leads to the best outcomes for women, their partners, and their children. After release of the 2013 WHO Consolidated Treatment Guidelines recommending combination ART for pregnant women, PEPFAR supported countries in rapidly implementing ART for pregnant women. In FY 2014 alone, the proportion of pregnant women receiving ART, rather than zidovudine prophylaxis, increased from 60 percent to 90 percent, and now stands at 98 percent. With release of the 2015 WHO Guideline on When to Start Antiretroviral Therapy and on Pre-exposure Prophylaxis for HIV,[21] which recommends lifelong ART for all pregnant women living with HIV, PEPFAR will work to ensure that all supported countries are providing lifelong ART to pregnant women living with HIV.

PEPFAR has focused efforts on providing funding and technical support to improve every step of the treatment and care continuum, from HIV testing to treatment for mothers and follow-up testing for babies. This ensures an effective PMTCT cascade, resulting in an HIV-negative baby and a mother with a suppressed viral load. In addition, PEPFAR will increase the focus on keeping pregnant women who test negative for HIV free from infection through increased partner testing. This will enable PEPFAR to identify and provide immediate treatment for men living with HIV and referral for VMMC for those who are negative, and will also allow PEPFAR to educate and empower women to protect themselves.

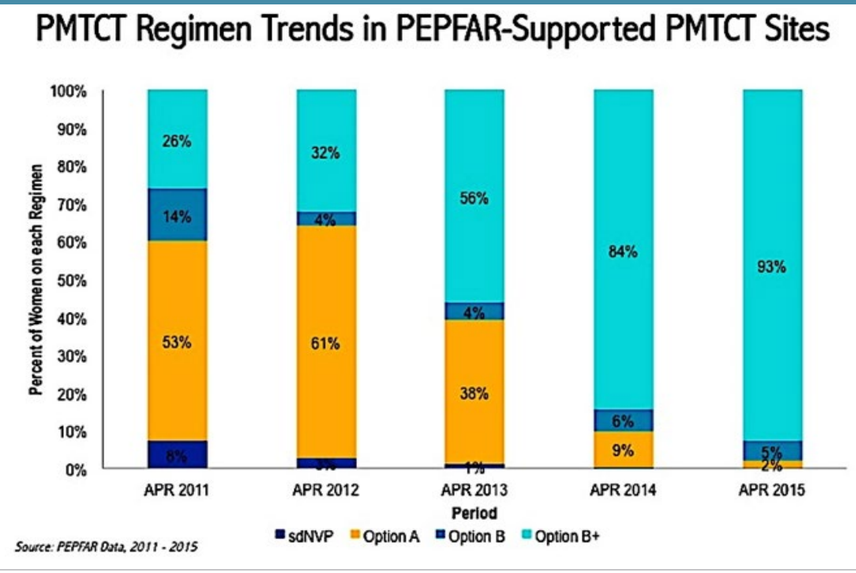
In FY 2015, PEPFAR directly supported HIV testing for more than 14.7 million pregnant women and provided technical support to clinics for an additional 3.5 million tested (Appendix W: Table 7). PMTCT service coverage, as well as an effective cascade of services, are variable and differ greatly between communities. PEPFAR uses site-specific data to ensure resources are focused in the highest-burden areas with the greatest need to maximize the impact on babies and their mothers. Countries are required to focus investments and to increase their targets in high-burden areas. Ultimately, the goal is to increase antenatal care attendance and to test 95 percent of pregnant women receiving an antenatal care visit.

PEPFAR has continued to shift resources from low-burden to high-burden areas to ensure strong linkages for HIV-positive pregnant women to the continuum of care. An additional benefit of this site-level analysis is the utilization of program data to geographically map the HIV epidemic at a granular level. This initiative, conducted by ICPI, is being replicated across partner countries to further focus the HIV response and to gain understanding of the evolving epidemic at a geographic and facility level.

In FY 2015, 14.7 million pregnant women learned their HIV status with PEPFAR support, 92 percent received ARVs during their pregnancy to reduce vertical transmission, and of these, 93 percent received Option B+—initiation of lifelong ART—and an additional 5 percent received triple combination regimens for prevention (Figure 35). ART reduces mother-to-child transmission at birth to less than 5 percent. Transmission rates under 1 percent are seen among women who conceive while on ART and who continue their ART throughout pregnancy. While 95 percent of babies are born HIV-free, if their mothers do not remain on treatment, there is a 15–25 percent risk for infection to be transferred to the infant during the breastfeeding period. Therefore, the breastfeeding period is a high-risk time for women to be lost from care. PEPFAR recognizes the need for data on retention of pregnant and breastfeeding women and is now requiring partner countries to report the percentage of women known to be alive and on treatment 12 months after initiation of lifelong therapy. During 2015, PEPFAR's retention rate in nine countries with the highest number of pregnant women was 63 percent (Appendix W: Table 6). Increased efforts are being directed at retaining pregnant and breastfeeding women in care and treatment and providing testing for their infants to allow for early treatment of infected infants. PEPFAR programs are working closely with civil society organizations and OVC programs to provide support to breastfeeding women and their families to maintain them on ART and ensure follow-up for their infants.

21 WHO. (2015). *Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV*. Available at: http://apps.who.int/iris/bitstream/10665/186275/1/9789241509565_eng.pdf

Figure 35. PEPFAR PMTCT Regimens: Ensuring the Most Effective Regimens to Save Mothers and Ensure Babies Are Born HIV-Free



The new WHO 2015 guidelines provide PEPFAR with a unique opportunity to change the message of PMTCT programs. Moving forward, all HIV-positive pregnant and breastfeeding women should be offered lifelong ART both for their own health and to prevent HIV infection in their babies.

APPENDIX L: Preventing New HIV Infections in Young Men—VMMC

VMMC is a one-time, low-cost intervention shown to reduce men's risk of HIV by approximately 60 percent in randomized control trials, and that preventive effect has been maintained over time. Recent evidence from Uganda (Rakai District) demonstrated that the HIV-preventive effect of VMMC continues to increase, rather

Popular Zimbabwean musician, Jah Prayzah signing a pride board at a male circumcision site soon after getting circumcised. He was part of a campaign to create demand for VMMC.

Figure 36. Significant Impact Is Assured with Greater Efficiencies When Targeting VMMC to the 15-24 Year Age Band

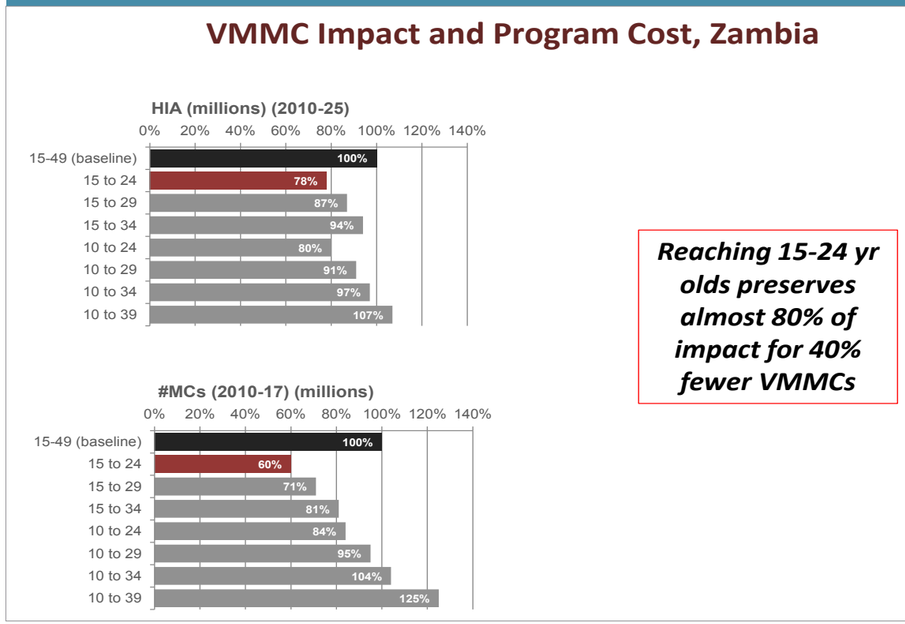
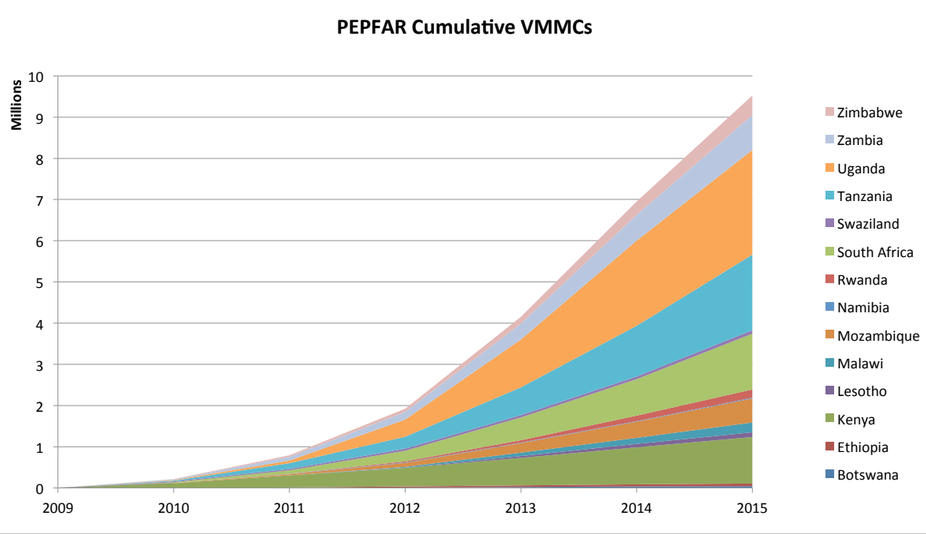


Figure 37. PEPFAR Cumulative VMMC Results, 2009-2015, Accelerated Slope Continues Across the Program



President Obama during historic visit to Kenya and Ethiopia speaking at the African Union.

"We're working together to ensure that girls have access to education and that women are protected from violence. Today, I can announce that Kenya will be part of our DREAMS initiative to help keep adolescent girls safe and AIDS-free. And across Africa, Kenya and the United States will keep working to strengthen public health systems and deal with outbreaks and diseases before they become epidemics."

–President Barack Obama, July 25, 2015

than decline.[22] VMMC has the potential to prevent millions of new infections and to save millions of lives and billions of dollars. Importantly, the procedure brings men into health services, some for the first time. As of September 30, 2015, PEPFAR has supported more than 8.9 million VMMC procedures in eastern and southern African countries (Figures 36 and 37; Appendix W: Table 9). PEPFAR programs strive to achieve 80 percent adult male circumcision coverage, prioritizing the high transmission areas among these 14 countries to maximally and efficiently reduce HIV incidence in the shortest period of time possible and contribute to PEPFAR's over-arching strategies for epidemic control. PEPFAR aims to support a cumulative 11 million VMMCs by the end of FY 2016 and a cumulative 13 million VMMCs by the end of FY 2017. Assuming each country reaches the 90-90-90 HIV treatment targets, modeling analysis projects that VMMCs conducted to date will avert more than 240,000 HIV infections by 2025. PEPFAR continues to prioritize this one-time intervention by increasing central funding to this intervention in 2015.

22 Gray, R. H., et al. (2012). The Effectiveness of Male Circumcision for HIV Prevention and Effects on Risk Behaviors in a Post-Trial Follow up Study in Rakai, Uganda. *AIDS 26*(5), 609–615. Available at: http://doi.org/10.1097/QAD.0b013e3283504a3f

APPENDIX M: Prioritizing Prevention of New HIV Infections in Women, Adolescent Girls, and Children

HIV remains the leading cause of death and disease in women of reproductive age, leading to increased risk of death for orphaned children as well.[23] In sub-Saharan Africa, 60 percent of those living with HIV are women, and in some of these countries, prevalence among young women ages 15–24 is three times higher than among men of the same age (Figures 38 and 39). Maternal mortality is the second leading cause of death, resulting in an estimated 287,000 deaths each year; 99 percent of these women live in low-income countries, and is higher among women living with HIV.[24] Without adequate treatment, women living with HIV are eight times more likely to die during pregnancy, delivery, or the early postpartum period.[25] One in three women will experience GBV in her lifetime.[26] Women account for two-thirds of the world's 774 million adults who are

23 Ortblad, K. F., Lozano, R., Murray, C. J.. (2013). The burden of HIV: insights from the Global Burden of Disease Study 2010. AIDS 27(13), 2003–2017.

24 WHO. (2015). Women's Health. Geneva.

25 Calvert, C., Ronsmans, C. (2013). The contribution of HIV to pregnancy-related mortality: a systematic review and meta-analysis. AIDS 27(10), 1631–1639.

26 United States Agency for International Development. (2015). Report on Gender Equality and Women's Empowerment. Washington, DC. January 2015.