Photo: EGPAF 2024

2024 Annual Report

37 Years of Impact

Elizabeth Glaser Pediatric AIDS Foundation

Fighting for an AIDS-free generation

> People say that they care, but actions are what save lives.
>
> **—Elizabeth Glaser**

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The Clock is Ticking for Children

Hello and Habari, friends and colleagues of the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF).

As the new president of EGPAF, let me extend my warm greeting and thanks for the support that you have given this vital and essential organization. I am honored to be carrying on our mission to end AIDS in children. I take to heart Elizabeth Glaser's declaration that "every child deserves a lifetime."

Elizabeth spoke those words at a time when things looked bleak. The world was not meeting the HIV/AIDS crisis with the urgency it required. She had just witnessed the death of her daughter, Ariel, from AIDS-related causes and the clock was ticking for her son, Jake, and for herself—and for everyone living with HIV.

Our Challenge

With the dramatic cuts to international HIV programs, these are, again, urgent times. Most programs funded by USAID were halted in early 2025 and cut back or cut entirely. UNAIDS estimates that if cancelled funding permanently disappears, HIV rates could return to the numbers that we saw in the early 2000s. This shock to the global health care system threatens to roll back the astounding progress we have made in sub-Saharan Africa—where 83% of HIV-positive births occur.

Each day, more than 328 children are born with HIV, and that number is now rising again. In 2024, 75,000 children died from AIDS-related causes. I fear what 2025 will mean in terms of children's deaths.

Now More Than Ever

Without treatment, a pregnant woman living with HIV has a 30% chance of transmitting the virus to her child. And if an HIV-positive child is not reached

with antiretroviral drugs during the first year of life, there is a 35% chance of that child dying. If left untreated, 80% of children infected with HIV will die by the age of 5. That risk can be eliminated simply by ensuring that pregnant women living with HIV are on treatment.

Over the past 25 years, prevention of mother-to-child HIV transmission (PMTCT) programs have protected 4.4 million children from acquiring HIV, setting the world on a path to an HIV-free generation. It would be heartbreaking to see this investment lost—not to mention the personal and household heartbreaks of every mother and every father who loses a child to an entirely preventable death.

So even as we strategize and innovate, we must be mindful of the time. The clock is ticking at this moment for a child who has been born with HIV and may not be tested and linked to lifesaving medication. The clock is ticking for a pregnant woman who may transmit HIV to her unborn child because she was not reached with PMTCT services.

We have the tools. We have the solutions. What we need most to end AIDS in children is sustained political will and financial investment.

Join me as we accelerate our efforts to advance this lifesaving mission for children, for mothers, and for families and our communities.

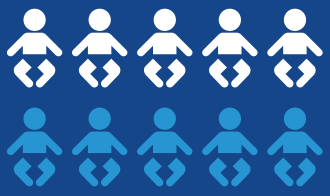
Doris Macharia, M.D.

President
Elizabeth Glaser Pediatric AIDS Foundation

Why it Matters

330 children are newly infected with HIV **EVERY DAY** because their families lack access to the health services they need to prevent transmission.

AIDS is a leading cause of death among young people in Africa.



Without diagnosis and treatment, 50% of HIV-infected infants will die before their second birthday.

Our Mission

The Elizabeth Glaser Pediatric AIDS Foundation seeks to end HIV and AIDS globally in children, youth, and families.

Our Work

PROVIDED

OVER 33 MILLION pregnant women worldwide with services to prevent transmission of HIV to their babies.

SUPPORTED

OVER 15,000 sites to offer HIV counseling, prevention, diagnosis, and treatment services alongside high-quality family healthcare.

AVERTED

OVER 410,000 new HIV infections in children since 2000 by offering prevention of mother-to-child services to pregnant women.

Our Impact 2024

Pregnant women supported with antenatal care services:

683,000 women

Children (0-14 years) tested for HIV:

483,054 children

HIV+ patients provided with antiretroviral therapy:

1,200,000 patients

Conducted:

67 research studies

Photo: Kevin Ouma for EGPAF 2023

Photo: Eric Bond for EGPAF 2014

Four Children Have Achieved HIV Remission

Interview: Deborah Persaud, M.D., Explains How This Breakthrough Will Save Children's Lives

At the Conference on Retroviruses and Opportunistic Infections (CROI) in March, Dr. Deborah Persaud announced that four children had achieved HIV remission. She sat down for an interview with EGPAF's Eric Bond to explain the significance of this breakthrough and what it means for the fight for an AIDS-free generation.

Could you explain the significance of your announcement at CROI?

We reported that four children had gone into what we call ART-free HIV remission. ART stands for antiretroviral treatment. With HIV, once you start someone on antiretroviral treatment, that treatment is lifelong to maintain the virus from replicating.

These children were enrolled in a clinical trial of very early treatment, meaning they received antiretroviral therapy within 48 hours of life and were treated through 5-and-a-half years of age. They then underwent what we call an analytic treatment interruption, meaning that we stopped their antiretroviral treatment, and we monitored them very closely to see if and when HIV would return in their bloodstream.

It's called ART-free remission because these children stayed off of their antiviral drugs for more than 48 weeks without the virus bouncing back. The clinical trial used 48 weeks or more to define ART-free remission in children.

It is crucial to understand that in almost every individual who acquires HIV, including babies and children, the virus forms a latent reservoir where it's able to integrate its genetic material into the person's genetic material and stay silent. Our current therapies cannot get rid of that form of HIV, and as a result, whenever you stop therapy, the virus bounces back. But this study demonstrates that by treating a newborn who is born with HIV within the first two days of life, remission can come about, a period of time when the virus is suppressed without the intervention of antiretroviral drugs.

How does this relate to the Mississippi baby, which was also a breakthrough for your team?

In 2013, we reported on a child referred to as the Mississippi baby, who was known to be infected with HIV, but who inadvertently went off treatment. Five months later, when her viral load was checked, there was no evidence of HIV in the bloodstream. There was no antibody to the virus, and there was no DNA. She went for 27 months before the virus came back.

We identified that what was unique about the Mississippi baby was that she received a three-drug regimen at 30 hours of age.

So, on the heels of this breakthrough, we developed an NIH clinical trial, IMPAACT P1115. IMPAACT stands for the International Maternal Pediatric Adolescent AIDS Clinical Trials Network.

In basic terms, what was the approach for the IMPAACT P1115 study?

The trial was opened in 2015, and we enrolled women who did not know their HIV status at the time they were giving birth. We ended up enrolling 54 infants who had been confirmed to have been born with HIV. Those babies were given a very early treatment regimen and monitored throughout the study until we stopped therapy, with six of them who stayed suppressed on their regimen and showed no HIV in their blood and tested negative for HIV antibody.

Now, why do we have to stop therapy? Unfortunately, there's no test that we can do when a child or an adult is on treatment to say that that person is in remission. You have to stop therapy

and continue to test to see if the virus comes back.

Four of the six children reached the 48-week benchmark. One went for 80 weeks without treatment, but then needed to be returned to treatment. We still have three who are off treatment and are still being followed.

This means that 11 years ago, we reported on a single case of ART-free remission in a child, the Mississippi baby. And in 2024, we've provided the proof of concept that very early treatment of babies born with HIV from infection in utero can achieve remission.

People do not necessarily think of remission when it comes to HIV, so could you explain this, and also explain how remission is different from a cure?

We're careful about using the word cure because we know that HIV persists in memory cells. Your memory cells are designed to live as long as you live, to provide you with immunologic memory, and at any point that cell can become reactivated and rekindle infection, unannounced.

For us, remission means not having to take antiretroviral drugs for some time to keep HIV in check. The question becomes this: Do we need to get to a total cure, necessarily? We are researching to see if we can get to the point where having HIV is similar to having viral infections, such as the chicken pox virus, that comes back as zoster. If you had chicken pox as a young child, you can then develop zoster or shingles later in life. The virus is still there, but you're able to control it. You might have an outbreak at different times in your life, but it is controllable.

A cure, on the other hand, would be a situation where you have completely cleared every cell that has an integrated, infectious HIV genome. That's a tall order to ask of simple treatments with conventional drugs.

In the cases of stem cell transplant, where your immune system is essentially eradicated through chemotherapy and radiation therapy and then replaced with HIV-resistant cells, I think you could venture to say that someone is potentially cured. We have seen success with this in conjunction with cancer treatment. But this is not feasible for most people living with HIV—unless you have HIV and develop cancer, of course.

Do you anticipate that early infant intervention could be scaled up to a point that this could be available for most babies who are born with HIV—potentially giving them the gift of remission?

Yes, I think so. This could be scaled up in terms of test and treat—test very early and treat very early with point-of-care tests. And those platforms are available, but they're not accessible in most areas of the world where the burden of the infection is.

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) plays a large role in this—providing access to point-of-care testing where babies can be identified and placed on the very early treatment. If we can get a child treated early and virally suppressed, we hope to figure out down the road on how to transition that child to remission.

The next phase of the trial will include a different antiretroviral drug cocktail—contemporaneous regimens such as integrase inhibitors, adding Immunotherapeutics. These clinical trials are costly. They are very labor intensive and require frequent monitoring.

But while the trials continue, we can start with treating kids very early. We know that very early treatment is lifesaving. What we need to figure out as a group is how to get better drugs for newborns to keep them virally suppressed.

Walk us through the experience of a mother or a caregiver participating in the study.

This study was done in 11 countries around the world, most in sub-Saharan Africa, which I think is what I'm most proud of. This is not a study that was done in the United State to benefit U.S. babies. This was done where the epidemic lies. It's really a global effort in the pediatric community to change the lives of children and their families living with HIV.

But one thing that we often lose when we report on these findings is the investment of the mothers or guardians and their babies—because these are kids coming frequently for blood draws, in order to test their viral load.

Some of these families come from rural villages

miles away to the research center to participate in this study. While the study shows the results, it doesn't really portray the commitment of mothers and guardians and the wellbeing of their children. And somehow, we need to figure out how to capture that —because without that, we would have no outcome and no results to report on.

The mothers deserve a lot of credit. We have to enroll their babies right after delivery, and we have to include women who have just learned that they are living with HIV. So that's heavy information. You're telling a mom that she has an HIV infection and that her baby could possibly be infected.

Of course, not every child born to a mom with HIV acquires the virus. We know that the risk of a mother with untreated HIV transmitting it to her baby in utero is somewhere between 6% to 8%.

And then there is a long consent process to make sure that the mother understands the study and wants to participate. Care providers become the source of support as the moms go through the process of learning their diagnosis and being assured that there's treatment and that with treatment, a child with HIV can live a long life. If your baby does turn out to be infected, we can continue those treatments.

Can you explain why early infant diagnosis is so important and what's needed to make it more accessible?

We know that early treatment means a healthy immune system and is lifesaving for children. And so, it's on us to make sure that every infant exposed to HIV is tested and treated in a timely, appropriate manner.

In most countries, because of convenience and cost, babies aren't tested until 6 weeks of age. The turnaround time for those tests could be weeks to months. In many cases, they're not being started on treatment until three to four months of age. We can't operate like that anymore.

For the study, we had a system of testing babies at the time of birth. There are now near point-of-care tests, with only a 90-minute turnaround time; this can revolutionize test and treat for infants.

We've shown that we can achieve remission in children—but the most important part was that we also showed that we can do very early testing and treatment across the globe at these 30 research sites in 11 countries.

What does this breakthrough mean to you on a personal level?

This has been an incredible journey. I first encountered pediatric HIV and AIDS during my fellowship training in New York City when many babies died, many mothers died, many fathers died. It has been a journey of decades from seeing a disease from which most children died to one where we're talking about remission and going off therapy. It has been gratifying.

I am fortunate to be part of a large team committed to this charge. The NIH invested in this sort of research in terms of proof of concept. The Elizabeth Glaser Pediatric AIDS Foundation has been pivotal for me because it provided my first funding to establish a research program, along with the Doris Duke Foundation. The Glaser Scientist program and the culture that was established through their annual meetings of bringing scientists together really allowed me to establish broad, wide collaborations.

This has really been a community investment in a cause. I gather the team, and we all think together. Everyone's doing their part with their own expertise to make this whole pie so that we can end up where we are today.

What's next for your research team?

We have several studies underway. One is intensifying the regimens to see if we can get better outcomes—so that they block the virus's genetic material from actually integrating into the whole cell.

Another big component we're designing now is a clinical trial looking at a therapeutic HIV vaccine in combination with broadly neutralizing antibodies that would reduce the impact of HIV, making it more like shingles or herpes simplex in that you may get a flare up, but it subsides.

Those studies are in development, and we hope to open them by January of next year.

Photo: EGPAF 2024

Responding to the Moment: Foreign Assistance Cuts

In 2025, a sudden shift in U.S. foreign assistance policy triggered the termination of lifesaving health programs across several countries, including longstanding initiatives led by the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF). These abrupt funding cuts impacted services for more than 350,000 people on HIV treatment, including nearly 10,000 children and more than 10,000 pregnant women living with HIV, in Lesotho, Eswatini, and Tanzania. For many, this meant a dangerous and immediate gap in access to essential care.

This marked the most significant setback in the global fight to end pediatric AIDS in nearly two decades.

PEPFAR-funded services, critical to preventing mother-to-child HIV transmission and supporting long-term treatment adherence, were paused or terminated with little warning. Clinics in remote, high-need areas lost vital supplies and staffing. Many of the health workers had spent years building trust in their communities and were laid off. Outreach and follow-up programs that kept children from falling through the cracks were suspended, leaving thousands without support.

The impact was swift and devastating. Families who had relied on EGPAF-supported services for years suddenly found themselves without treatment, counseling, or testing. In some areas, the only pediatric HIV programs available disappeared overnight.

EGPAF raised the alarm by engaging directly with policymakers, amplifying the voices of those affected, and advocating across global platforms. The Washington Post, Salon, and Fortune covered the crisis and its human toll, spotlighting the long-term implications of these cuts on health systems, children, and families. Partly due to this work, funding was restored for EGPAF's life-saving work in Tanzania.

In the face of this crisis, EGPAF is not retreating; we are evolving. EGPAF has adapted to the changes we encountered in 2025, and we move forward in a position of strength, with the technical capacity, country presence, and unwavering commitment required to double down on our mission to end AIDS in children.

Rooted in more than 36+ years of proven leadership, EGPAF is accelerating efforts to streamline organizational structure, diversify funding streams, strengthen local partnerships, and scale cost-effective innovations that ensure continuity of care.

For every program disrupted, there is a child, a mother, and a family whose future hangs in the balance. EGPAF remains standing with them, and is committed to achieving the HIV-free generation we know is within reach.

Photo: Eric Bond for EGPAF 2022

A Vital Reservoir

How a Data Lake is Helping Clinicians and Communities in Malawi

A fully supported electronic medical record system requires a central database so that the information is available for many uses, from tracking patients at the clinic level to national reporting and analysis of health trends. With EGPAF's support, Malawi's Ministry of Health now maintains a centralized data hub, known as the data lake.

"The data lake brings all of your patient level data into one place, which was a huge accomplishment—because before, all of the data just sat in different clinics on servers," says Veena Sampathkumar, EGPAF VP for Program Implementation and Country Management.

"Previously you got aggregated reports to say this clinic tested so many people, identified so many people, et cetera, but you did not have access to that information on the central level. The data lake opens up opportunities for making programmatic decisions, especially around HIV."

Data from the electronic medical records system, the lab information management system, and other inputs feed into the

data lake. That information can then be visualized through the Malawi Analytics Platform. Authorized staff and stakeholders can understand trends and make informed decisions to improve patient care and health service delivery.

"You can see what the current testing volume is, for instance. Are there peaks around the number of people being identified positive? Is there a supply shortage that's affecting our advanced HIV patients? If you look at most data analytics pipelines or systems, most institutions are using commercial software, while in our case we are using entirely open-source software," says Wiza Msuku, EGPAF Data Lake team lead.

The data lake helps staff and stakeholders understand trends and make informed decisions to improve patient care and health delivery.

"All the pipelines, all the tools that we are using, we've built in-house. We are managing huge volumes of data. We are also synchronizing data on a near real-time basis. That is something very unique if you look at Malawi or at Africa as a whole."

"Our goal is basically to do analytics that will get back to the clinics to improve treatment and care," says Msuku.

A central database also provides the possibility of continuity as patients change health centers or if local records are damaged or lost.

"So, for example, we are able to identify a family on the outskirts of Blantyre that was supposed to visit the clinic, but then they've missed the appointment. We are able to know that patient X from village Y was supposed to come in yesterday or last week and they did not come. So the clinical teams can take that information and return that patient back to care."

Data for Climate Resiliency

Climate change adds yet another dimension. When Cyclone Freddy hit Southeast Africa, the medical records at many facilities were lost due to flooding and damage to buildings. Some facilities in the region, still using paper-based filing systems, lost everything. But digitized medical records in Malawi were stored in the digital data lake—thanks to this, all records lost due to washed-away papers or servers have been recovered.

Photo: Eric Bond for EGPAF 2022


Photo courtesy of Natalie Burtson

Our Generous Donors

EGPAF Board Member, Donor, and Lifelong Humanitarian: A Chat with Natalie Burtson

We recently had the pleasure of sitting down with Board member Natalie Burtson as she shares why she supports EGPAF's mission. Natalie has long recognized that children are our most vulnerable population. In her own words, "All my philanthropic work is around creating pathways for children to thrive and succeed. At the end of the day, that's the heart of EGPAF's mission."

Advocacy for children has been both a professional and personal mission for you. What inspired your career journey and what sparked your passion for EGPAF's mission?

I spent many years at Save the Children and a guiding principle was making sure the work delivered meaningful impact. With EGPAF, in Africa, these aren't small things that we're trying to solve. These are large-scale problems in the places where we work. EGPAF is all about impact. So, devoting some of my life to being a part of change and a part of trying to make a better life for people, children in particular, is special.

What drew me to EGPAF is the deep core belief that the HIV/AIDS epidemic can be solved in my lifetime. There are people working non-stop to drive us to the finish line, and that is really compelling to me. Many of the problems for children around the world aren't going away anytime soon, but this one can be solved. The changes in testing and treatment for HIV and AIDS that have happened in the last 20 years are amazing and there's more work to be done, but we have a real pathwayto

having this epidemic under control to where kids are not getting sick and not dying. And so, for me to be on the Board, to be able to be part of that, was a "yes" right away.

Why is pediatric HIV the fight that demands our attention and resources right now?

That's a good question because all the broad statistics and data about progress we've made are impressive, but the statistics for children aren't as rosy. Only 55% of kids with HIV are getting their antiretroviral meds compared to 73% - 83% of adults. That's a massive spread between kids not getting care and adults getting care. So back to the fact that children have no ability to visit a doctor to get their medications, they rely on adults. These gaps need visibility so we can double-down on getting children what they need. The other statistic that's important to know is that 12% of deaths are children, but they are only 3% of the total population of people with AIDS. And you're like, wait a minute, that's because they're not getting cared for. So, we must double down on the work we're doing to shine a spotlight on kids and their mothers. Getting children the care they need to be able to be alive, to live past five, is crucial. For me, it's more important than ever that we continue to do our work and advocate for children. That's what EGPAF really focuses on and that's why I'm here as a Board member.

We started 2025 excited about lenacapavir, a new HIV prevention medicine requiring only twice-yearly injections. Game-changing prevention tools like these could finally end the HIV epidemic. What does the possibility of an AIDS-free generation mean to you?

To me it means maximizing human potential. It ends suffering and issues that distract from children thriving. It allows these innocent beings to develop into adults that could lead big lives. And without this focus, without the work we're doing, you never know if we've essentially blocked the avenues for someone to become a contributing human in this civilization.

Recent cuts to funding for global health and development means investment from individual donors like you are more important than ever.
What's your message to others who could join this fight?

I've thought about this a lot because right now it's much easier to see how contributions from private donors really make a difference. It's a very clear line from giving money to saving a life. At this moment our government has stepped back from funding the HIV/AIDS response that has driven much of the progress over the past two decades, so during this time the only way to counterbalance stepping back is to step up yourself.

A $1,000 donation today can directly go into getting medication and care for a child; getting screenings, treatment and monitoring for pregnant mothers. There was less clarity just last year about the direct flow to kids because private donors were part of a larger effort that included our government. Today I know that my money is directly saving lives. That's motivating.

What's the one thing everyone needs to understand about EGPAF's work?

I think there are a couple of things that are really important for people to know. One is that the *true north* of this organization is mothers and children. The commitment to the betterment of their lives is at the core of everything that's done. Within that, there's always a focus on supporting mothers, children, and working with the communities to deliver that big hug of care. To me that's the emotional piece of it. There's a connection, a respect for the need to really lay our hearts on the line in the places where we work for the people we work for. That is the real heart of this organization.

And the last thing I'll say is that this work is being done in the spirit of—how do we do it better? What's the innovation? How do we set up research that advances the types of care that we can give? And that is then picked up across the world to help others, even in places where we're not working. I find it powerful that EGPAF is committed to finding new, innovative, more cost-effective treatments, and forming partnerships to bring about ongoing improvements and changes for women and children.

Thank you to our Donors

January 1, 2024–December 31, 2024

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Alpha Epsilon Phi - University of Texas at Austin - Omega
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Baldwin Wallace College Dance Marathon
Benevity Community Impact Fund
College of The Holy Cross Dance Marathon
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UCLA Undergraduate Students Association

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Alex Torres
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Alpha Epsilon Phi Zeta Chapter at NYU
Andrew Tonnaccio and Alvin Ables
Audrey Brooks
Beki Toussaint
Carlos Cortina and Aurelio Hartman
Cathy Wilfert
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370
809
JEWELERS FOR CHILDREN
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Financial Statement Summary

Statement of Financial Position

December 31, 2024

ASSETS

Cash and investments	$16,521,009
Total receivables	$9,469,510
Prepaid expenses and fixed assets	$11,747,706
TOTAL ASSETS	$37,738,225

LIABILITIES AND NET ASSETS

Liabilities	
TOTAL LIABILITIES	$29,128,195
Net Assets	
Net Assets Without Donor Restrictions	$8,094,767
Net Assets With Donor Restrictions	$515,263
TOTAL NET ASSETS	$8,610,030
TOTAL LIABILITIES AND NET ASSETS	$37,738,225

Statement of Activities

PUBLIC SUPPORT AND REVENUE

Grants and Contracts (USG and non-USG)	$135,663,882
Contributions	$2,077,670
Investment Income	$841,330
Change in beneficial interest	$6,349
TOTAL PUBLIC SUPPORT AND REVENUE	$138,589,231

EXPENSES

Program services	
Program Implementation	$117,567,782
Research	$2,502,555
Communications	$1,838,155
Public Policy	$1,572,306
TOTAL PROGRAM SERVICES	$123,480,798
Management, general and administrative	$12,682,491
New business development	$2,825,498
Fundraising	$1,034,666
SUPPORTING SERVICES SUBTOTAL	$16,542,655
TOTAL EXPENSES	$140,023,453
CHANGES IN NET ASSETS	($823,314)

IN 2024, 88% OF EGPAF'S EXPENSES WERE DEDICATED TO PROGRAMMATIC PURPOSES.
The complete audited financial statements may be viewed on our website (www.pedaids.org)

EGPAF's financial performance and accountability are recognized by leading charity rating

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While the Elizabeth Glaser Pediatric AIDS Foundation makes effort to use photos which accurately depict the actions, topics, or populations referenced, unless specifically indicated, the photographs in this document do not imply program participation, health status, attitude, behavior, or action on the part of persons who appear therein.

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