

Executive Summary

In accordance with the America First Global Health Strategy (AFGHS), the State Department is signing “Memoranda of Understanding” (MOUs) with the governments of countries where the U.S. supports health programming. While the planning documents and purpose of these MOUs have already been widely distributed and discussed, there’s been limited analytical assessment of the MOUs themselves. This is primarily a result of few of them being released. To date, the State Department has announced 27 MOUs signed, but only seven have been publicly released: Ethiopia, Kenya, Liberia, Mozambique, Nigeria, Rwanda, and Uganda.

The metrics established in the MOUs are critical components of the integrity of the MOU process and the fundamental element of ensuring that the MOUs are both accountable and effective. Without the metrics, there’s no measurable check to ensure that they continue to support life-saving interventions, improve the health care system, and reduce and efficiently manage costs—including long-term health care costs for partner countries and U.S. foreign assistance. They are also the benchmarks Congress must understand to conduct any meaningful oversight of the State Department’s expenditure of the billions in tax dollars appropriated to foreign assistance. Moreover, the MOUs have language that allows the U.S. government to reduce funding if metrics aren’t met and/or provide additional incentive funds to governments where they are.

The success of PEPFAR in particular was driven in large part by rigorous data collection, transparent reporting, ambitious targets, and enforceable accountability mechanisms. Adopting these same principles to the MOU framework will be essential to achieving sustainable impact, maintaining congressional and public trust, and ensuring that U.S. investments deliver humanitarian and strategic returns. Across the seven countries discussed here, more than 6.9 million people were receiving treatment support from PEPFAR.

The least sustainable outcome both for the United States and our foreign government partners is one in which HIV, malaria, and other health programming fails to be maintained and allows for disease resurgence to occur. We engaged in this analysis to determine whether the HIV targets in the seven released MOUs have been set with the

requisite care and precision that should be expected of the tens of billions of taxpayer dollars allocated to them.

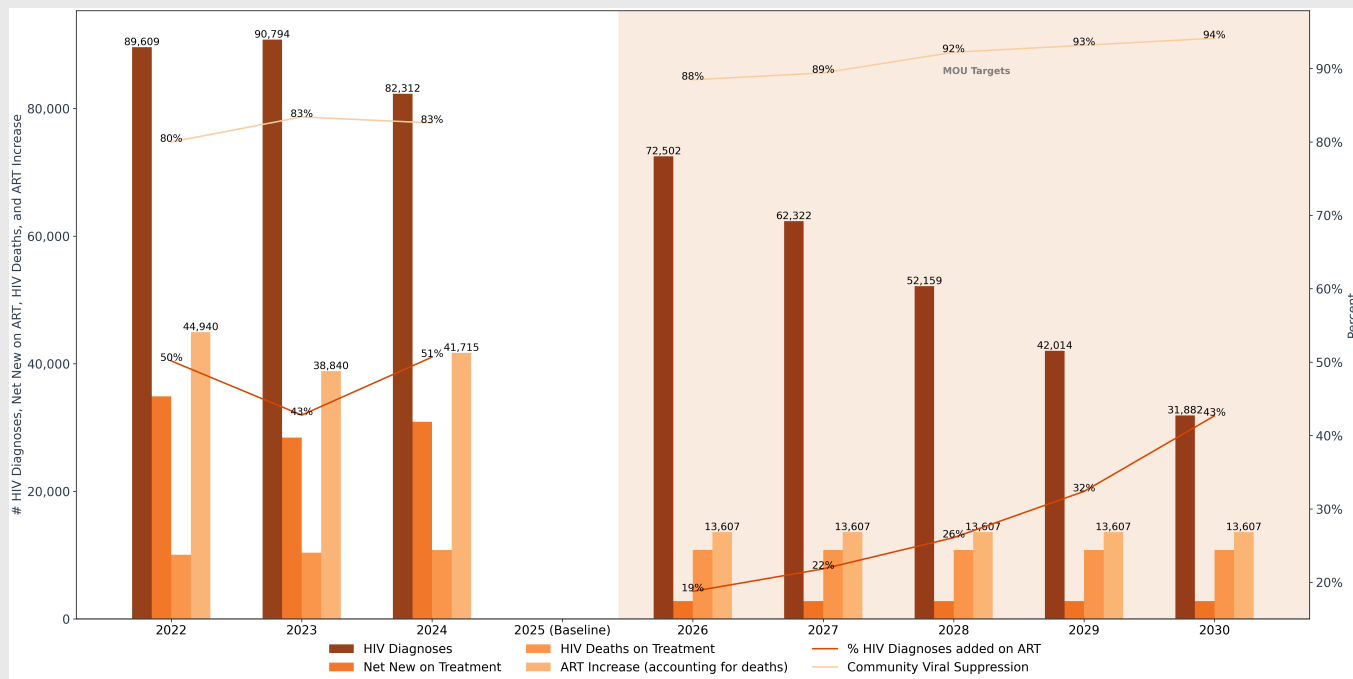
They have not.

Both the outcome and process metrics in the MOUs suffer from at least four fundamental flaws that ultimately undermine accountability and oversight:

- 1. The outcome metrics established cannot be assessed at the level of precision expected in the MOUs.** The outcome metrics are based on the 95-95-95 targets that 95% of people living with HIV (PLHIV) know their status, 95% of those that know their status are on treatment, and 95% of those on treatment are virally suppressed. While these have been important targets for the global HIV response, they inherently work backward from the unknowable estimate of the total number of PLHIV that comes with wide confidence intervals. They cannot provide the granularity of measurement the metrics set. The Population-based HIV Impact Assessment (PHIAs) have been the largest effort to date to provide a meaningful estimate at a national level for these indicators, and even the estimates and confidence intervals they provided, when measured against a number of people on treatment, spread well over 10 percentage points of uncertainty. While under the MOUs, the State Department intends to fund outcomes surveys at significant level in many countries, these cannot overcome this fundamental limitation to determine whether marginal improvements in the percentage of people living with HIV (PLHIV) who know their status and are on treatment have occurred, as the MOUs anticipate. Without the ability to meaningfully measure the outcome metrics, they are incapable of use for oversight or accountability.
- 2. The process metrics are internally inconsistent, incoherent, and actively work against each other as a mechanism for accountability.** The primary HIV-related process metrics are the “number of people newly diagnosed with HIV” and the “number of people on treatment.” These two metrics are meant to meaningfully relate to each other such that increases in HIV diagnoses result in increases in people on treatment. They are also meant to support assurance that the outcome metrics are being achieved or maintained. Yet the targets

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Kenya: HIV Diagnoses to Additional People on Treatment



PEPFAR's 2022-2024 data for Kenya show relatively consistent HIV diagnoses to increases on treatment percentages between 43% and 51% by year. The MOU targets, however, set the ratio in 2026 to only 19% of HIV diagnoses leading to treatment increases with a rapidly increasing trajectory. Targeted net new increase in treatment rolls in Kenya is 67% lower than PEPFAR's performance in 2024. Total HIV diagnoses are targeted at significant declines, with 2026 already 12% below 2024 performance and 2030's target 61% lower than 2024 performance.

established in the MOUs are set such that virtually any result can be explained away as either success or failure, rendering them useless for oversight and accountability. For example, in Kenya, only 19% of the target for HIV diagnoses leads to an increase in people on treatment in 2026, far below the historical trends in the country of around 50%. If Kenya merely achieves both its target for HIV diagnoses and people on treatment, it actually signals that the health care system is dramatically failing at initiating or retaining patients on treatment. If Kenya meets the treatment targets while failing on the diagnoses targets, that could signify improvement in retention and data quality, or the collapse of testing infrastructure. If Kenya meets its testing target and far exceeds the treatment targets, it renders all future targets in the MOU moot, and would still signal that the HIV epidemic is not under control. Across the MOUs, these conversion rates are on radically different trajectories that cannot be explained by individual country circumstances.

3. **The process metrics and performance provisions of the MOUs are ambiguous in terms of what direction they are even meant to be assessed.** The performance provisions of the MOUs—by which the U.S. Government

can withdraw funding if they are not achieved—only requires that countries “maintain the baselines” for both the outcome and process metrics. But “maintaining the baselines” is incapable of meaning when the targets decline from the identified baselines. Moreover, it’s unclear whether process targets like “number of new HIV diagnoses among infants (0-18 months)” should be interpreted as a minimum or a maximum result. If a minimum, it actively incentivizes poorly performing prevention of mother-to-child transmission programs. If a maximum, it could incentivize reducing HIV testing of infants to avoid going over the target.

4. **The transition to country data systems and the confidentiality provisions of the MOUs are designed to prohibit independent or external oversight of the MOUs or programmatic performance.** PEPFAR has developed an independent, public, and transparent data system for reporting the results of programming it supports. The AFGHS and the MOUs seek to dismantle that system and replace it with accessing data from national data systems. However, the MOUs and the data sharing agreements contain provisions that prohibit any public release of the data—or even privileged sharing of data with researchers, modelers, or analysts—along the

lines that PEPFAR has been doing for nearly two decades. Without public data, the only entities that will have access to performance data regarding the MOUs are the State Department and the foreign government itself, both of whom share a political interest that the MOUs appear to be working regardless of the results.

In their current form, the MOUs represent a fundamentally missed opportunity to collaboratively develop, establish, and set more meaningful metrics to guide the HIV response for the next phase of the epidemic. The 95-95-95 targets were instrumental in moving the world from a place where fewer than 50% of PLHIV were on treatment to one where several countries are estimated to have achieved and surpassed those targets. But they have also lost their utility as they can only ever be estimated with high levels of uncertainty and don't provide a meaningful basis for accountability and oversight as the differences in annual targets become marginal.

The next phase of the HIV response requires targets, metrics, and accountability systems that are geared toward the availability, acceptability, accessibility, and quality of care necessary to maintain the more than 20 million people in PEPFAR-supported clinics on treatment for the coming decades.

Based on this, we make the following recommendations:

- 1. The Bureau of Global Health Security and Diplomacy should convene and solicit recommendations for next generation HIV health systems targets for which partner governments and health systems will be held accountable under MOUs,** even if this requires re-negotiating or amending the provisions. These metrics should be based on the availability, accessibility, acceptability, and quality of care. Some of these could include:
 - Percentages of patients on treatment who are in a treatment interruption - measured at the facility level;
 - Patient access metrics: ensuring comprehensive health services are available within reasonable distances across all populations and/or sufficient patient transport is available;
 - Limiting unnecessary engagement with the health system - medicines provided on a six monthly basis for HIV; Push systems for patient medication;
 - Functional, effective, trusted, and accurate appointment systems allowing patients to spend the minimal amount of time possible waiting for services within clinics.
- 2. Independent accountability and oversight of the health systems supported by the MOUs must be developed, funded, and robustly implemented.** These must include both patient complaint mechanisms as well

as systematic assessments of patient experiences accessing health care services on an ongoing basis.

- 3. PEPFAR, PMI, and other global health programs should immediately return to regular order publishing of their budget, expenditure, and performance data.**
 - For PEPFAR, this would include publishing:
 - Bridge Plan planning documents;
 - Bridge Plan budgets at the national and implementing mechanism levels;
 - Publishing of the text and annexures of all MOUs as required by section 104A(e)(4) of the Foreign Assistance Act;¹
 - Publishing all implementation plan budgets for the MOUs including the recipients of funding, the mechanisms, award ID numbers, and line-item amounts;
 - Quarterly performance data for all MER indicators for all of 2025, including at the national, subnational, facility, and implementing mechanism levels as well as age and sex disaggregated data sets at the national, subnational, and implementing mechanism levels, and human resources for health data.
 - For PMI, this would include publishing:
 - Malaria Operational Plans for fiscal year 2025;
 - Bridge Plan planning documents;
 - Bridge Plan budgets at the national and implementing mechanism levels;
 - Reports on net distribution, indoor spraying, and other supported prevention and surveillance activities.
- 4. Congress should immediately impose public transparency and reporting requirements for all data shared under the framework of the MOUs.** Congress should also ensure that all indicators - including those required for on-going reporting requirements for PEPFAR under the Leadership Act - continue to be tracked and publicly released and consider adding additional reporting requirements for critical indicators. Public reporting should be required to be mapped to the traditional datasets that were previously released by PEPFAR that included:
 - National, subnational (1-3 administrative levels depending on the country), and facility level data.
 - Disaggregated data by sex and small age brackets at the national and subnational levels.
 - All financial data, including the budgets and expenditures of any implementing mechanisms funded under the framework of the MOUs.

¹104A(d) of the Foreign Assistance Act provides for authorized activities for PEPFAR, including in subsection (8) the authorization to develop "Compacts and Framework Agreements" with partner governments. 104A(e) sets the requirements and considerations for those compacts and framework agreements if they include the bilateral HIV funds, as the MOUs do.

Introduction

In accordance with the America First Global Health Strategy (AFGHS),² the State Department is signing “Memoranda of Understanding” (MOUs) with the governments of countries where the U.S. supports health programming. While the planning documents and purpose of these MOUs have been widely distributed and discussed, there’s been limited analytical assessment of the MOUs themselves. This is primarily a result of the fact that only seven of the 27 MOUs signed to date have been either officially or unofficially released.³ Officially released MOUs were released as part of the State Department’s obligations under the Case-Zablocki Act⁴ on March 12, 2026, though they were subsequently removed within four days. The officially released MOUs were for Ethiopia, Kenya, Mozambique, Nigeria, and Uganda. Unofficially, the Liberia and Rwanda MOUs have been published online.⁵

The MOUs are a cornerstone implementation of the AFGHS released in September 2025, the third goal of which is: “Strengthen bilateral relationships with key countries by entering multi-year bilateral agreements that contain the spread of infectious diseases, save lives, and enable economic growth.” They were and are being negotiated on an accelerated pace with countries and are meant—taken at face value—to obtain commitments from partner governments to commit more resources to their own health systems and transition out of U.S. support for many areas of work, including significant reductions in HIV, malaria, and tuberculosis (TB) bilateral assistance.

As stated in the AFGHS:

A key component of all our bilateral agreements with [sic] be staying committed to the ambitious goals that have been set over the past decades for HIV / AIDS, TB, malaria, and polio, with the acknowledgment that countries themselves are ultimately accountable for their outcomes

²Department of State, America First Global Health Strategy, (2025), available at: <https://www.state.gov/wp-content/uploads/2025/09/America-First-Global-Health-Strategy-Report.pdf> (hereafter, AFGHS)

³KFF, KFF Tracker: America First MOU Bilateral Global Health Agreements, accessed March. 24, 2026. <https://www.kff.org/global-health-policy/kff-tracker-america-first-mou-bilateral-global-health-agreements/>

⁴The Case-Zablocki Act of 1972 (1 U.S.C. § 112b) requires monthly releases of international agreements and non-binding instruments within 90 days of the agreements being signed.

⁵Liberia: Bass, Emily, *US gives 5 weeks for 5-Year Aid Plans*, (2026), available at: <https://emilysbass.substack.com/p/us-gives-5-weeks-for-5-year-aid-plans>; Rwanda: Bass, Emily, *US-Rwanda MoU for Health Records \$1.5 billion in Soft Commitments from Private Investors*, 2026, available at: <https://substack.com/@emilysbass/p-188951175>

*and U.S. government support will be but one component of the contribution towards national outcomes. The U.S. will also prioritize ending mother-to-child transmission of HIV/AIDS in a number of countries by the end of President Trump’s second term. [emphasis added]*⁶

For HIV, the AFGHS also set out four basic goals the agreements would seek to achieve: > * ensure that 95% of people living with HIV know their HIV status, 95% of people who know their status are receiving HIV treatment, and 95% of people on treatment are virally suppressed; > * 90% reduction in HIV infections by 2030 (from 2010 levels); > * 90% reduction in AIDS-related deaths by 2030 (from 2010 levels); and > * ending Mother-to-Child Transmission in several high-burden countries.

The MOUs have taken this direction and include outcome metrics that align with the UNAIDS 95-95-95 goals identified in the first bullet and set process metrics meant to serve as more specifically monitorable targets to establish whether the health system continues to make progress toward these goals. Unfortunately—aside from mother-to-child transmission, which makes up less than 9% of global HIV incidence⁷—no MOU released so far has any metrics for reducing HIV infections in alignment with the second bullet. Only Ethiopia has any metrics related to AIDS-related deaths in accordance with the third bullet. Outcome and process metrics are set in the MOUs, but vary from country-to-country.

The goal of this report is to understand whether the HIV metrics can function as a mechanism for accountability for the MOUs or diagnose if programming is succeeding or failing.

⁶AFGHS, pages 18-19.

⁷UNAIDS estimates for pediatric infections from 0-14 years of age are ~120,000 per year, about 9% of the total new incidence globally each year. In PEPFAR-supported programming in 2024, infant diagnoses made up less than 0.6% of annual HIV diagnoses.

Accountability Provisions in the MOUs

Before turning to the metrics themselves, it's necessary to understand how central they are to oversight and accountability of the MOUs on their own terms. In the original draft template language,⁸ provisions related to both auditing the results reported and the ramifications of failing to achieve the metrics were included. Section 4 of the draft MOU template included the following for audits:

4.1 Outcomes Survey: *Both Participants acknowledge the importance of ensuring accurate outcomes data. To this end, the U.S. Government plans to fund a survey for up to [\$10 million] in [each of 2027 and 2029], subject to the availability of funds, to objectively measure the outcomes outlined in Section 1.1. The U.S. Government and [INSERT COUNTRY NAME] intend to work together to mutually decide upon the design and execution of the survey.*

4.2 Process Metric Audit: *[INSERT COUNTRY NAME] acknowledges that so long as the U.S. Government is providing any funding in support of activities described in this MOU, the U.S. Government has a significant and material interest in ensuring the process metrics outlined in Section 1.2 and 1.3 are accurately collected, complete and maintained. To this end, [INSERT COUNTRY NAME] commits to provide the U.S. Government with any data access, on-site access, or other information needed to audit the process metrics in Section 1.2 and 1.3 in up to [five percent (5%)] of randomly selected and/or specific health facilities, clinics, labs, or programs identified by the U.S. Government.*

These surveys and audits will be discussed in their respective sections.

Section 5 of the draft MOU template further provided for withdrawal of US funding or additional incentive funds where metrics are met:

5.2 Performance: *In the event [INSERT COUNTRY NAME] does not maintain the baselines outlined in Section 1.1 and 1.2 or achieve the metrics outlined in Section 1.3, both Participants acknowledge that the U.S. Government may substantially decrease or eliminate funding for one or more Area of Cooperation in future years.*

⁸UNAIDS estimates for pediatric infections from 0–14 years of age are ~120,000 per year, about 9% of the total new incidence globally each year. In PEPFAR-supported programming in 2024, infant diagnoses made up less than 0.6% of annual HIV diagnoses.

5.3 Performance Incentives: *[ONLY INSERT FOR ELIGIBLE COUNTRIES] In the event that [INSERT COUNTRY NAME] achieves all the process and outbreak response metrics for 2027 or 2028 outlined in Section 1.2 and 1.3, [INSERT COUNTRY NAME] is expected to be eligible to receive a performance incentive for 2027 or 2028 respectively, subject to the availability of funds. The U.S. Government reserves the right to build a composite score of these metrics for the purpose of calculating eligibility for the performance incentive if doing so in no way decreases [INSERT COUNTRY NAME]'s eligibility for the performance incentive. In each year, the size of the performance incentive is expected to equal (the population in [INSERT COUNTRY NAME] divided by the population of all countries who are eligible for the performance incentive) times the size of the performance pool. In no event would [INSERT COUNTRY NAME]'s performance incentive for a given year be greater than \$1 per person per year. For the purposes of this calculation, [INSERT COUNTRY NAME]'s population is considered to be [INSERT COUNTRY POPULATION]. Performance incentives may be used by [INSERT COUNTRY NAME] to fund any health-related costs that would be allowed under this MOU. [NOTE: THIS PERFORMANCE INCENTIVE WOULD ONLY BE AVAILABLE TO SELECT COUNTRIES]*

Critically, in the seven MOUs at issue here, the language of 5.2 was accepted without modification in only four (Ethiopia, Liberia, Mozambique, and Rwanda). Three countries negotiated alternative terms suggesting the seriousness that both governments view these provisions. In both Nigeria and Uganda, a different approach was adopted:

5.2 Performance: *If the programmatic targets are not met, both Participants intend to institute a joint review of targets and outcomes and identify the root causes of performance and develop on implementation actions to address the root cause as outlined in Section 3.2 before any co-financing adjustments are made. After such consultation, both Participants acknowledge that the U.S. Government may substantially decrease or eliminate funding for one or more areas of cooperation in future years, including in cases where there is not a clear plan to improve performance and/or performance does not improve.⁹*

⁹Mozambique MOU para 5.2. Uganda's MOU is similar at para 5.3 stating: "Performance: In the event Uganda does not maintain the baselines outlined in Sections 1.1 and 1.2 or achieve the metrics outlined in Section 1.3, both Participants are expected to meet as the

In the case of Kenya, there are no provisions in the MOU allowing for withdrawal of funding based on the failure to meet or maintain metrics. The provision was removed entirely and the metrics reframed as: “The Participants aim to work together to achieve the following [outcome/process] metrics by the end of each of the specified years.”¹⁰

Access to the incentive funds are also not equal across the MOUs as Liberia’s MOU doesn’t contain provisions permitting access to the incentive funds. For Rwanda, the provision for accessing incentive funds is heavily modified.¹¹

In the transition from the traditional bilateral approach of PEPFAR, The President’s Malaria Initiative (PMI), and other global health programming included in the MOUs, maintaining health outcomes for the people being served must be the priority. That is essential to both transitioning programming sustainably and responsibly, and ensuring that U.S. tax-payer dollars are not being wasted on poor quality or performing programs. The least sustainable outcome both for the United States and our foreign government partners is one in which HIV, malaria, and other health programming fails to be maintained and allows for disease resurgence to occur.

The MOUs divide the metrics into two categories, “Outcome Metrics” and “Process Metrics”. “Outcome Metrics” are high-level targets providing a top level assessment of whether the entire program is working. “Process Metrics” are specific objectives such as service-delivery targets to be achieved in support of the outcome metrics. We turn to each now, though it is important to understand that there is meant to be a relationship between the outcome metrics and the process metrics set in support of them.

JHSC to conduct a root-cause analysis and to present the findings to both Governments in order to develop a joint remediation plan within a period of 90 days. Funding adjustments by the U.S. government should be a measure of last resort, and should be reviewed jointly and implemented in a phased manner to minimize system disruption if possible.”

¹⁰Kenya MOU paras 3.1 and 3.2

¹¹Rwanda MOU, Section 2.6.2 on “Performance Incentives” merely states: “The U.S. Government intends to employ performance incentives for achieving HIV and malaria metrics. This funding may be used by the Government of Rwanda in its strategic investment in the health sector, including Kigali Health City (KHC) and AI application for healthcare.”

Table 1: MOU 95-95-95 Targets, PLHIV on ART, and Community Viral Suppression

	2026	2027	2028	2029	2030
Ethiopia					
First 95	83.00%	86.00%	90.00%	92.00%	95.00%
Second 95	95.00%	95.00%	96.00%	96.00%	97.00%
PLHIV on ART	78.85%	81.70%	86.40%	88.32%	92.15%
Third 95	96.00%	96.00%	97.00%	97.00%	98.00%
Community Viral Suppression	75.70%	78.43%	83.81%	85.67%	90.31%
Kenya					
First 95	96.00%	96.00%	97.00%	97.00%	98.00%
Second 95	97.00%	97.00%	98.00%	98.00%	98.00%
PLHIV on ART	93.12%	93.12%	95.06%	95.06%	96.04%
Third 95	95.00%	96.00%	97.00%	98.00%	98.00%
Community Viral Suppression	88.46%	89.40%	92.21%	93.16%	94.12%
Liberia					
First 95	88.00%	89.00%	91.00%	93.00%	95.00%
Second 95	99.00%	99.00%	99.00%	99.00%	99.00%
PLHIV on ART	87.12%	88.11%	90.09%	92.07%	94.05%
Third 95	95.00%	96.00%	96.00%	96.00%	96.00%
Community Viral Suppression	82.76%	84.59%	86.49%	88.39%	90.29%
Mozambique					
First 95	92.05%	93.22%	94.35%	94.73%	95.10%
Second 95	92.05%	93.22%	94.35%	94.73%	95.10%
PLHIV on ART	84.74%	86.89%	89.03%	89.73%	90.43%
Third 95	92.05%	93.22%	94.35%	94.73%	95.10%
Community Viral Suppression	78.00%	81.00%	84.00%	85.00%	86.00%
Nigeria					
First 95	88.00%	90.00%	92.00%	93.00%	95.00%
Second 95	98.00%	98.00%	98.00%	98.00%	98.00%
PLHIV on ART	86.24%	88.20%	90.16%	91.14%	93.10%
Third 95	95.00%	95.00%	95.00%	95.00%	95.00%
Community Viral Suppression	81.93%	83.79%	85.65%	86.58%	88.44%
Rwanda					
First 95	98.48%	98.51%	98.55%	98.55%	98.55%
Second 95	98.48%	98.51%	98.55%	98.55%	98.55%
PLHIV on ART	96.98%	97.04%	97.11%	97.11%	97.11%
Third 95	98.48%	98.51%	98.55%	98.55%	98.55%
Community Viral Suppression	95.50%	95.60%	95.70%	95.70%	95.70%
Uganda					
First 95	95.00%	95.00%	95.00%	95.00%	95.00%
Second 95	95.00%	95.00%	95.00%	95.00%	95.00%
PLHIV on ART	90.25%	90.25%	90.25%	90.25%	90.25%
Third 95	95.00%	95.00%	95.00%	95.00%	95.00%
Community Viral Suppression	85.74%	85.74%	85.74%	85.74%	85.74%

Outcome Metrics

As already mentioned, for HIV, the outcome metrics in all the MOUs are effectively the UNAIDS “Three 95s” treatment targets that have informed programmatic decision-making and strategy for over a decade. They are proportional targets of:

- X% of People Living with HIV (PLHIV) Know their HIV-positive Status;
- X% of PLHIV who know their status are on treatment; and
- X% of PLHIV who are on treatment are virally suppressed.

In some cases, these three targets may be replaced with a “Community Viral Suppression” target that is just the three targets multiplied against each other, resulting in a target of “X% of PLHIV are virally suppressed.”¹² Each MOU may have additional targets negotiated on a country-by-country basis. For outcome metrics related to HIV in the released MOUs, only Ethiopia and Mozambique have set additional targets.¹³

Critically, the 95-95-95 targets (and the 90-90-90 targets that pre-dated them) have been an essential organizing principle for the global HIV response for over a decade. Built on the results of HPTN-052—the landmark study that demonstrated that PLHIV with a suppressed viral load

cannot transmit HIV to their partners¹⁴—they have helped hone the strategy of nearly every country in the world toward getting people diagnosed, on treatment, and virally suppressed as a primary intervention for both lifesaving treatment and reducing the numbers of new HIV infections. In that regard, they have been largely successful, with many countries approaching those goals, at least based on modeled data.

But as a metric to assess the outcomes of the MOUs, they are incapable of providing any meaningful metric for achievement. The 95s are premised on the denominator of the number of PLHIV and the number of people diagnosed being known or precisely estimated. In reality, the number of PLHIV in a given country is not precisely knowable and subject to wide confidence intervals even when robust studies or surveys are implemented.

The Population-based HIV Impact Assessments (PHIAs)¹⁵ conducted between 2017 and 2022 across a number of PEPFAR-supported countries were the largest attempt to reset, understand, and provide meaningful estimates on the number of PLHIV HIV incidence, and levels of access to treatment and viral suppression in each country. The PHIAs were nationally representative, robust surveys that took years to conduct. Based on direct observation and directly conducted HIV testing and laboratory assessments within thousands of households in each country,¹⁶ the HIV

¹²Rwanda’s MOU confusingly sets a singular target of “% of people living with HIV on ART who are virally suppressed (community viral load)” which mixes together two different concepts: the Third 95 and community viral suppression which is “% of people living with HIV who are virally suppressed.” Inclusion of the “on ART” clause in the outcome metric with the supplemental “(community viral suppression)” is incompatible. For the purposes of this analysis, we have treated this outcome metric as actual “community viral suppression” and derived the First, Second, and Third 95s by raising the percent to its cube root (i.e. $93.2\%^{1/3}$).

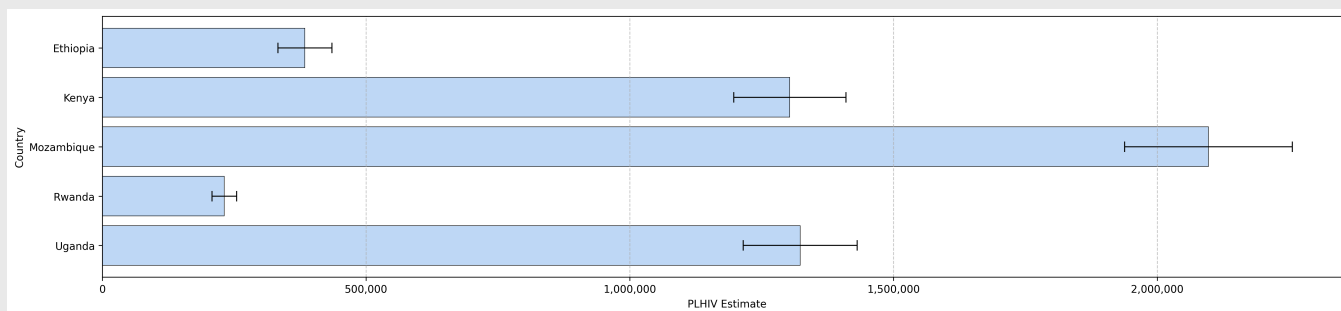
¹³Ethiopia: “# of AIDS related deaths” starting at a baseline of 9,560 and declining to 5,645. Mozambique: “Estimated rate of mother to child transmission” starting at 12.5% and declining to 5%.

¹⁴Myron S. Cohen, M.D., Ying Q. Chen, Ph.D., Marybeth McCauley, M.P.H., et al., Antiretroviral Therapy for the Prevention of HIV-1 Transmission, *N Engl J Med* 2016;375:830-839 (2016). Available at: <https://www.nejm.org/doi/full/10.1056/NEJMoa1600693>

¹⁵<https://phia-data.icap.columbia.edu/>

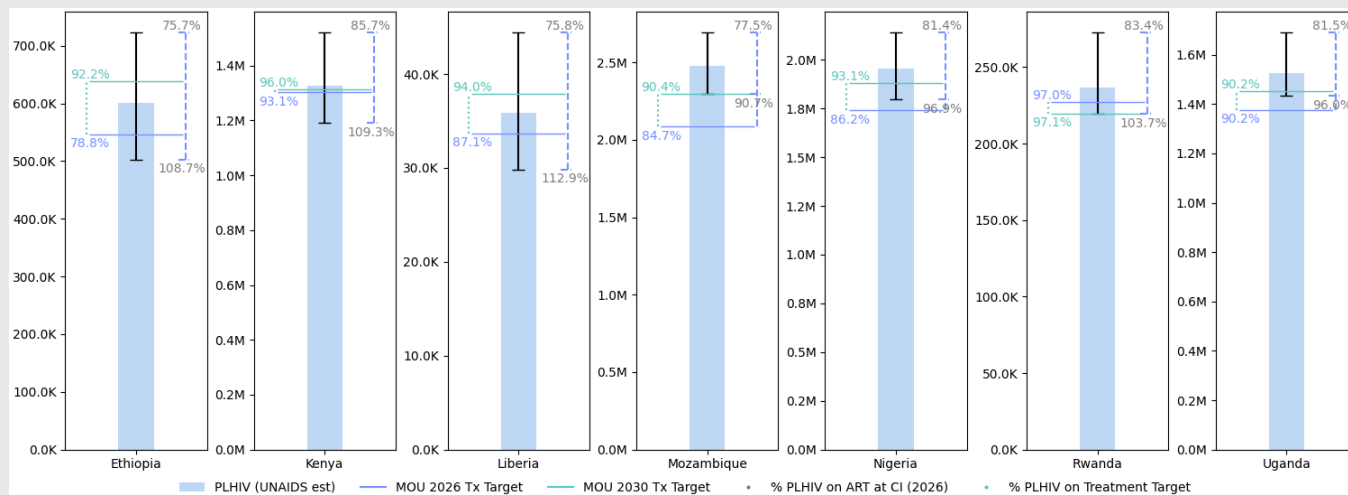
¹⁶Ibid. For the countries here, the number of households to be surveyed ranged from just over 9,000 in Mozambique to nearly 20,000

Figure 1: PHIA PLHIV Estimate by Country with 95% Confidence Intervals



Source: PHIA PLHIV estimates for Ethiopia, Kenya, Mozambique, Rwanda, and Uganda.

Figure 2: PLHIV Estimates with Confidence Intervals against MOU Targets for Treatment (2026-2030)



Source: PLHIV data from UNAIDS AIDSInfo database for 2024 (published July, 2025).

prevalence and PLHIV estimates still came with relatively large confidence intervals. (Figure 1) For instance, Mozambique’s PHIA estimated the number of PLHIV as between 1.938 million to 2.256 million, a range of more than 318,000 people with HIV incidence estimates ranging from 34,000 to 93,000 per year.¹⁷ This is not a criticism of the PHIA, actual prevalence and incidence data are exceptionally difficult to establish. Moreover, given the dual uncertainty in estimating both prevalence and incidence, the data become outdated rather quickly and were not designed to numerically serve as a robust baseline for continuously reliable estimates of the total number of PLHIV against which the 95s can be measured.

Table 1 shows the 95-95-95 targets set for each of the public MOUs. For PLHIV on ART targets (the second 95), the MOUs show intention to improve across all the MOUs ranging from Ethiopia (78.85% in 2026 increasing to 92.15% in 2030) to marginal increases in Kenya (93.12% to 96.04%) and Rwanda (96.98% to 97.11%) or stable in Uganda (90.25% for all years).¹⁸

While the targets themselves are essentially in-line with expectations, they provide no meaningful basis for actual oversight of whether the MOUs are meeting their objectives.

Figure 2 shows the 2024 PLHIV estimates along with 95% confidence intervals against the 2026 and 2030 treatment and PLHIV on ART targets established in the MOUs for each country. This illustrates that the percentage of PLHIV on ART

has an exceptionally wide range compared to the MOU treatment targets. The range of uncertainty in establishing whether countries are meeting their outcome metrics for the first two 95s span 37 percentage points at the widest (Liberia) to 13% at the lowest (Mozambique). With such high rates of uncertainty, if the targeted number of people on treatment in the MOU is achieved, it will be impossible to say whether this represents achievement of the outcome metrics or object failure.

Continuing with Mozambique to illustrate the range within the estimates: Mozambique’s outcome metric for the percent of PLHIV on ART in 2026 is 84.74%. If Mozambique achieves its treatment target for 2026 of 2,085,896, that could represent anywhere from 77.5% of PLHIV being on ART (missing the outcome metric target by 7.2 percentage points) to 90.4% of PLHIV on ART (beating the target by 5.7 percentage points) for the exact same result.

Even this level of uncertainty understates the issue as the uncertainty grows as progressions are done over five years. In effect, even if countries meet—or exceed—the process metrics targets in the MOUs, it will still be impossible to objectively establish whether countries are meeting their outcome metrics for HIV under the MOUs. Yet these targets are all part of the “Performance” terms of the MOUs, by which countries may see funding revoked or added depending on the interpretation of whether the metrics have been achieved.

As importantly, while most MOUs don’t cite a data source for how the metrics are to be determined, several do. Nigeria lists the Nigerian National AIDS and STDs Control Program (NASCP) while both Mozambique and Ethiopia reference modeling with SPECTRUM. In both cases, this

in Kenya. For each household, the PHIA investigators interviewed, tested, and verified results for all occupants in the selected households.

¹⁷Ibid.

¹⁸Uganda’s targets for all three 95s were set as “>95%” for all three metrics. We treated these as just 95% for the purposes of this analysis.

injects high stakes into the outcome of modeling that's meant to provide independent assessments of the status of programming. However, because continued funding is at stake if metrics are not achieved, modelers may be put under significant pressure from governments— from which they must obtain data in order to produce the models—to ensure that the results of the models are favorable to the country. Importantly, PEPFAR's independent data have been an essential part of SPECTRUM modeling, but as discussed below, that data system is being dismantled under the MOUs.

As mentioned earlier, some of the MOUs¹⁹ contain provisions for an “outcomes survey” to establish progress on the outcome metrics. These are unlikely to be capable of doing anything of the sort—at least for the HIV outcome metrics. While the outcomes surveys have substantial funding allocated to them (\$153 million across these seven MOUs in two rounds), the PHIA's highlight that surveys do not have the necessary precision to establish with any certainty whether incremental gains have been made in diagnosis, treatment, and viral suppression coverage of PLHIV. The confidence intervals on each metric are unlikely to shrink compared to those produced in the PHIA's. Even with the level of sampling and methodology in the PHIA's, the range of PLHIV estimates remained broad—especially as the basis of determining 1-2 percentage point differences in downstream indicators like the outcome metrics at issue here. The PHIA's also took years to conduct and process. While it's possible to reduce the timeframes for analysis, the reality is large survey methodologies require time to do robust data collection if a representative result is to be achieved.

The outcome metrics are—in effect— a mirage of numerical precision obscuring a lack of any meaningful information

Moreover, the outcome surveys in the MOUs are meant to cover all disease areas for which there are outcome metrics, which would increase per household cost and likely lead to less overall coverage and precision of the estimates.

This does not mean that the outcomes surveys themselves are wasteful, but rather that they cannot realistically be a mechanism for MOU accountability. This is not an implementation or design problem, but simply a scale

reality. Without surveying a massive proportion of the population on a representative basis, there's simply no mechanism for shrinking the range of the estimates that will be produced. While they will undoubtedly provide useful information for the purposes of future modeling and refined programmatic decision-making, they cannot overcome the inherent limitations of population-level surveys.

Conclusion on outcome metrics

The outcome metrics are end results to be achieved and are meant to work intricately with the process metrics also established in the MOUs. The mere fact that the outcome metrics in isolation are not objectively measurable is not the fundamental flaw. But, they cannot realistically be a basis for holding governments, programs, or the MOUs themselves accountable. Nor do they put Congress in a place to conduct oversight of the State Department's performance or assess the viability, sustainability, and continuation of HIV programming throughout the MOU timeframe or post-transition. The outcome metrics are—in effect—a mirage of numerical precision obscuring a lack of any meaningful information.

¹⁹Ethiopia section 4.1: \$10 million for surveys in each of 2027 and 2029; Kenya para 5.1: \$10 million in each of 2027 and 2029; Liberia section 4.1: \$1.5 million in each of 2027 and 2029; Mozambique section 4.1: \$35 in 2027 and 2030; Nigeria section 4.1: \$10 million in each of 2027 and 2029; Rwanda: No outcomes survey in the MOU; Uganda: section 4.1: \$10 million in each of 2027 and 2029.

Process Metrics

The HIV-related process targets in the MOUs are numerically focused targets similar to PEPFAR's traditional Monitoring, Evaluation, and Reporting (MER) indicators. They support the outcome metrics by providing more objectively measurable service delivery numbers on an annual basis. There are four core targets that appear in all the MOUs (along with their traditional MER equivalents):

- Number of People on ART: (TX_CURR);
- Number of new diagnoses among infants: (PMTCT_HEI_POS);²⁰

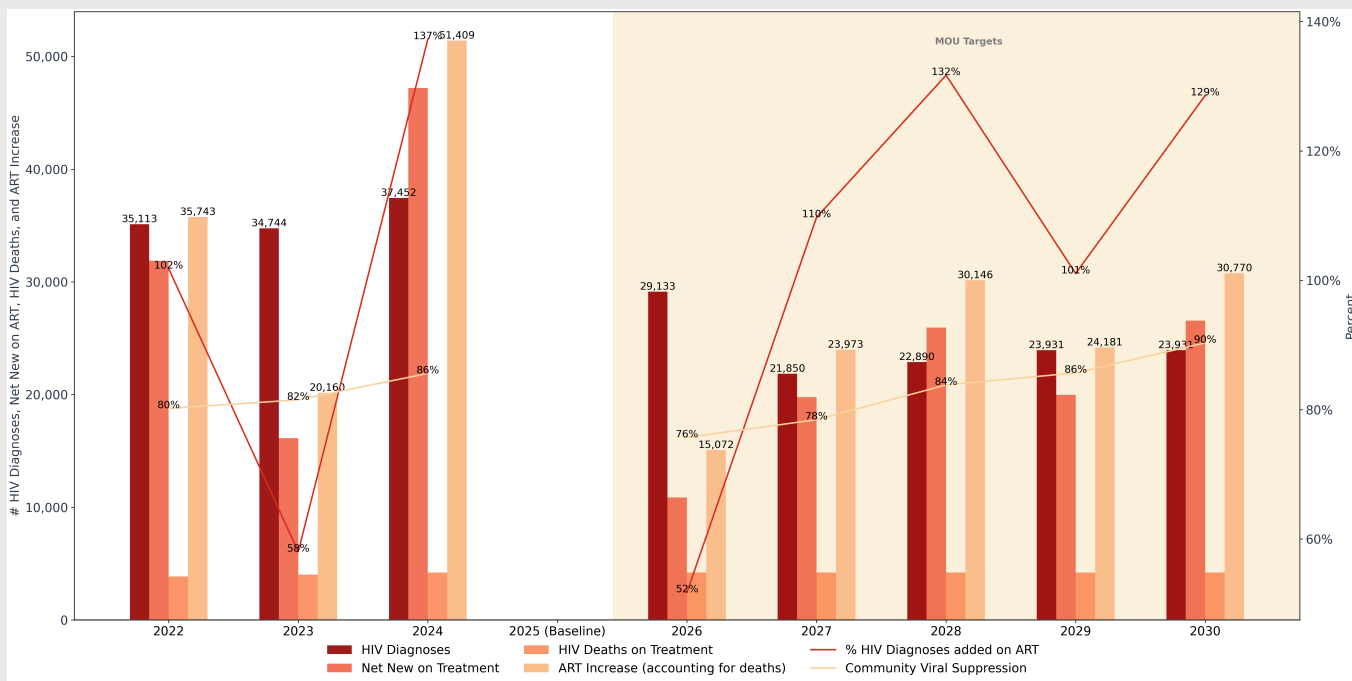
²⁰Note that Kenya's MOU process metrics have a gap as individuals diagnosed between 12 months and 18 months of age don't qualify to appear in either diagnoses among infants or diagnoses among children and adults.

- Number of new diagnoses among children and adults: (HTS_TST_POS); and
- Percent of pregnant and breastfeeding women living with HIV who receive ART: (PMTCT_ART or PMTCT_ART / PMTCT_STAT_POS).

Additional metrics have been added on a country-by-country basis.²¹ These metrics are logically both internally related and intertwined with the outcome metrics already discussed. Failure to diagnose PLHIV, support them to be initiated onto ART, and support them to be durably virally suppressed would undermine the outcome metrics

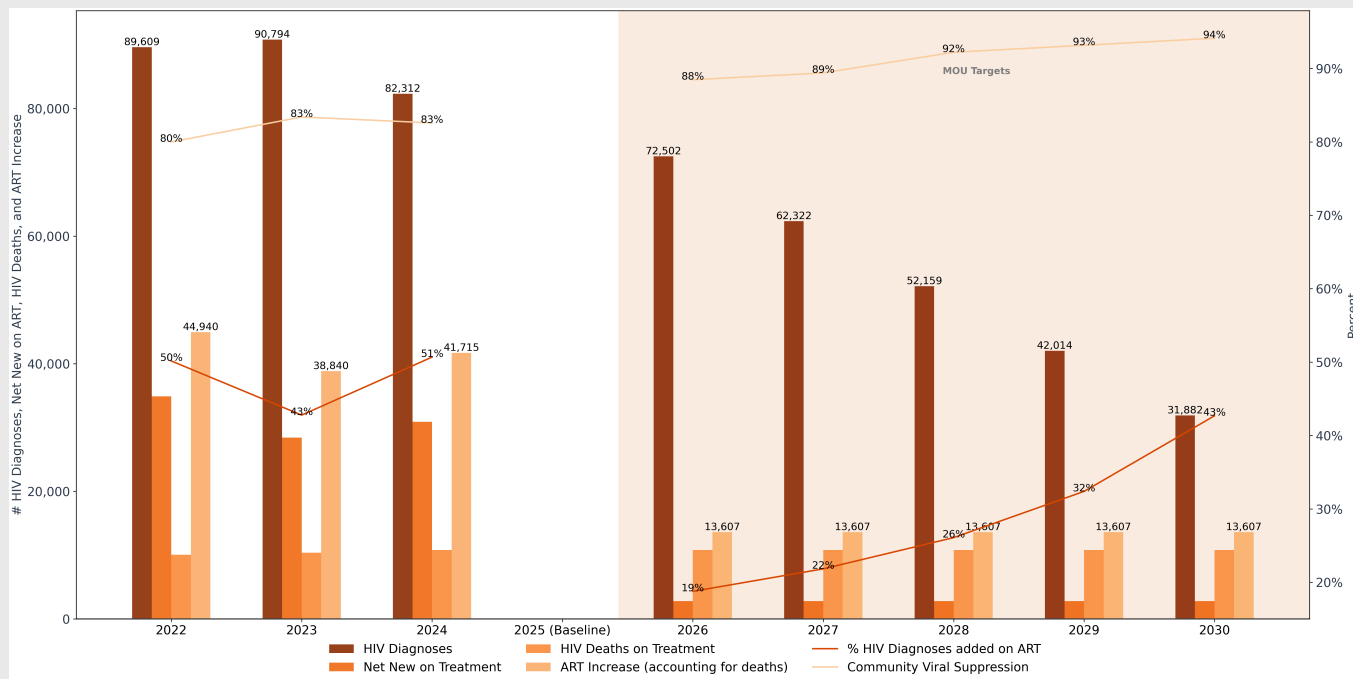
²¹Ethiopia and Mozambique's MOUs include targets for mother-to-child-transmission rates; Nigeria's includes targets for the number of PLHIV enrolled on health insurance.

Figure 3: Ethiopia: HIV Diagnoses to Additional People on Treatment



Ethiopia has undergone a data cleaning and significant changes in the scale of facilities reporting data to PEPFAR, increasing by 129 facilities between 2023Q4 and 2024Q4. This complicates country-level Net New on Treatment calculations resulting in an apparent increase in the Net New on treatment well beyond the numbers of people being diagnosed, which also undermines the calculation for HIV diagnoses added on ART. The MOU targets are, however, national level targets for Ethiopia as a whole, which don't involve such issues. The range for percent of HIV diagnoses added on ART goes from 52% (2026) to 132%, (2028) with four of the five years having rates over 100%, meaning more people are expected to be added to treatment than are diagnosed. There's no precedent for that, especially over an extended timeframe as shown. Targets for HIV diagnoses are 22% below 2024 PEPFAR results in the country.

Figure 4: Kenya: HIV Diagnoses to Additional People on Treatment



PEPFAR’s 2022-2024 data for Kenya show relatively consistent HIV diagnoses to increases on treatment percentages between 43% and 51% by year. The MOU targets, however, set the ratio in 2026 to only 19% of HIV diagnoses leading to treatment increases with a rapidly increasing trajectory. Targeted net new increase in treatment rolls in Kenya is 67% lower than PEPFAR’s performance in 2024. Total HIV diagnoses are targeted at significant declines, with 2026 already 12% below 2024 performance and 2030’s target 61% lower than 2024 performance.

described above. But that also means that there must be a clear relationship between the numbers of individuals to be diagnosed and the increase in the number of people meant to be on treatment each year. Diagnosing individuals but failing to initiate them on treatment undermines the Second 95 target. Over-diagnosing individuals relative to expectations signals one of two things or a combination: 1) That HIV incidence is substantially higher than expected—meaning that community viral suppression and prevention efforts are failing to reduce new infections; or 2) Significant numbers of patients are interrupting treatment and returning to care to be re-tested/re-diagnosed to be re-initiated on treatment. In all scenarios, this points to a health system that is failing to maintain high-quality patient care which, again, undermines durable community viral suppression and prevention efforts.

It must be acknowledged that these targets are difficult to set. For the reasons stated in the previous section, it is largely unknown how many PLHIV are yet to be diagnosed. Even for those diagnosed, health systems data often can’t track patients between health facilities to know if previously diagnosed patients actually initiated treatment. Most health systems use proxy indicators for these assessments, and they are valuable but flawed. While health systems are

moving in the direction of electronic medical/health records systems and/or unique patient IDs, these systems are not widely deployed and come with substantial privacy and safety risks as well as patient trust concerns—particularly when run by governments themselves. This shift to digital health records is critical for both this and the next section on data systems.

PEPFAR also historically struggled to set testing and diagnosis targets. Traditionally, these were calculated from an estimate of where the country was on the 95-95-95 estimates to identify the gaps remaining and then determine the numbers of diagnoses and treatment initiations necessary to reach the targets. The MOU targets seem to take a substantially different approach and have little to no relationship between the targets for patients being newly diagnosed and targets for the number of people to be initiated on treatment. Additionally, they bear little resemblance to PEPFAR’s recent performance data.

For each MOU, we assessed the MOU targets for HIV diagnoses against the targeted growth in individuals on treatment after accounting for deaths and compared these against PEPFAR’s data from 2022–2024. We use the term “HIV diagnoses” throughout this report because none of the

systems available for tracking data, including government systems and PEPFAR's, are capable of isolating "New Diagnoses" (as stated as the metric in the MOUs) from HIV diagnoses that include both genuine new diagnoses and people being re-tested as positive for a variety of reasons. We used UNAIDS data to estimate all cause mortality among PLHIV on treatment.²²

It's important to note up-front comparing PEPFAR data to expected results under the MOUs is problematic. PEPFAR's data represent only a sub-set of facilities that report data to PEPFAR as a result of receiving PEPFAR support. The number of facilities reporting and even which facilities vary from year to year. The MOUs set targets for the country as a whole, inclusive of facilities that have not traditionally reported data to PEPFAR. In some countries, like Liberia, Nigeria, and Rwanda, PEPFAR's presence was in a minority of facilities and regions. But that means targets under the MOUs for HIV diagnoses and increases in people on treatment should generally be expected to be higher than

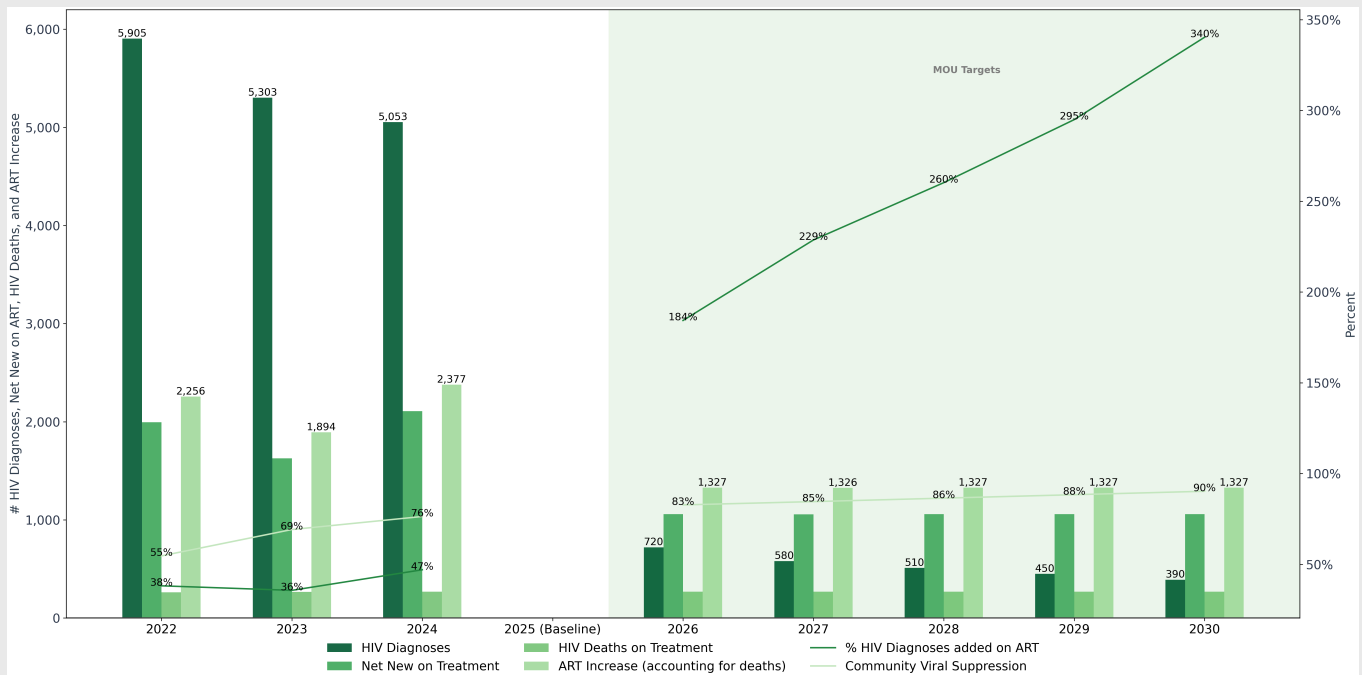
²²To estimate deaths while on treatment, we used UNAIDS data for "Deaths among PLHIV (all causes)" and subtracted "AIDS Deaths." AIDS Deaths were considered to be patients not on treatment. All remaining deaths were considered "HIV Deaths on Treatment." For the MOU years, 2024 UNAIDS numbers were used for all years.

PEPFAR's past performance. Moreover, when accounting for deaths among PLHIV while on treatment, the data are national data, which are not down-scaled to account for the PEPFAR data only being a national subset.

This analysis focuses on the ratio of HIV diagnoses to increases in individuals on treatment after adjusting for deaths (Percent Conversion). In an idealized setting not accounting for deaths, this ratio should generally approximate the Second 95 target. Meaning, approximately 95% of those diagnosed would be initiated on treatment leading to an increase in the total number of people on treatment. This is critical because performance below this level inherently degrades the achievement of the Second 95—which as shown in **Table 1** is targeted to be at least 95% in all of the countries being discussed here. When accounting for deaths, the ratio will be below 95%, but should retain a relatively stable relationship. This is particularly true when setting targets.

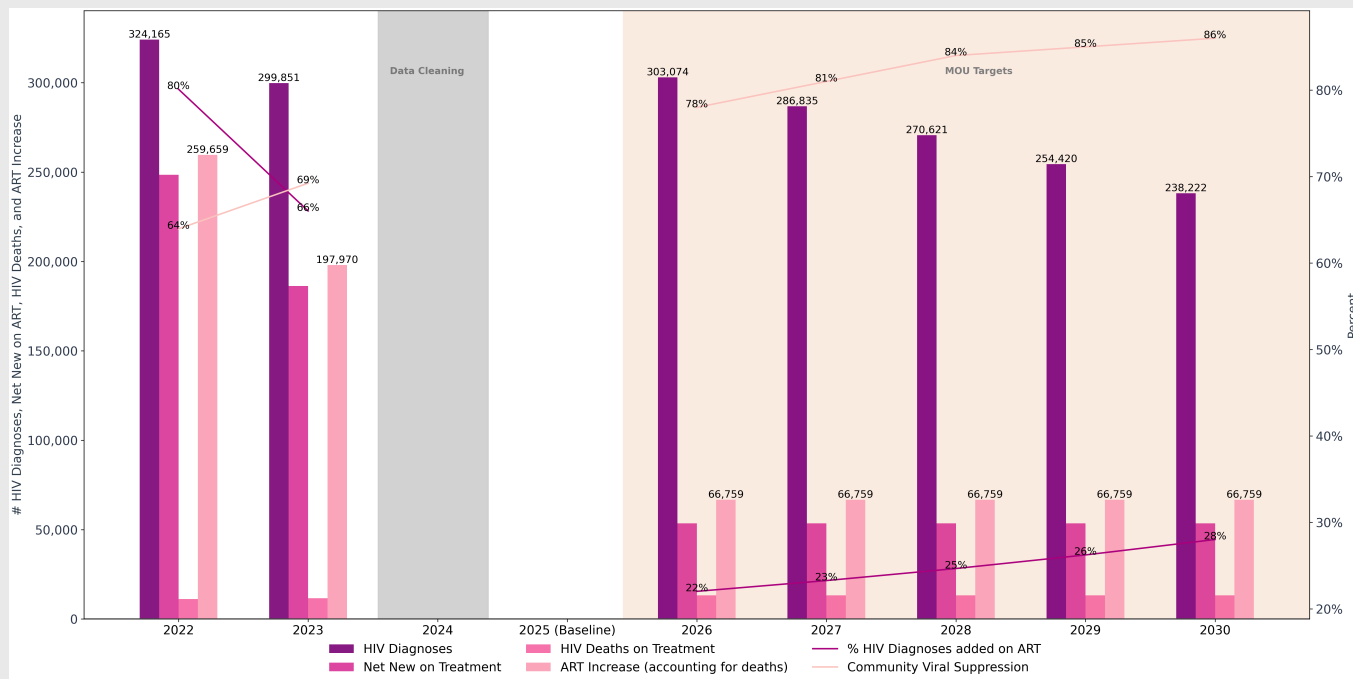
While every country has unique circumstances, the basic dynamics of diagnoses leading to treatment initiation are not fundamentally different. Even allowing for some variation, the metrics should at minimum be internally

Figure 5: Liberia: HIV Diagnoses to Additional People on Treatment



Liberia's MOU sets targets for increases in the number of people on treatment that cannot be achieved by the targets for the numbers of people to be diagnosed. The MOU targets are also exceptionally low compared to the results PEPFAR has reported for the past three years - amounting an 87% reduction in HIV diagnoses in 2026 relative to its 2024 results and a 44% reduction in the net increase in ART treatment. While some people may be added back onto treatment rolls who have interrupted, the targets are likely to be achieved by default, even if the program is largely failing.

Figure 6: Mozambique: HIV Diagnoses to Additional People on Treatment



Mozambique’s data have undergone a data quality assessment in 2024 that led to a drop of more than 100,000 in the number of people being identified as on treatment in PEPFAR supported facilities or about 5% of the total on treatment between 2023Q4 and 2024Q3. This is in-line with when data cleaning efforts were conducted in other countries. But because of those drops, the net new on treatment appear substantially negative when 2024 data are included. Nevertheless, the ratio of HIV diagnoses relative to the increases on treatment are not aligned to prior results, where data showed between 70-80% of HIV diagnoses led to increases on ART, while the MOU targets expect only 22-28% of HIV diagnoses to lead to increases on ART. Further, targeted net increases in ART are 66% lower than 2023 results.

consistent within an MOU and be on similar trajectories given that the outcome metrics in all MOUs effectively align.

Figures 3-9 show for each MOU the number of HIV diagnoses, the net increase in people on treatment, estimated deaths among PLHIV who are already on treatment, the ART increase accounting for deaths,²³ and the percent of HIV diagnoses added on ART.²⁴ Total community viral suppression is also plotted due to its relationship to expected changes in incidence to indicate whether decreases in HIV diagnoses are due to expected declines in incidence.

Individual country results are discussed in the captions to each chart, but overall, there is no pattern or coherent relationship between HIV diagnoses and increases on treatment either before or after accounting for deaths, and several of the MOUs set targets that are essentially impossible to simultaneously achieve. The targets establish

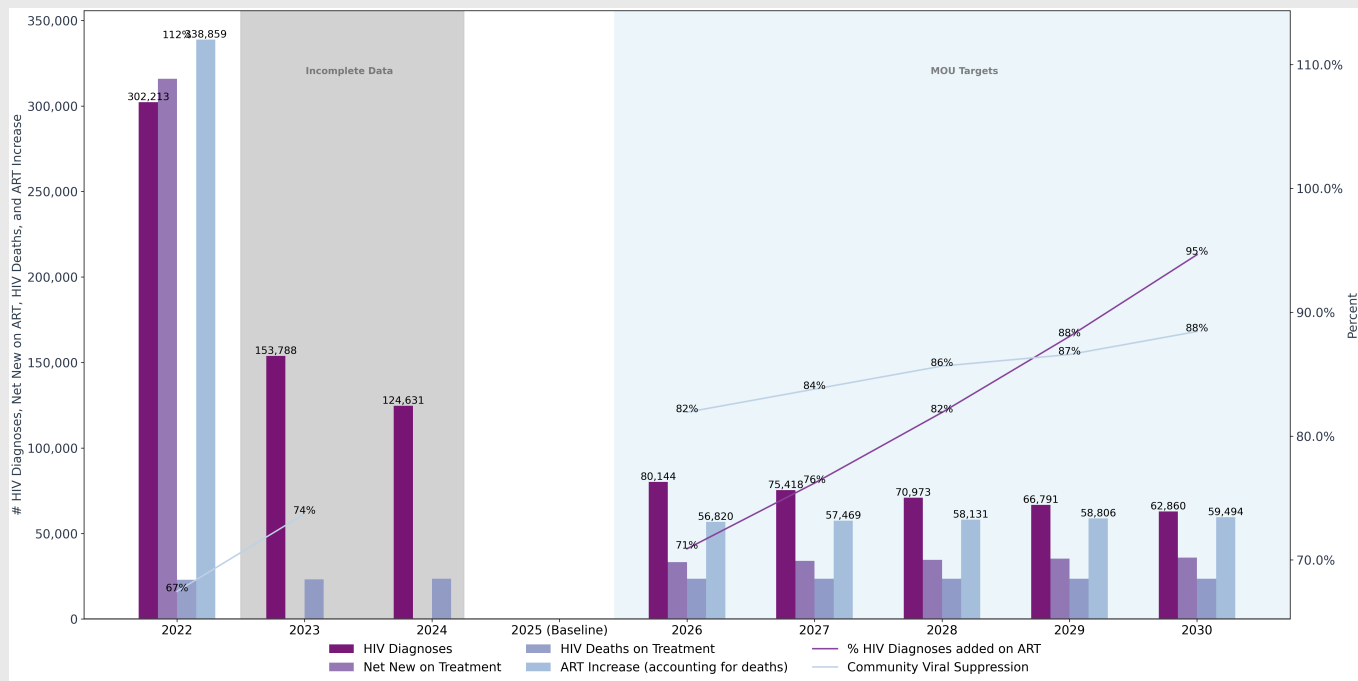
ratios of HIV diagnoses to targeted changes in treatment numbers that are radically different year-to-year over the course of the MOUs and are on radically different trajectories from MOU-to-MOU. Moreover, because the relationship between the two core indicators (number of people on ART and HIV diagnoses) is ruptured, they logically contradict each other in terms of whether the objectives are being achieved.

For example, in Kenya, the targeted increase in treatment in 2026 is only 2,800 people (not accounting for deaths; Accounting for deaths we estimate at 13,607), while the target for HIV diagnoses is 72,502. That is a conversion of only 3.9% of those “newly” diagnosed leading to an increase in ART (18.8% when accounting for deaths). While these are targets that can be surpassed, surpassing them doesn’t help us to understand whether the health care system is actually performing adequately nor provide us a mechanism to understand whether the MOU is succeeding or failing. For instance, if Kenya meets its 2026 treatment target in the MOU of 1,302,472, but only achieves 32,000 new diagnoses, has it met its objectives? It may be that incidence has plummeted, or data systems have improved to reduce

²³ART increase accounting for deaths is the sum of “HIV Deaths on Treatment” and “Net New on Treatment”

²⁴Calculated as “ART Increase accounting for deaths” / “HIV Diagnoses” in each year.

Figure 7: Nigeria: HIV Diagnoses to Additional People on Treatment



PEPFAR never released 2023Q4 data for Nigeria publicly due to data quality concerns. This makes the 2023 and 2024 data unusable for calculating new new increases. For conversion rate of HIV diagnoses to increases on treatment go from 71% to 95% on a linear trajectory. HIV diagnoses targets in 2026 are 36% lower than 2024 performance.

counting previously diagnosed patients as “new” diagnoses, or it could mean that the health system is completely failing to get new patients initiated. All are plausible explanations, but the targets will have clearly been missed. Alternatively, if Kenya achieves its diagnoses target of 72,502 and initiates far more people on treatment in 2026 than originally expected raising the total on treatment by 70,000, it can't be declared as a good sign for the health system. It's highly suggestive that incidence has increased, that there are errors in the data stream, or we are fundamentally incorrect about 93% of PLHIV already being on treatment. That result would also invalidate the MOU's treatment targets for 2027–2030 in the MOU, because they would now represent large losses.

Furthermore, the targets—if meant to be accountability measures—should at least be somewhat aligned with PEPFAR performance data for the seven countries, but they are not. For countries with consistent PEPFAR data for 2022–2024 (Liberia, Kenya, Rwanda, and Uganda),²⁵ the range for the Percent Conversion goes from 36% (Liberia, 2023) to

79% (Rwanda, 2024) with relatively consistent trajectories or stable results within each country. The MOU targets for 2026–2030, however, don't show any of this consistency. As targets, it should be expected that they are significantly more consistent across the countries than actual performance data. The results range from –2% (Rwanda, 2030—meaning people are being removed from treatment faster than they are initiated) to 340% (Liberia, 2030—meaning more than three times as many people are expected to be added to treatment in 2030 than the target for new diagnoses in 2030). The trajectories are also different with Ethiopia, Kenya, Liberia, Mozambique, and Nigeria on significant upward trajectories, while Rwanda and Uganda are on significantly downward trajectories. There is also no relationship between past performance in PEPFAR programming with the targets set in the MOUs. For example, Uganda's PEPFAR data for 2022–2024 show a consistent ~54% conversion rate. However, the Uganda MOU targets only 38% conversion rate and declining to only 17% by 2030. In Rwanda, PEPFAR data show a 73% conversion rate from 2022–2024, but the MOU targets are set such that only a 26% conversion rate is expected and declining to –2% by 2030. Importantly for Rwanda, there's effectively no change in community viral suppression rates that would indicate corresponding reductions in expected HIV incidence.

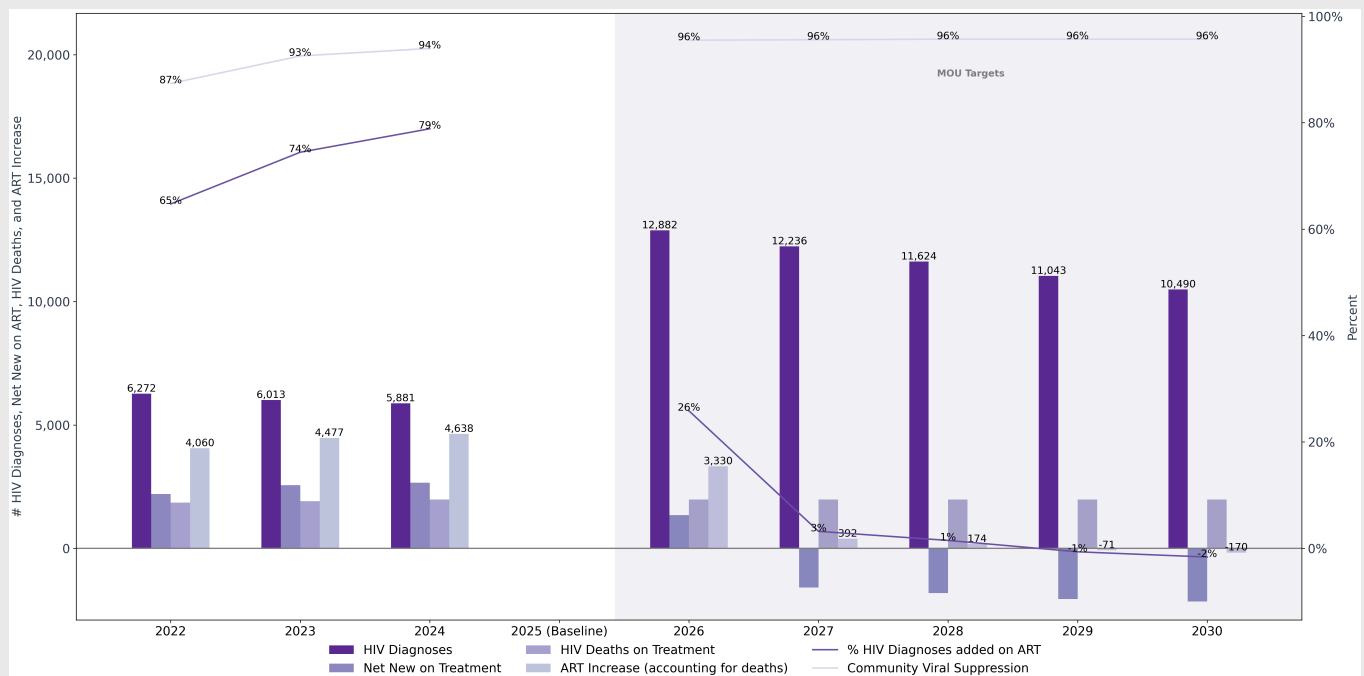
²⁵As described in the individual country notes, Ethiopia, Mozambique, and Nigeria have all undergone significant changes in the 2022–2024 period that complicate the analysis of past performance for this metric. That does not change, however, the expectation that the targets should be roughly aligned and consistent with other countries.

Conclusion on process metrics

The process metrics in the MOUs are set such that virtually any result can be explained away as either success or failure in any given year. Because there's no alignment between new diagnoses and additional people on treatment, the targets actively work against each other to provide competing explanations of whether any failure is actually a failure to meet the targets at all. This is not a reasonable basis for accountability of the MOUs. Quite simply, the process metrics have not been set with any of the specificity, care, attention to detail, or responsibility that should be ingrained in them to make them worthy of the tens of billions of taxpayer resources being invested. They provide little more than the appearance of accountability while effectively blinding any attempt at oversight.

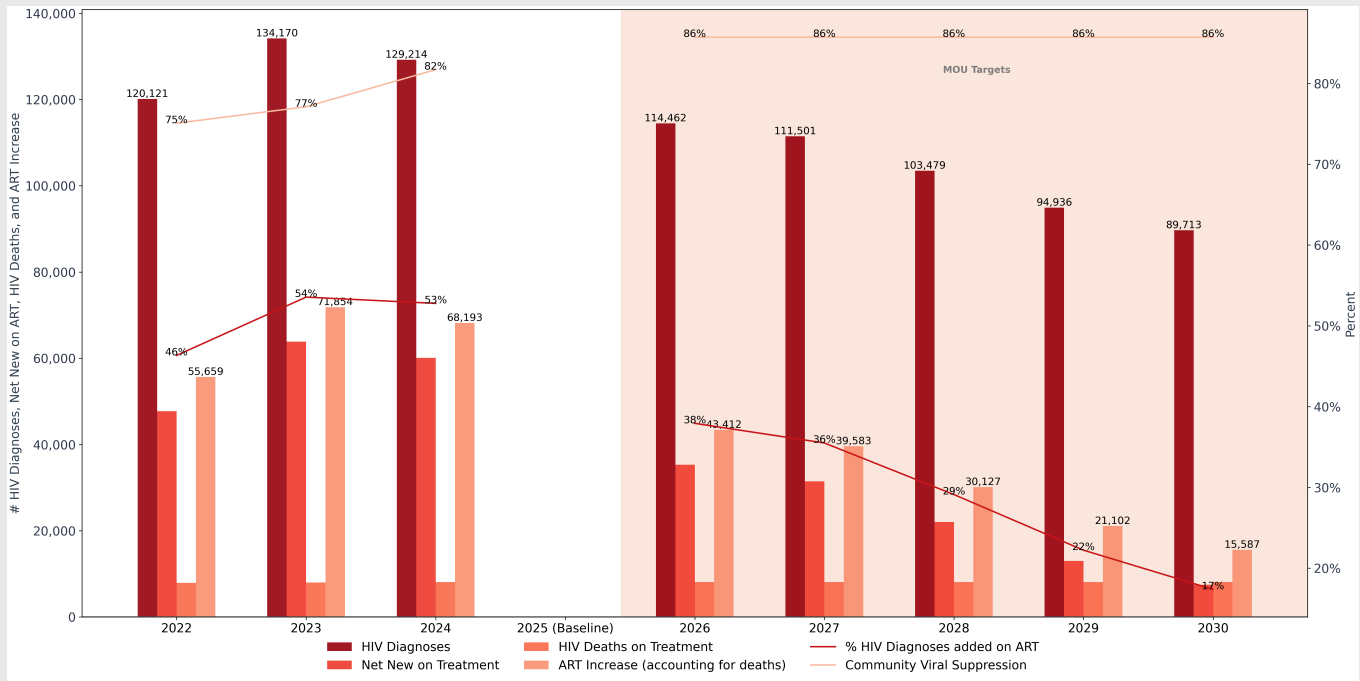
Quite simply, the process metrics have not been set with any of the specificity, care, attention to detail, or responsibility that should be ingrained in them to make them worthy of the tens of billions of taxpayer resources being invested. They provide little more than the appearance of accountability while effectively blinding any attempt at oversight.

Figure 8: Rwanda: HIV Diagnoses to Additional People on Treatment



PEPFAR's program in Rwanda supports a relative minority of facilities, reporting treatment data from only 206 facilities compared to the more than 1,800 facilities in the country. However, comparing the percent conversion from HIV diagnoses declines from 65-80% in PEPFAR's results to only 26% in the MOU's 2026 target and down to -2% in 2030. This is unprecedented and a trajectory unlike any other MOU's targets.

Figure 9: Uganda: HIV Diagnoses to Additional People on Treatment



Uganda’s trajectory for the conversion percent of HIV diagnoses to treatment increases set in the MOU is on a downward trajectory, reducing from only 38% in 2026 to only 17% in 2030. Additionally, while HIV diagnoses rates are similar to PEPFAR performance in 2024 (11% drop in 2026 down to 31% fewer in 2030), net increases on treatment are down 36% from 2024 performance data and declining to only 22% of 2024 results by 2030.

Performance Provision Contradiction

An additional flaw in the MOUs relating to accountability is that the template language on performance—adopted wholesale in the Ethiopia, Liberia, Mozambique, and Rwanda MOUs—is itself ambiguous with regard to the metrics themselves. The MOUs provide that:

*In the event [country] **does not maintain the baselines outlined in Section 1.1 outcome metrics and 1.2 process metrics** [...], both Participants acknowledge that the U.S. Government may substantially decrease or eliminate funding for one or more Area of Cooperation in future years” [emphasis added].*

It’s not clear what “maintain[ing] the baselines” means in the context of the targets set in the MOUs. The baselines for outcome metrics may provide a floor conceptually, but can’t be understood that way. For the process metrics, however, it’s not even clear what maintaining the baselines means when future targets in the MOU are set below the baseline number. For example, Rwanda’s total treatment target decreases over the course of the MOU. All the MOUs have declining targets for numbers of new diagnoses.

For new diagnoses, it’s also not even clear whether the number of diagnoses should be interpreted as a minimum expectation or a maximum. For instance, for new infant diagnoses, the targets for all the MOUs go down over time—as should be expected of high-performing PMTCT programs. But if the targets are a minimum threshold then if Mozambique only newly diagnoses 1,000 infants with HIV in 2027 compared to its target of 1,651, it’s not clear whether that is a good sign or a bad sign for the PMTCT program. It could be that the PMTCT program is working well and exceeding expectations, but it could also be that it has collapsed and is not diagnosing either pregnant women or infants. But Mozambique could have funding removed for the failure to meet its target, even though the target itself requires an underperforming PMTCT program.

The performance provisions make no indication of the directionality of the metrics. The default understanding would be that they are minimums, but that works against the direction that at least infant diagnoses should be trending. Moreover, again, it’s not clear what failure to “maintain the baselines” means in the context of the declining targets in the process metrics. Once again, it provides more or less unilateral authority for any outcome to be described as success or failure, because the metrics

are not calibrated to a goal of actual accountability or oversight.

This is also likely why Kenya, Nigeria, and Uganda have insisted during negotiations of their MOUs that the performance provisions be so heavily caveated. In the case of Kenya, they were negotiated out entirely.

Critically, all these same critiques also apply for the provisions providing countries with access to the Performance Incentive funds which state that “[i]n the event that [country] achieves all the process and outbreak response metrics for 2027 or 2028 outlined in Section 1.2 and 1.3, [country] is expected to be eligible to receive a performance incentive for 2027 or 2028 respectively.” However, as we’ve shown, simultaneous “achievement” of the HIV process metrics would actually speak negatively to overall health system performance, let alone as the basis for investing additional U.S. taxpayer resources. Something more substantive is expected and warranted.

For HIV diagnoses, it’s not even clear whether the number of diagnoses should be interpreted as a minimum expectation or a maximum. If targets are a minimum threshold then Mozambique only diagnosing 1,000 infants compared to its target of 1,651 would indicate failure, but could indicate it’s PMTCT program has improved or that it’s collapsed. But Mozambique could have funding removed for the failure to meet its target, even though the target itself requires an underperforming PMTCT program.

Data Systems and Transparency

The accountability story for the MOUs is further complicated by the ability for any independent entity to have access to the data necessary for oversight. The State Department has made clear that it seeks to shut down PEPFAR's independent data collection system (DATIM) and convert to utilizing national data systems as the basis for indicator collection. The MOUs have provisions relating to access to these data systems, including separate "Data Sharing Agreement" annexures to the MOUs and authority for the U.S. government to conduct audits of health facility reporting periodically.

Process Metric Audit: *Both participants acknowledge that so long as the U.S. Government is providing any funding in support of activities described in this MOU, both Participants have a significant and material interest in ensuring the process metrics outlined in Section 1.2 process metrics and 1.3 [infectious disease outbreak response metrics] are accurately collected, complete and maintained. To this end, Ethiopia intends to provide the U.S. Government with any data access, on-site access, or other information needed to audit the process metrics in Section 1.2 and 1.3 in up to five percent (5%) of randomly selected and/or specific health facilities, clinics, labs, or programs identified by the U.S. Government.²⁶*

Critically, the frequency of such audits are not articulated in the MOUs, nor is there clarity on whether the five percent of facilities is a cumulative total or a per-audit rate.

The transition from State Department developed, owned, and independently collected data to national data systems undermines the ability to assess progress and develop indicators independently to identify if programs are succeeding or failing. PEPFAR has done this on many occasions. While transitioning to national data systems is an admirable objective and eventually necessary, it has been a work in progress for over a decade. The challenges have always been in data quality, frequency, consistency, and granularity of the data stream that was controllable, cleanable, and identifiable within the reports PEPFAR would receive. For all its flaws and costs, PEPFAR's data system has been essential to its success and for measuring and accounting for the tasks Congress assigned it. Until 2025, PEPFAR was the most radically transparent global health program, providing updated data on a quarterly basis on its

²⁶Ethiopia MOU Section 4.2. Equivalent provisions are included in all seven MOUs.

website that included targets and results at the national, subnational, implementing partner, and even facility level. Data were disaggregated by age and sex to be able to identify gaps in service delivery for different populations and compare across countries. Independent researchers, civil society organizations, and others used these data to hold both PEPFAR and their own national governments responsible for failures. That system has been silenced, and the MOUs establish that it will remain so.

The MOUs include the following:

Confidentiality: *Unless otherwise authorized under this MOU or its appendices, **Participants are expected not to disseminate or otherwise make available any information exchanged under this MOU to any third party** (with the exception of the Participants' contractor support personnel) or use the information for purposes other than those for which it was provided, without the prior written consent of the Participant that provided the information, unless otherwise required by applicable law and regulations; however, for the avoidance of doubt, either Participant may make this MOU itself public.²⁷ [emphasis added]*

Per this provision, all public data dissemination, independent oversight, and analysis of the program is now prohibited under the terms of the MOU itself. The only entities with access to the data will be the State Department itself and the foreign Ministry of Health, both of which are politically motivated for the MOUs to appear to be working.

This marks the death knell for accountability. Without public release of performance data there can be no detailed, independent, or meaningful oversight. While governments can and should take up the mantle to publicly release data akin to what PEPFAR has traditionally done, they have little incentive to do so at present. With PEPFAR withdrawing its data system from the public sphere, that incentive is reduced even further. For U.S. taxpayers, this provision puts them in the position of having to request privileged access to data from foreign governments in order to do oversight of a U.S. government program that expends billions of taxpayer resources each year.

²⁷Ethiopia MOU Section 6.4; Kenya MOU para 11.1; Liberia MOU Section 6.4; Mozambique MOU Section 6.4; Nigeria MOU Section 6.4; Rwanda MOU Section 6.4; Uganda MOU Section 6.4.

Conclusion

The MOUs are the primary instrument of the America First Global Health Strategy. They hold incredible potential to transform domestic investment and change the landscape of global health investments in positive or negative ways. This report has not assessed the potential benefits that can come from the requirements around increased domestic resource commitments, which are necessary. But those do not offset the need for the MOUs themselves to be internally consistent and accountable. They are not.

As the foundation for the AFGHS, the MOUs generally and the HIV metrics and targets specifically have not been negotiated and developed with the requisite care, precision, and accountability that should be expected of them. Moreover—for HIV at least—they have missed the opportunity to support the identification and development of the critical metrics and accountability frameworks for the next phase of the global HIV response.

The 90-90-90 and 95-95-95 targets have been transformative in moving the global HIV response from one where fewer than 50% of PLHIV were aware of their status and on treatment and there was virtually no systematic testing infrastructure for viral loads, to one where many countries are now believed to have achieved those three 95s. They supported the setting of ambitious and essential targets that—even when wrong—provided the basis for being on a trajectory toward success. But for countries nearing the 95s, those metrics are now incapable of providing the basic framework for whether the health care system is continuing to succeed at reducing HIV incidence, supporting people on treatment, and preventing HIV resurgence. The relative differences at the top are no longer measurable.

What is needed instead is a new set of indicators that look at the overall health system's ability to sustainably maintain the HIV response focused on the availability, accessibility, acceptability, and quality of HIV service delivery—as well as the other disease areas included in the MOUs. This means developing, measuring, and making health systems accountable for patients interrupting treatment, the stigmatization and discrimination that many patients and populations experience in accessing care that delays and/or prevents individuals from being diagnosed, the burden for patients in accessing care, and the outreach services necessary to ensure patients are supported back to treatment if they interrupt care. For younger people being diagnosed with HIV today, they are expected to be on treatment for the next 50–60 years. Designing a health care

system capable of delivering that care means limiting the burden of interacting with the health care system itself. The MOUs provided an opportunity to begin to set out what those indicators and expectations would look like, but the State Department did not take that opportunity. Instead the MOUs now stand on a framework of metrics and targets that resemble both a different era of the HIV response and have been so poorly calculated that they are incapable of meaningful interpretation.

To this end, we make the following recommendations:

- 1. The Bureau of Global Health Security and Diplomacy should convene and solicit recommendations for next generation HIV health systems targets for which partner governments and health systems will be held accountable under MOUs**, even if this requires re-negotiating or amending the provisions. These metrics should be based on the availability, accessibility, acceptability, and quality of care. Some of these could include:
 - Percentages of patients on treatment who are in a treatment interruption - measured at the facility level;
 - Patient access metrics: ensuring comprehensive health services are available within reasonable distances across all populations and/or sufficient patient transport is available;
 - Limiting unnecessary engagement with the health system - medicines provided on a six monthly basis for HIV; Push systems for patient medication;
 - Functional, effective, trusted, and accurate appointment systems allowing patients to spend the minimal amount of time possible waiting for services within clinics.
- 2. Independent accountability and oversight of the health systems supported by the MOUs must be developed, funded, and robustly implemented.** These must include both patient complaint mechanisms as well as systematic assessments of patient experiences accessing health care services on an ongoing basis.
- 3. PEPFAR, PMI, and other global health programs should immediately return to regular order publishing of their budget, expenditure, and performance data.**
 - For PEPFAR, this would include publishing:
 - Bridge Plan planning documents;
 - Bridge Plan budgets at the national and implementing mechanism levels;

Congress should immediately impose public transparency and reporting requirements for all metrics and indicators tracked under the framework of the MOUs

- Publishing of the text and annexures of all MOUs as required by section 104A(e)(4) of the Foreign Assistance Act;²⁸
 - Publishing all implementation plan budgets for the MOUs including the recipients of funding, the mechanisms, award ID numbers, and line-item amounts;
 - Quarterly performance data for all MER indicators for all of 2025, including at the national, subnational, facility, and implementing mechanism levels as well as age and sex disaggregated data sets at the national, subnational, and implementing mechanism levels, and human resources for health data.
- For PMI, this would include publishing:
 - Malaria Operational Plans for fiscal year 2025;
 - Bridge Plan planning documents;
 - Bridge Plan budgets at the national and implementing mechanism levels;
 - Reports on net distribution, indoor spraying, and other supported prevention and surveillance activities.
4. **Congress should immediately impose public transparency and reporting requirements for all data shared under the framework of the MOUs.** Congress should also ensure that all indicators - including those required for on-going reporting requirements for PEPFAR under the Leadership Act - continue to be tracked and publicly released and consider adding additional reporting requirements for critical indicators. Public reporting should be required to be mapped to the traditional datasets that were previously released by PEPFAR that included:
- National, subnational (1-3 administrative levels depending on the country), and facility level data.
 - Disaggregated data by sex and small age brackets at the national and subnational levels.
 - All financial data, including the budgets and expenditures of any implementing mechanisms funded under the framework of the MOUs.

²⁸104A(d) of the Foreign Assistance Act provides for authorized activities for PEPFAR, including in subsection (8) the authorization to develop “Compacts and Framework Agreements” with partner governments. 104A(e) sets the requirements and considerations for those compacts and framework agreements if they include the bilateral HIV funds, as the MOUs do.

amfAR is a leading nonprofit dedicated to advancing scientific discovery and transforming global health with a primary and enduring commitment to ending the HIV/AIDS epidemic. Serving as a catalyst for breakthrough science, amfAR supports innovative research in areas where viruses and the immune system play a defining role, including cancer, neurological conditions, autoimmune disorders, and other viral diseases. Through strategic investments, global research partnerships, and evidence-based policy leadership, amfAR helps accelerate discoveries that improve health and save lives. Since 1985, amfAR has raised more than \$950 million and awarded in excess of 3,900 grants to scientists worldwide. Learn more at amfar.org



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