs in the other countries commented on mid-term reviews. The Central American PFIP also had a review conducted by USAID's implementing mechanism (AIDSTAR I), although this seemed appeared to be a final evaluation.

Twelve countries and one region had policy goals related to health systems, including efforts to improve health workforce issues (e.g., training, task-shifting, retention, and recruitment), supply chain, pharmaceuticals, and safety of biological materials and blood. Of these, Central America, Ghana, Malawi, Mozambique, Nigeria, and Swaziland had evidence of policies, laws and regulation changes. Although not always identified explicitly as strategies in the PFs or PFIPs, USG-supported health system restructuring efforts (e.g., decentralization and devolution) were evident in four countries (Dominican Republic, Ghana, Kenya, and Nigeria).

Thirteen countries had policy goals related to improving an enabling environment, including addressing gender-based inequality and violence, stigma and discrimination, workplace issues, rights of people living with HIV (PLHIV), and legal or regulatory barriers to services. Of these, only three countries (Central America, Kenya, and Lesotho) had evidence of policy, legislation, and regulation changes.

Often policies, laws, and regulations were adopted but implementation was uneven due to issues of transparency, governance, accountability, resource allocation, and health workforce challenges. For example, policies against stigma and discrimination were not enforced in Central America. In Mozambique, policies could not be implemented evenly due to significant human resources for health (HRH) shortages. In Angola, the PF/PFIP laid out potential strategies for policies, laws, and regulations, but no evidence was found of any implementation or impact.

The Caribbean Region and South Africa did not explicitly address strategies for policies, laws, and regulations. However, there was evidence in the Caribbean that policies for dealing with confidentiality and stigma and discrimination were developed during the PF/PFIP period.

Some examples of progress in this area are highlighted below:

- Central America established policies to support a conducive environment for HIV programming, recognizing the need for a special emphasis on key populations.
- Ghana, as part of its 2013 National HIV and AIDS Policy, required all public and private institutions to modify their workplace policies. A government mandate was issued stating that HIV prevention and treatment of opportunistic infections for PLHIV must be covered by the National Health Insurance Scheme. In 2013, the President of Ghana announced that PLHIV with valid national health insurance cards were exempted from paying monthly contributions to ART.
- Lesotho supported key policy changes that created a favorable legal environment for HIV prevention and control efforts, including enacting key legislation such as the Education Act, the Anti-Trafficking in Persons Act 2010, and the Children's Welfare and Protection Act 2011. The government also approved and supported the rollout of the health sector HIV and AIDS Workplace Policy.
- Vietnam passed the HIV and AIDS Prevention Law in 2013. Policy and legislative reforms related to HIV were included the Law on Health Insurance and the Law on Social Insurance.

Planning and Coordination

The PFs/PFIPs explicitly identified strategies for planning and coordination in 13 out of 16 countries (Table 11). The most frequently mentioned strategies were around formal structures for information sharing and decision making between USG and other donors (n=8), and between USG and local stakeholders, including government (n=7). Other strategies included monitoring and information sharing for program planning (n=4); joint annual planning (n=4); USG membership on coordinating bodies or committees (n=3); and budget cycle alignment (n=3). Two countries (Caribbean and Lesotho) did not outline specific strategies for planning and coordination beyond the PF or PFIP monitoring plan.

Evidence of activities to establish and/or strengthen formal structures for information sharing and decision making between USG and local stakeholders was found in seven countries. Of the countries with strategies, only Ghana, Kenya, and South Africa had evidence of implementing activities. The

other four countries (Angola, Nigeria, Rwanda, and Swaziland) had activities although no strategies were identified in the PFs/PFIPs. For formal structures between donors, the evidence was more consistent with the PFIP strategies. Five countries showed evidence of activities with donors (Angola, Dominican Republic, Kenya, Nigeria, and Vietnam), and all but Angola had outlined strategies in the PFs/PFIPs. Evidence of activities for the other planning and coordination strategies was also found in one or two countries: monitoring for program planning (Nigeria and South Africa), USG committee membership (Ghana and Dominican Republic), and joint annual planning (Angola). There was no evidence of activities around planning and coordination in Lesotho, Malawi, Mozambique, Ukraine, or Zambia.

Challenges were identified with coordination between PEPFAR agencies and implementing partners, which presented difficulties in the Caribbean and Central American Regions, as well as in Swaziland. For regional PFs/PFIPs, a lack of coordination compounded disconnection between framework goals developed at a regional level and alignment with national strategies. The financial crisis precipitated donor exit in both regions, forcing critical questions about national governments' role in coordination and ownership of the national response. In Swaziland, coordination among PEPFAR's implementing partners, and between them and others, was challenging but improved over the PFIP period.

Some examples of success are highlighted below:

- Ghana established a Partnership Framework Oversight Committee, which had representative members from the National AIDS Control Program, MOH, PLHIV umbrella associations, networks of HIV and AIDS NGOs, and businesses. The PEPFAR country team had close and continuous dialogue with leading Ghanaian government coordinating institutions, including the Ghanaian AIDS Council and the National AIDS Control Program throughout the implementation period.
- Rwanda through the MOH led coordination of donor assistance in the health sector. The Health Sector Working Group was established to support this process. In addition, health sector partners, including USG, were signatories to the Sector-Wide Approach (SWAp). Through these mechanisms, partners adopted a common approach for coordinated planning, implementation, and M&E under national oversight
- Nigeria developed a "Lead Implementing Partner" initiative for joint planning and analysis in each state, which was conducted in close collaboration with the National Primary Healthcare Development Agency.

Civil Society Engagement

Fourteen out of 16 PFs/PFIPs identified activities to engage a broad range of civil society actors (Table 4). Capacity-building of civil society members and organizations was the most common strategy (n=11), including building capacity for financial management and reporting, governance, service delivery, advocacy, and combating stigma and discrimination. Other strategies included improving the role of civil society in holding government accountable for HIV and AIDS activities (n=3), developing and/or supporting NGO umbrella organizations (N=3), engaging with the media (n=3), and engaging the private sector (N=3). Only the Caribbean and Vietnam did not outline strategies for increasing the role of civil society.

The role of civil society was explicitly identified as weak in several countries despite efforts undertaken during the PF/PFIP period. Evidence of capacity-building of civil society was found in 10 countries, including in the Caribbean and Vietnam, which had identified this strategy in the PFs/PFIPs. Activities improving the accountability role of civil society were identified in five countries (Central America, Dominican Republic, Lesotho, Nigeria, and Rwanda). Central America, Lesotho, and Nigeria had evidence of supporting NGO networks; and Central America and Nigeria also had evidence of engaging with the private sector. No evidence was found in any country of engaging with

the media. While some activities were described for Angola, Kenya, South Africa, Ukraine, and Zambia to promote the role of civil society within their PFs/PFIPs, there was limited evidence regarding impact. Some examples of success are highlighted below:

- Central America supported capacity building for civil society in select countries. USG and other donors encouraged national stakeholders to engage directly with civil society and to focus interventions on key populations.
- The Dominican Republic received USG support for civil society, building financial management capacity, with two NGOs going on to receive non-USG funds. Five civil society organizations served on Country Coordinating Mechanisms, and were more active in providing policy and program inputs to the national response and Global Fund activities.
- Mozambique increased capacity building of civil society and advocacy networks to inform government planning and to increase transparency and accountability. Civil society networks were created to better enable access to and sharing of key information, such as budgets, national plans, and laws.

Public Access to Information/Accountability

The primary activities defined in the PFIPs were associated with ensuring financial accountability and transparency, in particular for expenditure and procurement. The activities defined under this element have some overlap with the element on financial and economic data under the Strategic Information domain. Eleven out of 16 countries proposed potential activities in this area, ranging from broad financial management, accounting, audits, and compliance to resource monitoring. Other strategies included transparency of investments between the local government and USG, including PEPFAR budget activities being reported and included in local planning (n=4), explicit strategies to improve transparency around procurement (n=3), and strategies for reducing duplication and improving efficiency, including an audit of HRH (n=2).

Four countries had explicit evidence of implementation of interventions to promote financial accountability and transparency (Kenya, Nigeria, Rwanda and Zambia). For example, in Nigeria resource tracking exercises were undertaken (e.g., a Public Expenditure Tracking Survey), and training modules around financial accountability were developed under the national M&E plan. In Rwanda, Joint Health Sector Reviews were conducted regularly as planned to track and measure progress, and harmonized resource tracking was conducted to capture commitments from all partners. In Angola, decentralization was identified as an important factor challenging accountability. Only Rwanda and Zambia showed evidence of increased transparency of investments from USG. In the Dominican Republic, the planned HRH audit was successfully completed although next steps were not clear.

Table 3 PFIP Strategies for Policies and Governance[5]

Country	PFIP Strategies Described for Policies and Governance	Available Evidence Regarding Implementation and Impact
Angola	• Support policy reforms on these key areas: health workforce training reform, supply chain management, gender inequality, and male circumcision.	• No available evidence regarding impact.
Caribbean[6]	• Undertake a comprehensive policy assessment in the region.	• No available evidence.[7]
Central America	• Support implementation of existing policies and enforcement of existing laws towards stigma and discrimination, sexual violence, and gender inequities. • Conduct policy analysis, including for the military, to identify policy gaps and barriers to effective HIV programming. • Promote adoption of policies that create positive political environment for prevention, care, and treatment, including evidence-based regional prevention policies for key populations, policies to address HIV in workplaces, and contributions by each country to reach universal access. • Develop a regional policy to address mobile populations, along with partners.	• Established policies to support conducive environment for HIV programming- with a focus on the armed services and HIV workforce policies within the private sector. • Policies were adopted that recognized the need for a special emphasis on key populations in HIV prevention and control. However effective implementation was uneven due to issues with transparency, governance, resource allocation, and stigma and discrimination, especially within the public sector.
Dominican Republic	• Policy focus areas include: ○ Supporting implementation and enforcement of two recent laws: gender-based violence (passed) and revised AIDS law (submitted to Congress). ○ Policy change around HIV testing. ○ Updating biosafety regulations, ensure enforcement, and develop strategy for blood donation. ○ Engaging government in conversations with Haiti for joint approach to HIV, given the complex bi-national dynamics. • USAID Health Policy Project working on stigma and discrimination linking NGOs to local policymakers to address policy and regulatory issues • Policy dialogue to increase government's financial commitments to health sector and national response.	• Congress passed a new AIDS law in June 2011; however, integration of HIV services into the social security was not successful during that period. • There was no indication that proposed policies around opt-out HIV testing and regulations for administering HIV tests were addressed. • Stigma and discrimination continue to be issues.
Ghana	• Advocate for and support implementation of HIV-related policies, including National HIV and AIDS key population policy, with attention to stigma and	• The National Laboratory Strategic Plan was drafted in 2011 and prioritized HIV, malaria, and TB testing.

[5] For Tables 3 to 12, all information is sourced for USG documentation, including but not limited to PEPFAR PFs, PFIPs, COPs, and evaluations unless otherwise noted.

[6] Countries participating in the PEPFAR Caribbean Regional Program (Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Grenada, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago), as well as the Caribbean Community's Pan Caribbean Partnership against HIV and AIDS and the Organization of Eastern Caribbean States HIV and AIDS Program Unit.

[7] No available evidence in the second column indicates a lack of evidence based on the documentary review that would verify whether the proposed strategies had been undertaken and had impact. N/A is used when the activity was not applicable for that country or regional setting.

Country	PFIP Strategies Described for Policies and Governance	Available Evidence Regarding Implementation and Impact
	discrimination; integrating HIV and AIDS and other health services; inclusion of anti-retrovirals (ARVs) in the national health insurance scheme.	• Formal task-shifting policies established. Integration of reproductive health and HIV and AIDS services remains high on the policy agenda but are unresolved. • National HIV and AIDS Key Population Policy developed and was to be implemented through the National Key Population Implementation Plan. • As part of the 2013 National HIV and AIDS Policy, all public and private institutions are required to modify their workplace policies. • Inclusion of ART in National Health Insurance Scheme was debated but not implemented. A government mandate was issued stating that HIV prevention and treatment of opportunistic infections for PLHIV must be covered by the National Health Insurance Scheme. In 2013, the President of Ghana announced that PLHIV with valid national health insurance cards were exempted from paying monthly contributions to ART. • Decentralization processes at regional and district levels led to the establishment of multi-sectoral HIV and AIDS committees with the Regional Ministers and District Chief Executives as chairpersons in order to coordinate HIV interventions at decentralized levels.
Kenya	• Policy focus areas include support for Provider Initiated Testing and Counseling as the standard of practice in health settings; task-shifting; enhanced role of private and faith-based organizations/mission health facility sectors in provision of treatment and care; increased priority on TB screening, detection, and treatment within HIV and treatment care centers; and support for male circumcision implementation. • Conduct a legislative and policy review to identify and address: gaps in property rights and harmful traditional practices, HR, and workplace policies for all sectors. • Ensure HIV is mainstreamed in sector-specific policies and sector strategies so that by 2012/13 all ministries have HIV budget lines and report on HIV program implementation.	• Strong Kenyan government leadership supported effective policy implementation. • Government leadership for sensitizing law enforcement workers and health providers to provide a supportive environment for the right to health care by all populations.
Lesotho	• Policy implementation focus areas include: ○ HRH, with emphasis on recruitment and retention of health workers. ○ Enforcement of existing gender equality policy. ○ Passage of child protection and welfare law with a focus on OVC. ○ HIV testing and counseling policy revision. ○ Passage of national medicines policy. ○ Policies for service delivery, including male circumcision and TB/HIV coordination.	• The Lesotho government supported key policy changes that created a favorable legal environment for HIV preventions and control efforts, including enacting key legislation, such as the Education Act, the Anti-Trafficking in Persons Act 2010, and the Children's Welfare and Protection Act 2011. • The government also approved and supported the rollout of the health sector HIV and AIDS Workplace Policy.
Malawi	• Policy reforms proposed for nine technical areas: ○ HRH. ○ Gender. ○ Children's issues. ○ Uptake of counseling and testing.	• The PFIP Midterm review (2012) and COPs (2012/2013) noted that most of the policy reforms targeted for the nine areas defined under column one were completed, and that the USG and Malawi government were in discussions regarding new policy reforms for the next two years. Occasional delays in implementation of activities were attributed to lack of political will.

Country	PFIP Strategies Described for Policies and Governance	Available Evidence Regarding Implementation and Impact
	○ Increasing use of quality of pre-ART programs. ○ Access to quality, affordable medication. ○ Stigma and discrimination. ○ Strengthened multi-sectoral response. ○ Food and nutrition.	
Mozambique	• Policy focus areas in HIV service delivery included: ○ VMMC. ○ Virological monitoring of ART patients. ○ Anti-discrimination. ○ Preventing domestic violence. ○ Nutritional support for PLHIV, integration of OVC, counseling and testing. ○ Blood transfusion/ safety policy. • Policies for Health Systems Strengthening: basic social protection strategy; HRH development plan; and pharmaceutical and logistics master plan.	• Mozambique developed several official policies and guidelines on HIV and AIDS, the rights of PLHIV and persons affected by HIV and AIDS, and other health sector issues. • Completed policy changes, including assessment and development of Pharmaceutical Logistics Master Plan, national laboratory standards policy approved, blood transfusion policy approved, and national male circumcision strategy created. • Mozambique government developed a focused, evidence-based national policy and acceleration plan for the HIV response, with a comprehensive national vision that had clear objectives. • Some policies were not enforced or implemented, partly because of enormous HRH challenges. Although the Mozambique government increased funding for the health sector, there was a gap between the creation of these policies and allocation of staff and resources to guide policy implementation. • Pending policy changes: commodity security strategy, counseling and testing by lay counselors, and community health worker (CHW) implementation plan.
Nigeria	• Policy focus areas: ○ Anti-discrimination legislation to protect rights of PLHIV and affected persons. ○ Address gender in HIV programming and key populations. ○ Bill addressing violations of PLHIV's rights. ○ National HRH strategy, including task-shifting. ○ National medical laboratory policy. ○ Advocacy for workplace gender issues and women's empowerment. ○ Establishment of basic package of services for PLHIV and families. ○ National policies and guidelines for HIV prevention services, sexual and reproductive health, PMTCT, service integration, and HIV strategic behavior change communication. ○ National guidelines and procedures for support services, including laboratory services and child protection services. • USG support to strengthen state and local government capacity to plan and implement health system tasks, with a regionalization/rationalization strategy for coordinating efforts.	Nigeria completed the review and development of policies as follows: ○ Basic package of services for HIV-positive individuals and families was established by USG and the Nigerian government in FY2012. ○ HRH task-shifting—comprehensive task-shifting and task-sharing strategy for health cadres under development. ○ OVC—policies were pending National Executive Council's endorsement. ○ Anti-stigma bill—not yet passed. ○ Others—development of stigma index tool, operational definition of community- and home-based care, national guideline on care and support of widows and OVC, and lab accreditation policy. ○ Advocacy for policy change for women's empowerment and gender issues in workplaces. • Decentralization was a key strategy supported through PFIP as an avenue for realizing PEPFAR and Global Health Initiative goals of health services integration. PFIP Plus-Up funds were used for implementation of USG funded decentralization efforts.

Country	PFIP Strategies Described for Policies and Governance	Available Evidence Regarding Implementation and Impact
Rwanda	• Policy focus areas: ○ Implementation and/or evaluation of existing policies for HRH, quality assurance, gender, children, HIV counseling and testing, strategic information, and multi-sectoral policies. ○ Develop and/or endorse policies on medicine procurement, stigma and discrimination, decentralization, and increasing access to HIV services for key populations.	• Implemented task-shifting policies that have expanded the availability of ART. • Developed policies to strengthen HRH, including passing CHW policy • Alignment of the national HIV/AIDS program and policies with other national mandates like the Economic Development and Poverty Reduction Strategy, which elevated HIV/AIDS control as an economic imperative.
South Africa	• None identified	• N/A
Swaziland	• HRH policy, including task-shifting, recruitment, retention, and supervision. • National children's policy. • Pharmaceutical policy. • Decentralization of multi-sectoral approach. • Strengthen prevention policies. • Build commitment to male circumcision.	• HRH, Laboratory and Nutrition policies developed and approved.[8] • Pharmaceutical policy at parliament (PF review, 2014). • National Male Circumcision Policy and operational plan were developed and approved.
Ukraine	• Policy reform focus areas: ○ Reducing the various barriers to improving and expanding services for key populations, including financial, legal, administrative, and regulatory barriers. ○ Increase role of NGOs in service delivery for key populations and enable local governments to contract with NGOs. ○ Address contradictory policies for public health and drug control.	• AIDS law addressing support for drug substitution therapy, comprehensive prevention, and expanding NGO service delivery passed in 2011. Presidential orders to address drug use and improve HIV/TB response issued in 2011 and 2012. • Contradictory policies and police harassment continued to be a problem. Other areas of concern included policy barriers to programmatic expansion; poor health workforce pay and stigma, making it difficult to retain staff; and supply chain and procurement systems, which face poor oversight and lack funds for ARVs and commodities.
Vietnam	• Policy focus areas include harm reduction and drug substitution therapy, access to medications, human rights and stigma and discrimination, gender equity, children's issues, and strengthening HRH policy. • Strategies to improve policy areas including advocacy, and using existing USAID mechanisms for capacity-building. • Develop policy to bolster role of UN, and greater engagement of PLHIV in policy and programs.	• The Vietnam government passed the HIV and AIDS Prevention Law in 2013. Policy and legislative reforms related to HIV included the Law on Health Insurance and Law on Social Insurance. • Other legislation and policy directives included: ○ Mandate on increased government funding for HIV through the National Targeted Program on HIV (2011–2015). ○ Guidelines for HIV care and treatment that promote early access to ART. ○ Expansion of coverage of services for key populations, including removing barriers for prisoners in accessing care and treatment.
Zambia	• Support revisions of national policies for HIV/AIDS service delivery, biomedical and	• Government has driven the policy shift to Option B+ for HIV-positive pregnant

[8] Swaziland data sourced from PF review completed in 2014.

Country	PFIP Strategies Described for Policies and Governance	Available Evidence Regarding Implementation and Impact
	blood safety, and health workforce. • Other policy focus areas: HIV prevention and care for key populations, esp. MSM; gender-based violence; children's rights.	women. Other examples of policy reforms did not exist.

Table 4 PFIP Strategies for Planning and Coordination[9]

Country	PFIP Strategies Described for Planning and Coordination	Available Evidence Regarding Implementation and Impact
Angola	• USG to participate in development of a National Strategic Plan for HIV (2010–2014).	• PF served as a guide for developing PEPFAR activities, and it was an important step towards strengthening country collaboration, coordination, and accountability of HIV and AIDS programs by establishing and focusing on mutually defined strategies and measures of improved performance. • PEPFAR Angola staff were active participants in working group to assist development of National Strategic Plan. • By 2012, frequent meetings were held to share details and better coordinate activities, especially among donors. Plans developed to increase coordination of PEPFAR and Global Fund programs, with resources to be provided under Country Collaboration Funds.
Caribbean	• None identified	• N/A
Central America	• Host country-level meetings to discuss PF progress, with regional meeting; facilitated by the Central American Council of Ministers of Health to analyze progress and inform future planning.	• Evaluation found limited awareness of COMISCA and its role beyond MOH. Few respondents could name its contributions, and others noted that HIV was not a priority for ministers of health, so COMISCA has a potential role to play as a regional champion. • Planning and coordination between USG and local country stakeholders was difficult to assess given the regional nature of the PF/PFIP. However, the overlap between the development of the PF/PFIP and the Regional Strategy contributed to overall relationship-building and prioritization of common goals.
Dominican Republic	• Alignment between PF and the National Strategic Plan with ongoing consultation. • Dominican Republic government and PEPFAR consultation on implementation efficiencies.	
Ghana	• Establish PF Oversight Committee to ensure proper management and communication about the PF within the larger National Partnership Forum structure.	• The PF Oversight Committee was established with representative members from National AIDS Control Program, MOH, PLHIV umbrella association, network of NGOs in HIV and AIDS, and businesses. • The PEPFAR country team had close and continuous dialogue with leading Ghanaian government coordinating institutions, the Ghanaian AIDS Council, and National AIDS Control Program for policy and technical areas.
Kenya	• Improve coordination of stakeholders including development partners, Kenyan government, ministries, agencies, and civil society organizations (CSOs), especially those working with key populations and on gender. • Ensure regular, high-level Kenyan government policy and program engagement with all aspects of Global Fund operations and funds	• PEPFAR Kenya is part of the HIV Development Partners in Health Consortium, where donor and development partner health and HIV integrated agendas are promoted and shared.

[9] For Tables 3 to 12, all information is sourced for USG documentation, including but not limited to PEPFAR PFs, PFIPs, COPs, and evaluations, unless otherwise noted.

Country	PFIP Strategies Described for Planning and Coordination	Available Evidence Regarding Implementation and Impact
	management to strengthen accountability and performance of Global Fund resources. • Develop and support joint operational research agenda to ensure that HIV investments are optimally effective and epidemiological trends are continuously tracked and updated.	
Lesotho	• None identified.	• N/A
Malawi	• National AIDS Committee as a coordinator and major funder of the national response, and USG identified for policy oversight. • A technical steering committee created (including USG, MOH, Ministry of Finance and others) to oversee implementation of the PFIP.	• Mechanisms for accountability and transparency of the PF/PFIP included annual reviews of HIV and AIDS response, meetings of pool funding partners group, quarterly meetings of Country Coordinating Mechanisms and the Executive Committee of the Malawi Partnership Forum.
Mozambique	• Activities for PFIP included: o Increase joint planning and reporting. o Ensure alignment of USG COP and Mozambican government annual plans, with contributions to the HIV response accounted for and reported transparently in USG and Mozambican government planning and reporting cycles.	• The Mozambican government coordinated the five-year Health Sector Strategy development process. This process improved the clarity and focus of activities at the provincial level- harmonizing activities and targets across health programs to ensure measurable and coordinated outcomes.
Nigeria	• Strengthen coordination mechanisms of development partners and governments at all levels, and civil society to harmonize support to national response. • Increase efficiencies through economies of scale for joint training, supervision, or monitoring. USG and Nigerian government proposed to support functional State Action Committees on AIDS and Local Action Committee on AIDS to coordinate and monitor activities at state or local level. • USG, Nigerian government, and other stakeholder contributions benefit the same service delivery sites: USG will outline its contributions in terms of discrete activities and inputs, and not attribute results specifically to USG support.	• Joint planning and procurement design occurred between USG, the UK Department for International Development, UNICEF, and the World Bank with regard to sexual transmission prevention and OVC care and support efforts. • USG led a rationalization of treatment efforts through a geographic focus. A "Lead Implementing Partner" was identified for each state through joint planning and analysis in close collaboration with the National Primary Healthcare Development Agency, as well as the Global Fund under the Phase II Grants. Appropriate sites were identified to limit overlap and duplication. Fifty-four treatment sites, corresponding to 67,000 patients, were turned over to the National AIDS Council, which was to provide ongoing support using Global Fund resources.
Rwanda	• Provide leadership for the national strategic plans and coordinate programs/policies for implementation of the plan. • Ensure local stewardship by having host government institutions and individuals at the center of decision-making, leadership, and management of the national HIV/AIDS program.	• The MOH led coordination of donor assistance in the health sector. The Health Sector Working Group had been established to support this process. • Health sector partners, including USG, are signatories to the Sector-Wide Approach (SWAp). Through these mechanisms, partners adopted a common approach for coordinating planning, implementation, M&E under national oversight • Joint Health Sector Reviews were conducted regularly, providing an opportunity for effective tracking and measuring progress.

Country	PFIP Strategies Described for Planning and Coordination	Available Evidence Regarding Implementation and Impact
South Africa	• Ensure that the government's basic accounting system can generate timely reports on government spending for HIV and TB, and that PEPFAR can do the same for USG expenditures. • Design and test the "crosswalk" of resources between the South African government and PEPFAR expenditure categories so that the two funding streams are aligned and monitored. • Complete five-year Transition Plan for the transition of PEPFAR-supported clinical services tailored to individual/specific provincial needs. Engage provinces in related discussions. • PEPFAR activities to be integrated in South African government provincial and district plans. Provinces expected to budget for PEPFAR-funded activities and to make long-term plans for continuing to fund these programs. • Conduct annual expenditure analysis to assist in this effort and ensure that systems are in place for provinces and districts to have timely information about PEPFAR programs. Standardize district and provincial PEPFAR partner work plan templates.	• In FY2014, the PEPFAR budget decreased and funding amounts were shifted between activities. Funding shifts are reported as a result of analysis and planning with the South African government and other stakeholders to address gaps in the national HIV response and refocus PEPFAR investments. • Significant progress was made in planning and managing the transition for clinical services as well. • Comprehensive consultation process undertaken at the national, provincial, district, and partner levels to support the transition process.
Swaziland	• Strengthen national leadership and coordinate partners for prevention.	• Collaboration between PEPFAR and MOH appears to be effective, but collaboration with other ministries was less successful. • Coordination among PEPFAR implementing partners improved.
Ukraine	• Facilitate closer collaboration between government, CSOs, and donors, with a focus on coordination across partners.	• No available evidence regarding impact.
Vietnam	• Existing donor coordination mechanisms have limited effectiveness; it was hoped that joint planning structures, like PFIP, would re-energize donor coordination and improve efficiencies and strategic engagement.	• Coordination across donor agencies and stakeholders continues to improve, in part driven by a USG effort to encourage open dialogue about the most effective way to optimize collective support with diminishing resources.
Zambia	• Improve coordination and collaboration among the Zambian government, bilateral and multi-lateral cooperating partners, faith-based organizations, the private sector, and civil society.	• Strategy identified and no available evidence regarding impact.

Table 5 PFIP Strategies for Civil Society Engagement[10]

Country	PFIP Strategies for Civil Society Engagement	Available Evidence Regarding Implementation & Impact
Angola	• Support capacity development of civil society, including capacity strengthening of management and M&E systems for CSOs. • Enhance coordination of civil society through the creation of an Angolan Network of AIDS Service Organizations, a network of PLHIV, and a network of faith-based organizations. • Increase active participation of private sector network by up to 100 companies.	• Despite interest and leadership among NGOs and other local stakeholders, there is still limited capacity to fully take on activities.
Caribbean	• Build the capacity for leadership and advocacy of NGOs and community-based organizations (CBOs) working with and/or comprised of most at-risk populations.	• CSO capacity developed with focus on addressing stigma and discrimination for HIV programming among most at-risk populations.

Central America	• Support CSOs in addressing limited involvement and capacity in participating in strategic planning, policy design, and implementation, and M&E. Efforts to build capacity among civil society to assist with advocacy to government.
	• USG activities aimed at:
	  ○ Strengthening capacity of government and CSOs to enforce, monitor, and implement existing policies.
	  ○ CSOs participating and advocating in strategic planning and policy design and implementation.
	  ○ Strengthening skills of local organizations to integrate policies into interventions targeting structural and behavioral factors.
		• Supported CSO and NGO capacity-building in selected countries. There is still limited capacity among civil society for advocacy.
		• USG and other donors encouraged national stakeholders to engage CSOs and focus clearly on key populations (instead of the general population).

Dominican Republic	• Strengthen national response through active civil society participation in advocacy, policy dialogue, and activities. NGOs must become sustainable and need policy dialogue with the Dominican Republic government and private sector to support this. • Civil society proactively supports vulnerable populations, advocates for compliance with existing laws, and shares/disseminates best practices. • USG contractors to provide technical assistance (TA) for NGOs on administrative and financial capacities in order to reach MOH accreditation. • Umbrella grants to work with NGOs on institutional strengthening so that NGOs can eventually receive funds directly from MOH.	• Five CSOs serve on the Country Coordinating Mechanism and are more active in providing policy and program input. • USG supported CSOs and NGOs, building financial management capacity, with two NGOs going on to receive non-USG funds. • Civil society started to observe the influence of their advocacy on Global Fund and national response programs.
Ghana	• Strengthen capacity of CBOs to provide information and services to key populations and PLHIV.	• Thirty-five NGOs received technical and organizational training and mentoring to deliver high-quality interventions for key populations; 30 new drop-in care centers were established for this purpose.
Kenya	• Empower communities to advocate for better access to health services at the community level through effective implementation of and linkages to the Community Strategy.	• No available evidence regarding impact.

[10] For Tables 3 to 12, all information is sourced for USG documentation, including but not limited to PEPFAR PFs, PFIPs, COPs, and evaluations, unless otherwise noted.

Country	PFIP Strategies for Civil Society Engagement	Available Evidence Regarding Implementation & Impact
Lesotho	• PEPFAR will engage targeted civil society umbrella organizations to build capacity through training in financial and organizational management, mentorship and networking strategies, developing standards of service, and building data use capacity for program improvement. • The PF will collaborate with the National AIDS Commission, Lesotho Council of NGOs, and Global Fund to map CSO services and ensure an equitable spread of CSOs throughout Lesotho. As no Lesotho government ministry or agency has overall responsibility for coordinating civil society, the PF will seek to assist CSOs to develop stronger relationships with the Lesotho government, while maintaining independence in carrying out activities.	• Civil society in Lesotho is rather weak, and local organizations had limited capacity to implement programs. In addition, the Lesotho government lacked a strong M&E system to monitor civil society contributions and feedback on the HIV program and fiscal management. • CSOs were involved in the planning and development of the National HIV Prevention Strategy and the National Strategic Plan. They also played prominent roles in the development of the Elimination of MTCT strategy.
Malawi	• Provide TA to strengthen governance and build the capacity of CSOs in resource-tracking tools, and improve their ability to participate in the district budget process and health center oversight. • Train journalists and other media operatives to report on health sector issues and ensure adequate coverage of health sector problems and innovations.	• Civil society capacity is still very weak and needs further strengthening. The USAID funded Implementing Mechanism, AIDSTAR 2, was assigned responsibility to enhance CBO capacity to strengthen the AIDS response, including building a more favorable environment for advocacy and policy. • No evidence of engagement with journalists and other media.
Mozambique	• Support enabling environment for the engagement of the private sector in the design and delivery of health services.	• USG increased the capacity of CSOs and advocacy networks to inform Mozambican government planning and to increase transparency and accountability (e.g., the creation of civil society networks to better enable access to and sharing of key information, such as budgets, national plans, and laws).
Nigeria	• Support capacity-building to: assure implementation of policy; strengthen capacity of PLHIV to serve on decision-making bodies; and increase their representation; and empower CSOs to advocate for increased access to and funding for services. • Support community-based cadres of health and human rights educators to inform and mobilize communities on their rights to health, personal property, and freedom from violence and discrimination. • Support women-led and women-focused groups in developing and implementing plans promoting the rights of women living with or at risk for HIV.	• Nigerian government led efforts to develop and implement policies for PLHIV and people affected by AIDS. USG supported greater involvement of PLHIV and people affected by AIDS in decision making processes at all levels.
Rwanda	• Provide assistance to associations of PLWHA to shift to the status of cooperatives, and help income-generating activities of PLHIV to be more competitive and sustainable.	• USG developed direct arrangements with local CSOs to enhance Rwanda's local capacity.
South Africa	• Build capacity of community structures and leadership to coordinate with relevant South Africa government departments to improve and sustain the HIV/TB response by actively linking the community to HIV/TB services.	• No available evidence regarding impact.
Swaziland	• Develop capacity for NGOs and umbrella body, including technical, governance, HR, and financial capacity. • Provide complementary funding for NGO program and operational costs.	• Capacity-building of NGOs relatively successful.
Ukraine	• Focus on institutional capacity-building local NGOs, to improve capacity for planning and implementing national response.	• CSOs providing services for key populations but are fragile and sustainability is questionable. Services to key populations could not

Country	PFIP Strategies for Civil Society Engagement	Available Evidence Regarding Implementation & Impact
	• TA to NGOs for program capacity (e.g., management, quality assurance, HR, planning) and service delivery (e.g., prevention, stigma and discrimination).	be sustained without external support. Funding to CSOs is limited and capacity for service delivery is uneven.
Vietnam	• None identified.	• N/A
Zambia	• Focus on building partnerships and capacity within the private sector.	• No available evidence regarding impact.

3.3.2 National Health System and Service Delivery

The countries reviewed represented a wide spectrum of types of HIV epidemic, including in terms of HIV prevalence and affected populations. However, all PFIPs included a specific focus on host government support for national programs and service delivery. Under this domain, the common themes present in all 16 countries were: Service Delivery, HRH, Commodity Security and Supply Chain, Quality Management, Laboratory, and Key Populations. Following the narrative below are a series of tables outlining the implementation strategies and impact for those countries included in this study.

Service Delivery

All 16 countries had explicit language on increasing access to and demand for HIV prevention, care, and treatment services (Table 6). The approach and interventions varied based on economic status and country categories. In four countries/regions (Vietnam, Central America, the Caribbean, and the Dominican Republic) emphasis was on TA rather than direct service delivery. South Africa highlighted prevention activities, despite the transition of USG support from direct service delivery. In the remaining countries (n=7), high-impact biomedical interventions were a focus of prevention strategies, with activities ranging from policy interventions (e.g., VMMC and PMTCT policies and guidelines), to direct support for service delivery and quality assurance. Promotion and scaling of VMMC was a priority for Angola, Ghana, Kenya, Lesotho, Malawi, Swaziland, and Zambia. PMTCT also featured significantly as a focus of prevention efforts in these same seven countries, and as well as the Dominican Republic. Targeted prevention strategies and activities were defined to reach key populations and address HIV stigma and discrimination. For example, key population activities were specifically developed as a main focus in Angola, Central America Region, Dominican Republic, Nigeria, South Africa, Ukraine, Vietnam, and Zambia.

In addition to prevention strategies, all 16 countries prioritized strengthening HIV care and treatment, although the emphasis of interventions varied (Table 6). Countries such as Vietnam and South Africa began transitioning from direct service delivery through PEPFAR support towards more TA. Several countries achieved tremendous success in expanding ART to eligible populations of PLHIV. A few examples are highlighted below:

- At the time of initiation of the PFIP (2010) in Kenya, there were approximately 1.3 million PLHIV, with 56,000 new infections, and 41% of PLHIV accessing lifesaving ART (UNAIDS 2011, AIDS Info Database). At the end of the PFIP implementation period in 2013, there were approximately 1.4 million PLHIV, 56,000 new infections, and 55% of PLHIV were accessing ART (UNAIDS 2014, AIDS Info Database). In the Kenya COP 2013, PEPFAR reported that in addition to the 588,000 PLHIV on ART, over 900,000 PLHIV were engaged in care.
- Malawi increased the percentage of PLHIV accessing ART from 31% in 2010 to 50% in 2013 (UNAIDS 2011 and 2014, AIDS Info Database), and rolled out an electronic data system for better care coordination. Malawi also conducted significant and successful training for health workers, and supported the national public service delivery system to deliver ART services.
- Rwanda scaled up ART coverage from 44% of PLHIV in 2010 to 68% of PLHIV in 2013 (UNAIDS 2011 and 2014, AIDS Info Database), supporting ART services at no cost for patients. In addition, key policy changes such as task-sharing helped make ART available at more facilities.
- In Vietnam, HIV treatment coverage increased, demand for HIV testing and counseling increased, early treatment initiation improved, and the country scaled up ART coverage from 26% of PLHIV in 2010 to 37% in 2013.

Human Resources for Health

Countries or regions that identified HRH as a pivotal issue overwhelmingly shared priorities on improving HRH sufficiency. Priorities ranged from recruitment and hiring of new workers, to task-shifting, developing capacity of health workers through in-service training, and mentoring to improve management systems. All 16 countries mentioned some HRH strategies, although in some cases (e.g., Ukraine, Nigeria) they were not well elaborated.

In Lesotho, the PF/PFIP agreement dedicated over 50% of the PEPFAR budget to HRH and health systems strengthening activities, showing deep commitment to improving human resource capacity. Zambia planned to provide management courses, deploy a formal CHW strategy, and support task-shifting. Others had more-specific HRH issues to address, such as improving equity through HRH redistribution (Dominican Republic), external migration of skilled health workers (Caribbean Region), and improved information system to manage the workforce (South Africa). Vietnam focused on long-term institutional structures and workforce capacity. Human Resource Information Systems (HRIS) were key parts of the strategic plans for several countries, including Angola, Dominican Republic, Lesotho, and South Africa.

In practice, HRH investments achieved some significant health system gains, although persistent challenges remain. Successes include the following:

- Angola created a field epidemiology training program and developed the capacity of epidemiologists.
- Ghana made progress with training the health workforce: over 4,000 health staff planned to graduate by September 2014 from pre-service training. In addition, more than 1,000 staff were trained in quality assurance methods, and 3,500 health staff were trained in stigma reduction.
- The Dominican Republic completed a human resources audit leading to plans for acting on its results.
- Lesotho established an HRIS at the central level, deployed minimum staffing levels for health centers, approved and rolled out an HRH retention strategy, increased training for health workers and CHWs, and task-shifted to create a cadre of health assistant staff based at health centers. Lesotho also had funding through the central PEPFAR Nursing Education Partnership Initiative, which was used to improve the quality and quantity of enrollments.
- Given the limited overall numbers of health workers, Rwanda prioritized task-shifting and expanded nurse roles, while also focusing on capacity-building and retention.
- South Africa supported the development of an HRH strategy, with district health plans, as well as a government-managed HRIS system.
- Vietnam focused on improving HRH and used professional medical associations, which represent a new and important cohort for continued training.
- Zambia hired almost 2,000 new health care workers in 2012, invested to construct 650 health posts in 2013, and added a new cadre of Community Health Assistants.

Commodity Security, Supply Chain, Laboratory, Quality Assurance, and Improvement

All the PFs/PFIPs proposed activities that could be categorized under the umbrella of health systems strengthening. Most often this involved a focus on HRH as discussed above, as well as investments in supply chain management, laboratory capacity, and quality assurance and improvement. Supply chain issues were consistently referred to as a constraint, and were a priority for nine of the 16 countries. Laboratory system improvements generally focused on improving HIV and TB diagnostics and blood safety; these were highlighted in nine of the 16 PFIPs. These findings are further detailed in Table 8. Some program highlights are as follows:

- The Caribbean improved country laboratory systems and developed a functional regional reference laboratory network.
- Ghana supported the accreditation of national reference laboratories. The national blood transfusion service improved, and a logistics management system was established to ensure ARV security.
- Kenya increased capacity for supply chain management; the accreditation of laboratories was pivotal in turning around laboratory quality systems.
- Lesotho strengthened laboratory capacity, including the development of HIV Quality Assurance schemes and training for computerized laboratory systems. The government also established supply chain strategies for a functional and decentralized procurement system.
- Mozambique improved national laboratory infrastructure under the Becton-Dickinson laboratory strengthening program, and improved management of Central Medical Stores.
- Zambia strengthen the National Blood Bank, which is now semi-autonomous, and staff previously paid by PEPFAR transitioned to government. Zambia also strengthened intra-district logistics supply systems covering drugs and laboratory commodities by procuring essential vehicles.

Key Populations

Four out of 16 study countries included strategies to expand commitments to key populations in the PFs/PFIPs, including three countries with concentrated epidemics: Central America, Dominican Republic, and Ukraine (Table 9). Strategies proposed in the PFs/PFIPs were focused on engaging governments and other stakeholders in dialogue to recognize the need to emphasize key population-oriented programming. On the whole, these efforts were met with limited success, with host governments not directing needed funds towards key population activities. This was a considerable challenge in contexts where key population programming was only supported by donors and/or delivered by CSOs (i.e., Central America, Dominican Republic, and Ukraine). Nigeria and Vietnam had activities aimed at improving commitments to key populations, despite having no specific PF/PFIP strategy. Examples of success are described below:

- Vietnam conducted surveillance activities to determine size estimates for key populations, and specifically expanded services to key populations, including prisoners.
- Ghana developed a national HIV/AIDS Most At-Risk Population Policy that was implemented by the National Most At-Risk Population Implementation Plan. Thirty-five NGOs received technical and organizational training and mentoring to carry out high-quality key population interventions.

Table 6 PFIP Strategies for Service Delivery[11]

Country	PFIP Strategies for Service Delivery	Available Evidence Regarding Implementation and Impact	Selected PEPFAR APR Results[12] 2010[13]	2014
Angola	• Focus on prevention, with emphasis on VMMC, PMTCT, and TB co-infection.	• Developed USG cooperative agreement for support of National Blood Centre. • Started gender-based violence initiative. • The Angolan government supported the majority of HIV care and treatment, with additional support from the Global Fund.	• Current on ART: N/A • Current care and support (C&S): N/A • VMMC: N/A	• Current on ART: N/A • Current C&S: N/A • VMMC: N/A
Central America	• Address gaps in service delivery for key populations. • Address the limited availability of quality HIV/AIDS and STI services, and inadequate use of HIV testing and counseling services for key populations. • Regional program was primarily a TA model with less emphasis on direct service delivery.	• Ensured that key populations were a priority for PEPFAR support, working primarily through local NGOs and focusing on capacity-building of CSOs. • Supported STI sentinel surveillance at public clinics, and community-level outreach in rural areas and among the military. • Supported 90 hospitals in six countries on quality improvement; all countries have institutionalization plans. • Supported 27 community networks to promote prevention activities with key populations.	• Current on ART: N/A • Current C&S: N/A • VMMC: N/A	• Current on ART: N/A • Current C&S: N/A • VMMC: N/A

[11] For Tables 3 to 12, all information is sourced for USG documentation, including but not limited to PEPFAR PFs, PFIPs, COPs, and evaluations, unless otherwise noted.
[12] Sourced from PEPFAR Dashboards February 2016 - the selected PEPFAR results are taken for 2010-2014 for comparison across countries, even though some of the PFIPS ran over different years. Please note N/A indicates that data for this indicator was not available, whereas 0 indicates a reported result of zero.
[13] Some countries, especially those categorized as TA countries, did not have available data in the PEPFAR dashboards.

Country	PFIP Strategies for Service Delivery	Available Evidence Regarding Implementation and Impact	Selected PEPFAR APR Results[12] 2010[13]	2014
Caribbean	• Explore cost-effective methods of delivering services. • Institutionalize non-discriminatory services and reduce barriers to key populations receiving services.	• Provided TA to improve service delivery by integrating HIV services into primary care. • Used south-to-south TA from Guyana, Haiti, and the Dominican Republic. • The Pan Caribbean Partnership against HIV and AIDS developed regional guidelines and protocols for ART—results varied by country and donor support.	• Current on ART: N/A • Current C&S: 331 • VMMC: N/A	• Current on ART: N/A • Current C&S: 2,000 • VMMC: N/A
Dominican Republic	• Focus on prevention activities through local NGOs; key areas included PMTCT, ART, and blood safety. • Reach universal access to integrated care and treatment; program areas of focus were adult and pediatric care and treatment, TB/HIV co-infection, and OVCs.	• Supported 16 facilities (priority hospitals and national and armed forces reference labs) to provide quality PMTCT. • Implemented lab strengthening program. • Increased capacity building for service delivery.	• Current on ART: N/A • Current C&S: 24,500 • VMMC: N/A	• Current on ART: N/A • Current C&S: 17,300 • VMMC: N/A
Ghana	• Focus on direct services to decrease new infections and to increase access to care and treatment for PLHIV. • Specific strategies for improving quality, and building capacity for diagnostics. • Scaling up the HIV direct care services and reaching more of the target populations, especially for ART care. • PMTCT focus to reach 80% of eligible women.	• Forty facilities provided quality assurance activities for HIV services, and additional staff were trained. • ART drop-in centers contributed to 72% of ART coverage goal by end of 2013. • Supported interventions for key populations, and PLHIV services helped to exceed targets. • Thirty-five NGOs received technical and organizational training and mentoring to carry out high-quality key population interventions independently. Thirty new drop-in care centers were established	• Current on ART: N/A • Current C&S: 46,900 • VMMC: N/A	• Current on ART: N/A • Current C&S: 61,500 • VMMC: N/A
Kenya	• Prevention major goal of PFIP—e.g., create VMMC taskforce to influence policy and programs. • ART and PMTCT scale-up initiating new clients using updated guidelines.	• Sustained scale-up ensured provision of services. • Over 80% of HIV+ adults who knew their status were enrolled into care by December 2012.	• Current on ART: 410,200 • Current C&S: 1,300,000 • VMMC:112,500	• Current on ART: 744,100 • Current C&S: 1,300,000 • VMMC: 229,300
Lesotho	• Three of the five PFIP goals focused on service delivery to reduce HIV incidence by 35% by 2014, including through rapid scale-up of VMMC. • Scale-up of HIV and TB treatment.	• Developed national pediatric elimination strategy; adopted Option B+ regimen for PMTCT. • Revitalized TB/HIV technical committee. • Established Nutrition Technical Working Group. • No available evidence on the reduction of HIV incidence by 35% by 2014.	• Current on ART: 45,600 • Current C&S: 47,400 • VMMC: 0	• Current on ART: 118,400 • Current C&S: 162,800 • VMMC: 39,100

Country	PFIP Strategies for Service Delivery	Available Evidence Regarding Implementation and Impact	Selected PEPFAR APR Results[12] 2010[13]	2014
Malawi	• Government adopted new prevention strategy, with a focus on VMMC. • Expand coverage of ART and scale up of Option B+ for PMTCT.	• Strengthened community-based pre-ART and health service integration. • Improved pre-ART service quality by developing essential care package for facility- and community-based pre-ART care.	• Current on ART: N/A • Current C&S: 157,400 • VMMC: 0	• Current on ART: 488,100 • Current C&S: 765,000 • VMMC: 68,300
Mozambique	• Two goals focused on HIV care and treatment: expand ART enrollment, and ensure blood transfusion safety. • Strengthen capacity of government, CSOs, and private sector to deliver comprehensive HIV services for high-risk populations. • Develop clear plan for decentralization and integration of HIV services within Primary Health Care.	• Developed new tools for non-ART patients to allow a better longitudinal tracking system. • Improved coordination of care and support activities. • Mapped existing community and clinical services. • Developed a comprehensive HIV basic care package for PLHIV and OVCs.	• Current on ART: 138,800 • Current C&S: 584,900 • VMMC: 4,000	• Current on ART: 491,600 • Current C&S: 876,000 • VMMC: 160,600
Nigeria	• Establish package of HIV services that included TB/HIV activities and opportunistic infection prevention and management • Scale- up ART services in high burden states. • Promote health service integration. • Connect with social welfare services.	• Strengthened and scaled TB/HIV services. In 2011, 20,521 TB/HIV patients identified and put on treatment. • Increased commitment to rapidly scale-up key services, including increasing the number of women receiving PMTCT and the number of people on treatment with more streamlined regimens. • Increased number of people on ART and those on treatment for STIs.	• Current on ART: 334,600 • Current C&S: 1,100,000 • VMMC: N/A	• Current on ART: 610,500 • Current C&S: 2,700,000 • VMMC: N/A
Rwanda	Goals 1-3 focused on reducing incidence and expanding treatment to reduce mortality: ○ Reduce the incidence of HIV in the general population. ○ Reduce morbidity and mortality among PLHIV. ○ Ensure people infected and affected by HIV/AIDS have the same opportunities as the general population.	• Harmonized services among donors, which contributed to results. • Developed and adopted updated clinical guidelines and protocols. • Adopted Option B+ resulting in more than 95% of facilities providing PMTCT. Achieved over 90% ART coverage (2013).	• Current on ART: 53,700 • Current C&S: 183,600 • VMMC: 896	• Current on ART: 118,300 • Current C&S: 268,200 • VMMC: 74,800

Country	PFIP Strategies for Service Delivery	Available Evidence Regarding Implementation and Impact	Selected PEPFAR APR Results[12] 2010[13]	2014
South Africa	• Develop prevention framework and launch accelerated PMTCT. • Transition care and treatment to South African government and manage shift of PEPFAR resources from direct service delivery.	• Implemented the Accelerated PMTCT Plan that resulted in universal access to PMTCT services across the country and a decrease to 2.7% in early transmission. • Rapid increase in access to ART and improvement in the TB cure rate to 74% (2011). • In 2014, PEPFAR transitioned 35,000 patients to the South African government.	• Current on ART: 917,700 • Current C&S: 2,100,000 • VMMC: 14,900	• Current on ART: 2,600,000 • Current C&S: 3,800,000 • VMMC: 327,400
Swaziland	• Prevention was a priority with a focus on PMTCT and VMMMC, and reducing sexual transmission. • Support community-based HIV care and scale-up ART.	• Improved PMTCT coverage. • Improved access to care and treatment services but significant progress was required to ensure quality of care.	• Current on ART: 38,700 • Current C&S: 120,600 • VMMC: 19,700	• Current on ART: 88,000 • Current C&S: 196,200 • VMMC: 11,900
Ukraine	• PF proposed to increase focus on key populations. • Health service integration.	Increased focus on delivery of comprehensive and integrated package care within primary health care. Strengthened service integration addressing HIV co-morbidities, including TB and addressing stigma within the public sector.	• Current on ART: N/A • Current C&S: 13,900 • VMMC: N/A	• Current on ART: N/A • Current C&S: 1,900 VMMC: N/A
Vietnam	• Support the transitions to a TA model, rather than direct service delivery. • Goal 1 focused on key populations. • Improve policies and practices for HIV control among key populations.	• Shifted fully to focus on long-term strengthening of institutional structures. • Designed a transition program for implementing partners to strengthen their role as TA providers. • HIV treatment scale-up with a focus on health service integration. • Expanded ART coverage.	• Current on ART: 31,000 • Current C&S: 100,200 • VMMC: N/A	• Current on ART: 53,500 • Current C&S: 80,700 • VMMC: N/A
Zambia	• Prevention focused on PMTCT, VMMC, and reducing new infections. • Scale-up treatment and reduce loss to follow-up. • Improve adherence and retention.	• Supported PMTCT program as the country started implementation of Option B+, treating all HIV infected pregnant women with lifelong ART. • Direct government-to-government funding continued with Centers for Disease Control and Prevention's 16 cooperative agreements with 12 Zambian government entities.	• Current on ART: 285,900 • Current C&S: 976,000 • VMMC: 21,200	• Current on ART: 583,900 • Current C&S: 1,600,000 • VMMC: 239,400

Table 7 PFIP Strategies for Human Resources for Health[14]

Country	PFIP Strategies for Human Resources for Health	Available Evidence Regarding Implementation and Impact[15]
Angola	• HRH pre-service training, focused on long-term strategy to address low workforce capacity. • Conduct HRH assessment; support creation of HRH information systems; promote policy reforms for task-shifting; and address recruitment, retention, and administration concerns.	• Supported HRH through various mechanisms that used intensive interactions such as mentoring and on-the-job training (e.g., Strengthening Laboratory Management Towards Accreditation, and Field Epidemiology and Laboratory Training Program); close collaboration on common activities (e.g., antenatal care surveillance); and creation of sustainable systems for health. • Developed field epidemiology training program. • Created HRIS.
Central America	• Improve HRH sufficiency by addressing high staff turnover and performance management.	• Developed HRH capacity through revised/updated pre-service and in-service training curricula; established performance information system to monitor care and treatment. • Supported training at universities for comprehensive HIV care and to reduce stigma.
Caribbean	• HRH training to compensate for internal and external migration of skilled health personnel.	• Training focused on improving standard HIV treatment protocols. • Used south-to-south TA from Guyana, Haiti, and the Dominican Republic. Examples of programs to be replicated included the health worker buddy system model and the Haitian Group for the Study for Kaposi's Sarcoma and Opportunistic Infections, or GHESKIO's gender violence prevention program in Haiti, the strong NGO sector in Haiti and the Dominican Republic, and the HRH strategies with the Medex program and PMTCT program in Guyana.
Dominican Republic	• Improve performance of health workers and support proper training and deployment of current staff (rather than recruitment of new hires).	• HRH audits performed to improve health worker distribution and management. • Trained over 100 individuals in Field Epi program.
Ghana	• Increase recruitment to improve capacity and retention.	• Four thousand health staff planned to graduate in 2014 with pre-service training in HIV. • More than 1,000 staff trained in HIV Quality Assurance, and 3,500 health staff trained in stigma reduction. • Thirty-five NGOs received technical and organizational training and mentoring to carry out high-quality key populations interventions.
Kenya	• Support the Community Health Strategy.	• Deployed new nurses and CHWs to each district supported by the Community Health Strategy.

[14] For Tables 3 to 12, all information is sourced for USG documentation, including but not limited to PEPFAR PFs, PFIPs, COPs, and evaluations unless otherwise noted.

[15] The specific PEPFAR HRH indicators were not formally adopted at the time of PFIP implementation. The documents sourced therefore do not report HRH accomplishments in the form of the Indicators on Pre-Service training (HRH_PRE) or the development of a HRIS Assessment framework (HRH_HRIS).

Country	PFIP Strategies for Human Resources for Health	Available Evidence Regarding Implementation and Impact[15]
	• Task-shifting was a key HHR strategy to expand access to at least 80% of PLWHA.	• Expanded the provision of life-skills education training for teachers.
Lesotho	• Expand preservice training through infrastructure investment. • Address HRH policy gaps.	• HRH policies on retention and deployment; HRH retention policy approved. • Task-shifting a major focus of HRH strategies; new policy created a cadre of staff at health centers. • Established the HRIS for both public and private not-for-profit NGO sector.
Malawi	• Develop strategies to address HRH insufficiency. • Provide technical support to MOH to reduce staff turnover and build the capacity of health service staff through trainings.	• HRH Strategic Plan developed and TA provided to MOH to improve health worker retention. • Multiple health worker trainings conducted; continuous technical support to the Government of Malawi through trainings and mentoring of staff.
Mozambique	• Create cadres of community-based social workers to strengthen linkages between health and social systems at the district level.	• Intensified training and deployment of the revamped official MOH cadre of CHWs and rollout of the Community Adherence and Support Groups model.
Nigeria	• Provide TA in HRH management.	• Updated key training curricula.
Rwanda	• CHW policy. • Improve the availability and rational use of HRH.	• Task-shifting was a main priority, which resulted in an expansion of scope for nurses. By the end of 2012, at least 1,464 nurses had been trained to task-shift, enabling them to prescribe ARV drugs for standard ART patients (first line regimen). • Invested in recruitment, capacity-building, and retention strategies of health workers.
South Africa	• Support rollout of HRH strategy.	• Increased support to the South African government-managed HRIS to develop a plan for transition of 3,000 HRH posts from PEPFAR. • Within the first year of PFIP, the Transitional Task Team for Clinical Services assumed oversight of PEPFAR-supported HRH to the public sector.
Swaziland	• HRH identified as a major constraint affecting service delivery.	• Developed and approved the HRH policy and strategy. • Developed capacity for HRH management. • Salary support for key MOH positions, and capacity building of training institutions.
Ukraine	• TA to strengthen HRH planning systems.	• No available evidence.
Vietnam	• Prioritize human capacity-building, with a focus on pre-service training. • Improve the participation of professional medical associations to support HRH.	• Trained provincial personnel in updated data management software, such as HIV Info 3.0. • Improved capacity of the Vietnam Administration of HIV and AIDS Control and provincial committees.
Zambia	• Implement formal CHW strategy as part of task-shifting and deploy 10,000 CHWs. • Address HRH insufficiency.	• Government committed to hiring new health workers, and created cadre of Health Assistants. • Government integrated key staff originally on PEPFAR payroll.

Table 8 PFIP Strategies for Commodity Security, Supply Chain, Laboratory, Quality Assurance, and Improvement[16]

Country	PFIP Strategies for Commodity Security, Supply Chain, Laboratory, Quality Assurance, and Improvement(QA/QI)	Available Evidence Regarding Implementation and Impact
Angola	• Laboratory capacity was a main priority. • Infrastructure highlighted as a main area of focus. • Support decentralization by increasing provincial-level planning and finance management.	• Improvements made to laboratory and supply chain management through implementing mechanisms such as sustainable systems for health, SIAPS, SLMTA. • Increased capacity of provincial directorates of health to appropriately budget and plan for health activities including HIV.
Central America	• Develop institutional capacity for quality assurance. • Emphasize TA for supply chain management. • Improve laboratory capacity.	• Support provided for decentralization of care, TA for performance improvement, and supply chain management, including infrastructure improvements and logistics.
Caribbean	• TA to strengthen health systems related to drug procurements and laboratory strengthening.	• The Pan Caribbean Partnership against HIV/AIDS conducted regional bulk procurements; results varied by country and donor support. • Improved country laboratory systems and developed a functional regional reference laboratory network.
Dominican Republic	• Provide TA for improved planning and procurement of ARVs.	• Implemented laboratory strengthening program. • Supported capacity-building for blood safety and laboratory strengthening.
Ghana	• Support national Laboratory Strategic Plan and infrastructure. • Strengthen health management and capacity of CSOs.	• Accreditation of national reference lab laboratories. National blood transfusion service improved. • Logistics management system established to ensure ARV security. • Thirty-five NGOs received technical and organizational training and mentoring to carry out high-quality key population interventions. Thirty new drop-in care centers were established.
Kenya	• Develop and strengthen integrated quality-assured networks within the laboratory system. • Improve supply chain management. • Increase capacity of Kenyan health facilities to deliver quality HIV services.	• Increased capacity for supply chain management • Accreditation of laboratories was pivotal in turning around laboratory quality systems. • Over 1,000 health facilities across all 47 counties offered HIV care and support services by 2012.
Lesotho	• Strengthen laboratory services and supply chain management. • Build technical capacity in national drug supply organization.	• Strengthened laboratory capacity including the development of HIV quality assurance schemes and training for computerized laboratory systems. • Deployed supply chain strategies to establish functional and decentralized procurement system.

[16] For Tables 3 to 12, all information is sourced for USG documentation, including but not limited to PEPFAR PFs, PFIPs, COPs, and evaluations, unless otherwise noted.

Country	PFIP Strategies for Commodity Security, Supply Chain, Laboratory, Quality Assurance, and Improvement(QA/QI)	Available Evidence Regarding Implementation and Impact
Malawi	• Improve drug availability and build capacity of Central Medical Stores; leverage Global Fund resources. • Promote quality of laboratory services.	• Supported Central Medical Stores reform through technical advisors that were placed within the MOH. • Supported laboratory infrastructure, transport system for samples, and quality of services through trainings, mentorship, and equipment. • Refurbished a central reference laboratory for TB.
Mozambique	• Decrease direct procurement of ARV commodities to focus resources on strengthening laboratory, pharmaceutical management, and procurement systems.	• Improved national laboratory infrastructure, under the Becton-Dickinson laboratory strengthening program. • Improved management of Central Medical Stores.
Nigeria	• Invest in procurement and supply chain management.	• The USAID-funded Supply Chain Management project worked to strengthen procurement and the supply chain for HIV/AIDS commodities, and developed training modules and resources for partners managing supply chain activities.
Rwanda	• Strengthen the human and institutional capacity of the public health system to plan, manage, and implement sustainable health programs at all levels.	• Improved procurement and distribution system for HIV drugs and other health commodities.
South Africa	• Support capacity building in supply chain at the district levels	• Districts received support for leadership, management training, and mentorship to strengthen different health systems strengthening functions, including supply chain management.
Swaziland	• Improve the operation of public health facilities, including laboratory and central medical stores.	• Supported the Swaziland Medicines Regulatory Authority to ensure consistent availability of drugs and commodities.
Ukraine	• Laboratory strengthening, supply chain management, and capacity development are highlighted.	• Provided technical assistance and support to the Ukrainian Centre for Socially Dangerous Disease Control, especially around laboratories, data use, procurement, and supply chain • TA and logistical support provided for national HIV reference laboratory and regional laboratory network.
Vietnam	• Support the provision of sustainable HIV and AIDS services through strengthening systems.[17]	• Designed a transition program for implementing partners to strengthen their role as TA providers and gradually transfer activities to non-PEPFAR sources. • In the last year, USG activities shifted towards intensified TA for capacity-building at both the national and provincial levels, across institutions and for targeted recipients.

[17] Given Vietnam's categorization as a TA country, some specific health systems strengthening functions were often not delineated in detail; rather the emphasis was on building institutional structures and focusing on HRH and health financing as essential to health systems strengthening efforts.

Country	PFIP Strategies for Commodity Security, Supply Chain, Laboratory, Quality Assurance, and Improvement(QA/QI)	Available Evidence Regarding Implementation and Impact
Zambia	• Strengthen National Blood Bank. • Strengthen subnational logistics system.	• Blood Bank is now semi-autonomous, and staff previously paid by PEPFAR have transitioned to government. • Strengthened intra-district logistics supply systems covering drugs and laboratory commodities by procuring essential vehicles.

3.3.3 Strategic Investments, Efficiency and Sustainable Financing

We divide the discussion here into two related elements, domestic resource mobilization and measures to enhance technical and allocative efficiencies. Following the narrative below are a series of tables outlining the implementation strategies and impact for those countries included in this study.

Domestic Resource Mobilization

Host government funding for the national HIV and AIDS response varied widely, with some countries and regions financing most of the national response (i.e., Angola, Central America, and South Africa), and others relying heavily on external partners (i.e., Lesotho, Malawi, and Zambia). Middle-income countries typically faced considerable funding challenges due to decreasing donor funding and pressure from major funders to "graduate" from assistance. For example, Vietnam—a middle-income country—was expected to take on an increasing proportion of its HIV and AIDS funding. However, at the time when the PF was signed, it supported only a very modest proportion of total HIV and AIDS funding.

Twelve of the 16 PFs/PFIPs included explicit language about increasing domestic financing for HIV and AIDS. There were exceptions to this. For example, in Swaziland, the language of the PFIP suggested identifying appropriate benchmarks for domestic financing, which implied increasing domestic funding. In Malawi, there was no clear commitment to increased domestic financing, but instead an emphasis on securing follow-on financing from the Global Fund.

The activities and strategies to support the planned increase in domestic financing for HIV and AIDS varied by country, but include developing health financing strategies and policies (n=2); benchmarking government spending (n=2); supporting various forms of health insurance (n=3); exploring the scope for innovative financing mechanisms (n=2); conducting analyses such as National Health Accounts and projections regarding the funding gap (n=2); securing support from the Global Fund (n=2); and engaging different stakeholders, such as Ministries of Finance, through the development of an investment case to support increased funding allocations (n=1). Countries typically employed more than one strategy in this domain.

Table 10 presents available data on the implementation and impact of the PFIP in terms of securing additional domestic resources for HIV and AIDS. In seven out of the 16 countries (Ghana, Kenya, Lesotho, Mozambique, Rwanda, South Africa and Zambia) there are concrete achievements. Elsewhere the picture is more mixed. For example, in Vietnam, while the government made clear commitments to increase funding for HIV and AIDS, an unexpectedly deteriorating economic outlook prevented them from achieving this commitment. In other countries and regions (e.g., the Caribbean, Nigeria, and Swaziland), little progress could be identified based on the reviewed documents. Interestingly, Angola's funding of the HIV epidemic fell from 82% from the start of the PF (2009) to 62% in 2012. This may be an example of donors "crowding out" local funding.

Further examples are highlighted below:

- Mozambique focused on developing innovative approaches, including public-private partnerships, and increasing government revenue for health, which increased to 13% by 2013.
- Kenya committed to increasing budgetary commitments to health by at least 10% annually and reduced the proportion of budget appropriations to health that are returned "unspent" to the treasury by at least 20% annually for each year of the PFIP.
- Zambia increased domestic resource allocation for HIV. For example, the domestic budget for ARV procurement increased from $5 million in 2011 to $45 million in 2014; and government financing for procurement of laboratory commodities increased from $1.2 million in 2012 to $5.4 million in 2014 of an estimated $40 million needed annually.

- The Dominican Republic's national response was funded by external donors. The government committed in 2012 to increase its commitments up to USD $1.9 million for ARV drugs. This was partly driven by funding reductions from the Global Fund.
- The Rwandan government elevated domestic health financing as a national agenda and increased funding for health (from 10% at the start of the PFIP to a projection of 15% by the end of 2016).

Technical and Allocative Efficiencies

Fifteen out of the 16 study countries included some commitments in their PFs/PFIPs to improve efficiency in resource allocation and use. These details are presented in Table 11.

Many of these countries (n=8) included commitments to strengthening financial management capacity or systems, often at the subnational level. The second most popular strategy (n=7) concerned the use of analytics, such as cost-effectiveness analysis to enable countries to identify existing inefficiencies in their HIV and AIDS programming and address them, or national health accounts or expenditure tracking which would shed light on the sources and flow of funding for HIV and AIDS, and occurrence of bottlenecks. In three countries or regions (Central America, Dominican Republic, and Ukraine), the focus was primarily on resource allocation and matching the pattern of resource allocation to need.

In each of these contexts, the focus appeared to be on shifting funding towards programming for key populations. In a further three countries or regions (the Caribbean, Mozambique, and Vietnam), a central strategy for promoting efficiency was to improve coordination among donors, presumably to avoid over-funding specific aspects of HIV and AIDS programming and under-funding others.

Evidence regarding the extent to which strategies to enhance efficiency were actually implemented and had an impact is relatively weak, with this topic being less frequently addressed in subsequent COPs and other national documents reviewed than the area of domestic resource mobilization. In several countries, the proposed financial and economic analyses were implemented, but it is not clear what impact, if any, these had on policy and programming. Rwanda stands out as an exception to this pattern. The Rwandan government made some significant changes to enhance the efficiency of its HIV and AIDS programs through stronger monitoring, improved allocation of resources, and decentralization. Some other examples are described below:

- Vietnam undertook cost-effectiveness studies to guide allocations and conducted periodic reviews of its AIDS spending.
- Malawi committed to improved resource tracking and financial management through the institutionalization of National Health Accounts.
- Nigeria developed the National HIV and AIDS M&E Plan to track domestic/international spending by category, and developed the national composite index to measure performance and evaluates HIV impact on development.
- Mozambique supported MOH decentralization by strengthening institutional capacity, and transferring some resources directly to provinces.

Table 9 PFIP Strategies for Domestic Resource Mobilization for HIV[18]

Country	Percentage Total HIV and AIDS Funding from Government at Time of PFIP Start[19]	PFIP Strategies for Domestic Resource Mobilization for HIV	Available Evidence Regarding Implementation and Impact
Angola	82%	• None identified.	• Government support to HIV and AIDS fell to 60% by 2012.
Central America	Varied across countries- e.g. 39% in Nicaragua to 65% in Panama	• None identified.	lo available evidence
Caribbean	N/A	• Work with countries that are heavily reliant on donor funding to develop health financing reforms.	• 2013 COP proposed the need for sustainability plans that benchmark government funding needed (i.e., not in place by 2013)
Dominican Republic	16% government; 49% external donors-; rest out of pocket	• Increase government budget allocations, and benchmark government funding commitments. • Increase government's financial commitments to health sector and national response. • Improve procurement plan, and incorporate Global Fund financed HRH costs into national budget.	• Government committed to allocate $1.9 million for ARVs in 2012; unclear whether allocation was implemented (COP 2013)
Ghana	20%	• Strengthen domestic financing through National Health Insurance Scheme.	• In 2012, the government announced $100 million contribution to the National Strategic Framework III, with >50% increase in domestic funding; however disbursement of funding were delayed. • The 2013 National HIV and AIDS and STI policy commits to increasing domestic financing and reducing out-of-pocket payments.
Kenya	25%	• Increase general budget appropriations for health by >10% annually, and reduce budgeted appropriations for health that are returned unspent by at least 20% annually.	• Launched a national sustainable financing strategy review process involving HIV stakeholders. • Reduced percentage of budgeted appropriations for health returned unspent to treasury by at least 20% annually for each year of PF period

[18] For Tables 3 to 12, all information is sourced for USG documentation, including but not limited to PEPFAR PFs, PFIPs, COPs, and evaluations, unless otherwise noted.
[19] For all countries, this corresponds to the PFIP start date, i.e. the specific year when the PFIP was developed as outlined in Table 2 of Section 3, unless otherwise noted.

Country	Percentage Total HIV and AIDS Funding from Government at Time of PFIP Start[19]	PFIP Strategies for Domestic Resource Mobilization for HIV	Available Evidence Regarding Implementation and Impact
		• Explore innovative financing mechanisms, e.g., changes in taxation policy, and public-private partnerships.	• Increased direct budget support by >10% annually through purchase of ARVs.
Lesotho	5%	• Develop National Health Financing Policy to mobilize domestic resources for HIV. • Conduct further health financing analyses.	• Government increased its allocation to health to 14% of its budget. • HIV program received additional $38 million of public funding. • Government increasingly assumed greater responsibility for financial planning decisions.
Malawi	5%	• Conduct and institutionalize National Health Accounts. • Secure Global Fund support after the expiry of the Global Fund grant in 2012.	• National Health Accounts completed. • Received interim Global Fund grant in 2013 (but needs to re-apply for longer-term commitment).
Mozambique	Projected at 25% in 2009	• Develop innovative approaches to domestic health financing (including public/private partnerships). • Secure stable Global Fund and other donor funding. • Transition financial sustainability of key health expenditures to government.	• For 2013, government allocated nearly 13% of its budget to health, a considerable increase on its 2012 allocation. • Global Fund increased resources for Round 9 Phase II grant. • USG preparing to decrease allocation of HIV commodities in FY2014.
Nigeria	7%	• Increase government financing from 7% of national HIV and AIDS response in 2008 to 50% by 2015. • Create investment case to promote appropriate funding for HIV and AIDS.	• 2013 President requested AIDS commission to develop two-year action plan to address funding shortfall. • Plans to track spending and index developed to assess impact of HIV spending.
Rwanda	Projected at 10% (2009/10)	• Government to take over funding of specific elements of HIV response. • Increase support for Rwanda's already existing community-based health insurance.	• Government has increased funding for health (from 10% at start of PFIP to 15% of government budget). • Elevated health financing as a national agenda.
South Africa	Approx. 68%	• PEPFAR funds to decrease gradually, projecting government covering 88% of HIV and AIDS funding by 2017.	• Decline in PEPFAR funding took place more rapidly than anticipated. By 2013, government was funding 75% of overall HIV and AIDS programs
Swaziland	Approx. 30%	• Define funding gaps and set accurate benchmarks for financial commitments.	• Continued limited understanding of the costs of scaling up HIV response.

Country	Percentage Total HIV and AIDS Funding from Government at Time of PFIP Start[19]	PFIP Strategies for Domestic Resource Mobilization for HIV	Available Evidence Regarding Implementation and Impact
Ukraine	Data not available	• Overall aim to increase government allocations to HIV at national and subnational levels; USG to provide analytical support.	No available evidence.
Vietnam	2% (PEPFAR funding, 88%)	• Increase domestic financing and improve donor coordination. • Pilot health insurance scheme for PLHIV.	• New program to promote financial sustainability for HIV developed for period 2013–2020; emphasis on health insurance and public/private partnerships. • Despite positive commitments, HIV and AIDS program experienced reduced funding from government due to economic recession in-country.
Zambia	1.4%	• Explore strategies to increase domestic financing, e.g. establish an HIV and AIDS fund.	• Government allocations to the HIV response increased significantly during (e.g., domestic budget for ARV procurement increased from $5 million in 2011 to $45 million in 2014). • Government financing for procurement of laboratory commodities increased from $1.2 million in 2012 to $5.4 million in 2014 of an estimated $40 million needed annually.

Table 10 PFIP Strategies for Technical and Allocative Efficiencies[20]

Country	PFIP Strategies for Technical and Allocative Efficiencies	Available Evidence Regarding Implementation and Impact
Angola	• Support provincial-level operational planning, financial monitoring, and gap analysis, including follow-up to National Health Accounts conducted in 2009. • USG to provide TA to strengthen financial management, accountability, and planning systems.	• No available evidence.
Central America	• Change resource allocation to better reflect epidemic needs (e.g., stronger focus on key populations). • USG to provide TA to strengthen fiscal management, allocative efficiency, compliance with financial commitments, and costing analyses.	• Little or no change in resources allocated by government to services for key populations. • Prevention activities continue to be funded by donors.

[20] For Tables 3 to 12, all information is sourced for USG documentation, including but not limited to PEPFAR PFs, PFIPs, COPs, and evaluations, unless otherwise noted.

Country	PFIP Strategies for Technical and Allocative Efficiencies	Available Evidence Regarding Implementation and Impact
Caribbean	• Reduce inefficiencies impacting service provision across the region, including contracting and procurement rules that differ by agency, requirements for redundant reviews and reports, and competing national and regional priorities. • Regionalize certain functions, e.g., bulk procurement of commodities to enhance efficiency. • Conduct financing assessment and cost analyses to identify scope for enhanced efficiency.	• Mid-term evaluation suggests that these goals were not fully met.
Dominican Republic	• Explore how the government can support NGOs directly or through advocacy to the private sector (which was funding some work). • Encourage the government to increase financial allocations to NR • Provide TA to MOH for ARV planning, procurement and financing.	• With forecasting support from USG, the Dominican Republic government agreed to allocate USD $1.9 million for ARV procurement, with huge pressure by reduced future funding from the Global Fund. • The Global Fund and PAHO held discussions with the Dominican Republic government regarding future funding, and both were willing to help the government to project future needs.
Ghana	• Improve targeting of HIV and AIDS expenditure. • Conduct cost-effectiveness studies to enhance efficiency of services.	• Cost-effectiveness studies were conducted and revealed very low (<1%) allocation to key population programs.
Kenya	• Plan to sustain HIV-related resource allocation from the Exchequer to all ministries to support Sectoral mainstreaming of HIV and AIDS in line with Kenya National AIDS Strategic Plan (KNASP) III and medium term plan (2008-2012).	• Sustained HIV-related resource allocation from Exchequer to all ministries to support sectoral mainstreaming of HIV and AIDS in line with the KNASP III and the medium term plan.
Lesotho	• Facilitate more-effective tracking of HIV and AIDS resources using methodologies such as National AIDS Spending Assessments (NASA) and National Health Accounts, to enable greater government responsibility for funding. • Integrate financial management systems across relevant government ministries.	• Government took on responsibility for strategic development and financial planning decisions.
Malawi	• Conduct and institutionalize National Health Accounts, including HIV and AIDS subaccounts, and enhance ability to use them. • Strengthen financial management.	• National Health Accounts were completed. • Strengthening of financial management is ongoing.
Mozambique	• Ensure financial and admin autonomy for Central Medical Stores and increase efficiency and flexibility of procurement. • Improve utilization of available state and donor resources.	• USG supported MOH decentralization by strengthening institutional capacity, and transferring some resources directly to provinces.
Nigeria	• Increase use of performance tracking between state and local governments and incentives (i.e., fund matching) to improve management of programs. • Develop database mapping of donor resources.	• National HIV and AIDS M&E Plan to track domestic/international spending by category. • National Composite Index developed to measure performance and evaluate HIV impact on development.
Rwanda	• Provide TA to the MOH financial unit to improve its capacity for cost reduction, revenue generation, and cost-sharing of services.	• Observed stronger commitment from government to increase efficiencies including:

Country	PFIP Strategies for Technical and Allocative Efficiencies	Available Evidence Regarding Implementation and Impact
	• Provide support to the development of performance based financing systems.	○ Allocating domestic resources to priority areas such as health workforce; ○ Devolving responsibilities to the district level; and ○ Improved monitoring mechanisms and joint sector reviews.
South Africa	• Strengthen national and provincial capacity to more efficiently manage funds.	• Developed joint USG and SAG consensus for sustainability. • Key priorities included planning in close partnership with provincial and district leadership to transition PEPFAR-supported patients to the public sector; mapping PEPFAR-supported HRH in public sector health facilities; and deliberate absorption into the government payroll.
Swaziland	• Build capacity and implement stronger financial management systems. • Develop more robust cost estimates for planned interventions.	• Ongoing challenges in coordinating funds available through different sources. • Continuing need for stronger management systems to track available funds. • Limited understanding of the costs associated with HIV scale-up.
Ukraine	• Provide TA to support more-effective allocation of resources, especially to key populations.	• No available evidence.
Vietnam	• Improve coordination of donor activities to promote more effective use of existing resources.	• Government undertook cost-effectiveness studies to guide allocations and is conducting periodic reviews of its AIDS spending. • Government is developing a plan to improve access to quality and affordable HIV commodities beyond 2015.
Zambia	• Strengthen financial management capacity and transparency to protect against future "irregularities."	• No available evidence on addressing irregularities. However government support for the procurement of laboratory commodities increased from $1.2 million in 2012 to $5.4 million in 2014. According to the MOH Medium Term Expenditure Framework for 2012-2014, government resources for the health sector in general and HIV/AIDS specifically increased.

3.3.4 Strategic Information

All of the country PFIPs developed strategies and actions to support the availability and coordination of data on the HIV response across government entities, donors, and partners. Most of the interventions focused on the core area of harmonizing indicators and M&E approaches to align with the UNAIDS principle of "Three Ones."[21] Ten out of the 16 countries also developed strategies to improve country capacity for data surveillance, performance of surveys, and epidemiological studies. There was less emphasis on strategies to improve use of financial data collection for resource and expenditure tracking, although a few examples are highlighted under the Domestic Resource Mobilization domain (for example, in Lesotho and Malawi). Accordingly, this discussion has been divided into the following areas: Epidemiological and Health Data, Performance Data, and Financial and Economic Data. Following the narrative below are a series of tables outlining the implementation strategies and impact for those countries included in this study.

Epidemiological and Health Data

Ten of the 16 countries developed strategies for host governments to assume increased oversight for data management, including capacity building for conducting epidemiologic surveys and studies, and data analysis to inform program and policy decisions. Angola, Mozambique, Ukraine, Vietnam, the Dominican Republic, and the Central American region proposed implementation of different studies and behavioral surveillance surveys to enhance disease estimation, including among key populations. Ghana, Lesotho, Mozambique, Nigeria, and Rwanda all highlighted capacity building and strengthening for national surveillance systems, with a focus on improving data quality and use.

Progress and achievements made in this area were not easily ascertained in the reports reviewed, as efforts in building capacity in data and management were not frequently reported independent of related service delivery statistics or health outcomes. However, emerging success stories are highlighted below:

- Ghana implemented several surveillance activities. Ghana also made significant progress in surveillance M&E, and upgraded the Health Management Information System (HMIS) reporting to a web-based system, the District Health Information System (DHIS2).
- Vietnam developed capacity of the Vietnam Administration of HIV and AIDS Control (VAAC) to improve data collection and tracking of financial data, and to improve HIV epidemiologic surveillance systems.
- The Caribbean supported national and regional human capacity for surveillance and routine program monitoring though training, supportive supervision, and mentorship.
- Central America supported STI sentinel surveillance; MEGAS study; M&E courses; knowledge, attitudes, and practices studies for key populations; and behavioral surveillance surveys. These studies represent reliable sources of evidence for policies and proposals.

Performance Data

Coordinating between PEPFAR Next Generation Indicators and indicators in National Strategic Plan M&E frameworks was a priority identified across PFIPs, as illustrated in Table 13. Ten countries (Angola, Central America, Dominican Republic, Ghana, Lesotho, Malawi, Nigeria, Rwanda, Vietnam,

[21] The Three Ones refers to three key principles of an HIV and AIDS response as defined by UNAIDS: (1) one agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners; (2) one National AIDS Coordinating Authority, with a broad-based multi-sector mandate; and (3) one agreed country-level M&E system.

and Zambia), proposed activities for the harmonization of indicators between PEPFAR and national M&E systems. These were often combined with capacity development for local national institutions, improving the accessibility of data, and creating an enabling environment for transparency.

Some examples are highlighted below:

- Vietnam trained provincial personnel in updated data management software, e.g. HIV Info 3.0.
- Nigeria adopted the DHIS as a national platform for electronic reporting, developed the five-year year Nigerian National Response Information Management System and Operational Plan, and conducted annual Joint National Data Quality Assessments.
- Malawi introduced a new electronic data system and touchscreen technology, and supported institutionalization of the M&E framework at the national level. The government developed an interagency Data Quality Assessment strategy to focus on verifying data quality with support from the USG Strategic Information team.
- Lesotho developed a new data system, the Lesotho Output Monitoring System for HIV and AIDS, to support implementation.
- Ghana strengthened the national M&E system, and the District Health Information Management System was upgraded to DHIMS2, a web-based and secure system with support from USG.
- Central America provided TA to foster a regional M&E plan with nine common indicators agreed upon through a consultative process.
- Angola harmonized PEPFAR Next Generation Indicators with the National Strategic Plan and the National M&E Plan, and transitioned EPI-Info based data management component of the 2011 antenatal care survey to the Angola School of Public Health.

Financial and Economic Data

Financial and economic data was broadly addressed in the 16 PFs/PFIPs in a myriad of ways, but commonly in the context of financial accountability, resource tracking, and transparency. Eleven out of 16 countries outlined potential activities related to broad financial management, accounting and audits, compliance, and transparent resource monitoring and planning. Other strategies included transparency of investments between the local government and USG, including PEPFAR budget activities being reported and included in local planning (n=4), explicit strategies to improve transparency around procurement (n=3), and strategies for reducing duplication and improving efficiency, including an audit of HRH (n=2). Four PFs/PFIPs (Central America, Ghana, Lesotho, and Zambia) did not identify strategies around financial and economic data.

Four countries had explicit evidence of activities around promoting expenditure data collection (Nigeria, Rwanda, Vietnam, and Zambia). For example, resource-tracking exercises were undertaken in Nigeria (e.g., Public Expenditure Tracking Survey), and training modules around financial accountability were developed under the national M&E plan. In Rwanda, harmonized resource-tracking was conducted to capture commitments from all partners. In Angola, decentralization was identified as an important factor challenging expenditure tracking. Rwanda and Malawi are two of the countries which showed evidence of increased expenditure tracking.

Table 11 PFIP Strategies for Epidemiological and Health Data

Country	PFIP Strategies for Epidemiological and Health Data	Available Evidence Regarding Implementation and Impact
Angola	• Implement three behavioral surveillance surveys with an AIDS indicators survey and qualitative studies on sexual behavior and male circumcision.	• Supported behavioral surveillance surveys to estimate HIV prevalence and behavioral patterns among prisoners, diamond miners, and long-distance truck drivers (key populations in Angola).
Central America	• TA to improve monitoring, including surveys and surveillance with key populations.	• Supported STI sentinel surveillance, MEGAS study, M&E courses, and knowledge, attitudes, and practices studies for key populations; and behavioral surveillance surveys. Studies represent the most reliable source of evidence for policies and proposals.
Caribbean[22]	• Train a critical mass of surveillance officers, M&E staff, epidemiologists, and service providers with skills in advanced data analysis, report writing, advanced epidemiology, surveys and special studies, and population size estimation.	• Supported national and regional human capacity for surveillance and routine program monitoring though training, supportive supervision, and mentorship.
Dominican Republic	• Support studies to characterize the epidemic among key populations.	• Supported data collection efforts with a focus on Demographic Health Surveys and Behavioral Surveillance Surveys for key populations. • Strengthened surveillance systems for TB, established new reportable diseases system, and made improvements in electronic medical records.
Ghana	• Support national surveillance and M&E systems; conduct HIV incidence surveillance and integrate health and HIV data systems.	• Several surveillance activities were implemented: HIV-1 incidence in Ghana; Ghana Female Sex Worker Study; Ghana Men's Study; HIV risk factors in Kumasi prison; program needs of young female sex workers; and transactional sex among female university and technical college students (2011).
Kenya	• Emphasizes using the goals, indicators, and M&E framework developed in the KNASP III. • Use the KNASP III to guide the collection of HIV epidemiological data, e.g., through the Kenya AIDS Indicator Survey, Demographic Health Survey, or the Modes of Transmission Study.	• Conducted different surveys to guide programs. High level outcome indicators and trends in HIV prevalence were captured using population based surveys (e.g. , Kenya AIDS Indicator Survey and Kenya Demographic Health Survey). • Demographic Surveillance Systems were used to monitor HIV/AIDS-related mortality, and antenatal care sentinel surveillance were used to track annual trends
Lesotho	• Support information technology and coordinate the development of population-based surveys, surveillance systems, and other service availability mapping.	• No available evidence.
Malawi	• None specific to surveillance.	• No available evidence - focus in Malawi was less on population based epidemiologic surveys/surveillance activities, and more on improving routine HMIS data systems as described in the table on performance data.

Country	PFIP Strategies for Epidemiological and Health Data	Available Evidence Regarding Implementation and Impact
Mozambique	• Strengthen national disease surveillance systems to improve the quality of services and data.	• Conducted sentinel surveillance work (antenatal care surveys) and behavioral surveillance among key populations (2011).
Nigeria	• Support Nigerian government efforts to use DHIS as a reporting platform. • Develop a national surveillance system to track HIV incidence rates.	• DHIS was formally adopted by government. • Increased support for country ownership and ability to oversee national data systems.
Rwanda	• Conduct program monitoring through a range of strategic information activities: surveillance data, population-based surveys, facility surveys, program evaluations, and, public health evaluations to assess impact.	• Developed and instituted an electronic data monitoring system, the TRACnet.
South Africa	• Support improvements in DHIS; rol lout of three-tier ART reporting system, and development of core national surveillance systems including incidence monitoring.	• No documentation was found on results from M&E of the PFIP. • The PFIP M&E Framework was supposed to mirror that of the newly developed South Africa National Strategic Plan. • Other efforts were made to increase support for the South African government on surveillance, surveys, and data quality assurance.
Swaziland	• Planned study of sexual networking to create tools to measure and monitor multiple partner concurrency; no results on whether conducted.	• Evaluation indicated that behavioral surveillance and program evaluation of HIV prevention efforts were conducted once in 2010.
Ukraine	• Focus on building surveillance systems and capacity to collect and analyze data on the epidemic and key populations.	• No available evidence.
Vietnam	• Include surveillance methodologies in future preservice training curriculum. • Develop Vietnam government's SI planning and capacity to undertake surveillance, M&E, and management information system.	• Improved HIV epidemiologic surveillance systems focusing on five main components: HIV case reporting, health systems strengthening, STI surveillance, size estimates for key populations, behavioral surveillance surveys, and training of key personnel.
Zambia	• Strengthening the capacity for surveillance and use of data for decision-making and programming.	• The Zambian MOH and its respective HMIS functions were split into two during implementation, with the creation of the Ministry of Community Development and Maternal and Child Health. Embedded key in both ministries, helped to develop capacity by working side-by-side with ministry counterparts. Key areas included organizational-level capacity and systems to collect, store, analyze and present HIV-related data.

Table 12 PFIP Strategies for Performance Data[23,24]

Country	PFIP Strategies for Performance Data	Available Evidence Regarding Implementation and Impact
Angola	• Provide TA to support indicator harmonization, data synthesis, and operations research. • Request for USG support to build the evidence base for decision making.	• Harmonized PEPFAR Next Generation Indicators with the National Strategic Plan and the National M&E Plan. • Transitioned EPI Info based data management component of the 2011 antenatal care survey to the Angola School of Public Health.
Central America	• Support harmonization indicators and systems. • Promote use of data for decision-making. • Share data across the region.	• TA to foster a regional M&E plan with nine common indicators agreed upon through a consultative process. • Supported national HMIS and helped harmonize monitoring tools across the region. • Continued support for monitoring capacity with trainings in data analysis/use.
Caribbean	• Develop harmonized data collection methodologies for strategic information at the national, facility, and community levels to facilitate trend analyses and comparisons of HIV and AIDS data within a country and across the region.	• No evidence, but mid-term report suggested that gaps in local capacity for M&E persisted.
Dominican Republic	• Harmonize indicators between PEPFAR and government. • Support development of a single, integrated M&E system.	• Harmonized PEPFAR and Dominican Republic government indicators in 2010.
Ghana	• Strengthen and use the national M&E system to inform the HIV and AIDS response. • Support data harmonization, acquisition, analysis, and dissemination to support HIV and AIDS prevention and treatment services. • Build capacity of the Ghana AIDS Commission and the National AIDS Control Program.	• National M&E system was strengthened. The District Health Information Management System was upgraded to DHIMS2, a web-based and secure system by the Ghanaian health service with support from USG. • Improvements were made to ensure M&E completeness and timeliness of HMIS reporting.
Kenya	• Conduct quarterly and semi-annual program reviews, and a mid-term and end-of-term review, as described in the KNASP III.	• Government of Kenya assumed leadership in harmonizing indicators for the national M&E framework, PEPFAR, UNGASS, and universal access reporting requirements. • No available evidence on conducting regular semi-annual/end-of-term reviews.
Lesotho	• Ensure monitoring plans support the "Three Ones" principle. • Strengthen data quality, dissemination, and use, e.g., through the mentoring of district health management teams and District AIDS Councils to produce quarterly reports.	• Supported data harmonization for the "Three Ones" through working with the Lesotho government, the Millennium Challenge Account-Lesotho, and other donors to build consensus and operate with one M&E system. • Developed new data system (the Lesotho Output Monitoring System for HIV and AIDS) to support implementation.

[23] For Tables 3 to 12, all information was sourced for USG documentation, including but not limited to PEPFAR PFs, PFIPs, COPs, and evaluations, unless otherwise noted.

[24] Strategies on tracking, collecting, and analysing financial/expenditure data were not consistently reported as a key strategy under the PFIP reviews. There were some exceptions where the PFIP made reference to conducting expenditure/financial tracking or using these systems; these are discussed in the narrative.

Country	PFIP Strategies for Performance Data	Available Evidence Regarding Implementation and Impact
Malawi	• Roll out electronic data systems in high-volume facilities. • Align USG monitoring indicators with Malawi government indicators. • Provide TA to districts and zones to better use data to improve the quality of their programs.	• Introduced a new electronic data system and touchscreen technology. • Supported institutionalization of the M&E framework at the national level. • Developed an inter-agency data quality assessment strategy to focus on verifying data quality with support from the USG strategic information team.
Mozambique	• Build strategic information capacity within local Mozambican institutions.	• Strengthened strategic information systems to provide quality information for monitoring and decision making.
Nigeria	• Finalize and disseminate a national HMIS that incorporates electronic data down to individual patient and cohort levels. • Harmonize M&E indicators and tools development.	• Adopted the DHIS as a national platform for electronic reporting. • Developed the five-year year Nigerian National Response Information Management System and Operational Plan, and Annual Joint National Data Quality Assessments.
Rwanda	• Improve data accessibility and quality. • Enhance data utilization and coordinate reporting systems. • Support the electronic data monitoring system.	• Developed and instituted an electronic data monitoring systems, the TRACnet. The success of this program may not be directly attributed to the PF/PFIP; however, it was developed in 2004 through PEPFAR support as a national HIV database.
South Africa	• Support implementation of unique patient identifiers to improve patient tracking in the system. • Support improvement of DHIS.	• The PFIP M&E Framework was designed to mirror that of the newly developed South Africa National Strategic Plan.
Swaziland	• Limited capacity for M&E. • Conduct exercises to improve M&E design and implementation.	• No available evidence.
Ukraine	• Support the building of a national system M&E system for HIV. • M&E of the PFIP was intended to capture all partner contributions through measurable indicators on multiple levels (e.g., goals and targets, policy reform, harmonization with others, and building capacity).	• No available evidence.
Vietnam	• Harmonize the different systems into one national M&E system through the "Three Ones." • Train provincial personnel in updated data management software, such as HIV Info 3.0.	• Improved strategic information systems to harmonize the different systems into one national M&E system as recommended by the United Nations. • Trained provincial personnel in updated data management software, such as HIV Info 3.0, and improved capacity of the Vietnam Administration of HIV and AIDS Control and provincial committees.
Zambia	• Develop M&E capacity. • Strengthen partner reporting system and facilitate data use. • Mainstream national M&E framework and harmonize in line with the "Three Ones."	• Supported harmonization of the HMIS between the two ministries and established policies and procedures for continued functioning of the two systems.

Table 13 PFIP Strategies for Financial and Economic Data[25]

Country	PFIP Strategies for Financial and Economic Data	Available Evidence Regarding Implementation and Impact
Angola	• None identified.	• N/A
Caribbean	• Work with countries, regional organizations, and donors to streamline program and financial reporting, promote efficiencies in HIV programming, and help plan for long-term financial sustainability of HIV programs in the region.	• No available evidence.
Central America	• None identified.	• N/A
Dominican Republic	• Support active and transparent competition process for procurement. • HRH audit planned to support rational redeployment.	• In an effort to improve Dominican Republic government management capacity, the MOH vice Minister (who chairs the Country Coordinating Mechanism) asked the Country Coordinating Mechanism to name the Vice Ministry for Collective Health as the Primary Recipient of Global Fund TB funds. Three PEPFAR agreements are in place with MOH to strengthen capacity and improve stewardship at MOH. • HRH audit completed in 2011; MOH to use the results to revamp the HRH system.
Ghana	• Improve the targeting of resources through use of resource tracking exercises, e.g. the Resource Needs Model, and the National AIDS Spending Assessments.	• Conducted study to explore the influence of National Health Accounts, but this was not followed by system changes. • Conducted costing assessments that revealed HIV spending across key program areas, e.g., one important finding revealed that less than 1% of the overall national HIV/AIDS program budget was for most at-risk population interventions, although most at-risk populations had the highest prevalence.
Kenya	• None identified specific to resource/expenditure tracking.	• N/A
Lesotho	• None identified specific to resource/expenditure tracking.	• N/A
Malawi	• Conduct National Health Accounts exercises, including sub-accounts for HIV, malaria, child health, and family planning/reproductive health. • Institutionalize National Health Accounts to ensure that activities related to collecting, analyzing, and reporting health care spending are systemized. • Ensure availability and accuracy of information on health expenditure.	• Supported National Health Accounts in that was conducted in 2010 and officially disseminated in 2012. • The National Health Accounts revealed greater reliance on development partner support than previously understood, although the government did not make a specific commitment to increase its own funding for HIV programs (low resource country).

[25] For Tables 3 to 12, all of the information was sourced for USG documentation, including but not limited to PEPFAR PFs, PFIPs, COPs, and evaluations, unless otherwise noted.

Country	PFIP Strategies for Financial and Economic Data	Available Evidence Regarding Implementation and Impact
Mozambique	• Costing exercises were planned to inform planning and budgeting.	• No available evidence.
Nigeria	• Develop improved financial management, automated procurement, and audit management system to achieve certification on use of funds. • Conduct resource tracking.	• The Public Expenditure Tracking Survey in Nigeria and the Health Systems 20/20 Project in FY2008–2009 showed weaknesses in resource tracking across states and local government authorities. • Conduct training on financial management for health system managers to focus on local and state-level managers.
Rwanda	• Improve financial accountability and resource tracking.	• Harmonized resource tracking tools were developed with USG support to capture commitments from all partners and facilitate coordinated planning and transparency in both partner and MOH budgets.
South Africa	• Design and test the "cross walk" between SAG and PEPFAR expenditure categories so that the two funding streams can be aligned and monitored.	• Conducted the "cross walk" expenditure tracking activities that informed funding decisions by the South African Government, which increased HIV spending through conditional grants. • Progressive shifts in funding were reported as a result of analysis and planning with SAG and other stakeholders to address gaps in the national HIV response and refocusing of PEPFAR investments.
Swaziland	• Develop more robust cost estimates for planned interventions, precisely defining funding gaps and setting accurate benchmarks for financial commitments. • Build capacity and implement stronger financial management systems.	• Evidence on implementation is unclear but it is noted that Swaziland continues to face challenges to effectively monitor the funds currently available through existing supporting institutions and funding sources, and there is need to develop management systems in both the public and non-governmental sector to allow better tracking and absorption of available funds.
Ukraine	• Improve financial management, including resource monitoring, and strengthen national and subnational councils to improve planning and budgeting capacity.	• No available evidence.
Vietnam	• Increase government financial accountability through periodic reviews of its AIDS spending.	• Conducted National AIDS Spending Assessments (2010) to provide a benchmark for future resource tracking activities.
Zambia	• None identified.	• No available evidence.

4. DISCUSSION

4.1 Development and Implementation

In many respects, **the process of developing the PFs/PFIPs epitomized the spirit of country ownership with the engagement and active leadership of a large number of country partners**. The consultative processes employed appeared to be inclusive of a variety of stakeholders, though in some settings, especially those with concentrated epidemics, PLHIV organizations were excluded. The PFs/PFIPs also sought high-level engagement by national governments as reflected in the array of signatories to the PF, which typically went beyond the minister of health.

The process of PF/PFIP development also varied across PEPFAR regions and countries depending on categorization of countries, income levels, and the operating units involved. For example, **the development was considerably more complex for the regional PFs/PFIPs** (Central America and Caribbean), involving a multitude of local partners, as well as multiple national HIV and AIDS strategies.

While there were significant changes and achievements made, at times the implementation process did not meet the ambitious goals expressed within the PFIP/PF agreements. Based on the four PFIP evaluations and detail derived from implementation documents, it was evident that **PF/PFIP implementation processes often failed to sustain high-level oversight of the PF/PFIP, and management structures typically dissipated quickly**. Despite language in the original documents that addressed oversight and accountability structures, PFs/PFIPs in practice did not provide a way of holding stakeholders accountable. The structures proposed in the PF/PFIP either did not have authority to ensure the commitments were followed through, or seemed to never be fully operationalized.

Furthermore the **PFs and PFIPs were not living documents that could remain relevant during a changing donor landscape and economic crisis**. While activities described in the PF/PFIP were constantly reprogrammed in the COPs, there was no systematic process for re-evaluating and revising the PF/PFIP, particularly in response to changing environments. The Vietnam PF/PFIP was an exception; this PF/PFIP did explicitly consider the rapidly changing aid environment and sought to take account of how other development partners might change their funding strategies over the course of the PF/PFIP. In other cases, however, there was no explicit consideration of these points, and this may have left countries vulnerable as multiple funders changed support strategies in an uncoordinated fashion. This was especially true for countries/regions undergoing transition planning, where the timing and nature of the transition was unpredictable.

4.2. Sustainability Domains

Governance, Leadership, and Accountability

In general, national governments demonstrated a high level of commitment to and leadership of the HIV response. At the time the PF/PFIPs were developed, many governments were also developing or finalizing national instruments and institutions to manage the response. For example, national AIDS strategic plans and national AIDS councils existed in all of the countries examined. The majority of countries outlined strategies, and implemented policy and legislative reforms. These were primarily focused on expanding and scaling up HIV service delivery, policies on strengthening health systems, and creating a positive and enabling environment for HIV/AIDS programming, i.e., addressing stigma and discrimination, reducing gender based violence, and promoting rights of PLHIV. The results of

these efforts were mixed across countries, with distinct progress witnessed in increasingly favorable legal and policy environments, enacting national HIV prevention laws and workforce policies.

Similarly, most countries (n= 13)) did emphasize improved planning and donor coordination as a key principle within the PFs and PFIPs. Strengthening formal structures for information sharing was explicitly planned for in half of the PFs or PFIPs, and was important enough in many countries to be reflected throughout implementation. Formal structures took on various modalities, including oversight committees, health sector working groups, health development partner initiatives, and lead partner initiatives.

Most PFs/PFIPs (n=14) included civil society engagement as important for diverse groups and stakeholders to make contributions and provide feedback for the successful implementation of the response. Efforts in this area placed a special emphasis on capacity strengthening, as well as specific work on advocacy, financial management, and network building activities. While several countries supported and worked with CSOs, the effects and outcomes of CSO engagement are difficult to measure. In addition, it was recognized that civil society strengthening is a long-term effort.

National Health Systems and Service Delivery

All PFs/PFIPs explicitly highlighted service delivery goals, and almost all achieved progress in service delivery for HIV/AIDS prevention, care and treatment. While the emphasis varied by country, prevention was a major program area, focusing on the scale up of high impact interventions such as PMTCT and VMMC. Achievements in expanding ART to eligible populations were made in all countries that delivered services directly. However, it was more difficult for countries with more concentrated epidemics and a TA approach to demonstrate attributable results in specific service outcomes.

Health systems strengthening was a major area of focus for all PFs/PFIPs, and the majority of countries invested in HRH, supply chain, laboratory capacity, and quality assurance. HRH in particular was a pivotal issue across all 16 countries. Strategies addressed HRH availability and distribution through task-shifting, increased recruitment, mentoring, and building capacity. Some countries supported more specific HRH issues, such as long-term institutional structures (Vietnam) CHW strategies (Mozambique and Kenya), and developing auxiliary staff capacity through laboratory technician trainings and field epidemiology programs (Angola). Increased attention was given to improved HRH management, e.g., HRIS (South Africa and Lesotho), and HRH audits (the Dominican Republic). HRH challenges remained in many countries. For example, in the Central America region, HRH gains are threatened by issues related to retention and inadequate career paths for health workers. Malawi had developed a strategic HRH plan but constraints continued to be severe.

More than half of the countries invested in laboratory capacity and supply chain management. Laboratory system improvements ranged from national laboratory infrastructure, accreditation, and strengthening reference laboratory networks to developing the capacity of laboratory technicians. Increased use of technology also featured strongly through computerized laboratory systems, improved diagnostic capabilities, and strengthening district hubs to coordinate services. Related was special emphasis on national blood bank services and transfusion safety. Ghana and Zambia emphasized and demonstrated success in strengthening national blood bank and transfusion services.

Supply chain management issues were consistently referred to as a constraint, and areas covered included quality assurance and the need to create more functional systems for logistics management. In alignment with PEPFAR's shift away from purchasing commodities, strengthening logistics was critical for many countries.

Strategic Investments, Efficiency, and Sustainable Financing

Domestic resource mobilization for the national HIV/AIDS response varied widely, with some countries and regions financing most of the national response (Angola, Central America, and South

Africa), while others relied heavily on external partners (Lesotho, Malawi, and Zambia). Middle-income countries typically faced considerable funding challenges due to decreasing donor funding and pressure from major funders to "graduate" from assistance. Eleven out of the 14 PFs/PFIPs had explicit domestic financing strategies, which included specific benchmarking of government spending on HIV, supporting health insurance schemes, and conducting economic and financial analytics. There were mixed results in terms of securing additional domestic resources, with evidence of confirmed increased domestic funding in under half of the countries reviewed. In particular, countries that were experiencing economic downturns at the time of PFIP implementation faced challenges in meeting the commitments documented in the PF/PFIP documents. Besides increasing domestic resources, other notable successes included greater government responsibility for financial planning decisions, use of public private partnerships, and establishment and/or support for health insurance schemes.

Improving efficiencies in resource allocation was another major theme across all PFs/PFIPs to address sustainable financing. Fifteen of the 16 countries described activities to support analytical processes and improve efficiencies in resource allocations. The evidence on the extent to which these strategies were effectively implemented varied considerably. Some examples which do stand out include Rwanda, which made special efforts to enhance efficiency and improve resource allocation through decentralization. In Malawi, the proposed analytics were implemented through institutionalization of the National Health Accounts. In Mozambique, the Caribbean and Vietnam, the central strategy for improving efficiencies was to improve donor coordination.

Strategic Information

PFs/PFIPs presented several activities to strengthen the use of strategic information and data to inform program and policy decisions. Strategies included improving access to epidemiologic data through surveys, surveillance, and behavioral studies. Other strategies included the core area of harmonizing indicators and monitoring approaches in keeping with the UNAIDS "Three Ones" principle, which calls for one HIV/AIDS national framework, coordinating authority, and agreed upon M&E system.

While improvements in this area were often not reported independently of service delivery data, key achievements were made in building capacity for surveillance activities. In particular, four operating units had notable success in these areas (Vietnam, the Caribbean, Ghana, and the Central America region). Harmonizing PEPFAR and national M&E approaches, and strengthening an M&E culture were often inter-related, and was a priority in at least 10 of the 16 countries reviewed. This was often combined with capacity development of key institutions and increasing the accessibility of data. Financial and economic data interventions included resource expenditure tracking, accounting audits, and broad financial management. There was explicit evidence of activities promoting expenditure tracking in Nigeria, Vietnam, Rwanda, and Zambia.

4.3. Value Added of PFIPs

PFs/PFIPs clearly had a positive impact on the relationship between partner governments and PEPFAR, and also positive impacts across national HIV and AIDS responses. Notably, these include the following:

PF/PFIPs led to deeper conversations between USG and country partners about their respective roles and relationships and how this might evolve in the future. In Vietnam, for example, the PF/PFIP sought to engineer a shift in doing business whereby the USG provided more technical collaboration than direct service delivery, and also sought to deepen civil society engagement. In South Africa, the PF/PFIP appears to have provided an opportunity to plan for financial transition and strengthen working relationships through the creation of new structures for collaboration, particularly working groups and committees. Based on the reviewed documents alone, actual changes in the nature of partnerships could not be fully assessed.

In some cases, the **PF/PFIP processes appeared to drive greater alignment with country plans**. Success in this area depended to some degree on how fortuitous the timing of the PF/PFIP process was. Where PFs/PFIPs were initiated around the same time as a new national strategy or a new national operational plan, the two documents were frequently closely interlinked and aligned.

It seems likely that **the PF/PFIP processes generated a stronger focus on critical systems issues impacting HIV care and treatment**, encompassing issues of domestic health financing, service integration, health workforce issues, supply chain, laboratory and strategic information. While PEPFAR had clearly been paying increasing attention to these topics, the PFs/PFIPs appear to have intensified this focus. However, monitoring indicators remained more narrowly focused on HIV and AIDS services and outcomes, with less attention to health systems strengthening objectives. Assessing impact of systems work is challenging without clear indicators, but successes were noted and good practices developed, although it was hard to determine the lasting impact, if any.

Some of the areas where the most **concrete progress was evident tended to be in HIV service delivery**, including rolling out high impact interventions for HIV/AIDS prevention, such as VMMC and PMTCT, and expanding ART through massive acceleration and scale-up initiatives. It is unclear whether or not this progress would have occurred without the PFs/PFIPs.

4.4. Study Limitations

This study constitutes a documentary review based on existing PFs, PFIPs, and other available literature, such as PEPFAR COPs. While the document review can cast light on the intentions behind the PF and PFIP, it is very difficult to trace through the COPs the extent to which the PF/PFIP strategies were effectively implemented on the ground. The documents available typically do not explain why implementation did not occur as planned, and as USG products they may present a one-sided perspective of the PF/PFIP process. Also, some of the country-specific documents that were reviewed did not directly reference the relationship with the PF/PFIP. Further in-country research could have developed a more in-depth understanding of why elements of the PF/PFIP were or were not implemented, and ensured a more holistic view of the PF/PFIP process. In addition, apparent lack of impact may be due to a lack of existing documents available to highlight progress or impact.

5. LESSONS LEARNED

Current and future efforts to achieve the same goal of donor-country partnership, such as the Global Funding Facility, can benefit from the lessons of PF/PFIP. These include the following:

- In most settings, **the effort expended in developing collaborative, participatory PFs/PFIPs** strengthened the linkages between USG, national stakeholders, and other partners. Similar efforts should be used for future planning.

- The **PF/PFIP process provided an institutional backbone and fostered potential mutual accountability** to align PEPFAR efforts to national strategic plans for the HIV response, which might otherwise not have been adhered to. This was especially true in cases where the development of the PF/PFIP coincided with the development of national HIV strategic and/or operational plans.

- Despite the potential value of regional approaches, **future frameworks should re-evaluate how to meet both regional and national level needs** in a holistic way.

- From this limited review, it is unclear why M&E of PFs/PFIPs were not successfully implemented as planned, and **it is critical to rethink how to operationalize this key accountability component in the future**. Where implemented, in-depth evaluations generated important and useful findings about what activities needed to be strengthened or reoriented.

- In contexts where existing M&E and governance systems are weak, **efforts to strengthen those systems can provide a valuable entry point to review partnership progress** and use locally-generated evidence in decision-making

6. CONCLUSION

When PEPFAR was first launched by President George W. Bush in 2003, it was an emergency response. The world was facing a significant health security crisis that threatened to destabilize an entire continent, as HIV treatment was simply unreachable. In the first five years of PEPFAR, the USG and the Global Fund did what many thought was the impossible and brought HIV prevention, care, and treatment programs to Africa and other countries around the globe where they were most needed—saving 3.2 million adult years of life and preventing seven million new infections (PEPFAR WAD 2008). As part the 2008 reauthorization of PEPFAR, Congress requested that PEPFAR engage with partner governments in new ways to ensure the sustainability of the response. Twenty-two PEPFAR countries and regional operations completed PFs, identifying the type of partnership between stakeholders and common goals.

These PF and PFIP documents represent a landmark achievement in the history of PEPFAR. They established joint strategic roadmaps agreed and signed by governments, and their implementation represented for the first time the promotion of accountability and sustainability in the fight against AIDS. Moreover, although not perfect, they advanced dialogue with partner countries about investment necessary for sustained national HIV programs and an AIDS Free Generation. Today PEPFAR and partner governments face the challenge of delivering on the promise of an AIDS Free Generation with stagnant and in some cases declining donor funding. The lessons learned from the PFs are significant during this period as collaboration between stakeholders grows, domestic resources are mobilized, and ultimately epidemic control is achieved.

With the end of PFs and PFIPs, and no other high level joint HIV strategy document guiding countries, it is critical for USG to support Country Health Partnerships or another such strategy document to fill the void of a joint HIV strategy. Lessons from the review of PFs and PFIPs indicate that this strategy document must build on experiences of the PFs and PFIPs. The strategy must be one that stays dynamic, is used, monitored, and responsive to changing needs. It must be supported by partner governments and PEPFAR, as well as other stakeholders (such as civil society and other donors). Clear partnership on HIV commitments and outcomes is critical to ensure best impact, highest efficiency, and transparency to achieve sustained HIV epidemic control together.

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ANNEX 1: COUNTRIES WITH PFS AND PFIPS

Country	PF	PF Date	PFIP	PFIP Date
Angola	X	2009–2013	Thought to have developed PFIP	
Botswana	X	2010–2014		
Caribbean Regional	X	2010–2014	X	2010
Central America Regional	X	2009–2013	X	2010
Dominican Republic	X	2009–2013	X	2010
Democratic Republic of Congo	X	2009–2014		
Ethiopia	X	2010–2014		
Ghana	X	2008–2012	X	2010
Haiti	X	2012–2017		
Kenya	X	2009/10–2012/13	X	2010–2014
Lesotho	X	2009–2013	X	2009–2013
Malawi	X	2009–2013	X	
Mozambique	X	2009–2013	X	2010–2014
Namibia				
Nigeria	X	2010/11–2015/16	X	2010–2015
Rwanda	X	2009–2012	X	2009–2012
South Africa	X	2012/13–2016/17	X	2012/13–2016/17
Swaziland	X	2009–2013	X	2009–2013
Tanzania	X	2009–2013		
Ukraine	X	2011–2015	X	2011–2015
Vietnam	X	2010–2015	X	2010–2015
Zambia	X	2011–2015	X	2011–2015

ANNEX 2: PROFILE OF DOCUMENTS REVIEWED

	PF/PFIP	Country Operating Plan	Other USG Documents	Host Government Documents	Other	Total
Angola	1	3	0	0	0	4
Caribbean Region*	2	4	1	0	1 (Regional Document)	8
Central American Region*	2	4	2	3	0	11
Dominican Republic	2	5	0	1	3 (Regional Document)	11
Ghana	2	5	0	4	1	12
Kenya	2	4	0	3	3	12
Lesotho	2	5	0	4	2	13
Malawi	2	6	0	0	0	8
Mozambique	3	4	1	1	3	12
Nigeria	3	4	0	5	0	12
Rwanda	2	4	0	3	1	10
South Africa	2	4	0	0	1	7
Swaziland	2	1	0	0	0	3
Ukraine	1	3	0	0	0	4
Vietnam	2	4	1	4	1	12
Zambia	2	5	0	0	0	7

* Central American region included seven countries: Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama. The Caribbean included 12 countries: Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Grenada, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago.

BOLD THINKERS DRIVING
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