ENGENDERING BOLD LEADERSHIP:

THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF

First Annual Report to Congress

Cover photo caption:
The Ethiopian young people on the cover are members of Edom Youth and Street Children Unity Anti-AIDS Association. They are in training to become peer educators and have received HIV/AIDS counseling and testing through Zewditu Hospital in Addis Ababa, which is supported by the Emergency Plan.

This report was prepared by the Office of the United States Global AIDS Coordinator in collaboration with the United States Departments of State (including the United States Agency for International Development), Defense, Commerce, Labor, Health and Human Services (including the Centers for Disease Control and Prevention, the Food and Drug Administration, the Health Resources and Services Administration, the National Institutes of Health, and the Office of Global Health Affairs), and the Peace Corps.

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United States Department of State

Washington, D.C. 20520

March 4, 2005

Dear Senator/Representative:

Two years ago, in his State of the Union address, President Bush announced the President's Emergency Plan for AIDS Relief - the largest international health initiative in history initiated by a single government to address one disease. On behalf of the President of the United States, it is my privilege to submit to you the first Annual Report of the Emergency Plan, as required by Section 305 of P.L. 108-25, the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003.

The vision of the Emergency Plan, laid out by the President in his Five-Year Global HIV/AIDS Strategy, is to turn the tide of the global pandemic. On January 23, 2004, Congress approved the first funds to put the President's vision into motion. Today, a coordinated, accountable, and powerful U.S. Government effort, utilizing those funds and the funds that have followed, is combating HIV/AIDS in more than a hundred nations around the world, working to relieve the suffering of millions infected and affected by the disease. The goals of this unprecedented effort include a special focus on 15 nations that account for more than 50 percent of the world's infections, where we will support treatment for 2 million people infected with HIV/AIDS, prevent 7 million new HIV infections, and support care for 10 million people infected and affected by HIV/AIDS.

Today, I am heartened by the early results of America's urgent action and innovation and pleased to report that our efforts are succeeding. The heart and soul of President Bush's Emergency Plan for AIDS Relief is to work collaboratively within the national strategies of our host nations, coordinating and combining our efforts with those of other donors. Our dedicated U.S. Government field staff feel a deep sense of privilege in working with all those who are involved in each country. In particular, we are pleased that 80 percent of our approximately 1,200 partners on the ground are indigenous organizations. The engagement of and support for our host nations must be central to the efforts of all of us. Lasting success depends on leadership by host governments and nongovernmental sectors and, ultimately, on local ownership of the capabilities and capacity required to address this pandemic. The Emergency Plan's results described in this report were achieved largely through the work of talented and dedicated people in-country, and the real credit rests with them.

The results of this cooperative effort have been remarkable. The Emergency Plan reached 155,000 people with treatment support in just eight months - 152,000 of them in sub-Saharan Africa. To put it in perspective, in December 2002, one month before President Bush announced the Emergency Plan for AIDS Relief, the World Health Organization estimated 50,000 people were receiving lifesaving antiretroviral therapy in all of sub-Saharan Africa. We were able to support three times that number in an astonishing eight months after Congress first approved funding. In those same eight months, 1.2 million women benefited from services to prevent transmission of HIV from mother to

child. We were also able to support care for more than 1.7 million people infected and affected by HIV/AIDS, including 630,200 orphans and vulnerable children.

In some of the countries and communities most devastated by AIDS, American leadership has proved to be a catalyst for action. While we still have a long way to go to beat this disease, success and leadership on the issue have spread rapidly around the world since the President announced the Emergency Plan. Hope, which breeds further success, is following quickly.

Thank you for your efforts to support the American people's fight against global HIV/AIDS.

Ambassador Randall L. Tobias

U.S. Global AIDS Coordinator

Acknowledgments

This first Annual Report of the President's Emergency Plan for AIDS Relief represents just one picture of the incredible hard work, effort, and dedication of U.S. Government staff in the field, their host-government counterparts and local partners, and hundreds of other organizations that have joined with the Emergency Plan in this fight. Their service to the millions living heroically with HIV/AIDS will fulfill the Emergency Plan's ultimate vision - to turn the tide against this global pandemic and, in doing so, turn despair into hope.

Acronyms and Abbreviations

AACTG	Adults AIDS Clinical Trials Group
ABC	Abstain, Be faithful, and, as appropriate, correct and consistent use of Condoms
AIRTP	AIDS International Research and Training Program
ART	Antiretroviral treatment
ARV	Antiretroviral
CCM	Country coordinating mechanism
CDC	Centers for Disease Control and Prevention
CEO	Chief executive officer
CHAVI	Center for HIV/AIDS Vaccine Immunology
CIPRA	Comprehensive International Program for Research on AIDS
COH	Corridors of Hope project (Zambia)
COP	Country operational plan
COPRS	Country Operational Plan and Reporting System
CSH	Child survival and health
DfID	Department for International Development (U.K.)
DoD	Department of Defense (U.S.)
DoL	Department of Labor (U.S.)
DOT	Directly observed therapy
EU	European Union
FDA	Food and Drug Administration
FY	Fiscal year
GHARP	Guyana HIV/AIDS Reduction and Prevention Project
HHS	Department of Health and Human Services (U.S.)
HMIS	Health management information system
HPTN	HIV Prevention Trials Network
HRSA	Health Resources and Services Administration
HVTN	HIV Vaccine Trials Network
IAVI	International AIDS Vaccine Institute
KAPC	Kenya Association of Professional Counselors
M&E	Monitoring and evaluation
NBTC	National Blood Transfusion Center (Cambodia)
NGO	Nongovernmental organization
NIH	National Institutes of Health
OAR	Office of AIDS Research
OGAC	Office of the U.S. Global AIDS Coordinator
OVC	Orphans and vulnerable children
PACTG	Pediatric AIDS Clinical Trials Group
PAVE	Partnership for AIDS Vaccine Evaluation

PEPFAR	President's Emergency Plan for AIDS Relief (Emergency Plan)
PMTCT	Prevention of mother-to-child HIV transmission
RSLAF	Republic of Sierra Leone Armed Forces
SCMS	Supply chain management system
STD	Sexually transmitted disease
STI	Sexually transmitted infection
SUCCESS	Scaling Up Community Care to Enhance Social Safety-nets (Zambia)
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary counseling and testing
WHO	World Health Organization
ZAMPS	Zimbabwe All Media Products Survey

President Bush signs the legislation establishing the President's Emergency Plan for AIDS Relief on May 27, 2003.

"America has undertaken a 15 billion dollar effort to provide prevention, treatment, and humane care in nations afflicted by AIDS, placing a special focus on 15 countries where the need is most urgent. AIDS is the greatest health crisis of our time, and our unprecedented commitment will bring new hope to those who have walked too long in the shadow of death."

President George W. Bush
September 21, 2004

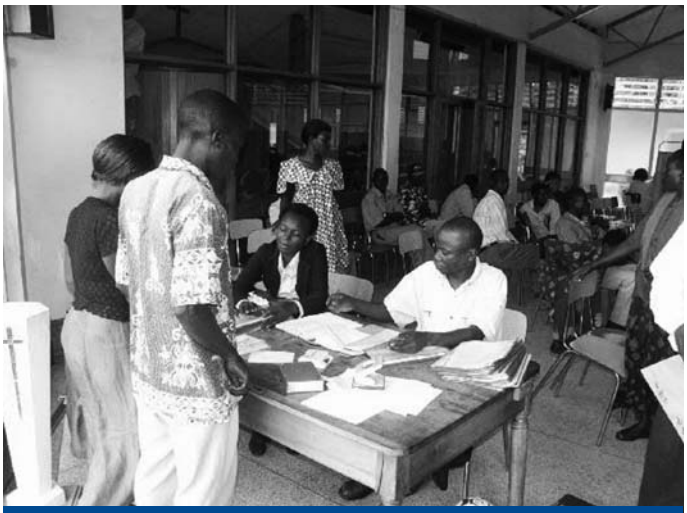
Executive Summary

President Bush's Emergency Plan for AIDS Relief (PEPFAR/Emergency Plan) embodies the compassion and generosity of the American people. As the largest international health initiative in history initiated by one nation to address a single disease, the Emergency Plan's bold leadership and action mark a turning point in the response to the global HIV/AIDS pandemic. With the endorsement of the U.S. Congress, this effort has moved rapidly to fulfill the United States' promise of leadership, providing new hope for millions.

The Emergency Plan represents urgent action and a sharpened focus. Going beyond financial leadership, the United States has fundamentally changed the way it is attacking this disease by bringing its global HIV/AIDS efforts together under a unified strategy with consolidated leadership. This new interagency approach enables the United States to more cohesively support the national strategies of host governments and adapt itself to the individual needs and challenges of each nation where the Emergency Plan is at work. The United States' decades of experience combating the HIV/AIDS pandemic, combined with the new integrated approach, are helping the Emergency Plan achieve unprecedented success in HIV/AIDS prevention, treatment, and care today, while at the same time supporting the development of sustainable capacity to ensure continued scale-up in the future. Early achievements build the foundation for later success.

The early results of the United States' focused action offer tremendous hope. The President's Emergency Plan is on target to achieve its ambitious goals in the 15 focus countries in Africa, Asia, and the Caribbean.[1] In these nations, the Emergency Plan aims to support treatment for 2 million people living with HIV/AIDS, prevent 7 million new HIV infections, and support care for 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children, by 2008 (the "2-7-10" goals). These 15 focus countries are among the world's most severely affected and home to approximately half of the world's 39 million HIV-positive people and almost 8 million children orphaned or made vulnerable by HIV/AIDS. The Emergency Plan has also strength-

1 Botswana, Côte d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia



In Uganda, a U.S.-supported clinic registers people for antiretroviral therapy in the early days of Emergency Plan implementation.

ened U.S. leadership through bilateral HIV/AIDS efforts and support for key multilateral organizations. With an eye to the future, the United States has maintained its position as the global leader in HIV/AIDS research and innovation, with an emphasis on developing safe and effective vaccines and microbicides. The 2004 Emergency Plan data will be the baseline for comparison for all future Emergency Plan annual reports.

Early Results

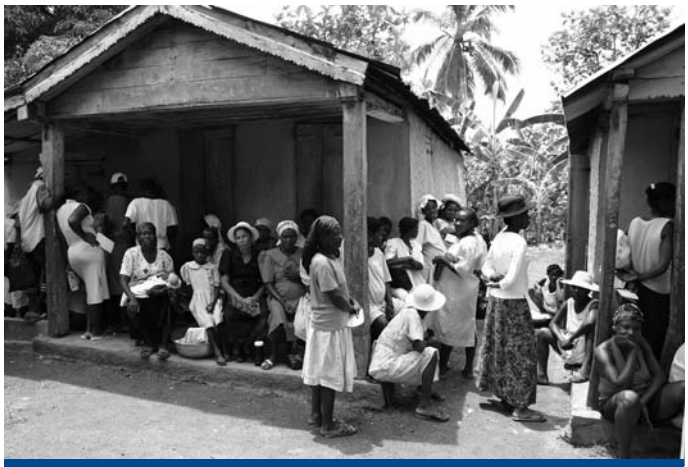
This first Annual Report describes the rapid progress of the President's Emergency Plan from the first appropriation of funds from the Congress on January 23, 2004 through September 30, 2004. In fiscal year 2004, the United States committed $2.4 billion to the Emergency Plan. That total included more than $865 million to support national scale-up of integrated prevention, treatment, and care programs in the 15 focus countries. The remaining $1.54 billion was used to support HIV/AIDS programs in 96 additional countries, international research, and other HIV/AIDS efforts, including the Global Fund to Fight AIDS, Tuberculosis and Malaria.

On February 23, 2004, one month after receiving its first appropriation, the Office of the U.S. Global AIDS Coordinator (OGAC) announced the President's Five-Year Global HIV/AIDS Strategy for the Emergency Plan. The Strategy outlined a unified U.S. Government response to the global pandemic constituting a "new way of doing business" and emphasizing evidence-based interventions, accountability, and performance toward goals. Simultaneously, OGAC released the first $350 million for the focus countries. After an intense period of field-based program planning and development, an additional $515 million was released in June 2004; thus, June 2004 marks the beginning of full implementation.

The United States' rapid and strategically targeted deployment of resources has led to remarkable results. In December 2002, one month before President Bush announced the Emergency Plan, an estimated 50,000 people were receiving lifesaving antiretroviral therapy (ART) in all of sub-Saharan Africa. By September 30, 2004, just eight months after the first appropriation of funds by Congress, the Emergency Plan worked under national strategies in the 15 focus countries to support ART for 155,000 HIV-positive adults and children, on target to exceed its Year One goal to support ART for at least 200,000 by June 2005.

The pandemic has also created an unprecedented need for care for those infected and affected by HIV/AIDS, including orphans and vulnerable children. The Emergency Plan supported care for more than 1,727,000 adults and children in the period ending September 30, 2004 - already achieving 150 percent of its interim goal to support care for 1.15 million by June 2005. Of those served, 1,096,900 were HIV-positive people and more than 630,000 were orphans and vulnerable children.

Prevention is a critical component of the Emergency Plan. With 14,000 new HIV infections every day, the tide cannot be turned without effective evidence-based prevention efforts. The vast majority of new infections in the focus countries occur through sexual transmission. The centerpiece of the President's prevention strategy, the balanced "ABC" approach (Abstinence, Being faithful, and, as appropriate, correct and consistent use of Condoms) - first developed in Uganda - is a highly effective way to prevent infections. In its first eight months, the President's Emergency Plan supported national strategies to reach well over 120 million people with



Haitian women receive services at a mobile PMTCT site supported by the Emergency Plan.

ABC messages through mass media campaigns and other interventions.

The United States has led the global effort to prevent mother-to-child transmission (PMTCT) of HIV/AIDS, which began with President Bush's International Mother and Child HIV Prevention Initiative. This groundbreaking initiative remains a key component of prevention efforts, and in fiscal year 2004 the Emergency Plan for AIDS Relief supported programs under national strategies to reach 1.2 million women with PMTCT services. More than 125,000 of these women received primarily short-course antiretroviral preventive therapy, averting an estimated 23,766 newborn infections. Preventing infections through blood transfusions and unsafe medical injections is another important component of the Emergency Plan's prevention strategy. In the first eight months of the Plan, more than 4,000 individuals have been trained in injection safety and more than 2,000 in blood safety.

It is worth noting that U.S. personnel and Emergency Plan partners on the ground, including host governments, have achieved these early successes under extraordinarily challenging circumstances. Challenges faced vary country by country and range from those related to under-resourced settings - limited availability of human resources, poor infrastructure, and inconsistent access to transportation, electricity, clean water, and other necessary supplies - to the civil unrest experienced by countries such as Haiti and Côte d'Ivoire, where Emergency Plan staff stayed to keep essential programs going even as many others evacuated. The commitment of people on the ground to stop HIV/AIDS, even under difficult circumstances, makes them the true heroes of this fight.

Building Capacity

A guiding principle of the President's Emergency Plan is to build local and host-nation capacity so that national programs can achieve results, monitor and evaluate their activities, and sustain their programs for the long term. While rapidly moving to support prevention, treatment, and care services now, the Emergency Plan has an eye to the future, supporting the development of capacity to achieve, and sustain, success for years to come. Without local capacity, nations cannot fully "own" the fight they must lead against HIV/AIDS.

In Zambia, young people who are trained as HIV/AIDS caregivers discuss achievements after a year of providing home-based care. Through a program funded by the Emergency Plan, these youth gain important life skills training and offer an invaluable service to their communities while learning to protect themselves from HIV transmission.

In the Plan's first eight months, 80 percent of the more than 1,200 partners working on the ground were indigenous organizations. The Emergency Plan promoted the expansion of existing health care networks and the development of new public and private network systems to enhance the delivery of HIV/AIDS services in remote areas. The Plan supported 3,800 programs offering pre-

Kien Kes Health Education Network in Cambodia's Battambang province teaches orphans and vulnerable children about HIV with Emergency Plan support.

vention services, including media campaigns, community outreach, and 2,200 sites for PMTCT; 300 sites for treatment; and more than 8,000 sites for care, including 700 sites for orphans and vulnerable children and 2,100 sites for counseling and testing.

Responding to the critical shortage of trained health workers at all levels, the Emergency Plan supported training for 312,000 providers in its first eight months. Among these were 227,200 individuals trained in providing prevention services, including 24,600 health workers trained in PMTCT. Training in providing ART reached 12,200 health workers, while 36,700 individuals received training in palliative care, 14,100 in counseling and testing, and 22,600 in orphan care. In under-resourced settings, providers may have more than one area of responsibility. As such, it is likely that the number of providers trained includes overlap in some areas.

The President's Emergency Plan has fostered indigenous leadership in the fight against the HIV/AIDS pandemic, which is indispensable to a sustainable and effective response. Plan efforts have included technical assistance for appropriate policy development, including policies protecting women and girls, and for strengthening local institutions and organizations, including organizations of people living with HIV/AIDS. In the first eight months of the Emergency Plan, 3,500 programs provided technical assistance and more than 24,000 individuals were trained in skills for institutional and organizational development, including program management.

Other important components of building local capacity include surveillance, reporting, evaluation, and other strategic information needs. These tools allow accountability and provide the information necessary for data-based adjustments that enhance program effectiveness. In fiscal year 2004, 9,300 individuals were trained in strategic information.

The Emergency Plan continues its efforts to foster "wrap around" HIV/AIDS programs by coordinating with and leveraging resources from other agencies and sectors, including food and nutrition, education, and microfinance, to ensure a comprehensive response to the pandemic and further promote program sustainability and effectiveness.

Emergency Plan Programs Beyond the Focus Countries

The Emergency Plan's investments outside the focus nations are substantial. The Plan maintains active HIV/AIDS programs in an additional 96 countries beyond the 15 focus countries, encouraging bold leadership, innovation, and accountability in the fight against the HIV/AIDS pandemic. It also supports key multilateral organizations, including the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Joint United Nations Program on HIV/AIDS (UNAIDS).

The Plan's historic increase in resources for HIV/AIDS, with the United States contributing more than all other donor governments combined, mandates a U.S. leadership role in donor coordination. In April 2004 in Washington, D.C., OGAC cosponsored the UNAIDS-initiated "Three Ones" agreement for cooperation among donors in support of *one* national strategy, *one* national coordinating mechanism, and *one* monitoring and evaluation system in each host country. Since that time, the President's Emergency Plan has led efforts to advance all three objectives. Furthermore, the U.S. strategy recognizes that the private and public sectors in host nations must own the fight against the HIV/AIDS pandemic in

their countries. By continuing to work shoulder-to-shoulder with in-country partners to increase local capacity under national strategies, the Emergency Plan will continue to build on its early success.

Recognizing that HIV/AIDS does not respect borders, the Emergency Plan incorporates bilateral programs in countries around the world that are heavily burdened by the effects of HIV/AIDS, including, but not limited to, India, Russia, and China. In India, where the United States has its largest bilateral program outside the 15 focus nations, the Plan increased the U.S. commitment by nearly 25 percent from fiscal year 2003 to fiscal year 2004. In Russia, the United States increased funding by nearly 50 percent from fiscal year 2003 to fiscal year 2004. The U.S. commitment in fiscal year 2004 of $37 million for bilateral health assistance to China for HIV/AIDS and other diseases has had an impressive impact on U.S.-Chinese health cooperation. In all, the Emergency Plan increased resources for HIV/AIDS programs in nearly 30 countries beyond the focus nations, including India, Russia, Cambodia, Swaziland, and Lesotho.

In addition, the United States remains the largest single country donor to the Global Fund to Fight AIDS, Tuberculosis and Malaria, which provides grant support to more than 130 countries. In 2004, one-third of the Fund's grant support came from U.S. contributions. In China, India, and Russia alone, for example, where the Fund has made more than $350 million available in two-year approved grants, the U.S. contribution amounted to approximately $117 million.

Multilateral Leadership

The President's Emergency Plan is a leader in multilateral efforts against HIV/AIDS. The United States recognizes that the Global Fund offers an opportunity for other nations to sharply increase their commitment to global HIV/AIDS, as the United States has done. The success of the Fund is thus central to the Plan's vision of turning the tide against the HIV/AIDS pandemic.

The Executive Director of UNAIDS, Peter Piot, and Ambassador Tobias.

Therefore, the Emergency Plan is helping to provide the leadership to ensure the Fund's success. President Bush made the founding contribution to the Fund in 2002, available in two-year grants. In fiscal year 2004 the United States remained by far the Fund's largest single country donor, with the American people contributing one-third of all of the Fund's resources. To ensure the full participation of our international partners, U.S. law limits the American contribution to the Fund to 33 percent of total contributions. Unfortunately, insufficient contributions from the world community in 2004 - even after the U.S. Global AIDS Coordinator extended the time in which other donors could make qualifying contributions by two months - limited the maximum U.S. contribution appropriated by Congress in fiscal year 2004.

In addition to its financial contribution, the United States also provided significant technical assistance to the Global Fund Secretariat in Geneva and to numerous countries where the Fund operates throughout the world. The Emergency Plan also coordinates programs with UNAIDS, the World Health Organization, the United Nations Children's Fund, the World Bank, and others.

Conclusion

Less than two months after the first congressional appropriation of resources for the President's Emergency Plan for AIDS Relief, a former hospice in South Africa was transformed into an HIV/AIDS

treatment clinic when it began providing antiretroviral therapy to its dying patients. With support from the peoples and governments of South Africa and the United States, the site honored World AIDS Day on December 1, 2004, as a celebration for the living rather than a day of remembrance.

The President's Emergency Plan has turned despair into hope, leading the world from an era of concern into an era of compassionate action - the "decisive, historic action" the President envisioned. American leadership is proving to be a catalyst for action. Around the world, success is spreading rapidly, and hope, which breeds further success, quickly follows. Many challenges remain, and much hard work lies ahead. But the United States will not waver in its resolve to work with our friends in-country, and across the globe, as together we turn the tide against the HIV/AIDS pandemic.

In rural Mozambique, a crowd gathers to watch a play that communicates HIV/AIDS prevention messages.

"Proven methods of prevention are slowing the spread of this disease in some parts of the world … HIV/AIDS can be beaten. We're committed to ending the plague."

President George W. Bush
June 23, 2004

Chapter 1

Critical Intervention in the Focus Countries: Prevention

Prevention is one of the cornerstones of the President's Emergency Plan for AIDS Relief (PEPFAR/Emergency Plan). To limit the progression of the HIV/AIDS pandemic, there must be a dramatic reduction in new infections. By 2008, the President's Emergency Plan will seek to prevent 7 million new HIV infections in the 15 focus countries. The President's Emergency Plan is working rapidly to deploy prevention resources and build sustainable systems for future prevention efforts, recognizing the reality that in 2004, 14,000 people were newly infected around the world every day. More than half of those infected were between the ages of 15 and 24.

Prevention Summary

Five-Year Goal in the 15 Focus Countries
Prevent 7 million infections by 2010

Year One Target
Reach 47.8 million people with prevention messages/programs by June 2005

Progress Achieved by September 30, 2004
More than 120 million people reached with prevention messages/programs via mass media interventions alone (250 percent of Year One target)

Allocation of Resources in Fiscal Year 2004
$193,097,000 to support prevention in the 15 focus counties (34 percent of total resources committed)

It is estimated that existing prevention efforts reach fewer than one in five of those at risk. Thus, one of the most significant challenges the Emergency Plan faces is to scale up prevention efforts to reach the millions of people at risk of HIV infection worldwide. To this end, in fiscal year 2004 the Emergency Plan committed $193,097,000 to prevention programs in the focus countries.

Young people are an important focus of the Emergency Plan's prevention efforts. Of particular concern are the dramatic increases in HIV infection among girls and young women, who now make up more than 60 percent of 15- to 24-year-olds living with HIV/AIDS in some

focus countries. In some of the focus countries, adolescent girls face infection rates that are up to six times higher than those of boys of the same age.

The President's Emergency Plan employs a combination of prevention programs in order to support individual risk behavior change; improve preventive medical services; influence social norms regarding risk behaviors; and address social, economic, legal, and policy barriers to effective prevention. These programs include promotion of behavior change aimed at risk avoidance and risk reduction; prevention of mother-to-child transmission of HIV; provision of comprehensive programs for individuals who engage in high-risk behavior (including connecting them to HIV counseling and testing services, treating them for sexually transmitted diseases, and providing them with condoms, when appropriate); and reduction of medical transmission of HIV by ensuring safe blood supplies, safe medical injections, and training in universal medical precautions.

President Bush's Emergency Plan is committed to the development and application of evidence-based best practices that are informed by and responsive to local needs, local epidemiology, and distinctive social and cultural patterns, and are coordinated with the HIV/AIDS strategies of host governments. The Plan promotes the strong engagement and involvement of people living with HIV/AIDS, because engaging these people in HIV prevention is critical to successful interventions. The involvement of people living with HIV/AIDS can help reduce transmission by providing effective advocates for change and increasing adoption of prevention behaviors.

The Emergency Plan builds upon the synergies that exist among prevention, care, and treatment. Just as prevention programs are unlikely to achieve full impact in the absence of treatment, the impact of care and treatment programs is reduced without vigorous prevention efforts. In 2003, it is estimated that 3 million people died of AIDS. At the same time, 5 million more became infected. In the long fight against HIV/AIDS, the tide will not turn in the absence of effective prevention.

Abstinence and Be Faithful Programs

Results: Rapid Scale-Up

In fiscal year 2004, the Emergency Plan made significant progress in targeting messages and interventions to specific groups, especially young people. In many countries in which the Emergency Plan works, the demographics are such that youth (ages 10 to 24) represent approximately one-third of the total population. The vast majority of new infections in the 15 focus countries occur through sexual transmission. Evidence from countries such as Kenya, the Dominican Republic, Thailand, Ethiopia, Zambia, and Uganda indicate that changing social norms through the promotion of behaviors aimed at risk avoidance and risk reduction will likely avert a large number of new infections and reduce the spread of HIV. The approach endorsed by the Emergency Plan - ABC: Abstain, Be faithful, and, as appropriate, correct and consistent use of Condoms - employs population-specific, targeted interventions that emphasize abstinence for youth and other unmarried people, including delay of sexual debut; mutual faithfulness and partner reduction for sexually active adults; and correct and consistent use of condoms by those whose behavior or circumstances place them at risk for transmitting or becoming infected with HIV. This targeted approach results in a comprehensive and effective prevention strategy that helps individuals personalize risk and develop tools to avoid the risk behaviors that are under their control.

In fiscal year 2004, the Emergency Plan supported a range of interventions and programs to reach individuals with lifesaving prevention messages and skills. These included the mobilization of communities through peer education and school-based and workplace programs; the engagement of local leaders, including the faith community; and the development and use of multiple targeted media channels, including television, radio, and print. These interventions focused on seven central themes:

- Promotion of abstinence, including delayed initiation of sexual activity and secondary abstinence for youth who have already become sexually active

- Promotion of mutual faithfulness in reducing HIV transmission among individuals in long-term sexual partnerships
- Elimination of casual sex and multiple sexual partnerships
- HIV counseling and testing for individuals and couples who do not know their HIV status
- Development of skills for sustaining marital fidelity
- Adoption of social and community norms supportive of marital fidelity and partner reduction using strategies that respect and respond to local customs and norms
- Adoption of social and community norms that denounce forced sexual activity in marriage or long-term partnerships

During the reporting period, $91,630,000 was dedicated to prevent the sexual transmission of HIV; $50,545,000 (56 percent) was allocated to abstinence and faithfulness (AB) programs. When resources for PMTCT, blood safety, and safe medical programs are considered, 27 percent of total prevention funding was dedicated to AB programs. These funds supported 1,000 community outreach programs that promoted abstinence and faithfulness, reaching more than 24 million individuals. Of the more than 17 million of these people for whom gender is known, more than 8.3 million were female. As a subset of AB programs, 200 programs that promoted abstinence as their primary behavioral objective reached approximately 11.5 million individuals. The President's Emergency Plan supported 135 mass media programs focused on AB messages that reached an estimated 120 million people. More than 32.1 million people were reached by 25 mass media campaigns promoting abstinence.

Table 1.1 - Prevention: FY04 Results of Community Outreach Programs that Promote Abstinence and Being Faithful[1] (AB)

Country	Number of community outreach HIV/AIDS prevention programs that promote AB	Number of individuals reached with community outreach HIV/AIDS prevention programs that promote AB[3]	Number of community outreach HIV/AIDS prevention programs that promote abstinence[2]	Number of individuals reached with community outreach HIV/AIDS prevention programs that promote abstinence[2, 3]
Botswana	4	89,600	0	0
Côte d'Ivoire	125	119,300	1	1,500
Ethiopia	173	989,700	0	0
Guyana	17	221,800	3	8,400
Haiti	2	6,000	1	300
Kenya	20	791,300	10	365,000
Mozambique	6	385,000	1	0
Namibia	19	101,300	7	19,600
Nigeria	159	5,873,900	44	1,938,200
Rwanda	9	9,400	7	165,300
South Africa	152	239,600	37	34,800
Tanzania	97	1,516,500	53	1,139,700
Uganda	122	13,095,70	15	7,820,500
Vietnam[4]	-	-	-	-
Zambia	127	602,700	5	37,100
Total[3]	**1,000**	**24,041,800**	**200**	**11,530,400**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnotes:

1 AB programs promote as their primary behavioral objectives that: (1) unmarried individuals abstain from sexual activity as the best and only certain way to protect themselves from exposure to HIV and other sexually transmitted infections, and (2) individuals practice fidelity in marriage and other sexual relationships as a critical way to reduce risk of exposure to HIV. Programs may focus on individual behavior change or may address relevant social and community norms.

2 Abstinence programs promote as their primary behavioral objective that unmarried individuals abstain from sexual activity as the best and only certain way to protect themselves from exposure to HIV and other sexually transmitted infections. Programs may focus on individual behavior change or may address relevant social and community norms. Abstinence programs are counted as a subset of AB programs.

3 Numbers are rounded to nearest 100.

4 Vietnam received Emergency Plan funds late in FY04 and is not required to report during this cycle.

Reaching Youth in a Language They Understand

Kenya's youth hold many perplexing notions about HIV and sexuality, and the newspaper *Straight Talk* tries to help them. *Straight Talk* is written in Sheng, a patois of Kiswahili and English especially popular among Kenya's youth. It reaches them on their own terms, addressing topics not found in the pages of daily newspapers. One edition confronted the rumored practice of schools putting small amounts of petroleum in student lunches in the belief that it would hinder their sexual urges. Sexual abuse, pregnancy, and gender inequality are frequent topics examined through articles, columns, question-and-answer interviews, and cartoons.

With Emergency Plan support, the Kenya Association of Professional Counselors (KAPC) produces 360,000 monthly copies of *Straight Talk*. Aimed at young people ages 15 to 19, the newspaper and a network of *Straight Talk* clubs at schools across the country form a two-pronged effort to provide young people with accurate information in safe, nonthreatening forums. They help improve adolescent health and well-being by fostering peer-to-peer discussion of HIV, by helping youth share experiences confronting high-risk situations, and by helping them develop behavior negotiation skills through role-playing activities.

A 30-minute Saturday morning radio program, a Web site, and educational videos further reinforce KAPC's messages of healthy living for youth. Teacher training ensures that instructors are able to handle adolescent concerns with sensitivity. The *Straight Talk* programs have increased dialogue between adolescents and teachers and between adolescents and their parents, says Project Manager Simon Kokoyo. Emergency Plan funding supports KAPC staff, media outreach, and training to help teachers guide the clubs, counsel students, and nurture their confidence.

Clearly, this formula has tapped into something special among young people. *Straight Talk* receives some 500 letters each month from across Kenya. Many are directed at "Dr. Straight," a physician who consults for KAPC and serves on the *Straight Talk* editorial board. The paper also features a "Please Advise" column in which adolescents respond to questions from their peers. "We want to empower the students themselves to raise as many questions as possible," says Joy Masheti, a KAPC field officer.

A 2003 survey commissioned by KAPC found that of 800 youth in seven provinces, 74 percent claimed to have been strongly influenced on reproductive health and HIV/AIDS by *Straight Talk*. As a result, many reported talking about the disease to friends and family and abstaining from sexual activity.

Sustainability: Building Capacity

As in other areas of the Emergency Plan, the long-term sustainability and success of prevention programs depends on the ability of local organizations, communities, and individuals to develop, implement, and support programs over time. This is particularly important in the area of behavior change, as constant support and adaptation are required to sustain the changed social norms that promote safe sexual behaviors. Given the complexity of the issues, success also greatly depends on the long-term involvement and commitment of local organizations, leaders, and communities. To achieve this, the Emergency Plan supports activities reaching from the highest level of a country to the local community. For example, the Emergency Plan supports the development of national life skills curricula in schools to give youth the tools they need to lead healthy sexual lives. At the community level, support is provided to train local lead-

Table 1.2 - Prevention: FY04 Results of Mass Media Programs that Promote Abstinence and Being Faithful[1] (AB)				
Country	**Number of mass media HIV/AIDS prevention programs that promote AB**	**Estimated number of individuals reached with mass media HIV/AIDS prevention programs that promote AB[3]**	**Number of mass media HIV/AIDS prevention programs that promote abstinence[2]**	**Estimated number of individuals reached with mass media HIV/AIDS prevention programs that promote abstinence[2, 3]**
Botswana	2	810,000	0	0
Côte d'Ivoire	18	14,961,800	3	4,941,700
Ethiopia	22	137,600	0	0
Guyana	6	400,000	1	216,000
Haiti	3	574,200	1	2,500
Kenya	5	7,330,000	5	2,620,000
Mozambique	1	9,600	0	0
Namibia	4	169,400	2	50,000
Nigeria	12	57,375,600	1	7,003,300
Rwanda	4	2,500,000	1	2,480,000
South Africa	6	13,449,500	2	30,000
Tanzania	19	8,052,600	6	7,108,900
Uganda	32	14,233,100	2	7,632,000
Vietnam[4]	-	-	-	-
Zambia	1	70,000	1	70,000
Total	**135**	**120,073,400**	**25**	**32,154,400**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnotes:

1 AB programs promote as their primary behavioral objectives that: (1) unmarried individuals abstain from sexual activity as the best and only certain way to protect themselves from exposure to HIV and other sexually transmitted infections, and (2) individuals practice fidelity in marriage and other sexual relationships as a critical way to reduce risk of exposure to HIV. Programs may focus on individual behavior change or may address relevant social and community norms.

2 Abstinence programs promote as their primary behavioral objective that unmarried individuals abstain from sexual activity as the best and only certain way to protect themselves from exposure to HIV and other sexually transmitted infections. Programs may focus on individual behavior change or may address relevant social and community norms. Abstinence programs are counted as a subset of AB programs.

3 Numbers are rounded to nearest 100.

4 Vietnam received Emergency Plan funds late in FY04 and is not required to report during this cycle.

ers, the faith community, and youth through peer education programs. Activities strengthen local organizations to help them implement strong technical programs and manage their organizations effectively. During the reporting period, more than 116,600 people were trained to support the promotion of abstinence and/or be faithful prevention services, including more than 79,600 trained to provide abstinence-only prevention programs largely targeted to youth.

Key Challenges and Future Directions

Despite the great progress made in reaching people with lifesaving prevention messages and tools, important challenges remain and will be addressed in the upcoming year. These challenges include the need to continue to refine and focus behavior change interventions toward target groups and individuals, ensuring that implementation is consistent with the Emergency Plan's results-driven strategy. It will also be important to deepen the knowledge base about determinants of sexual behavior in order to ensure effective abstinence programs.

Combating stigma, sexual coercion, exploitation, and violence continues to be a significant challenge. Faith communities have a special role to play in continuing to broaden and deepen their efforts to combat stigma, discrimination, and sexual violence, as do programs that target boys and men. Given the importance of partner reduction and mutually faithful relationships in reducing HIV transmission, the "Be faithful" component of ABC programs will be strengthened in the upcoming year. There is a need to further identify the parameters of a quality program and outcome indicators, given the wide array of diverse community organizations and approaches to behavior change.

Emergency Plan-supported Nairobi Women's Hospital provides rape survivors with counseling as well as post-exposure prophylaxis that reduces the chances of contracting HIV from an attack.

Table 1.3 - Prevention: FY04 Abstinence and Being Faithful Prevention[1] Capacity Building Results

Country	Number of individuals trained to provide HIV/AIDS prevention programs that promote abstinence and/or being faithful[2]	Number of individuals trained to provide HIV/AIDS prevention programs that promote abstinence[2, 3]
Botswana	600	0
Côte d'Ivoire	1,900	0
Ethiopia	6,600	0
Guyana	2,900	1,000
Haiti	100	80
Kenya	8,800	7,200
Mozambique	7,200	3,400
Namibia	900	200
Nigeria	8,500	5,900
Rwanda	2,100	2,100
South Africa	0	0
Tanzania	11,800	7,100
Uganda	47,000	46,100
Vietnam[4]	-	-
Zambia	18,200	6,500
Total	**116,600**	**79,600**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnotes:

1 AB programs promote as their primary behavioral objectives that: (1) unmarried individuals abstain from sexual activity as the best and only certain way to protect themselves from exposure to HIV and other sexually transmitted infections, and (2) individuals practice fidelity in marriage and other sexual relationships as a critical way to reduce risk of exposure to HIV. Programs may focus on individual behavior change or may address relevant social and community norms.

2 Abstinence programs promote as their primary behavioral objective that unmarried individuals abstain from sexual activity as the best and only certain way to protect themselves from exposure to HIV and other sexually transmitted infections. Programs may focus on individual behavior change or may address relevant social and community norms. Abstinence programs are counted as a subset of AB programs.

3 Numbers are rounded to nearest 100.

4 Vietnam received Emergency Plan funds late in FY04 and is not required to report during this cycle.

Prevention for People Who Engage in High-Risk Activity

Results: Rapid Scale-Up

The ABC approach recognizes that comprehensive services, including risk reduction and risk avoidance counseling, linkages to HIV counseling and testing, treatment of sexually transmitted infections (STIs), and promotion of correct and consistent condom use, are an essential means of reducing, but not eliminating, the risk of HIV infection for individuals who engage in high-risk activity. Such high-risk activity includes engaging in casual sexual encounters; engaging in sex in exchange for money or favors; having sex with an HIV-positive person or one whose status is unknown; using drugs or abusing alcohol in the context of sexual interactions; and using intravenous drugs. Discordant couples, in whom one partner is HIV-positive and the other is not, are a crucial target group. In Uganda, for example, approximately one-third of couples are discordant. Women, even if faithful themselves, can still be at risk of becoming infected by their spouse, regular male partner, or someone using force against them.

The experiences of Thailand, Cambodia, the Dominican Republic, Senegal, and other countries illustrate that targeted efforts with people who engage in high-risk activity can be effective in preventing the spread of HIV infection. In countries such as Vietnam and Guyana, where HIV infection has yet to move into or is at low levels in the general population, aggressive prevention strategies among people who engage in high-risk activity are critical to stop the spread of infection; because these individuals often serve as a "bridge" to those at lower risk, they

Table 1.4 - Prevention: FY04 Results of Condoms and Other HIV/AIDS Community Outreach Prevention Programs[1]

Country	Number of community outreach HIV/AIDS prevention programs that promote other prevention strategies	Number of individuals reached with community outreach HIV/AIDS prevention programs that promote other prevention strategies[2]
Botswana	3	435,400
Côte d'Ivoire	6	5,900
Ethiopia	5	5,200
Guyana	1	13,400
Haiti	45	96,300
Kenya	46	2,118,000
Mozambique	2	757,400
Namibia	18	38,000
Nigeria	64	852,200
Rwanda	6	1,400
South Africa	14	542,200
Tanzania	102	213,200
Uganda	149	5,558,200
Vietnam	21	307,400
Zambia	16	955,700
Total[2]	**500**	**11,899,900**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnotes:

1 Other HIV/AIDS prevention includes behavior change activities, outside of those promoting abstinence and being faithful, that are aimed at preventing HIV transmission. Examples of other prevention strategies are mass media and community outreach programs to promote avoidance of or reduction of HIV risk behaviors, community mobilization for HIV testing, and the social marketing and/or promotion of condoms, including work with high-risk groups such as intravenous drug users, men-who-have-sex-with-men, commercial sex workers and their clients, and people living with HIV and/or AIDS.

2 Numbers are rounded to nearest 100.

are an essential target group. Such people at high risk, including sex workers and their clients, men who have sex with men, and injecting drug users, are among those who are most marginalized in society and have the least access to basic health care, yet they are often in the greatest need of services.

During the reporting period, the Emergency Plan supported activities that target specific outreach, services, and comprehensive prevention messages directed at ending risky behavior. Strategies included:

- Interpersonal approaches to behavior change, such as counseling, mentoring, and peer outreach
- Community and workplace interventions to eliminate or reduce risky behaviors
- Initiatives to promote the use of testing and counseling services, including developing innovative strategies to encourage and increase HIV testing, such as provider-initiated voluntary testing where appropriate
- Promoting and supporting substance abuse prevention and treatment targeting HIV-positive individuals
- Promoting a comprehensive package for sex workers and other high-risk groups, including HIV counseling and testing, STI screening and treatment, targeted condom promotion and distribution, and other risk reduction education
- Promoting correct and consistent condom use during high-risk sexual activity
- Media interventions with specially tailored messages appropriately targeted to specific populations
- Addressing sexual coercion and exploitation of young people and women, including providing psychosocial and other assistance (such as post-exposure HIV prophylaxis for rape victims) for victims of sexual abuse

During the reporting period, the Emergency Plan committed $40,518,000 to programs and services that rely on a range of prevention strategies intended to reach people who engage in high-risk sexual activities. These funds supported 500 community outreach programs targeting people engaging in high-risk activity, reaching almost 12 million people. In addition, 200 media campaigns that included a range of prevention messages reached approximately 76.6 million people.

Building on the mechanisms developed to support bilateral programs for reproductive health, the Emergency Plan is now utilizing the Commodity Fund, which was established at the U.S. Agency for International Development (USAID) in fiscal year 2002. This fund has provided between $25 million and $28 million each fiscal year to procure male and female condoms for HIV/AIDS

Table 1.5 - Prevention: FY04 Results of Condoms and Other HIV/AIDS Mass Media Prevention Programs[1]

Country	Number of mass media HIV/AIDS prevention programs that promote other prevention strategies	Estimated number of individuals reached with mass media HIV/AIDS prevention programs that promote other prevention strategies[2]
Botswana	2	516,000
Côte d'Ivoire	10	10,020,100
Ethiopia	3	3,200,000
Guyana	5	360,000
Haiti	5	4,800,000
Kenya	11	12,100,000
Mozambique	6	5,816,700
Namibia	2	400,000
Nigeria	0	0
Rwanda	1	1,000,000
South Africa	31	16,604,800
Tanzania	1	5,000
Uganda	73	20,898,000
Vietnam	-	-
Zambia	5	900,000
Total[2]	**200**	**76,620,600**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnotes:

1 Other HIV/AIDS prevention includes behavior change activities, outside of those promoting abstinence and being faithful, that are aimed at preventing HIV transmission. Examples of other prevention strategies are mass media and community outreach programs to promote avoidance of or reduction of HIV risk behaviors, community mobilization for HIV testing, and the social marketing and/or promotion of condoms, including work with high-risk groups such as intravenous drug users, men-who-have-sex-with-men, commercial sex workers and their clients, and people living with HIV and/or AIDS.

2 Numbers are rounded to nearest 100.

prevention and to ensure their expedited delivery to countries. By procuring condoms centrally, low prices and economies of scale are achieved. In fiscal year 2004, close to 96 million condoms were purchased and shipped to Emergency Plan focus countries through this mechanism. In addition to the Commodity Fund mechanism, many focus country programs have other long-standing condom supply arrangements and distribution mechanisms that are also supported by the U.S. Government, including assistance to host-country governments and other partners. Through these mechanisms, the Emergency Plan contributed to the distribution of more than 340 million additional condoms in the focus countries.

Sustainability: Building Capacity

As discussed above, correct and consistent messages are crucial factors in determining the effectiveness of behavior change-oriented prevention strategies. The Emergency Plan has supported extensive training and capacity building of local groups to promote and sustain the use of correct and consistent evidence-based strategies for youth and other unmarried people, sexually active adults, and those who engage in high-risk behaviors. For those who engage in high-risk behaviors, the Emergency Plan trained more than 51,000 individuals to provide prevention services that included information on the correct and consistent use of condoms when appropriate and other risk-reduction strategies.

Key Challenges and Future Directions

A key challenge to delivering comprehensive ABC programs is a lack of well-trained outreach workers and providers. The Emergency Plan is addressing this issue by strengthening and expanding existing networks of public and private services through training and enhanced linkages. More programs are employing the experience and expertise of people living with HIV/AIDS. Additional tools, such as enhanced prevention counseling and improved linkages to care, are required to help discordant couples protect themselves. There will be continued emphasis on improving prevention services for vulnerable girls and young women and on scaling up prevention for HIV-positive people.

In July 2004, Vietnam was selected as the 15th Emergency Plan focus country. People who engage in injecting drug use are an important population at risk for acquiring or transmitting HIV infection in Vietnam. Another challenge to the existing Plan strategy is to develop policies and programs for substance users. In the next funding cycle, the Emergency Plan will seek to support comprehensive HIV prevention and care programs for injecting drug users. Emergency Plan funds will not support needle or syringe exchange. The Plan will work to develop multicomponent HIV prevention programs that include outreach; risk reduction counseling and prevention education for substance abusers; HIV counseling and testing in substance abuse programs; HIV treatment or referral for HIV-positive substance users; and medication-assisted treatment of addiction.

Increasing HIV/AIDS Awareness Through Bold Leadership

Deciding whether or not to go for counseling and testing was not easy for Clement, a Zambian Defense Force soldier stationed at rural Mikango Army Barracks. Before he attended an Emergency Plan-supported HIV/AIDS awareness workshop at the barracks, Clement would turn off the TV or go to sleep whenever a program about HIV came on. The magnitude of the HIV/AIDS problem in Zambia was not enough to persuade Clement to think about how the disease might affect his life.

Clement reluctantly attended the HIV/AIDS workshop that his commanding officer, Colonel Banda, was leading. "In the back of my mind, I kept telling myself, 'This is just a program, it's just talking. It will pass.' But it was as if all the things Colonel Banda was talking about, he was talking straight to me." Clement went home after the workshop and couldn't stop thinking about what the commander had said. "I looked at my wife, looked at my children, and started feeling sorry for them. They were all innocent."

The next day, he decided to go for counseling and testing, certain that he was HIV-positive. When the results came back, Clement was shocked to see that he was HIV-negative. After going through counseling and testing and learning more about HIV and how to prevent it, Clement says his behavior has completely changed. "When I go on operations now, even if they give me condoms, I won't use them. It's better for me to be faithful to my wife. I know that wherever I go in the world, it's only my wife and me who I can know are negative."

Now Clement encourages his fellow soldiers to take more responsibility for their health and their families. His efforts continue to reach his friends and colleagues. The majority of soldiers at Mikango still have not gotten up the courage to heed Clement's advice, but many more are now seeking counseling and testing than before. In one month, 36 people were counseled and tested at Mikango, more than six times the highest number who had ever accessed the services there before. In part, this is a result of Colonel Banda's efforts to make the services accessible, which he did by assigning a counselor on duty 24 hours a day (made possible by Emergency Plan funding support) and by reallocating staff to make space for a dedicated counseling and testing room at the clinic.

The increased numbers for testing are also a result of the heightened awareness created by the workshops and of the efforts of new community mobilizers who, like Clement, have gone through counseling and testing and are now "publicizing" the services. Clement continues to talk to his fellow soldiers about how being tested and talking about HIV with a peer counselor changed his life. Not knowing his status was "mental torture," worrying every time he or one of his children became sick. That worry goes away with testing, regardless of the results. And for him, one of the greatest benefits of having been tested is being able to be with his family. "Before, I had to budget for my girlfriend. Meanwhile, my son or daughter had no shoes. Whatever I get now is for my family. I'm a happy soldier."

Prevention of Mother-to-Child Transmission

Results: Rapid Scale-Up

The prevention of mother-to-child transmission (PMTCT) remains a high-priority intervention under the Emergency Plan. Prior to the President's Mother and Child HIV Prevention Initiative, fewer than 4 percent of HIV-positive pregnant women had access to antiretroviral drugs to prevent HIV transmission to their infants.

In fiscal year 2004, total PMTCT obligations in focus countries exceeded $50 million. The Emergency Plan works to expand access to comprehensive programs that offer HIV testing for pregnant women, prevention inter-

Table 1.6 - Prevention: FY04 HIV/AIDS Prevention Capacity Building Results for Condoms and Other Prevention Services	
Country	**Number of individuals trained to provide other HIV/AIDS prevention services[1]**
Botswana	5
Côte d'Ivoire	200
Ethiopia	900
Guyana	25
Haiti	5,500
Kenya	23,100
Mozambique	800
Namibia	75
Nigeria	3,000
Rwanda	1,300
South Africa	4,100
Tanzania	1,200
Uganda	2,800
Vietnam	3,700
Zambia	4,500
Total	**51,000**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnote:

1 Numbers above 100 are rounded to nearest 100.

ventions for those who are HIV-negative, and medical support for those who are HIV-positive. The primary goal of these programs is to prevent transmission of HIV during pregnancy through the provision of a minimum package of services that includes counseling and testing for pregnant women; antiretroviral prophylaxis to prevent mother-to-child transmission; counseling and support for safe infant feeding practices; family planning counseling or referral; and referral for HIV/AIDS treatment. In fiscal year 2004, the Emergency Plan supported PMTCT services under national strategies for 1,271,400 women, of whom 125,100 received mostly short-course antiretroviral preventive therapy, averting an estimated 23,766 infections of newborns. As impressive as these results are, there are also multiple other benefits of PMTCT programs not reflected in these data. As a venue for HIV counseling and testing, PMTCT programs provide an

Table 1.7 - Prevention: FY04 Prevention of Mother-to-Child Transmission[1] Results

Country	Number of pregnant women receiving PMTCT services[2]			Number of pregnant women receiving ARV prophylaxis[2]			Total estimated infant infections averted[5]
	Number receiving upstream system strengthening support[3]	Number receiving downstream site-specific support[4]	Total	Number receiving upstream system strengthening support[3]	Number receiving downstream site-specific support[4]	Total	
Botswana	26,900	3,600	30,500	1,700	300	2,000	375
Côte d'Ivoire	6,400	18,500	24,900	400	1,500	1,900	350
Ethiopia	2,400	4,200	6,600	71	100	171	41
Guyana	0	5,700	5,700	67	0	67	13
Haiti	0	28,000	28,000	0	500	500	93
Kenya	130,600	203,100	333,700	7,500	9,100	16,600	3,149
Mozambique	16,800	19,300	36,100	1,400	900	2,300	442
Namibia	0	7,800	7,800	0	1,300	1,300	243
Nigeria	6,200	16,700	22,900	300	300	600	103
Rwanda	0	49,300	49,300	0	2,800	2,800	533
South Africa	446,500	40,800	487,300	65,300	10,400	75,700	14,392
Tanzania	0	42,800	42,800	0	1,800	1,800	339
Uganda	35,300	95,900	131,200	700	5,900	6,600	1,254
Vietnam	0	1,200	1,200	0	0	0	3
Zambia	0	63,300	63,300	0	12,800	12,800	2,436
Total	**671,100**	**600,200**	**1,271,300**	**77,400**	**47,700**	**125,100**	**23,766**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnotes:

1 PMTCT includes activities aimed at providing the minimum package of services for preventing mother-to-child transmission, including HIV counseling and testing for pregnant women, preventive ARV prophylaxis, counseling and support for safe infant feeding practices, and family planning counseling or referral.

2 Numbers above 100 are rounded to nearest 100.

3 Number of individuals reached through upstream systems strengthening includes those supported through contributions to national, regional, and local activities such as training, laboratory support, monitoring and evaluation, logistics and distribution systems, and protocol and curriculum development.

4 Number of individuals reached through downstream site-specific support includes those receiving services at U.S. Government-funded service delivery sites.

5 Infant infections averted are calculated by multiplying the total number of deliveries per year by the rate of HIV prevalence among pregnant women in a given country. The result is then multiplied by the transmission rate expected when a specific PMTCT prophylactic regimen and infant feeding practice (breastfeeding or formula) is used. In short, we estimate the extent to which HIV transmission from mothers to their infants is reduced by the use of PMTCT regimens and safe infant feeding practices.

important opportunity for women who are HIV-negative to learn strategies to remain negative. In addition, thanks to the strong linkages being developed through the Emergency Plan, not only are infections in infants prevented, but also mothers and fathers who need care and support are brought into long-term antiretroviral treatment (ART) programs, thus helping to prevent a new generation from being orphaned.

Sustainability: Building Capacity

During the reporting period, the Emergency Plan made important progress in strengthening the capacity of national governments to comprehensively serve pregnant women and to implement and manage the distribution and logistics systems essential for PMTCT programs. In addition, the Plan provided support to ensure that host-country personnel were trained in both the delivery and management of these programs. During fiscal year 2004, the Emergency Plan supported training of 24,600 health workers in the provision of PMTCT services and supported 2,200 service outlets that provide the minimum package of PMTCT services.

Key Challenges and Future Directions

The establishment of effective PMTCT programs in resource-limited settings has required addressing a range of challenges, including developing and implementing models of HIV primary care services focused on women and families that can be easily adapted and widely replicated; implementing reliable systems for the regular supply of pharmaceuticals and testing supplies; ensuring appropriate patient monitoring in settings where access to laboratory services is limited; developing simple, comprehensive training strategies for health care providers; and developing effective, locally appropriate strategies to encourage treatment adherence.

The President's Emergency Plan will continue to address the ongoing challenges in PMTCT programs, including the stigma of HIV, which poses a barrier to service and increasing access; the failure of women to return for HIV test results where rapid testing is not available; low acceptance of ART offered to HIV-positive women at antenatal clinics; poor adherence to "take home" ART for mothers and newborns by HIV-positive mothers; and low acceptance of recommended infant feeding behaviors to minimize mother-to-child transmission. Additionally, there is a need to address the difficult issues of reaching women who deliver at home and ensure referrals to treatment for mothers and children who need it. As the Emergency Plan moves forward, the PMTCT program will seek to address these barriers and to expand to new sites, especially rural health care sites and settings with limited health systems infrastructure.

Prevention of Medical Transmission of HIV

Results: Rapid Scale-Up

Throughout the developing world people still acquire HIV through blood transfusions and unsafe medical injections. The Emergency Plan supports host-country efforts to improve the quality of their blood supply, introduce practices that prevent transmission through unsafe injections, and improve infection prevention. In addition, health workers exposed to blood during their daily work need training in universal medical precautions to avoid exposure to bloodborne infections. The Plan works closely with national governments to support policies, infrastructure, commodity procurement, and management capacity to ensure a safe and adequate blood supply.

Similar support is provided for medical injection safety. The safe injection initiative includes two components - decreasing unnecessary injections and making injections

A mother and newborn in a Mozambique hospital benefit from Emergency Plan-supported PMTCT services.

Table 1.8 - Prevention: FY04 Prevention of Mother-to-Child Transmission[1] Capacity Building Results		
Country	**Number of USG-funded service outlets providing the minimum package of PMTCT services[2]**	**Number of health workers newly trained or retrained in the provision of PMTCT services[2]**
Botswana	12	100
Côte d'Ivoire	26	900
Ethiopia	22	1,300
Guyana	24	200
Haiti	21	1,000
Kenya	500	3,500
Mozambique	21	500
Namibia	21	1,600
Nigeria	17	700
Rwanda	86	500
South Africa	1,100	8,800
Tanzania	100	1,400
Uganda	100	2,800
Vietnam	9	200
Zambia	95	1,10
Total	**2,200**	**24,600**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnotes:

1 PMTCT includes activities aimed at providing the minimum package of services for preventing mother-to-child transmission, including HIV counseling and testing for pregnant women, preventive ARV prophylaxis, counseling and support for safe infant feeding practices, and family planning counseling or referral.

2 Numbers above 100 are rounded to nearest 100.

safer. Specific activities include support of distribution supply chain logistics, appropriate disposal of injection equipment and other related equipment and supplies, and training in universal medical precautions. Currently, 14 focus countries have developed national injection safety strategic plans, and nine have established national injection safety advisory groups.

Activities for preventing medical transmission are based on plans that can adapt to a country's specific needs. For example, some countries conducted needs assessments in 2004 to identify a strategy for improving their national blood safety and injection safety programs. Other countries had already conducted appropriate assessments and were ready to begin training for health care workers, commodity procurement, and improving systems for the prevention of medical transmission. In the Emergency Plan's first eight months, 2,200 individuals were trained in safe blood techniques and 4,300 in injection safety. Additionally, almost 250 programs funded by the Emergency Plan focused on blood safety activities.

The total budget for medical transmission prevention activities was $51,955,000.

Sustainability: Building Capacity

The Emergency Plan for AIDS Relief made progress during the reporting period in strengthening the capacity of national governments to implement and manage the distribution and logistics systems essential for effective blood safety, medical injection safety, and condom programs. In addition, support was provided to ensure that host-country personnel were trained in the delivery and management of these programs.

Key Challenges and Future Directions

As with other approaches to prevention, a key challenge in delivering blood safety and safe injection programs is a

Table 1.9 - Prevention: FY04 Medical Transmission[1] Capacity Building Results			
Country	**Number of service outlets/ programs carrying out blood safety activities**	**Number of individuals trained in blood safety[2]**	**Number of individuals trained in injection safety[2]**
Botswana	1	0	300
Côte d'Ivoire	0	0	18
Ethiopia	0	0	85
Guyana	1	0	0
Haiti	0	0	200
Kenya	108	1,300	500
Mozambique	0	0	400
Namibia	1	0	89
Nigeria	95	200	51
Rwanda	0	0	0
South Africa	39	400	400
Tanzania	4	200	200
Uganda	0	84	1,900
Vietnam	-	-	-
Zambia	0	0	200
Total	**249**	**2,200**	**4,300**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnotes:

1 Medical transmission includes programs in blood safety (supporting a national coordinated blood program that includes policies, infrastructure, equipment, and supplies; donor recruitment activities; blood collection, distribution/supply chain/logistics, testing, screening, and transfusion; waste management; training; and management to ensure a safe and adequate blood supply) and programs in injection safety (policies, training, waste management systems, advocacy, and other activities to promote medical injection safety, including distribution/supply chain/logistics, cost and appropriate disposal of injection equipment, and other related equipment and supplies).

2 Numbers above 100 are rounded to nearest 100.

lack of well-trained personnel. This issue is being addressed by providing training on infection control, universal medical precautions, and safe injection and blood safety techniques to new health care workers before they enter the workforce, while certification programs and on-the-job training are provided for current health care workers. Consistent and secure supply chains for health care commodities and medications are an additional challenge. Through an announced request for applications, the Emergency Plan will provide technical assistance to countries to strengthen existing supply chains, develop new supply chains, provide bulk purchasing at a reduced price, and accurately forecast procurement needs.

Accountability: Reporting on the Components of Prevention

To account for Emergency Plan prevention programming, in-country teams total all of the programs, services, and activities aimed at preventing HIV transmission. This includes mass media and community outreach programs to promote abstinence, faithfulness, correct and consistent condom use, and other behavior change to support avoidance of or reduction of HIV risk behaviors; community mobilization for HIV testing; and preventing mother-to-child transmission and medical transmission (blood safety and injection safety). These indicator data are drawn from country program reports collected in-country from partners with guidance from the Office of the U.S. Global AIDS Coordinator. Condom shipments are tracked by a central database within the U.S. Government.

To account for programs addressing medically transmitted HIV, country teams identify programs that support a national blood program that includes policies, infrastructure, equipment, and supplies; donor recruitment activities; blood collection, distribution and supply chain logistics, testing, screening, and transfusion; waste manage-

Helping a Woman Protect Her Baby from HIV

The story of Michelle is just one example of the Emergency Plan's commitment to preventing mother-to-child HIV transmission (PMTCT), a central Emergency Plan prevention strategy. Michelle is a 29-year-old Guyanese teacher with an 11-year-old son and a 10-month-old daughter. Michelle is also HIV-positive and has lost one 4-year-old son to AIDS; the HIV status of another child who passed away was unknown.

During her most recent pregnancy, Michelle attended the antenatal clinic at the Emergency Plan-supported Dorothy Bailey Clinic in Georgetown. Nurses and counselors at this clinic, one of the first in Georgetown to offer PMTCT services, convinced Michelle of the value of knowing her HIV status. She made a fully informed choice and agreed to be tested. When her test came back positive, as she had suspected it might, it helped Michelle that the nurses at the clinic were so caring. Soon she began to feel as though she had found a new family. The nurses encouraged her to join a support group of HIV-positive mothers who meet at Dorothy Bailey, and Michelle has derived a great deal of comfort from participating in this group.

Thanks to Emergency Plan support, the Dorothy Bailey Clinic has continued to expand and develop its capacity. In 10 short months, the clinic served 1,820 antenatal care clients, providing pretest counseling to all and HIV testing, counseling and other PMTCT services as needed. During the same period, the project reached more than 25 percent of all pregnant women in Guyana, with over 80 percent accepting testing and over 75 percent receiving needed antiretroviral prophylaxis.

Thanks to the generosity of the American people, the Emergency Plan is offering new hope to women like Michelle - and her baby daughter.

In Mozambique, women who have come to care for sick relatives wait outside a U.S.-supported hospital.

ment; training; and management to ensure a safe and adequate blood supply. In addition, they identify policies, training, waste management systems, advocacy, and other activities that promote medical injection safety, including distribution and supply chain logistics, cost, and appropriate disposal of injection equipment, and other related equipment and supplies.

Country teams monitor activities aimed at providing the minimum package of PMTCT services for preventing mother-to-child transmission, including counseling and testing for pregnant women; preventive antiretroviral prophylaxis; counseling and support for safe infant feeding practices; and family planning counseling or referral. These data are drawn from program reports and health management information systems.

Currently, significant gaps exist in the evidence base for determining the impact of HIV prevention efforts and their effect on country epidemic trajectories. Services provided and people reached through activities do not provide sufficient data to predict the number of infections averted. The number of infections averted as a result of expanded programs must be estimated through modeling since it is impossible to measure directly (by definition, it is a non-event). To provide as much accountability as possible, the Emergency Plan will estimate infections averted based on periodic prevalence studies, with the U.S. Census Bureau taking the lead on progress toward the goal of 7 million HIV infections averted by 2010 in the focus countries. The modeling approach will establish prevalence trends for each country using data through 2003. In 2005, these prevalence trends will be re-estimated for those countries with additional surveillance data available for 2004 and 2005. The difference in these two prevalence trends will represent the net impact of program activities since the start of the Emergency Plan. During the five years of the Emergency Plan, each focus country will have a number of assessments at strategic intervals; infections averted will be estimated following those assessments.

Addressing the Vulnerabilities of Women and Girls

Data demonstrate that girls and young women are becoming increasingly vulnerable to HIV infection. This disproportionate impact is linked to biology and to harmful gender-based societal norms and practices that restrict women's access to HIV/AIDS information and services, severely limit girls' and women's control over their sexual lives, and deprive them of economic resources and legal rights necessary for them to protect themselves from HIV/AIDS.

As discussed in detail in chapter 4, "Gender and HIV/AIDS: Responding to Critical Issues," the Emergency Plan supports girls and women specifically and explicitly in its HIV/AIDS prevention programs, which include activities to:

- Reduce stigma
- Increase the gender equity of HIV/AIDS programs and services
- Address male norms and behaviors
- Reduce violence and coercion
- Increase girls' and women's access to income and productive resources
- Increase women's legal protection

Emergency Plan-supported programs are designed to remove barriers to ensure that women and girls are educated about the spread of HIV/AIDS and that prevention programs meet the unique needs of women and girls, including orphans, that make them vulnerable to sex trafficking, abuse, and exploitation. At the same time, Emergency Plan prevention programs also address male norms and behaviors that increase vulnerability to HIV among women and girls, such as multiple sex partners outside of marriage, cross-generational sex, and transactional sex. The Plan is committed to reducing men's violence against women; supporting women to mitigate violence against them, especially in the context of disclosing their HIV status; and linking HIV programs with community and social services to prevent gender-based violence, strengthen conflict resolution skills, and protect and care for victims.

For many disadvantaged women and girls, transactional sex is one of the few options available to them for survival. The Emergency Plan recognizes that efforts must be undertaken to ensure more sustainable livelihoods for women and girls in order to enable them to escape lives of prostitution, protect themselves from HIV/AIDS, and deal with its impact. Several programs are underway to address this critical issue and others, including public-private partnerships and linkages with U.S.-supported economic development and microfinance programs. Many of the norms and practices that increase women's vulnerability to HIV/AIDS and limit their capacity to deal with its consequences are reinforced by discriminatory policies, laws, and legal practices. The Plan therefore is supporting efforts to review, revise, and enforce laws relating to sexual violence and women's property and inheritance rights; enhance women's access to legal assistance; and eliminate gender inequalities in civil and criminal codes.

Ambassador Tobias celebrates the opening of a new HIV/AIDS treatment site in rural Haiti by providing the first patient with his first dose of antiretroviral medication.

"When they get the antiretroviral drug, there's a Lazarus effect and people, all of a sudden, say, 'I have hope …' There's nothing better than a hopeful society in dealing with the pandemic. A hopeful society means you think you can win. A non-hopeful society says, 'I surrender.' America is not going to surrender to the pandemic."

President George W. Bush
June 23, 2004

Chapter 2

Critical Intervention in the Focus Countries: Treatment

A historic aspect of President Bush's Emergency Plan for AIDS Relief (PEPFAR/Emergency Plan) is the focus on scaling up quality antiretroviral treatment (ART) in 15 focus countries in Africa, Asia, and the Caribbean. Quality ART requires a host of essential activities and services, including assessments of current capacity and resources for efficient and effective roll-out; training and support for care providers; adherence training and monitoring; infrastructure enhancement, including clinics, laboratories, and medical records systems; routine laboratory monitoring tests; antiretroviral (ARV) drugs and other medications; hospitalization capability when necessary; the development and maintenance of secure distribution, logistics, and management systems; and much more. In the resource-limited settings of the focus countries, few of these essential activities and services were available prior to the Emergency Plan. Although it is critical to move as quickly as possible to save as many lives as possible, moving too quickly without ensuring the provision of the highest-quality ART could do more harm than good for the generations that will live or die with decisions made now. The emergence of widespread

Treatment Summary

Five-Year Goal in the 15 Focus Countries
Support antiretroviral treatment (ART) for 2 million HIV-infected individuals

Year One Target
Support ART for at least 200,000 people in the 15 focus countries by June 2005

Progress Achieved by September 30, 2004

- Supported ART for 155,000 people in the 15 focus countries (78 percent of the June 2005 target)
- Supported training of 12,200 health providers in ART services
- Supported 300 ART sites

Allocation of Resources in Fiscal Year 2004
$231,906,000 to support ART in focus countries (41 percent of total resources committed)

drug resistance from suboptimal therapy could severely curtail the fight against the global pandemic. President Bush's Emergency Plan is committed to supporting national strategies to guarantee the full spectrum of quality treatment through both public and private providers, ensuring that HIV-infected adults and children receive the greatest benefit from therapy and that the risks of developing resistance are limited.

A fundamental means of rapidly expanding services while developing sustainable capacity is to support national strategies to build HIV/AIDS care and treatment networks. Network systems ensure comprehensive reach of high-quality services by building capacity to support centers of excellence at referral hospitals, with health professionals trained in all aspects of HIV/AIDS care and treatment, adequate physical infrastructure, and laboratory capability. These core institutions link to regional hospitals and district facilities down to community-level satellite clinics, mobile units, and community-based services. These linkages provide clinical support for laboratory tests, training, logistical and distribution systems, monitoring and reporting systems, and other aspects of quality care and treatment. By working with host governments to support the development of comprehensive indigenous network systems, the Emergency Plan will ensure that capacity and services are sound, sustainable, and prepared to respond to the long-term challenge of turning the tide of the HIV/AIDS pandemic.

Antiretroviral Treatment

Results: Rapid Scale-Up

The Emergency Plan has moved rapidly to support national strategies for treatment in partnership with the

Defining Support for Antiretroviral Treatment

What does it mean to provide support for antiretroviral treatment (ART)? That is a complicated question because the provision of treatment is itself complicated. In addition, the needs of host countries as defined by their national strategies are different. There are a number of significant components of quality ART, including general clinical support for patients, such as non-antiretroviral medications and laboratory tests; training and support for health care personnel; infrastructure, including clinics, counseling rooms, laboratories, and distribution and logistics systems; monitoring and reporting systems; and the various other relevant components of treatment, including the antiretroviral (ARV) drugs themselves.

The cost of ARV drugs is estimated to be less than 30 percent of the average cost per person per year for the complete ART package. Drugs remain a significant component of cost, to be sure, but are not now the fundamental obstacle to treatment that they once were. This simply serves to illustrate the importance of all the components required to provide quality ART.

Where partnership limitations or technical, material or financial constraints require it, the Emergency Plan, or another donor, may support every aspect of the complete package of ART at a specific public or private delivery site, in coordination with host-country national treatment strategies. In many areas, the Emergency Plan will coordinate with other partners to leverage resources at a specific site, providing those essential aspects of quality ART that others cannot provide due to limited technical and/or financial circumstances. For example, in some settings ARV drugs are provided to specific sites through the host-country government or other donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, while the Emergency Plan may contribute other essential services, training, commodities, and infrastructure to support treatment. "Downstream" site-specific support refers to these instances where the Emergency Plan is providing all or part of the necessary components for quality ART at the point at which services are delivered.

public and private sectors, committing more than $231.9 million for ART, or 40.8 percent of the total resources committed to prevention, treatment and care in the 15 focus countries. The results of these joint U.S./host-country efforts are impressive. In the first eight months of the Emergency Plan, the United States has supported ART for 155,000 HIV-infected adults and children in the 15 focus countries, achieving 78 percent of its target for June 2005. As a reference point for this rapid progress, in December 2002, one month before President Bush announced the Emergency Plan, only 50,000 people were reported to be receiving ART in all of sub-Saharan Africa. Eight months into the Emergency Plan, three times that number were receiving treatment. The Emergency Plan is well on track to meet the goal of supporting ART for 2 million adults and children in five years.

Of the 155,000 people receiving support for ART from the Emergency Plan, 67,000 were treated at U.S. Government-supported health centers, and 88,000 benefited from upstream support provided by the Emergency Plan to strengthen national health care networks and systems for ART provision. Of the 67,000 adults and children treated at specific sites, 40,000 began therapy during the reporting period, with the remainder taken up by the Emergency Plan at its launch to ensure continuing treatment. Reporting systems for upstream support do not currently provide an accurate count of those patients who began ART during the reporting period.

The Emergency Plan is dedicated to expanding care and ART to HIV-infected children, supporting ART for at least 4,800 children during the first reporting period. Few sites are currently able to disaggregate data by adults and children, so the number of children receiving ART is

Beyond the site-oriented downstream components of treatment, support is required to provide other critical elements of treatment, such as the training of physicians, nurses, laboratory technicians, and other health care providers; laboratory systems; strategic information systems, including surveillance and monitoring and evaluation systems; logistics and distribution systems; and other support that is essential to the effective roll-out of quality ART. This coordination and leveraging of resources optimizes results while limiting duplication of effort among donors, with roles determined within the context of each national strategy. Such support, however, often cannot easily be attributed to specific sites because it is national or regional in nature, and, in fact, many sites benefit from these strategic and comprehensive improvements. Therefore, this support is referred to as "upstream" support and is essential to developing network systems for care and treatment.

Upstream support is vital to creating sustainable national systems. In Botswana, for example, the government has led an aggressive and highly successful multisectoral response with its own resources and significant downstream contributions from the private sector through the African Comprehensive HIV/AIDS Partnerships (funded by the Bill & Melinda Gates Foundation and the Merck Company Foundation). As the Emergency Plan began, extensive consultations with the government and other donors identified the greatest added value to be strengthening national laboratory and training systems and developing national protocols. This upstream support contributes to the overall success of Botswana's national strategy.

This report covers patients who are receiving upstream and downstream Emergency Plan support. The complexities of both forms of support highlight the vital importance of implementing the "Three Ones" agreement (see chapter 7, "Strengthening Multilateral Action"). In working with major partners, including the Global Fund, the World Health Organization, and the Joint United Nations Program on HIV/AIDS, the Emergency Plan is coordinating its monitoring and evaluation efforts and reporting criteria to develop consistent methodologies to determine the number and attribution of patients receiving treatment through upstream and downstream support from multiple organizations.

Table 2.1 - Treatment[1]: FY04 Overall Results					
Country	June 05 Target[3, 4]	Results[2]			
		Number of individuals receiving upstream system strengthening support for treatment[5]	Number of individuals receiving downstream site-specific support for treatment[6]	Totals	
				Total number of individuals reached	Total percentage of Year One target met
Botswana	29,000	31,900	1,000	32,900	113%
Côte d'Ivoire	10,000	0	4,500	4,500	45%
Ethiopia[7]	15,000	9,500	0	9,500	63%
Guyana	300	100	400	500	167%
Haiti	4,000	0	2,800	2,800	70%
Kenya	38,000	9,100	8,000	17,100	45%
Mozambique	8,000	4,800	400	5,200	65%
Namibia	4,000	100	3,900	4,000	100%
Nigeria	16,000	7,800	5,700	13,500	84%
Rwanda	4,000	100	4,200	4,300	108%
South Africa	20,000	7,300	4,900	12,200	61%
Tanzania	11,000	0	1,500	1,500	14%
Uganda	27,000	6,600	26,400	33,000	122%
Vietnam[8]	1,000	0	-	-	-
Zambia	15,000	10,200	3,400	13,600	91%
All countries[9]	**200,000**	**87,500**	**67,100**	**155,000**	**78%**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnotes:

1 Treatment includes the provision of antiretroviral drugs and clinical monitoring of ART among those with advanced HIV infection in either an ART or a PMTCT+ setting. PMTCT+ includes a minimum package of services - HIV/AIDS counseling and testing for pregnant women; ARV prophylaxis to prevent mother-to-child transmission; counseling and testing for safe infant feeding practices; family planning counseling or referral; ARV therapy for HIV+ women, their children, and their families.

2 Numbers are rounded to nearest 100.

3 The first disbursement of Emergency Plan funds occurred in late February, 2004. The June 2005 target, of at least 200,000 receiving treatment, was set to allow the countries an achievable goal after one full year of programming. This is a Year One anomaly.

4 The June 05 targets were set by the countries in March 2004 to approximate the overall yearly target for the Emergency Plan.

5 Number of individuals reached through upstream systems strengthening includes those supported through contributions to national, regional, and local activities such as training, laboratory support, monitoring and evaluation, logistics and distribution systems, and protocol and curriculum development.

6 Number of individuals reached through downstream site-specific support includes those receiving services at U.S. Government funded service delivery sites.

7 In FY04, Ethiopia did not use USG funds to provide treatment at service delivery sites.

8 Vietnam received Emergency Plan funds late in FY04 and is not required to report during this cycle.

9 All Countries line has been adjusted to match the Emergency Plan target of 200,000 individuals receiving treatment by June 2005 and the Total Number of Individuals Reached for All Countries has been rounded up to the nearest 1,000. As such, totals may not equal the sum of every column.

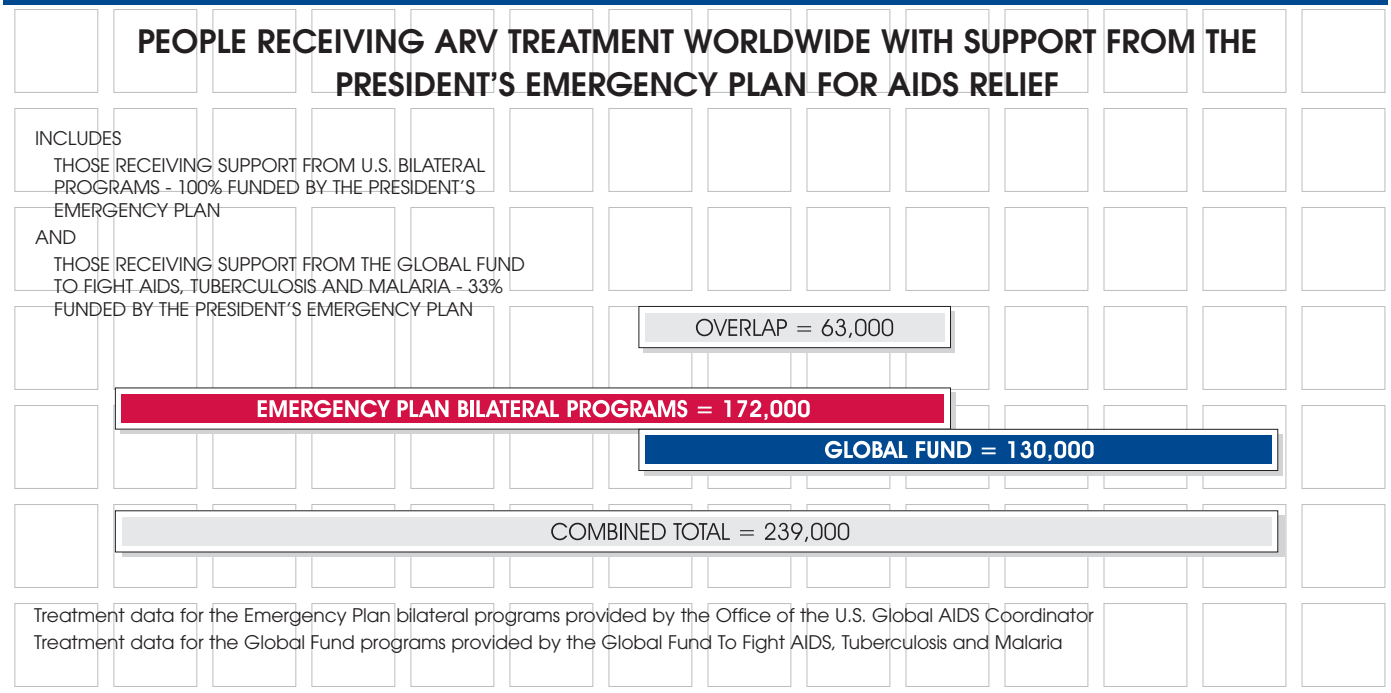
likely under-reported. Women (who are disproportionately infected with HIV, particularly in Africa) must be ensured access to quality ART. During the first reporting period, not all sites captured the numbers of women and girls receiving ART; however, among the sites reporting such numbers, 56 percent of new clients receiving ART were female. Reporting on women and children receiving ART will improve significantly in the coming years.

In addition to support for ART in focus countries, in fiscal year 2004 the President's Emergency Plan supported ART for 17,000 HIV-positive people through bilateral programs in other countries, for a total of 172,000 women, men, and children in focus countries and other countries combined. A fundamental component of the Emergency Plan is the commitment of resources to the Global Fund to Fight AIDS, Tuberculosis and Malaria. In January 2005, the Global Fund reported that it had supported ART for 130,000 HIV-positive people globally through December 2004. Of those, 63,000 received support from both the bilateral and multilateral resources of the Emergency Plan, as shown in figure 2.1 below.

Sustainability: Building Capacity

A key aspect of the Emergency Plan is to rapidly build capacity as services are being scaled up to provide the foundation for sustainable high-quality services. Human resource capacity is a fundamental limitation to quality

Figure 2.1 - Treatment Worldwide



ART in many settings; because ART is new in many places, there is limited number of trained providers. The Emergency Plan coordinates with host-country national strategies to support significant training for health care providers to ensure the quality of ART services and the success of national plans in both public and private sectors. In the first eight months of the Emergency Plan, the United States supported training for 12,200 service providers. In addition to training, sites must be prepared for quality ART, including the strengthening of physical infrastructure, laboratories, procurement and distribution of essential supplies, and other key areas. In the reporting period, the Emergency Plan supported 300 sites for ART in the 15 focus countries.

Antiretroviral drugs as a component of antiretroviral treatment. Safe, effective, high-quality ARV drugs are a critical component of quality ART. ARV drugs are a significant component of the cost of ART. There are various sources of ARV drugs, including host governments and other donors. The Emergency Plan often provides other essential components of ART (see Defining Support for Antiretroviral Treatment above). In addition, no one regimen is adequate for the needs of all patients. Drug interactions, such as those between ARVs and anti-TB drugs, can alter the preferred first-line therapy in many patients.

Table 2.2 - Treatment[1]: FY04 Capacity Building Results

Country	Number of USG-funded sites providing ARVs	Number of health workers trained, according to national and/or international standards, in the provision of treatment (ART and PMTCT+ sites combined)[2]
Botswana	1	34
Côte d'Ivoire	16	61
Ethiopia[3]	0	0
Guyana	2	34
Haiti	11	300
Kenya	46	2,100
Mozambique	3	200
Namibia	17	600
Nigeria	16	35
Rwanda	14	500
South Africa	86	5,300
Tanzania	16	300
Uganda	54	1,700
Vietnam[4]	-	-
Zambia	31	1,000
Total[2]	**300**	**12,200**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnotes:

1 Treatment includes the provision of antiretroviral drugs and clinical monitoring of ART among those with advanced HIV infection in either an ART or a PMTCT+ setting. PMTCT+ includes a minimum package of services - HIV/AIDS counseling and testing for pregnant women; ARV prophylaxis to prevent mother-to-child transmission; counseling and testing for safe infant feeding practices; family planning counseling or referral; ARV therapy for HIV+ women, their children, and their families.

2 Numbers above 100 are rounded to nearest 100.

3 In FY04, Ethiopia did not use USG funds to provide treatment at service delivery sites.

4 Vietnam received Emergency Plan funds late in FY04 and is not required to report during this cycle.

Showing What Courage, Collaboration, and Resources Can Do in Northern Uganda

Uganda's Gulu district has long been known for the challenges it faces - an 18-year war, poverty, and diseases including Ebola and high HIV prevalence. In fact, Gulu has the highest HIV prevalence among pregnant women in Uganda. Until recently, only 150 HIV patients were receiving antiretroviral therapy (ART) from the Uganda Ministry of Health, while a few hundred others were able to afford their own treatment.

In just one month, however, two organizations working in the district demonstrated what courage, collaboration and resources can do in the face of seemingly overwhelming challenges. St. Mary's Hospital, Lacor is a nonprofit 474-bed hospital in Gulu. Founded in 1959, St. Mary's has offered HIV/AIDS services since 1993, when the hospital created an AIDS clinic and began offering voluntary counseling and testing (VCT). St. Mary's offers consultation, counseling, and treatment of opportunistic infections to the 6,000 HIV patients registered in the clinic. Comboni Samaritan Organization, also in Gulu, is a local community-based nongovernmental organization in operation for the past 13 years.

Through a new Emergency Plan-supported project, St. Mary's and Comboni have joined together in a unique partnership that already is achieving tremendous results. In their first month of working together, the partners registered 1,000 HIV patients and began ART for 200 adults. St. Mary's daily AIDS outpatient clinic has been busier than ever, averaging 400 consultations a week compared with the 120 clients it used to see each week. With the prospect of receiving effective treatment, St. Mary's VCT service is now testing 100 clients a day - double the previous number.

It is projected that Emergency Plan programs will support the hospital's goal of providing ART to 1,000 patients by February 2005, including 800 adults and 200 children. Comboni is supporting the patients enrolled in the project with caregivers who conduct initial assessments of clients and provide daily follow-up to ensure that they adhere to their ART regimens. In the face of daunting challenges such as those faced in Gulu, St. Mary's, Lacor and Comboni Samaritan Organization are proving that by working together it is possible to achieve what they could not achieve on their own. They are impressively demonstrating what collaboration and courage can do when backed by the resources needed to serve their community.

In certain settings, more than 30 percent of patients who begin ART cannot use the preferred national first-line regimen because of the need to simultaneously treat HIV and TB. In addition, as access to ART expands, drug toxicities and drug resistance will increase, thus requiring a sufficiently broad formulary to sustain quality ART. The United States is committed to providing the necessary elements of a formulary to ensure safe, effective, high-quality ARVs for sustainable ART. In the reporting period, the Emergency Plan provided nearly $12 million for the purchase of ARV drugs in the focus countries.

The Emergency Plan is fully committed to providing funding for the lowest-cost ARV drugs from any source, regardless of origin, be they copies, generic, or branded, as long as those drugs are proven safe, effective, and of high quality, and purchase is consistent with international law. In May 2004, then U.S. Secretary of Health and Human Services Tommy Thompson and U.S. Global AIDS Coordinator Randall L. Tobias jointly announced an expedited process for review of ARVs through the U.S. Food and Drug Administration (FDA). This process establishes an eight-week review from the time a completed application is received. Since May, the FDA has worked with multiple companies from Africa, Asia, and the Caribbean to ensure the success of the expedited review process, providing technical support and guidance for the preparation of applications.

Treatment Spurs Testing

A 38-year-old woman living in Ngombe, Zambia, was widowed when her husband died in 1998. She has four children ranging in age from 10 to 19 years. She recently began to feel sick and chose to go for counseling and testing. She discovered that she was HIV-positive, and it was later determined that she was eligible to start antiretroviral therapy (ART).

This news became the impetus for her one-woman campaign to sensitize her neighbors to the need for voluntary counseling and testing. She talked freely of her status with five other women in the neighborhood and encouraged them to get tested. They all found out that they were HIV-positive. With the availability of funds for ART through the Emergency Plan, each woman was able to enroll in an ART clinic at a Zambian government-sponsored health center and receive HIV/AIDS care at no cost. These women are grateful that the Zambian and U.S. governments took an interest in their well-being. Without this support, these women would be planning for the ends of their lives; instead, they are planning their futures.

In December 2004, the FDA approved a generic form of didanosine (Barr Pharmaceuticals, U.S.), a drug commonly used in second-line regimens. In January 2005, the FDA approved a generic copackaged ARV "blister pack" (Aspen Pharmcare, South Africa). The three-drug combination contained in the blister pack (the fixed-dose combination of zidovudine/lamivudine and the single drug nevirapine) is one of the most commonly used regimens in resource-limited settings and provides patients with an easy-to-use package of two tablets twice per day. This approval took two weeks from the time a complete application was received by the FDA. Other companies have also announced their intention to enter the FDA expedited review process in fiscal year 2005.

Key Challenges and Future Directions

Human capacity. There are insufficient numbers of health care providers in both the public and private sectors trained in the many aspects of quality ART. This is due in part to the fact that ART is relatively new in most settings so there has been little need for training to date. However, there is also a significant shortage of health professionals. For example, in Mozambique there are 500 to 600 physicians for 18 million people. Some focus countries do not have their own medical schools. There is a chronic shortage of nurses, exacerbated by "brain drain" of trained personnel to developed countries and by the fact that many personnel are themselves at risk for HIV infection. Many national strategies, and the Emergency Plan, recognize these key challenges and are working to provide the upstream support necessary to provide sustainable solutions. Progress has been made in innovative training programs that provide preservice training for health workers in school and on-the-job training (which prevents depletion of an already limited worker pool during training sessions). The "network system" of health care is essential in resource-limited settings; limited human capacity requires that different levels of care and ART be provided by those with the necessary training to perform tasks well, while limiting the use of highly specialized professionals when their expertise is not required. In certain circumstances, changes in national government policy or legislation are required to bring greater flexibility to health care delivery. In Uganda and Haiti, home health aides perform routine follow-up and patient adherence counseling in the home setting. Innovative approaches to fully integrate a network ART system will be necessary to achieve a rapid scale-up of quality ART.

Expanding ART in rural areas. In many areas where the Emergency Plan is working, a significant segment of the population resides in rural communities. To achieve the treatment goals of supporting ART for 2 million people in five years, it will be necessary to expand services from the urban centers in which they are often concentrated to rural areas. Again, the network system favored by national strategies and the Emergency Plan is essential to maximize the reach of quality ART. Community- and faith-based organizations and private sector providers are a key component of the strategy to extend the reach of care and treatment to the community level. Ensuring that women have access to treatment as it expands is a

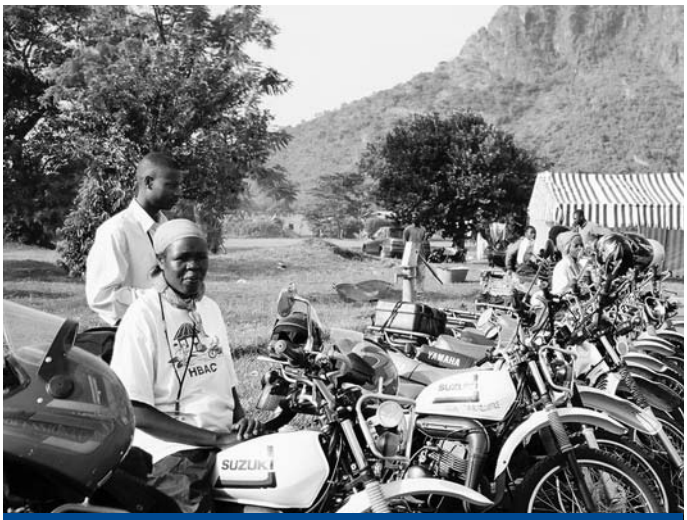
Retaining the services of health care professionals like these nurses in Nigeria is an important objective of the Emergency Plan.

focus of the Emergency Plan. In addition, novel approaches to place health care professionals in rural settings are needed. In 2004, the Emergency Plan supported a pilot project in Namibia to provide incentives to physicians and other health care professionals to move to underserved rural areas. As a result of this program, physicians, pharmacists, and nurses relocated to these areas and began providing services to thousands of HIV-positive people. In 2005, the Emergency Plan will expand the Namibian program and other countries, such as Mozambique, will employ a similar strategy.

Secure and reliable ARV drug supply. A secure and reliable drug and commodity supply chain is a key component of safe and effective ART and quality HIV prevention and care. An interruption in drug supply poses significant risks of patients developing resistance to ARV drugs and to patient and community confidence in national strategies. Accurate forecasting is essential to ensure proper levels of ARV production. Currently, the partners of the Emergency Plan are utilizing existing supply chain systems to expand programs. While this is an appropriate emergency response to rapidly expand services, for the long term a more robust approach is needed. The Office of the U.S. Global AIDS Coordinator (OGAC) has overseen the release of a request for applications to develop a secure, reliable supply chain management system (see chapter 5, "Building Capacity for Sustainability"). This performance-based contract will be awarded in fiscal year 2005. The fundamental intent of the contract, and of current U.S. efforts, is to provide technical assistance to develop national supply chain systems for drugs and commodities.

Accountability: Reporting on the Components of Treatment

The Emergency Plan supports national HIV/AIDS treatment strategies, leveraging resources in coordination with host-country multisectoral organizations and other donors to ensure a comprehensive response. Host nations must lead a multisectoral national strategy for HIV/AIDS for an effective and sustainable response. Donors must ensure that interventions are in concert with host government national strategies, responsive to host country needs, and coordinated with both host governments and other partners. Stand-alone service sites managed by individual donors are not desirable or sustainable. In such an environment, attribution is complex, including both "upstream" (system strengthening) and "downstream" (site-specific) activities (see Defining Support for Antiretroviral Treatment above), often with multiple partners supporting the same sites to maximize comparative advantages. OGAC is conducting audits of its current reporting system to refine methodologies for the future, and in the coming fiscal year will further assess attribution and reporting methodologies in collaboration with other donors.



Health care workers travel difficult roads on motor scooters to provide home-based HIV/AIDS treatment and care to rural Ugandans.

Table 2.3 - Treatment[1]: FY04 Progress Toward 2008 Target of 2 Million Individuals Receiving Treatment

Country	2008 Target	Total number of individuals reached[2, 3]	Total percentage of Year Five target met
Botswana	33,000	32,900	100%
Côte d'Ivoire	77,000	4,500	6%
Ethiopia[4]	210,000	9,500	5%
Guyana	2,000	500	25%
Haiti	25,000	2,800	11%
Kenya	250,000	17,100	7%
Mozambique	110,000	5,200	5%
Namibia	23,000	4,000	17%
Nigeria	350,000	13,500	4%
Rwanda	50,000	4,300	9%
South Africa	500,000	12,200	2%
Tanzania	150,000	1,500	1%
Uganda	60,000	33,000	55%
Vietnam[5]	22,000	-	-
Zambia	120,000	13,600	11%
All countries	**2,000,000**	**155,000**	**8%**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnotes:

1 Treatment includes the provision of antiretroviral drugs and clinical monitoring of ART among those with advanced HIV infection in either an ART or a PMTCT+ setting. PMTCT+ includes a minimum package of services - HIV/AIDS counseling and testing for pregnant women; ARV prophylaxis to prevent mother-to-child transmission; counseling and testing for safe infant feeding practices; family planning counseling or referral; ARV therapy for HIV+ women, their children, and their families.

2 Total includes the number of individuals reached through contributions to national, regional, and local activities such as training, laboratory support, monitoring and evaluation, logistics and distribution systems, protocol and curriculum development, and those receiving services at U.S. Government-funded service delivery sites.

3 Numbers are rounded to nearest 100.

4 In FY04, Ethiopia did not use USG funds to provide treatment at service delivery sites.

5 Vietnam received Emergency Plan funds late in FY04 and is not required to report during this cycle.

During this reporting period, to account for Emergency Plan treatment programming, in-country teams counted those activities that supported ART provision, including training, the provision of ARV drugs, clinical monitoring of ART for people with advanced HIV infection, related laboratory services, infrastructure support, and other activities described above. Where downstream service delivery sites were directly supported by U.S. Government funding, distinct individuals receiving services at those sites were counted. Support to a specific site may or may not be in partnership with other funders of HIV prevention, care, and treatment. For example, the U.S. Government may fund the clinical staff delivering ARV treatment, while Global Fund monies support the pharmaceuticals used in the clinic. For support to national treatment programs provided upstream (for which funding is not directly given to a specific service delivery site or program), the Emergency Plan estimated, in conjunction with other partners and national governments, the number of individuals receiving care or treatment as a result of the U.S. Government's contribution to national, regional, or local activities.

President George W. Bush and Laura Bush visit with children while touring the TASO Center of The AIDS Support Organization in Entebbe, Uganda, July 11, 2003.

"You've got 14- and 15-year-old kids raising their brothers and sisters. So part of the effort is to provide love and hope for these brave young kids who have been handed an incredibly tough burden, an awesome burden."

President George W. Bush
June 23, 2004

Chapter 3

Critical Intervention in the Focus Countries: Care

President Bush's Emergency Plan for AIDS Relief (PEPFAR/Emergency Plan) supports a strategy that integrates care for those infected or affected by HIV/AIDS with prevention and treatment, recognizing that worldwide there are 39 million people now living with HIV/AIDS and 14 million children orphaned or made vulnerable by HIV/AIDS. In the Emergency Plan's focus countries, nearly 20 million people are living with HIV/AIDS and at least 8 million children have been orphaned or made vulnerable due to HIV/AIDS. Many of these people are in desperate need of care and support, yet limited resources and capacity exist to mitigate the impact of the HIV/AIDS epidemic on struggling communities and nations.

Beyond the millions who live in daily pain and suffering as a result of HIV/AIDS are millions of orphans left to grow up without the love and support of their parents. Orphans are defined as children under the age of 18 years who have lost either a mother or father, and vulnerable children are those affected by HIV through the illness of a parent or principal caretaker.

Care Summary

Five-Year Goal in the 15 Focus Countries
Support care for 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children

Year One Target
Support care for 1,153,400 people living with HIV/AIDS and orphans and vulnerable children by June 2005

Progress Achieved by September 30, 2004
Supported care for 1.7 million people (150 percent of Year One target), including:

- Care for 630,200 orphans and vulnerable children
- Care for more than 1 million people living with HIV/AIDS, including 241,200 who received care and treatment for tuberculosis
- Counseling and testing for nearly 1.8 million people

Allocation of Resources in Fiscal Year 2004
$142,812,000 to support care for people living with HIV/AIDS and orphans and vulnerable children (25 percent of total resources committed)

Many of these children have experienced the added trauma of caring for their ill parents before they succumbed to the disease. In some countries, like Botswana, orphans and vulnerable children account for 20 percent of all children and more than 75 percent of orphans from all causes. Fully addressing the needs of these children is an enormous challenge.

Family members have traditionally stepped into the breach to care for orphans and people living with HIV/AIDS, but the magnitude of the epidemic has stretched communities to the breaking point. Caring for family, friends, and children infected and affected by HIV/AIDS diverts scarce resources and increases vulnerability as people lose the ability to work and carry out other social responsibilities. The lack of care services fuels stigma and denial - as communities come under increasing strain, rejection and discrimination become more common and individuals who need care are often left to fend for themselves. The fear and hopelessness that result can keep people from acting on vital prevention messages or seeking testing, care, and treatment.

The cycle of care for those infected with HIV begins with HIV testing and a diagnosis of HIV infection. Therefore, counseling and testing is a key entry point to the full spectrum of life-sustaining care and treatment. Counseling and testing plays a role in prevention as well, reducing stigma and identifying important target groups for prevention messages, including discordant couples (couples in whom one person is HIV-positive and the other HIV-negative). Currently, however, fewer than 10 percent of individuals living in resource-poor settings know their HIV status.

The Emergency Plan thus works in concert with national strategies to:

- Support basic needs for orphans and vulnerable children
- Support care for HIV-positive people
- Support counseling and testing for HIV, because knowledge of one's HIV status is the entry point to care

The Emergency Plan has moved rapidly to support the expansion of care services, with the remarkable achievement of supporting care for 1.7 million people living with HIV/AIDS and orphans and vulnerable children in the Plan's first eight months of implementation. The Emergency Plan is well ahead of schedule to reach its June 2005 target of supporting care for 1.1 million people. Although this reporting period covers just the first eight months of the Emergency Plan, already 17 percent of the five-year care target has been reached.

Table 3.1 - Care: FY04 Orphans and Vulnerable Children[1] Results

	Number of OVCs who were served by an OVC program[2]		
Country	**Number receiving upstream system strengthening support[3]**	**Number receiving downstream site-specific support[4]**	**Total**
Botswana	0	5,100	5,100
Côte d'Ivoire	0	100	100
Ethiopia	0	15,100	15,100
Guyana	0	800	800
Haiti	0	300	300
Kenya	0	56,800	56,800
Mozambique	0	46,500	46,500
Namibia	58,600	18,500	77,100
Nigeria	0	4,100	4,100
Rwanda	60	200	260
South Africa	2,500	64,000	66,500
Tanzania	0	12,000	12,000
Uganda	17,500	70,100	87,600
Vietnam	0	87	87
Zambia	0	257,800	257,800
Totals	**78,700**	**551,500**	**630,200**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnotes:

1 Activities for orphans and vulnerable children are aimed at improving the lives of children and families directly affected by AIDS-related morbidity and/or mortality.

2 Numbers above 100 are rounded to nearest 100.

3 Number of individuals reached through upstream systems strengthening includes those supported through contributions to national, regional, and local activities such as training, laboratory support, monitoring and evaluation, logistics and distribution systems, and protocol and curriculum development.

4 Number of individuals reached through downstream site-specific support includes those receiving services at U.S. Government funded service delivery sites.

Esther Okafor, a radio reporter in Lagos, Nigeria, interviews Jennifer, a child whose parents died of AIDS, for a project supported by the Emergency Plan that raises public awareness about the needs of the over 1.3 million orphans and vulnerable children in the country.

Care for Orphans and Vulnerable Children

Results: Rapid Scale-Up

The Emergency Plan includes a range of activities aimed at improving the lives of children and families affected by HIV/AIDS. Activities include caregiver training; access to education; economic support; targeted food and nutrition support; legal aid; medical, psychological, and emotional care; and other social and material support.

President Bush's Emergency Plan moved rapidly to expand services for orphans and vulnerable children, committing $36,322,000 of the resources available in the focus countries. With an emphasis on strengthening communities to meet the needs of orphans and vulnerable children affected by HIV/AIDS, supporting community-based responses, helping children and adolescents meet their own needs, and creating a supportive social environment, these resources led to supportive care for 630,200 orphans and vulnerable children in the 15 focus countries, provided primarily through community- and faith-based organizations. The Emergency Plan also supported antiretroviral treatment for at least 4,800 orphans and vulnerable children living with HIV/AIDS, significantly increasing funds for this important group (see chapter 2, "Critical Intervention in the Focus Countries: Treatment"). Of the 630,200 orphans and vulnerable children who received support from the Emergency Plan, 551,500 received services at sites directly supported by

HOPE for Children in Côte d'Ivoire

Ten-year-old Fidèle has faced a difficult life in Côte d'Ivoire. After his mother and father died of AIDS when he was only 2, he was taken in and raised by a minister and his wife. At age 9, Fidèle tested positive for HIV. When the minister informed his wife of Fidèle's HIV status, anxiety and fear led her to reject the boy, refusing all contact with him. Isolated and confused, Fidèle felt guilty and alone.

During community outreach in Fidèle's village, he met local staff from HOPE Worldwide, an Emergency Plan partner. U.S. funding helps HOPE provide home- and community-based counseling and basic health and nutritional services to thousands of orphans. This support is desperately needed in places such as Côte d'Ivoire, where many children have been orphaned and are often isolated because others assume they have HIV. In Côte d'Ivoire alone, 440,000 orphans are HIV-positive. Most of these children contracted the disease from their mothers during birth or through nursing.

Fidèle never misses a meeting of his HOPE support group, which provides him with psychological support, information about HIV/AIDS, and lots of love. Fidèle also receives medical treatment from a local public health care center that has a special service for HIV-positive children. He has begun taking antiretroviral drugs and his health has radically improved. Fidèle has never completed a year of school because of his frequent illnesses, but now he has joined a tutorial group run by a nongovernmental organization under HOPE's supervision. "He is making fine progress and will be able to attend regular school next year," says Nina Toyo of HOPE.

Fidèle is an example of the impact of the President's Emergency Plan on the lives of vulnerable children in Côte d'Ivoire and around the world.

Services Provided to Orphans and Vulnerable Children by President Bush's Emergency Plan

- Strengthening the capacity of families to identify, locate, protect, and care for orphans and vulnerable children by prolonging the lives of parents and caregivers and by providing therapeutic, economic, psychosocial, and other risk reduction support to orphans and vulnerable children and their families and caregivers
- Mobilizing and supporting community-based responses to provide both immediate and long-term therapeutic and socioeconomic assistance to vulnerable households
- Ensuring access for orphans and vulnerable children to essential services, including education, health care, case management, birth registration, and other resources
- Ensuring that governments protect the most vulnerable children through improved policy and legislation and by channeling resources to communities, particularly those with disproportionate numbers of orphans and vulnerable children with unmet therapeutic and service needs
- Raising awareness at all levels through advocacy and social mobilization to create a supportive environment for children affected by HIV/AIDS

Table 3.2 - Care: FY04 Orphans and Vulnerable Children[1] Capacity Building Results

Country	Number of USG-funded service outlets or programs providing OVC care and support	Total number of individuals trained to provide OVC care[2]
Botswana	15	500
Côte d'Ivoire	2	200
Ethiopia	133	400
Guyana	7	15
Haiti	2	200
Kenya	71	3,900
Mozambique	130	8,400
Namibia	23	1,300
Nigeria	5	300
Rwanda	2	0
South Africa	90	1,900
Tanzania	28	1,000
Uganda	136	2,100
Vietnam	1	0
Zambia	15	2,400
Total[2]	**700**	**22,600**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnotes:

1 Orphans and vulnerable children activities are aimed at improving the lives of children and families directly affected by AIDS-related morbidity and/or mortality.

2 Numbers above 100 are rounded to nearest 100.

In South Africa, children celebrate outside a community-based resource center where orphans and vulnerable children receive food, computer training, help in accessing government support, and the encouragement of adults in their own community.

the U.S. Government, while the remainder were attributed to Emergency Plan contributions to national, regional, and/or local activities such as training, systems strengthening, and policy and protocol development.

Programs supported through the Emergency Plan include a day care center for orphans and vulnerable children in Namibia. Located in a heavily populated neighborhood, the center provides meals, before- and after-school activities, and a preschool for small children. It also links with the school system to ensure that children are attending school and that such barriers as lack of a school uniform or school supplies are addressed. This type of approach not only provides a safe and nurturing environment for children but also offers considerable relief and support to their caregiver families. Another example is a program in South Africa, in which the Emergency Plan is funding mobilization and training of volunteers; this effort

Helping Children by Helping Their Caregivers

Sophia Salamba is a widow in the village of Mache, Kenya. She cares for five young children three of her own and two orphaned boys, Felix and Veron, ages 1 and 4. When a community mentor first visited her household, it was clear that Sophia had given up hope. The entire household was quite dirty, everyone was infected with scabies, and the children were malnourished. Sophia did not welcome the mentor's visits - what was the point?

The mentor did not give up. She was trained by an Emergency Plan-supported program, Speak for the Child, which supports families and communities in caring for young children affected by AIDS. AIDS most drastically affects young children, because they are more vulnerable than older children to disease, malnutrition, and unmet psychosocial needs critical for socialization and survival. The program thus focuses on immunizations, school enrollment, weekly home visits by trained mentors, caregiver support groups, and community action to increase human and financial resources.

Weekly visits from the mentor and continuous counseling on health, nutrition, and psychosocial care for young children finally forged a trusting relationship. Sophia gained the courage to join a caregiver support group and share her story. During the group meetings, other caregivers discussed child care and general life skills for orphan caregivers. Slowly, things began to change.

"We thought we had nothing to offer to the community, but the mentor has enlightened us. We have realized that we actually have a lot of potential and we can do so much by ourselves. The fire in us has been lit." - Rael Khandasi, widow with six children

"Before we were looked down upon after our husbands died, but now … people want to make friends with us. We had lost hope but now we have reason to smile." - Eclay Nashimiyu, grandmother caring for eight children

Sophia's household has now undergone a complete transformation. The scabies are cleared up and the compound is clean. Sophia feeds the children at least three times a day, and she has learned how to combine and enrich meals to increase the nutritional impact of available food. The children are active and healthy.

With funding from the President's Emergency Plan for AIDS Relief, Speak for the Child is now able to expand its services to orphans. While scaling up required a significant investment, the results have been worth the effort. With the increased support from the Emergency Plan, the program rapidly expanded from serving 400 children in March 2004 to 3,300 children by the end of September 2004.

Sophia, for her part, thanks Speak for the Child for coming in when she had given up. In her view, the help she received saved the lives of the children in her care.

reached 4,000 orphans and vulnerable children in fiscal year 2004. The program is training volunteers in seven communities and will establish five new resource centers over the next year. The resource centers offer meals, counseling services, assistance with school fees, life skills training (including computer training), and assistance in obtaining government services.

Sustainability: Building Capacity

The Emergency Plan has supported projects to increase the capacity of families and communities to provide care and support to children affected by the HIV/AIDS pandemic. Activities have included supporting training for 22,600 caregivers, promoting the use of time- and labor-saving technologies, supporting income-generating activi-

ties, and connecting children and families to essential health and other social services where available. After family, the community is the next safety net for children affected by HIV/AIDS. During fiscal year 2004, the Emergency Plan supported 700 service outlets or programs providing care and support for orphans and vulnerable children.

Key Challenges and Future Directions

Scaling up support to families and communities. The evidence is clear that in the vast majority of cases, the best situation for orphaned children is to remain in a family setting within their community. This is difficult, however, and at times overwhelming. Family members are often caring for several children, with few, if any, additional resources. Caregiver families may also have members who are ill with AIDS themselves. Stigma confronts both the children and the families that take them in. There is also a dearth of specialized expertise, such as professionals trained in child psychology and social work. To address these issues, the Emergency Plan will continue to focus resources at the community level, working through community- and faith-based organizations to identify and support best models and practices to bring to scale the support and assistance needed to care for these children.

Quality of programs for orphans and vulnerable children. Given the wide array of community organizations and approaches to care for orphans and vulnerable children, there is a need to develop and institute quality standards for programs and services. There is a growing body of evidence to help define these standards, establish the parameters of a quality program, and monitor to ensure standards are met. The Emergency Plan will pursue these activities in the upcoming year. Many host-country governments and their partners are working to develop a standard package of services for orphans and vulnerable children along with appropriate program monitoring and evaluation. Key to quality care are an enabling political environment and support for family- and community-based programs for orphans and vulnerable children. The Emergency Plan is working with governments to develop and disseminate national policies, develop and implement protocols and guidelines down to the local level, and ensure that these protocols and guidelines incorporate best practices and lessons learned. The President's Emergency Plan has informed communities about policies, rights, and benefits regarding orphans and vulnerable children through information and education campaigns, regional training, and community mobilization activities.

Working with other sectors for a multisectoral approach. The needs of orphans and vulnerable children go far beyond traditional health partners and networks. They require access to food, education, job and skills training, and opportunities. To address these needs, the Emergency Plan is reaching out to new partners to ensure a coordinated holistic approach. For example, programs in Guyana, Kenya, Namibia and Zambia are working closely with the education sector and providing scholarships, uniforms and other basic necessities for children orphaned and made vulnerable by HIV/AIDS. The Emergency Plan will work to strengthen these linkages in the upcoming year.

Leveraging partners and resources. The magnitude of the challenges facing orphans and vulnerable children requires far more resources than those available from the U.S. Government alone. With help from donors and the private sector, countries must also tackle these challenges to ensure that government systems and structures are in place to reach these children. South Africa, for example, is working to strengthen birth registrations and the provision of child support grants to caregiver families.

In many countries, children are orphaned by a host of causes other than AIDS. Uganda, Ethiopia, and Rwanda, for example, are all struggling with large numbers of orphans from a variety of causes. While the focus of the Emergency Plan is to reach children affected by AIDS, close cooperation with host governments, other donors, the private sector, and communities themselves can help ensure that the basic needs of all orphans and vulnerable children for food, shelter, education, and play are met.

Care for People Living with HIV/AIDS

For HIV-positive people, care covers a continuum from diagnosis with HIV infection until death. While the vast

Table 3.3 - Care: FY04 Palliative Care[1] Results						
Country	Number of HIV-infected individuals who received palliative care/basic health care and support[2]			Number of individuals who received TB care and treatment[2]		
	Number receiving upstream system strengthening support[3]	Number receiving downstream site-specific support[4]	Total	Number receiving upstream system strengthening support[3]	Number receiving downstream site-specific support[4]	Total
Botswana	34,400	1,900	36,300	10,300	1,100	11,400
Côte d'Ivoire	0	19,500	19,500	0	7,500	7,500
Ethiopia	0	14,500	14,500	0	1,000	1,000
Guyana	0	300	300	100	15	115
Haiti	0	29,500	29,500	0	300	300
Kenya	0	55,700	55,700	0	59,700	59,700
Mozambique	0	27,700	27,700	0	0	0
Namibia	0	18,100	18,100	0	1,700	1,700
Nigeria	0	39,700	39,700	0	0	0
Rwanda	3,600	12,100	15,700	400	1,500	1,900
South Africa	354,400	47,100	401,500	128,600	3,300	131,900
Tanzania	0	13,400	13,400	0	200	200
Uganda	6,600	148,000	154,600	0	10,300	10,300
Vietnam	0	900	900	0	33	33
Zambia	0	27,400	27,400	0	15,100	15,100
Totals	**399,000**	**455,800**	**854,800**	**139,400**	**101,700**	**241,100**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnotes:

1 Palliative care includes all clinic-based and home/community-based activities aimed at optimizing quality of life of HIV-infected (diagnosed or presumed) clients and their families throughout the continuum of illness by means of symptom diagnosis and relief; psychological and spiritual support; clinical monitoring and management of opportunistic infections including TB and malaria and other HIV/AIDS-related complications; culturally appropriate end-of-life care; social and material support such as nutrition support, legal aid, and housing; and training and support for caregivers.

2 Numbers above 100 are rounded to nearest 100.

3 Number of individuals reached through upstream systems strengthening includes those supported through contributions to national, regional, and local activities such as training, laboratory support, monitoring and evaluation, logistics and distribution systems, and protocol and curriculum development.

4 Number of individuals reached through downstream site-specific support includes those receiving services at U.S. Government-funded service delivery sites.

majority of HIV-positive people do not meet clinical criteria for antiretroviral treatment (ART), they nonetheless need basic health care, symptom management, social and emotional support, and compassionate end-of-life care. Basic health care and support includes routine monitoring of disease progression and prophylaxis and treatment of opportunistic infections, cancers, and other complications of immune suppression, such as waterborne diseases and tuberculosis. This holistic approach to the full spectrum of care services from the time of a diagnosis of HIV infection until death is considered to be palliative care. Building upon definitions of palliative care developed by the U.S. Department of Health and Human Services and the World Health Organization, President Bush's Emergency Plan supports an interdisciplinary holistic approach and interventions to relieve physical, emotional, and practical suffering.

Results: Rapid Scale-Up

A total of $62,589,000 was devoted to care for people living with HIV/AIDS in the Emergency Plan's focus countries in the first eight months of Plan activities. These funds achieved rapid and significant results. During the reporting period, the Emergency Plan supported care for more than 1 million adults and children living with HIV/AIDS, almost achieving the June 2005 overall care goal of 1,153,400 with this category of care alone. Overall, 11 percent of resources available for programs in the 15 focus countries were dedicated to care for HIV-positive people.

Of this amount, $28,473,000 was for clinical care and support (including routine clinical follow-up for people not yet requiring ART and diagnosis and treatment of tuberculosis) and $34,116,000 was used in programs supporting symptomatic relief, psychosocial services, and

Basic Palliative Care Services Provided Through the Emergency Plan

Palliative care comprises a broad range of services including physical, psychological, and social support services with the following elements:

- Routine clinical monitoring and management of HIV/AIDS complications
- Opportunistic infection prophylaxis and treatment (e.g., cotrimoxasole, bed nets for malaria, treatment for mycobacterium tuberculosis infection)
- Management of opportunistic cancers
- Management of neurological and other HIV/AIDS-associated diseases
- Symptom diagnosis and relief, including pain control
- End-of-life care, including bereavement support for family members
- Mental health care and support
- Social support, including organization of basic necessities such as nutrition, financial assistance, legal aid, housing, and permanency planning
- Support for caregivers

Table 3.4 - Care: FY04 Palliative Care[1] Capacity Building Results

Country	Number of USG-funded service outlets or programs providing palliative care[2]	Total number of individuals trained to provide palliative care[2]
Botswana	1	34
Côte d'Ivoire	33	200
Ethiopia	200	900
Guyana	2	38
Haiti	34	300
Kenya	1,800	6,000
Mozambique	71	6,800
Namibia	200	1,600
Nigeria	100	800
Rwanda	300	1,200
South Africa	1,100	5,200
Tanzania	200	900
Uganda	700	3,200
Vietnam	14	1,000
Zambia	600	8,500
Totals	**5,400**	**36,700**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnotes:

1 Palliative care includes all clinic-based and home/community-based activities aimed at optimizing quality of life of HIV-infected (diagnosed or presumed) clients and their families throughout the continuum of illness by means of symptom diagnosis and relief; psychological and spiritual support; clinical monitoring and management of opportunistic infections including TB and malaria and other HIV/AIDS-related complications; culturally appropriate end-of-life care; social and material support, such as nutrition support, legal aid, and housing; and training and support for caregivers.

2 Numbers above 100 are rounded to nearest 100.

end-of-life care for people with AIDS. The population receiving care included 455,800 people who received services at U.S. Government-supported sites.

In addition to providing support to sites that deliver HIV/AIDS care services, the Emergency Plan also supports national strategies, filling specific gaps in national training, laboratory systems, and strategic information systems (e.g., monitoring and evaluation, logistics, and distribution systems) essential to the effective roll-out of quality care.

HIV/AIDS and tuberculosis are a deadly combination. HIV/AIDS is fueling a resurgence of TB in resource-limited settings. In many areas of the 15 focus countries, upwards of 50 percent of people living with HIV/AIDS are co-infected with TB, which is a leading cause of death in HIV-positive people. Because of the key and tragic synergy between HIV/AIDS and TB, the Emergency Plan monitors programs dedicated to people living with HIV/AIDS-TB co-infection. During the reporting period, the Emergency Plan supported TB care and treatment for 241,100 co-infected people. This included diagnosis of latent TB infection, treatment to prevent the development of active disease, and general TB-related care. Of the 241,100 adults and children who received TB care, 101,700 received it at U.S. Government-supported delivery sites, while the remainder received support through U.S. Government contributions to national, regional, and local programs.

Sustainability: Building Capacity

Effective care for people living with HIV/AIDS requires the support of a network of health providers connected to a fully engaged community with an aggressive outreach to people in their homes. The involvement of community- and faith-based groups, which have led home-based care in many focus countries, is key to success. The

Emergency Plan is strengthening the capacity of HIV care systems by building on and widening networks that connect clinic facilities with higher-level providers to home-based care programs. The Emergency Plan is also strengthening referral systems to ensure that families have access to other resources beyond their medical needs. To achieve this, in fiscal year 2004 the Emergency Plan supported training for 36,700 care providers in the focus countries. A total of 5,400 service sites received support for personnel, infrastructure development, logistics, strategic information services, and many other components of delivering quality care services.

Key Challenges and Future Directions

Human capacity. As with prevention and treatment, a key challenge to the delivery of quality palliative care is a lack of well-trained providers. Unfortunately, nurses, the mainstay of care services in the health sector, are in short supply in the focus countries both due to the limited number being trained and "brain drain" from resource-limited to wealthier settings. The supply of other health care providers is also limited. Volunteers, an integral part of care delivery in resource-limited settings, can help fill these gaps, but many are now being hired away as resources become available, threatening the fabric of traditional care systems. Those engaged in the compassionate work of caring for the sick and dying are often overworked with emotionally and physically draining tasks.

The Emergency Plan is addressing these issues through the expansion of existing networks and the development of new networks linking care services to ART services. On-the-job training, preservice training to provide HIV/AIDS education to health care professionals before they enter the workforce, certificate programs to train existing health care professionals, and other training projects are ramping up. Pilot projects on innovative approaches for volunteer remuneration and incentives show encouraging results. A growing number of programs that use the experience and expertise of people living with HIV/AIDS in providing care are being developed. However, much work remains to fill the gap between the number of people who need care and the number of people able to provide it.

Changing key policies that limit care. In certain circumstances, national policies restrict the ability of health aides, including nurses, to carry out important care activities such as prescribing medications to prevent and treat opportunistic infections or control symptoms and pain. Policies are needed to advance quality home-based care and ensure that quality care is a priority. In particular, the integration of a holistic physical, psychological, and supportive approach to end-of-life care is crucial. There are few hospice programs in resource-limited settings, and end-of-life care has received little attention. In many settings, opioids have not been registered for the relief of suffering. The Emergency Plan aggressively promotes policies that will enhance the care of people living with AIDS. The South African Palliative Care Association, for example, has been engaged to provide regional support for basic care and end-of-life care.

In resource-poor settings, the Emergency Plan helps local health systems retain quality health care personnel, like these nurses in Guyana.

The Emergency Plan has developed a "basic preventive care package" that includes key support and preventive therapies such as medications to prevent opportunistic infections and bed nets to prevent malaria. Pilot projects and national programs are being supported to scale up such support, but more efforts are needed to ensure that those in need receive the components of basic care.

Addressing burdens on women and girls. It is well documented that the burden of care for people living with HIV/AIDS falls heavily on the shoulders of women and

girls, both at the clinic and community levels; thus the availability and accessibility of comprehensive quality care at the community level will greatly relieve burdens on women and girls. The Emergency Plan is working to integrate comprehensive care in health networks that reach to the community and even household level. The Plan is also engaging in policy advocacy to increase women's and girls' access to and control over resources. In addition, community outreach projects are underway to spread the burden of care more widely. For example, pilot projects in Haiti, Ethiopia, Namibia, and other countries target and support men as care providers. These strategies will limit the emotional, physical, and financial toll of caring for HIV-positive people and reduce the burdens on women and girls. Chapter 4 of this report discusses gender-related issues in more detail.

Food and nutrition. Basic nutrition is important in the care of HIV-positive people, including those who are receiving ART. The Emergency Plan works to leverage resources from other U.S. Government sources, such as USAID's Title II program, and from other donors, including the World Food Program. The Emergency Plan also provides limited resources for food and nutritional support for people living with HIV/AIDS. The Emergency Plan will redouble efforts to better leverage resources, looking for a wider spectrum of partnerships, including those with private sector, in the coming months and years. The Office of the U.S. Global AIDS Coordinator (OGAC) has spearheaded the creation of an interagency technical working group on food and nutrition, with participation from the U.S. Department of Agriculture, USAID, and the U.S. Department of Health and Human Services, which is making progress in identifying specific program partnerships that will result in comprehensive coverage for people infected and affected by HIV/AIDS.

SUCCESS Scales Up Community Care in Zambia

Muleta Yuyi, a 49-year-old Zambian police officer and father of eight children, struggled to go to work for two years and feared losing his much-needed job. Weakness and weight loss resulting from AIDS-related illnesses often confined him to bed. When caregivers from the Emergency Plan-supported SUCCESS home-based care project visited Muleta for the first time in early 2004, he weighed only 77 pounds.

SUCCESS (which stands for Scaling Up Community Care to Enhance Social Safety-nets) started in October 2003. The project scaled up rapidly in four Catholic dioceses in Mansa, Mongu, Mpika, and Solwezi provinces, increasing the number of clients and caregivers, expanding the package of palliative care service delivery, improving the quality of care rendered to clients, and adding distribution of locally procured nutritional supplements. Emergency Plan funding enabled the project to add nutritional supplements for the project's home-based care clients. With Emergency Plan funds, in May 2004 the project purchased high-energy protein supplements and cooking oil to distribute to households with members who were severely ill with AIDS and malnourished. Muleta was one of the first recipients of these nutritional supplements. Over three months, his health progressively improved and he gained more than 22 pounds. By the end of August, Muleta weighed 115 pounds. His latest weight check in October showed a 70-pound weight gain. In less than five months, Muleta's health improved dramatically enough for him to return to his daily work as a police officer. SUCCESS has distributed nutritional supplements to more than 7,000 home-based care patients like Muleta.

Adequate nutrition is a critical component of palliative care for people living with AIDS. Food supplements can be the difference between life and death for many chronically ill AIDS patients by helping them regain their strength and improve their health status. In countries like Zambia, where antiretroviral drugs are not yet readily available countrywide, nutritional food supplements can prolong life and give people with AIDS the chance to seek treatment.

Table 3.5 - Care: FY04 Counseling and Testing Services Results						
Country	Number of individuals receiving upstream system strengthening support[1, 3]	Number of individuals receiving downstream site-specific support[2, 3]				Total number of individuals receiving counseling and testing[3]
		Total	Male[4]	Female[4]	Percent Female[5]	
Botswana	49,500	56,200	26,900	29,300	52%	105,700
Côte d'Ivoire	3,400	27,000	12,100	14,900	55%	30,400
Ethiopia	0	62,900	31,400	31,500	50%	62,900
Guyana	900	8,000	1,000	7,000	88%	8,900
Haiti	0	77,500	39,100	38,400	50%	77,500
Kenya	74,200	275,800	163,200	112,500	41%	350,000
Mozambique	0	138,800	66,600	72,300	52%	138,800
Namibia	2,500	12,500	4,500	8,000	64%	15,000
Nigeria[6]	0	22,200	-	-	-	22,200
Rwanda	24,000	80,000	42,200	37,900	47%	104,000
South Africa	177,900	58,000	22,500	20,600	36%	235,900
Tanzania	0	105,100	54,500	50,600	48%	105,100
Uganda	150,000	308,700	137,400	171,300	55%	458,700
Vietnam	0	23,200	15,600	7,700	33%	23,200
Zambia	0	53,600	20,600	32,900	61%	53,600
Totals	**482,400**	**1,309,500**	**637,600**	**634,900**	**52%**	**1,791,900**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnotes:

1 Number of individuals reached through upstream systems strengthening includes those supported through contributions to national, regional, and local activities such as training, laboratory support, monitoring and evaluation, logistics and distribution systems, and protocol and curriculum development.

2 Number of individuals reached through downstream site-specific support includes those receiving services at U.S. Government funded service delivery sites.

3 Numbers are rounded to nearest 100.

4 Information on the gender breakdown of individuals served is only collected at USG-supported sites.

5 Percentage Female for all countries is calculated as an average for those countries that reported females.

6 In FY04, systems in Nigeria were unable to capture gender-specific counseling and testing data. These data will be available in FY05.

Involvement of people living with HIV/AIDS. Largely because of stigma and discrimination, there is limited involvement and leadership of people living with HIV/AIDS in care activities (as well as prevention and treatment activities). However, several focus countries are improving this situation. In Ethiopia and Namibia, for example, the Emergency Plan is supporting organizations of people living with HIV/AIDS in providing care, treatment literacy, and adherence counseling. In addition, the Emergency Plan will scale up its funding for support groups for people living with HIV/AIDS.

Secure and reliable supply chain for drugs and commodities. As with antiretroviral drugs, a consistent and secure supply chain for commodities and medications is necessary for quality care. The Emergency Plan has issued a call for applications to develop a secure and reliable supply chain management system (see Key Challenges and Future Directions in chapter 2, "Critical Intervention in the Focus Countries: Treatment").

Through mobile testing and counseling sites, Emergency Plan partners in Tanzania are bringing services to remote areas.

Table 3.6 - Care: FY04 Counseling and Testing Capacity Building Results		
Country	**Number of USG-funded service outlets providing counseling and testing[1]**	**Total number of individuals trained in counseling and testing[1]**
Botswana	28	47
Côte d'Ivoire	18	100
Ethiopia	100	600
Guyana	7	42
Haiti	58	600
Kenya	300	1,500
Mozambique	87	400
Namibia	15	400
Nigeria	48	200
Rwanda	28	300
South Africa	900	3,300
Tanzania	100	500
Uganda	300	4,800
Vietnam	37	400
Zambia	100	900
Totals	**2,100**	**14,100**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnote:

1 Numbers above 100 are rounded to nearest 100.

HIV Counseling and Testing

Entry into care or treatment for people living with HIV/AIDS begins with a diagnosis of HIV infection. Therefore, counseling and testing is a key entry point to the full spectrum of life-sustaining care and treatment. Counseling and testing plays a role in prevention as well, reducing stigma and identifying important target groups for prevention messages, including discordant couples (couples in whom one person is HIV-positive and the other HIV-negative). Despite the obvious need for counseling and testing, access remains extremely difficult. Barriers to services include distance from facilities, the absence of trained providers and rapid tests, and enormous psychological barriers as a result of stigma and the threat of violence against those thought to be HIV-positive. Even in situations where the majority of patients are likely to be HIV-positive (hospital wards, for example), testing is often not available. Increasing access to and use of testing is a central component of the Emergency Plan's global strategy, and the Plan is making considerable progress in this area.

Results: Rapid Scale-Up

With Emergency Plan support, nearly 1.8 million people in the Plan's focus countries received counseling and testing services. Of these, 1,309,500 received these services at U.S. Government-supported sites. Emergency Plan support for strengthening countries' capacity to provide services (including assistance for national and regional policies, communications, protocols to ensure quality services, laboratory support, and purchase of test kits) enabled another 482,400 people to receive counseling and testing services. Because of the key role of counseling and testing in achieving care, treatment and prevention goals, $43,901,00, or 7.7 percent of resources available to the focus countries in fiscal year 2004, were committed to counseling and testing.

Stigma, discrimination, and cultural barriers often inhibit the participation of women in counseling and testing. Of those receiving counseling and testing at a U.S. Government-supported site, 634,900 (or 52 percent) were female.

Sustainability: Building Capacity

As the nexus for effective care, prevention, and treatment programs, it is essential that counseling and testing services be rapidly expanded to ensure that people living with HIV/AIDS learn their status. Capacity needs include the development of counseling and testing sites, the provision of equipment and commodities, and support for training. The Emergency Plan's results for fiscal year 2004 were impressive - 14,100 individuals, including counselors and people able to perform HIV tests, received training, and 2,100 counseling and testing sites in the 15 focus countries received important support.

Key Challenges and Future Directions

Increasing the number of people tested. To reach the care and treatment goals of the Emergency Plan, tens of millions of people will need to receive counseling and testing. Identifying people living with HIV/AIDS is the key step in reaching this goal. While the first-year results are impressive, a massive scale-up in counseling and testing is required. Several activities of the Emergency Plan in fiscal year 2004 laid the groundwork for success in moving forward. The most effective HIV counseling and test-

Supporting Integration of Provider-Initiated HIV Counseling and Testing into Antenatal Care in Botswana

Supporting national strategies for providing care services is central to the President's Emergency Plan. In Botswana, the United States is supporting a national strategy to increase counseling and testing.

President Festus Mogae announced a new testing strategy in his 2003 Christmas message to the nation. Beginning in 2004, HIV testing would be integrated into routine health care visits in public settings, with patients having the right to "opt out" if desired. The goal of the new provider-initiated strategy was to normalize testing and increase uptake of HIV prevention, care, and treatment services by citizens.

Accordingly, the United States collaborated with Botswana's national program for preventing mother-to-child HIV transmission (PMTCT) to implement and evaluate a model for provider-initiated antenatal HIV testing in 12 clinics in Francistown. Four large clinics received intensive support to implement the new model, while eight more clinics received training alone.

The U.S.-Botswana team designed a testing model that included group education sessions for pregnant women. During these sessions, women were informed that they had the right to "opt out" of any medical tests or procedures, as well as to speak to a counselor privately. Women were then tested as part of their antenatal care and provided individual post-test counseling for all tests, including HIV. For women who tested HIV-positive, post-test counseling focused on PMTCT, psychosocial support, and medical care.

Early results from the focus sites indicate that more women prefer provider-initiated HIV testing than voluntary testing (91 percent and 76 percent, respectively). Integration of HIV testing into antenatal care has not adversely impacted care-seeking behavior.

The national PMTCT program has endorsed the Francistown model for provider-initiated HIV testing during antenatal care, and the Emergency Plan is collaborating in scaling up the model nationally. The four focus clinics are used as demonstration sites; midwives and counselors from all other districts in Botswana visited the clinics on study tours in August 2004. The patient discussion guide will soon be distributed to antenatal care clinics nationwide, helping to ensure that pregnant women receive consistent and accurate information as part of HIV testing.

ing programs target testing of people with a higher likelihood of being HIV-positive than the general population. The Emergency Plan is aggressively encouraging provider-initiated voluntary counseling and testing (formerly known as "routine testing") of pregnant women, people with tuberculosis or a sexually transmitted infection, and those entering medical facilities. National leaders are recognizing the importance of this issue. In 2004, President Festus Mogae of Botswana, for example, declared provider-initiated testing a national policy.

Increasing the number of people who obtain their results. Not all people who undergo testing receive their results. In certain settings it can take more than one month to obtain laboratory results, and as many as half the people who consent to a test might not return to receive them. Rapid testing can lead to a significant increase in the number of people who know their HIV status. The Emergency Plan has and will continue to strongly promote and support the use of rapid tests. In fiscal year 2004, Namibia moved to rapid testing with Emergency Plan support.

Table 3.7 - Care[1]: FY04 Progress Toward 2008 Target of 10 Million Individuals Receiving Care and Support			
Country	**2008 target**	**Total number receiving care and support services[2, 3]**	**Total percentage of Year Five target met**
Botswana	165,000	52,800	32%
Côte d'Ivoire	385,000	28,100	7%
Ethiopia	1,050,000	30,600	3%
Guyana	9,000	1,215	14%
Haiti	125,000	30,100	24%
Kenya	1,250,000	172,200	14%
Mozambique	550,000	74,200	13%
Namibia	115,000	96,900	84%
Nigeria	1,750,000	43,800	3%
Rwanda	250,000	17,860	7%
South Africa	2,500,000	599,900	24%
Tanzania	750,000	25,600	3%
Uganda	300,000	252,500	84%
Vietnam	110,000	1,020	1%
Zambia	600,000	300,300	50%
Totals	**10,000,000**	**1,727,100**	**17%**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined.

Footnotes:

1 Care and support includes the areas of Palliative Care: Basic Health Care & Support; Palliative Care: TB/HIV; and Orphans and Vulnerable Children.

2 Total includes the number of individuals reached through contributions to national, regional, and local activities such as training, laboratory support, monitoring and evaluation, logistics and distribution systems, and protocol and curriculum development, and those receiving services at U.S. Government-funded service delivery sites.

3 Numbers above 100 are rounded to nearest 100.

Increasing partner testing. Partner testing is important to increase the number of people who know their status and who know about HIV prevention methods. Innovative pilot programs (sometimes dedicated exclusively to couples) include facilitating access to counseling and testing in the evenings and on weekends to encourage men to get tested. A pilot couple counseling project in Rwanda has been highly successful. Another innovative approach is home-based testing. Not only can partners be tested in the home, so can other family members, including children. The results from pilot projects are encouraging; in rural Uganda, uptake of home-based testing has exceeded 90 percent.

Increasing the number of women tested. With more than 634,900 women and girls receiving counseling and testing (52 percent of those for whom gender was reported), the Emergency Plan made great strides in fiscal year 2004, but much work remains. Each of the key challenges and future directions mentioned above relates to the effective care of women, in particular those for increasing provider-initiated testing in pregnant women, programs that encourage partner testing, and programs that help to reduce the stigma and cultural barriers that inhibit women's access to services. In certain countries, the percentage of women and girls being counseled and tested meets or exceeds the percentage of HIV-infected women and girls in the population. The Emergency Plan will continue to strengthen its efforts to ensure full and equal access, free of stigma and discrimination, to counseling and testing and the care and prevention services that follow. The Emergency Plan will expand programs that address complex issues such as disclosure of HIV status, stigma, discrimination, and violence.

Accountability: Reporting on the Components of Care

The Emergency Plan supports national HIV/AIDS treatment strategies, leveraging resources in coordination with host-country multisectoral organizations and other donors to ensure a comprehensive response. Host nations must lead a multisectoral national strategy for HIV/AIDS for an effective and sustainable response. Donors must ensure that interventions are in concert with host government national strategies, responsive to host country needs, and coordinated with both host governments and other partners. Stand-alone service sites managed by individual donors are not desirable or sustainable. In an environment with both "upstream" (system strengthening) and "downstream" (site-specific) activities (see "Defining Support for Antiretroviral Treatment" above) often with multiple partners supporting the same sites to maximize comparative capabilities, attribution is complex. OGAC is conducting audits of its current reporting system to refine methodologies for the future, and in the coming fiscal year will further assess attribution and reporting methodologies in collaboration with other donors.

During this reporting period, results for Emergency Plan care programming were determined by totaling all the programs, services, and activities aimed at optimizing quality of life for orphans and vulnerable children; at car-

ing for patients and their families throughout the continuum of illness; and at diagnosing HIV-infection through counseling and testing.

Activities aimed at improving the lives of children and families directly affected by AIDS-related morbidity and/or mortality are counted as orphans and vulnerable children programs. These may include training caregivers; increasing access to education; economic support; targeted food and nutrition support; legal aid; medical, psychological, and emotional care; and/or other social and material support. Institutional responses are also included.

Given the need to independently account for TB prevention, care, and treatment, palliative care totals are made up of two service categories - basic health care and support and TB/HIV care and support. Basic health care and support includes all clinic- and home/community-based activities aimed at optimizing quality of life of HIV-infected (diagnosed or presumed) clients and their families by means of symptom diagnosis and relief; psychological and spiritual support; clinical monitoring and management (and/or referral for these) of opportunistic infections, including malaria and other HIV/AIDS-related complications; culturally appropriate end-of-life care; social and material support, such as nutrition support, legal aid, and housing; and training and support for caregivers. TB/HIV care and support activities include examinations, clinical monitoring, treatment, and prevention of tuberculosis in HIV palliative care settings as well as screening and referral for HIV testing and TB-related clinical care. U.S. Government in-country staff derive these counts from program reports and health management information systems.

In the area of HIV testing, results report on numbers of individuals trained, numbers of sites where HIV testing is supported, and numbers of individuals tested, disaggregated by gender. Equipment and commodities, in particular test kits, are provided through the program and are inventoried and tracked through standard U.S. Government reporting and accounting systems by the grantees acquiring the goods.

Through an Emergency Plan-supported partnership between Moi University in Kenya and Indiana University, Kenyan women living with HIV/AIDS benefit from a comprehensive program that provides antiretroviral treatment as well as income-generating opportunities.

"Jennifer Birungi is a widow who lives in Uganda's capital, Kampala. She has two children. She has HIV, and earlier this year she was diagnosed with meningitis … Without treatment, her life expectancy would have been six days. Because America acted, because the American people acted, she's getting treatment, and the extra years she now hopes for will mean everything to her children."

President George W. Bush
June 23, 2004

Chapter 4

Gender and HIV/AIDS: Responding to Critical Issues

The President's Emergency Plan for AIDS Relief (PEPFAR/Emergency Plan) recognizes that social inequalities between women and men, in conjunction with harmful gender-based cultural norms and practices, not only perpetuate women's vulnerability to HIV but also continue to fuel the HIV epidemic among both men and women. Strategies to address these issues, critical to achievement of the President's "2-7-10" goals in the focus countries, are highlighted in the U.S. Five-Year Global HIV/AIDS Strategy and incorporated in the Emergency Plan's prevention, treatment, and care efforts. Specifically, the Emergency Plan is supporting interventions to increase gender equity in HIV/AIDS programs and services, reduce violence and coercion, address male norms and behaviors, increase women's access to income and productive resources, and increase women's legal protection. Planned activities for fiscal year 2005, the first year for which data will be consistently available, already indicate that 32 percent of all Emergency Plan program activities will have a component addressing gender issues.

Issues and Challenges

The number of women and girls living with HIV is growing rapidly. In 1998, 41 percent of adults living with HIV were women; this number rose to 50 percent by 2004. Sixty percent of people living with HIV in sub-Saharan Africa are female. Girls and young women are especially at risk. In some of the worst-affected countries, girls between the ages of 15 and 19 are infected at rates three to six times higher than boys their age. This disproportionate impact is linked to biology and to harmful gender-based societal norms and practices. Women, especially young women, are biologically more susceptible to HIV infection than men; male-to-female transmission of HIV is estimated to be eight times more likely than female-to-male. Harmful social norms and practices include those that 1) restrict women's access to HIV/AIDS information and services; 2) severely limit women's control over their sexual lives, leaving them vulnerable to sexual violence and abuse as well as putting them at increased risk of HIV transmission; and 3) deprive them of economic resources and legal rights necessary to protect themselves from HIV/AIDS and contribute productively to caring for others affected by the disease. Some of the implica-

At a youth club sponsored by the Emergency Plan in Ethiopia, teenage girls learn skills to protect themselves from violence and HIV/AIDS.

tions of these challenges are introduced in chapter 1, "Critical Intervention in the Focus Countries: Prevention."

Results

Increasing gender equity in HIV/AIDS programs and services. Emergency Plan-supported programs are designed to provide equitable access to services for both women and men; ensure that women and girls are educated about HIV/AIDS; and meet the unique needs of women and girls, including orphans and victims of sex trafficking, rape, abuse, and exploitation. In focus countries where gender-specific data are available, during fiscal year 2004 approximately one-half of individuals in contact with community-based abstinence and faithfulness programs (more than 8 million women) were female, and more than half of those impacted by comprehensive community-based prevention programs were women (approximately 4 million). Approximately 52 percent of all those accessing counseling and testing services were women, and nearly 1.3 million pregnant women accessed prevention of mother-to-child transmission (PMTCT) services.

Women in Africa, who are disproportionately infected with HIV, in particular must be ensured access to quality antiretroviral treatment (ART). During the first reporting period, not all sites captured the number of women and girls receiving ART; however, among the sites reporting such numbers, 56 percent of new clients receiving ART were female. Reporting by sex and age will improve significantly in the coming years.

In Côte d'Ivoire, a family-centered approach to care and treatment is reaching women and providing increased access to ART. The Emergency Plan supports PMTCT-Plus services for pregnant women and their newborns, partners, and other children through two community-run maternal and child health clinics in the most densely populated areas of Abidjan. Since opening in August 2003, they have served 446 HIV-positive pregnant or delivering women. These women serve as an entry point to building a family care HIV program. To date, 192 HIV-infected women and 27 of their children have started ART. Among the women's partners, 116 have come for testing, with 64 testing HIV-positive and 33 starting ART. At the U.S. Government-supported HEART Project, which operates in a large government-run primary care center in Abidjan, a dedicated HIV clinic for adults and another for children have enrolled 2,217 people living with HIV/AIDS, including 1,177 women and 338 children, in the last six months. Of those, 966 are receiving ART, including 526 women and 213 children.

Another program in Haiti is geared to meet the needs of women in rural areas through mobile PMTCT and ART services. The Emergency Plan is funding a local Haitian health organization to provide HIV care and treatment to women with limited access to established health facilities. Since July 2003, more than 5,000 pregnant women at 26 monthly mobile clinic sites have been counseled and tested for HIV. HIV-positive women are provided nevirapine or triple-drug therapy to prevent mother-to-child transmission. They also receive antenatal care, counseling, family planning services, and food supplementation (with joint funding from USAID's Title II program). To date, 350 women who qualify also are enrolled in an ART program.

Reducing violence and coercion. A strong relationship exists between sexual and other forms of abuse against women and their risk of being HIV-infected. Additionally, fear of violence from community members as well as partners keeps women from seeking HIV infor-

mation, getting HIV counseling and testing, and receiving care. The Emergency Plan is committed to reducing men's violence against women; supporting women in mitigating potential violence, especially in the context of disclosing their HIV status; and linking HIV programs with community and social services to prevent gender-based violence, strengthen conflict resolution skills, and protect and care for victims.

In order to prevent violence and coercion against women and girls, it is essential to target youth as well as adults. Emergency Plan-supported programs in Botswana and Kenya, for example, are working with youth to tackle issues of violence and sexual abuse, including messages in education-entertainment interventions, youth-focused newspapers and other publications, discussion forums, videos, Web sites, and negotiation skills workshops.

The "Lifeline Childline" program in Namibia is an example of a program addressing the roots of gender violence. It uses age-appropriate messages to teach girls and boys about HIV/AIDS, sexual abuse, domestic violence, and the resources available to vulnerable children through specialized counseling and other services. An estimated 16,000 children and teachers in more than 35 schools are benefiting from this program.

In Vietnam, the "Men in the Know" program provides training through workshops for men to promote safer sex within relationships and challenges the social norms prevalent in some communities that contribute to the sexual abuse of women.

Addressing male norms and behaviors. Practices such as multiple sex partners, cross-generational sex, and transactional sex increase vulnerability to HIV infection, particularly among women and girls. These risky practices are perpetuated by norms that reinforce such behaviors among men and leave women and girls with few options to avoid them. Emergency Plan prevention efforts recognize that these deep-seated norms must be addressed in order to achieve the widespread behavior change necessary to curb the HIV epidemic.

People Living with HIV/AIDS Free a Woman from Her Chains

The silhouette of a thinning and weak 32-year old Zambian woman is seen against a row of iron-framed hospital beds. Fortunately, the woman is recovering and will soon be released. She first became sick following the death of her husband, whose cause of death was unknown. As her condition deteriorated, she progressed to dementia. Based on their traditional belief system, her family believed that the ghost of her deceased husband was following her and causing the mental illness. The woman was taken to the village to seek a traditional cure. When traditional medicine failed, her family brought her back to Lusaka and chained her to a tree for over a month.

A support group for people living with HIV/AIDS in the local community learned of the woman's plight and sought to help. When the group arrived, they found her seated with a blanket covering the shackles that bound her feet and hands. After the group pleaded on her behalf, the woman's family consented to allow her to receive medical care, and she was admitted to the hospital. Now, she is receiving antiretroviral therapy and is on the road to recovery.

The support group had been funded by the United States - in fact, all Emergency Plan and Zambian government-sponsored clinics offer such support groups. These are groups of mostly HIV-positive members who have banned together for emotional support. They take a holistic approach to looking out for each other by helping with adherence to drug regimens, running errands, helping with transportation and baby-sitting, and growing and selling food. In a culture based on the extended family, this network of support groups is rapidly becoming a crucial extension of family.

> *" Because of the lack of recreation, drinking and [having] sex is what people do for recreation. The training the men have in taking risks informs them [about] taking risks where their sexual life is concerned ... It will take talking, teaching, soul searching. We're talking about changing the inside of a person ... You can teach a soldier to dress properly, you can teach a soldier to march properly. But to change his insides will take a lot more effort." -* A Zambian military officer who has championed a program of follow-up activities

For example, the Emergency Plan is working with the Zambian Defense Force to train peer educators and commanding officers to raise awareness in the military about the threat posed by HIV/AIDS, and to enlist their support in addressing it. Training workshops cover basic facts about HIV/AIDS and its impact, including transmission, prevention, stigma, sexuality, gender, positive living, counseling and testing, and care. Due to the popularity of the workshops, they have been extended to include officers' spouses, dependents, daily employees, and nearby civilian communities.

In Kenya, outreach activities with Maasai communities supported by the Emergency Plan have led to changes in traditional practices that eliminate high-risk sexual behavior but preserve cultural heritage. For example, new cohorts of warriors are renouncing the practice of being honored by young women with sexual favors. At a recent ceremonial gathering, a polygamous Maasai man addressed his peers and said, "Now it is high time for us to go back to our families and come up with family-based resolutions on how to keep to our marriage vows."

With Emergency Plan support, several health centers in Rwanda's Gitarama and Byumba provinces have initiated highly successful programs to engage men in PMTCT services. Partners are invited discreetly (via letters from health facility staff) to accompany women to prenatal visits and receive voluntary counseling and testing. They participate in reproductive health services provided to their partners such as prenatal counseling. Associated community activities work to change male attitudes and behaviors that compromise their own health as well as the health of women and children. Partner involvement has grown dramatically as a result of these activities. At one clinic, 88 percent of partners are now coming for HIV counseling and testing, up from 10 percent in December 2002. In fact, the majority of women's partners now come to PMTCT counseling sessions without receiving the invitation letter.

The Emergency Plan also is addressing gender norms that govern caring for people with HIV. Although women traditionally bear the responsibilities of providing home-based care for people living with HIV/AIDS, the Emergency Plan aims to alleviate some of this burden by supporting innovative programs to help men play a more active role. In South Africa, for example, the Emergency Plan supports a very successful male involvement program known as "Men As Partners." In addition to dealing with HIV/AIDS prevention issues that include masculinity, stigma, and domestic violence, men are encouraged to assume a larger share of responsibilities for family and community care by spending more time with their children, mentoring young boys in the community, and visiting terminally ill AIDS patients.

Increasing women's access to income and productive resources. For many disadvantaged women and girls, transactional sex is one of the few options available to them for survival. The Emergency Plan recognizes that efforts must be undertaken to ensure more sustainable livelihoods for women and girls in order to enable them to escape prostitution, protect themselves from HIV/AIDS, and deal with its impact. Several programs are under way to address this critical issue and others, including public-private partnerships and linkages with U.S. Government-supported economic development and microfinance programs, are in development.

At a clinic in South Africa, for example, training in beadcraft skills, materials, and marketing assistance are available to HIV/AIDS patients to generate income. The clin-

Helping Men Take Leadership of HIV Prevention in South Africa

Moriting Park in Tembisa, a township southeast of Pretoria of approximately 1.8 million people, was transformed into a hub of activity on Saturday, March 27, 2004. The Emergency Plan-supported Solidarity Centre, in partnership with the local HIV/AIDS community organization Youth Channel Group and several other participating organizations, organized a "Men as Partners" counseling and testing day for workers' unions and the surrounding community. Among the unions were the National Council of Trade Unions, the Federation of Unions of South Africa, and the Congress of South African Trade Unions.

Linah, a union member, took part in order to better understand why there is so much suffering from AIDS and the role of men in the epidemic. Phindile, a counselor and trainer from the local clinic, wanted to erase the stigma that surrounds counseling and testing and to help the public know where the local testing site is.

The daylong program was designed to get men involved in preventing HIV transmission and violence against women. The program provided an opportunity for men and women to speak freely about their concerns related to HIV/AIDS and examine the role that gender plays in HIV transmission. Steve, the facilitator for the day, posed a question to the audience - "Why do you think it is important for men to be involved in fighting HIV and AIDS?" The session was quite heated and very emotional, with people voicing their personal experiences.

Participants stressed that men must be more involved in teaching and learning about HIV/AIDS. One woman added that "it would be most helpful if we had more workshops like these, with more men, and more frequently." Information on testing was also offered, and participants were encouraged to "learn their status." In fact, 25 of the 100 community residents gathered at Moriting Park were tested on that day alone. One clinic worker, Anna, was very pleased with the results. "We see about 11 to 15 people (for testing) in a day at the clinic," she said. "To think that we saw 25 people in two hours or so was a runaway success."

At a "Men as Partners" meeting in a South African township, men discuss the importance of treating women with respect and commit to reducing gender violence in their community.

"I know I can go to my congregation and impart the knowledge I gathered here today" - The Reverend Steve Mahlatsi, who could not stop raving about the workshop

"It is good that we had this workshop. This, according to me, is not the end of the road. It will still go on in the sense that I am going to have a meeting with those that could not make it today and spread the message" - David Lelaka, a shop steward

Helping a Woman Make the Decision for a Better Future

Bupe, now age 18, began sex work when she was 12 years old. Her parents are alive but were unable to provide for her basic needs, including education. She was vulnerable when her friends introduced her to sex work. Like many young girls in poor situations in Zambia and elsewhere, Bupe was attracted by the seeming excitement, nice clothes, male attention, and constant source of money afforded by commercial sex work. Bupe never realized she was risking her health or her life.

At age 16, Bupe became pregnant. She came into contact with "Corridors of Hope" (COH), an Emergency Plan-supported program, during a behavior change and communication workshop COH organized for sex workers. During the workshop, Bupe realized she was at high risk of contracting HIV and feared for the future of her child. Through the project, Bupe learned about HIV prevention methods and decided to use condoms with all clients and sexual partners. As her pregnancy advanced, however, Bupe saw no future for her or her child if she continued her life as a sex worker. She made the decision to change her life and asked COH staff for help in finding an alternative way of life.

"I am grateful to COH for helping me get back to school and hope to complete my education and be able to support my child." - Bupe, young mother and former sex worker

COH referred Bupe to the Department of Social Welfare. There, she was able to get support to further her education and is now in the ninth grade. Bupe encourages all her friends from the streets to go to the COH drop-in center to learn about HIV so that they can make good decisions for their lives.

ic also supports a choir, which generates income for treatment drugs through the sale of music CDs. A local nongovernmental organization in Nigeria that offers care and support to people living with HIV/AIDS includes training for women in income-generating ventures such as soap-making, cooking, and fabric production. In Zambia, a drop-in center and "Care Club" for commercial sex workers has established links to the Department of Social Welfare, which offers support for education, an ideal mechanism for helping women move out of sex work.

Increasing women's legal protection. Many of the norms and practices that increase women's vulnerability to HIV/AIDS and limit their capacity to deal with its consequences are reinforced by policies, laws, and legal practices that discriminate against women. The Emergency Plan, therefore, is supporting efforts to review, revise, and enforce laws relating to sexual violence and women's property and inheritance rights; enhance women's access to legal assistance; and eliminate gender inequalities in civil and criminal codes.

Future Directions

Emergency Plan goals will not be attained until trends in infection rates among women and girls are reversed and women are guaranteed equal access to care and treatment services. The Emergency Plan has initiated a multitude of gender-focused programs to tackle critical gender issues during its first year. In the coming years, the Plan will intensify its efforts.

Country five-year strategies and fiscal year 2005 operational plans prepared this year include specific approaches that the Emergency Plan will take in each country to address the key gender issues outlined above. Reviews of the 2005 operational plans for the 15 focus countries indicate that 106 programs/activities are planned that address women's legal protection; 103 address women's access to income and productive resources; and 203 programs/activities address reducing violence and coercion. Progress on these plans will be monitored, and new program approaches will continue to be developed and tested. Lessons learned will be shared and applied across countries, and successful programs will be taken to scale.

President George W. Bush is given a demonstration of laboratory equipment during his visit to National Hospital in Abuja, Nigeria.

"We will train doctors and nurses and other health care professionals so they can treat HIV/AIDS patients. Our efforts will ensure that clinics and laboratories will be built or renovated and then equipped. Child care workers will be hired and trained to care for AIDS orphans, and people living with AIDS will get home-based care to ease their suffering."

President George W. Bush
July 2, 2003

Chapter 5
Building Capacity for Sustainability

The fight against HIV/AIDS must be owned by the host nations. The heart and soul of the President's Emergency Plan for AIDS Relief (PEPFAR/Emergency Plan) is to support national strategies to reach prevention, treatment, and care goals, including building local capacity for sustainable HIV/AIDS programs. Because building capacity goes hand-in-hand with expanding services, the previous sections addressing the Emergency Plan's prevention, treatment, and care activities also summarize efforts to ensure sustainability. This section addresses in more detail specific aspects of capacity building, including crosscutting support to strengthen networks and systems to ensure quality HIV/AIDS services for the future.

Across many of the focus countries, there are common barriers to expanding and sustaining prevention, treatment, and care activities. Among these barriers are a lack of human resources and capacity; limited insitutional capacity; and health care system weaknesses in such areas as health networks, physical infrastructure, and commodity distribution and control.

Human Resource Capacity Building

Results

In fiscal year 2004, the Emergency Plan supported training for more than 312,000 service providers (with some overlap likely if providers participated in different service trainings) in the focus countries, including:

- 202,600 people trained in prevention services targeted to behavior change, including abstinence, faithfulness, condom use where appropriate, and medical transmission
- 24,600 health workers trained in services related to the prevention of mother-to-child HIV transmission
- 14,100 trained to provide counseling and testing
- 36,700 trained to care for HIV-positive people
- 22,600 trained to care for orphans and vulnerable children
- 12,200 health workers trained to provide antiretroviral treatment

Building Human Resources and Capacity

Appropriate and adequate human capacity and resources provide the backbone of accessible, high-quality, sustainable care. The paucity of trained health professionals and other human resources in the focus countries to combat HIV/AIDS is a stark indicator of the challenges faced by the Emergency Plan. The Emergency Plan supports national strategies with innovative approaches to training and retention; broadened policies regarding who can administer HIV/AIDS services; and the use of volunteers and twinning relationships to rapidly build the army of local service providers required to combat this disease.

To rapidly expand training activity, in 2004 the Emergency Plan launched a formal program to establish a Twinning Center to support twinning and volunteer activities for implementing the Emergency Plan. The Center will help strengthen human and organizational capacity by using health care volunteers and twinning relationships between similar organizations to facilitate skills transfer and rapidly expand the pool of trained providers, managers, and allied health staff delivering quality HIV/AIDS services. Eligible participants may be public or nonprofit private entities, including schools of medicine, nursing, public health, management, and public administration; health sciences centers; and community- and faith-based organizations.

Training Networks

Policies that mandate that only health professionals can provide health services - when trained community health providers could provide components of care at the home and community level - worsen problems related to the lack of human resources, including people's access to services. Strengthening health provider networks by training individuals to provide services at the hospital, clinic, community, and home levels helps expand the reach of a limited pool of trained professionals such as doctors and nurses. For example, during the reporting period the Emergency Plan supported a program in South Africa to build on existing health care networks to train additional personnel for HIV/AIDS services. The Plan is supporting the development of nine regional training centers for HIV/AIDS prevention, care, and support, which will be paired with tertiary institutions to fast-track necessary training in the regions. In just one site, more than 80 doctors, 65 nurse clinicians, and 25 community health workers had received training as of mid-2004. An important aspect of such networks is to anchor the training in advanced centers to ensure quality. The Emergency Plan is focused on developing tools to assess the quality of the training and, therefore, the quality of the services provided.

In other countries such as Uganda and Haiti, the Emergency Plan is supporting training of home health aides to perform routine follow-up and patient counseling for adherence to drug regimens. In Tanzania, the Emergency Plan supports the training of 470 traditional birth attendants as community health care providers. After training, these aides go into communities to enroll pregnant women in services for prevention of mother-to-child HIV transmission (PMTCT), including preventive antiretroviral treatment and ongoing counseling on infant feeding, early detection of complications, and referrals during the postnatal period. Capacity-building programs are increasingly forging relationships with associations and groups of people living with HIV/AIDS and training members to provide patient education, adherence counseling, and conduct patient follow-up. In addition to freeing clinical staff to serve more specialized needs, such strategies for involving people living with HIV/AIDS help combat HIV/AIDS-related stigma.

A special challenge is that while service providers participate in an off-site training program, they are not available to assist patients. The Emergency Plan thus supports programs for on-the-job HIV/AIDS training for health care workers to educate them about HIV/AIDS services without taking them out of care settings.

To reach prevention, treatment, and care goals, and to provide services equitably, networks must reach down to the community level, often in rural areas that are not appealing places to live for many health care professionals. In 2004, the Emergency Plan supported a pilot project in Namibia to provide incentives to physicians and other health professionals to locate to underserved rural areas. As a result of this program, a number of doctors, pharmacists, and nurses moved to these areas and began

Helping Build Capacity at the Community Level

The Peace Corps has more than 3,000 volunteers working on HIV/AIDS projects, including 1,000 volunteers committed as a result of the Emergency Plan. The goal of Peace Corps HIV/AIDS activities is to build community-level capacity to address the pandemic's social, economic, and health impacts, particularly in rural areas. All volunteers serving in Africa, regardless of sector, are trained to serve as advocates and educators for HIV/AIDS prevention. In addition, the Peace Corps offers a short-term program called the Crisis Corps that mobilizes former Peace Corp volunteers to help countries address critical needs. Strategic advantages of Peace Corps volunteers include:

- Knowledge of the cultural context and language
- Ability to integrate cultural concepts and community participation into their work
- Presence in areas where there is limited access to services
- Ability to work with counterparts to build capacity and transfer skills at the community level

In Uganda, for example, Peace Corps volunteers are helping to expand the reach of HIV/AIDS services supported by the Emergency Plan. Peace Corps volunteers support community-level activities in 23 districts, assisting with capacity building in the prevention, care, and treatment of HIV/AIDS and complementing the rapid extension of services resulting from Emergency Plan funding.

President Bush with Peace Corps volunteers serving in Botswana.

providing services to thousands of HIV-positive people. In 2005, the Emergency Plan will expand the Namibian program, and other countries, such as Mozambique, will employ similar strategies.

Access to Health Professionals and "Brain Drain"

Ethiopia has one doctor for every 34,000 people in the country and one nurse for every 4,900 people. In Mozambique, 500 physicians serve a country of 18 million people - one doctor for every 38,000 people, or a ratio of 2.6 doctors per 100,000 people. In contrast, the United States has 279 physicians per 100,000 people. "Upstream" causes of limited human capacity include shortfalls in preservice academic training, both in availability of professional education (Botswana, for example, has no medical school) and accessibility of HIV/AIDS curricula within professional schools. The Emergency Plan supports the development and implementation of curricula in preservice settings and preservice training for key health care professionals. HIV infection and stigma also contribute to limiting the number of clinical providers, which is why prevention and leadership to combat stigma remain essential pillars of the response to HIV/AIDS.

Few developing-country economies can support salary structures that encourage retention of medical professionals, particulary in the face of the lucrative salaries offered by wealthy nations. The resulting "brain drain" exacerbates the shortage of health care personnel. Brain drain can also occur within a country - as resources expand, the buying power of certain organizations can deplete human capacity in key institutions such as ministries of health. The Emergency Plan is supporting innovative programs to curtail brain drain. In Guyana, in consultation with the Ministry of Health, five hospitals were

selected for upgrading as model PMTCT facilities. Staff at the Guyana HIV/AIDS Reduction and Prevention Project (GHARP), a joint project of the governments of Guyana and the United States, carefully planned the recruitment process for necessary staff. To avoid recruiting health care providers already employed with the Ministry of Health, GHARP staff hit on an innovative solution. Guyana's public service requires mandatory retirement for nurses at age 55. GHARP, in conjunction with the Ministry of Health, brought these highly trained and experienced nurses back to public service. Through advertisements that specifically encouraged retired nurses to apply, GHARP received 495 applications, about half of whom were retired nurses with previous PMTCT training. Some were recent social work graduates, a nontraditional choice for health care outreach but perfect for the counseling positions needed at the hospitals.

Institutional Capacity Building

Results

In fiscal year 2004:

- More than 1,000 (80 percent) of over 1,200 partners (both prime and subcontractors) were indigenous
- More than 47 percent of the Emergency Plan's "prime" partners - organizations with the program and financial management expertise to receive U.S. funds directly - were indigenous
- More than 83 percent of subpartners receiving support under the management supervision of an eligible prime partner were indigenous

Building Institutional Capacity

The President's Emergency Plan has brought unprecedented focus to building the institutional capacity of local organizations - including host governments and community- and faith-based organizations - to plan, implement, and manage HIV/AIDS programs to ensure sustainability. The organizing structure, management, coordination, and leadership provided by capable host governments are essential to an effective, efficient

Health care providers in Ethiopia discuss solutions to human capacity challenges with Ambassador Tobias.

HIV/AIDS response. Local community- and faith-based organizations remain an underutilized resource for expanding the reach of quality services. They are among the first responders to community needs, with a reach that enables them to deliver effective services for hard-to-reach or underserved populations, such as people living with HIV/AIDS and orphans. Community- and faith-based groups, trained in program management and HIV/AIDS best practices, often design the most culturally appropriate and responsive interventions and have the legitimacy and authority to implement successful programs that deal with normally sensitive subjects. The Emergency Plan has provided technical assistance and infusions of key resources to help host governments and local organizations develop and maintain high-quality services, with training in both HIV/AIDS service provision and improving managerial capacity.

The Emergency Plan prioritizes the development of new partnerships with local groups and organizations as a key strategy for increasing access and building sustainability. Review of the U.S. five-year strategy and the annual country operations plan in each country includes an evaluation of efforts to increase the number of indigenous organizations partnering with the Plan. This emphasis has led to impressive results.

Strengthening the institutional capacity of host governments and national systems is a fundamental strategy of the Emergency Plan. Historically, donors have often

Helping Côte d'Ivoire Mobilize Action on Preventing Mother-to-Child Transmission

In January 2004, Côte d'Ivoire's Minister of Health, accompanied by U.S. Ambassador Arlene Render, launched the national PMTCT program. The Emergency Plan helped Côte d'Ivoire craft a national PMTCT policy, guidelines, and a national roll-out plan for integrating PMTCT with other services. The target goal is to increase national coverage fivefold to around 10 percent.

This represents an impressive turnaround in the national PMTCT response in a short time. In addition to U.S. support, four factors allowed this rapid evolution to occur: 1) political leadership from the national authorities; 2) an effective coordination forum and inclusive participatory process; 3) mobilization of technical expertise from multiple partners; and 4) financial resources from other donors in addition to the Emergency Plan.

bypassed these institutions and implemented autonomous management structures, investing directly in sites and providing funding for ongoing expenses. This strategy, however, is inefficient and works only as long as donors are there. Even if financing continues beyond the donor's management engagement, interventions fail because existing health facilities have not acquired management capacity.

The Emergency Plan has sought to avoid this pitfall. As a result, more than 20 percent of Emergency Plan partners in fiscal year 2004 were host government entities, including ministries of health and associated institutions, research organizations, and AIDS coordinating authorities. The Emergency Plan has supported the development of national policy and training in planning, budgeting, performance improvement, monitoring of activities and finances, and other management skills. In several focus counties, U.S. personnel are located in, or detailed to, ministries of health. Innovative approaches to support human resources in government institutions have been successful. In Namibia, the Emergency Plan supports physicians, nurses, and counselors through contracting agencies.

While working in partnership with governmental authorities, the Emergency Plan is also pursuing innovative approaches to strengthening the capacity of local nongovernmental organizations (NGOs). In Botswana, the United States initiated and supported Tebelopele, the largest provider of voluntary counseling and testing, with 16 freestanding sites and four mobile caravans. In fiscal year 2004, Tebelopele was "spun off" to become an independent NGO, with all staff and assets transferred from the U.S. Mission. A U.S. Government-funded partner is working with Tebelopele to expand management capacity and ensure that it succeeds as a sustainable organization.

Faith-based groups are priority local partners. In many focus countries, more than 80 percent of citizens participate in religious institutions. In certain nations, upwards of 50 percent of health services are provided through faith-based institutions, making them crucial delivery points for HIV/AIDS information and services. In fiscal year 2004, more than 20 percent of all Emergency Plan partners (including both prime and subcontractors) were faith-based. In fiscal year 2005, planned activities indicate that this proportion will rise to nearly a quarter of all partners.

To support expanded faith-based work, South Africa's Emergency Plan program is developing strategic plans with five faith-based communities for training, other capacity development, and service delivery. Tanzania's program is supporting a national needs assessment within the Islamic community to assess current HIV/AIDS work and next steps, with additional plans under way to support voluntary counseling and testing and PMTCT services in 30 dioceses, 13 church denominations, and 20 mosques. The Emergency Plan has launched pilot programs in multiple countries that allow small groups to apply directly to Emergency Plan country teams for rapid approval of small grants in order to get funds quickly to local organizations doing needed work on the ground.

Working with Grassroots Organizations to Extend the Reach of Care in Ethiopia

Burial societies, known as *idir*, are found throughout Ethiopia, and almost all Ethiopians are involved with one. *Idir* have recently begun to take on an important new role in serving the living - addressing the needs of people living with HIV/AIDS.

Government sources indicate that more than 1.5 million people are living with HIV/AIDS in Ethiopia, 120,000 of them children. The current HIV prevalence in Addis Ababa is estimated at 14.6 percent, with urban hospital bed occupancy by AIDS patients estimated to be nearly 60 percent. An epidemic of this scale places serious demands on an already overextended and ill-equipped health care system, creating a need that can only be filled by community- and home-based care.

Recognizing their prominent position in Ethiopian communities, the President's Emergency Plan has joined forces with the *idir* to bring home-based health care to thousands of people with AIDS and other chronic illnesses. "There is no other way you could reach so many people," says Dr. Ashenafi Haile, head of the Addis Ababa HIV/AIDS Prevention and Control Office. Indeed, the participation of community groups is essential to sustainable, quality home care. Ethiopia is one of the five poorest countries in the world, and working through established and valued groups ensures the efficient mobilization of limited resources. For example, transporting volunteers, often a difficult and costly endeavor, poses no problem for the *idir* because they live in the community. Frequent - even daily - home visits are feasible for them.

Another advantage of working with the *idir* is the community respect they command. People living with HIV/AIDS in Ethiopia - where many still believe that HIV infection is a punishment for sins - face considerable discrimination. That respected members of the local *idir* are involved in their care is helping to gradually reduce the stigma these people have suffered.

With U.S. support, more than 900 volunteers from 60 *idir* in Addis Ababa have been trained so far and have initiated what is expected to become the country's largest home care program. With additional U.S. resources, this model of community-based care is being expanded to 13 other towns in Ethiopia.

One impediment to working with many local groups is the limited technical expertise in accounting, auditing practices, and other activities required to receive funding directly from the U.S. Government. Under the Emergency Plan, the U.S. Mission in South Africa is using a local "umbrella" contractor to manage these activities for local organizations for a small fee. In fiscal year 2005, several focus countries will pursue the use of local umbrella contractors, including those that serve as local fiduciary agents for the Global Fund to Fight AIDS, Tuberculosis and Malaria. In addition, the Emergency Plan is working to incorporate "graduation" language in contracts and grants with its non-indigenous prime partners. This language provides for the performance of these prime partners to be evaluated, in part, on their success in transferring skills to their indigenous subpartners, who can, in turn, become prime partners of the Emergency Plan.

Strengthening Essential Health Care Systems

Years of development challenges and resource limitations in many of the hard-hit focus countries of the Emergency Plan have resulted in health care systems poorly equipped to respond to the HIV/AIDS crisis. In most of these countries, achieving the Plan's goals and long-term aims in combating HIV requires implementing and strengthening essential systems, including health care

networks; enhancement of clinics, laboratories, medical records systems, and other infrastructure components; and commodity procurement, distribution, and management systems. The Emergency Plan is taking these challenges head on, determined to put down the roots that will truly turn the tide against HIV/AIDS.

Health Care Networks

The HIV/AIDS epidemic has placed a huge burden on the health care systems of many high-prevalence countries. In many of the focus countries of the Emergency Plan, AIDS has reached into the farthest corners of the country - where infrastructure and services often cannot reach those in need. Major disparities often exist between urban and rural health services, with a concentration of health professionals and institutions in the major cities. In some countries, as much as 40 percent of the population has no access to formal health care.

Health authorities and service providers in most high-prevalence countries require considerable assistance in order to meet the high demand for prevention, treatment, and care services. The Emergency Plan is meeting the enormous demand for services by rapidly expanding existing indigenous health networks in support of the national HIV/AIDS strategy. This includes supporting the development and improvement of linkages and coordination between central health facilities and outlying health clinics, including those in rural areas, to deliver quality HIV/AIDS services more effectively. The Emergency Plan also helps strengthen linkages and coordination between health and other service delivery institutions and organizations, public and private, that provide necessary prevention, treatment, care, and other support to people infected and affected by HIV/AIDS. The goal is to increase the number of people accessing comprehensive HIV/AIDS services by improving reach and filling gaps in service delivery.

In support of this goal, in fiscal year 2004, a U.S. interagency meeting was held in Uganda, a country with excellent models of networked health care delivery, to examine indigenous HIV/AIDS network models. Opportunities to leverage Emergency Plan resources to strengthen and expand local networks within national plans were explored. These discussions have influenced future operational plans, and the Emergency Plan's efforts to strengthen health care networks will intensify in 2005. Across the focus countries, 500 activities with health network development components - fully a quarter of all Emergency Plan activities - are planned.

Helping to develop local health care infrastructure, the Emergency Plan supports construction of an HIV/AIDS wing at the hospital in Eldoret, Kenya.

Physical Infrastructure

Inadequate physical infrastructure is a basic barrier to Emergency Plan implementation. Common obstacles include under-resourced facilities; unreliable electricity and water supplies, especially outside urban areas; outdated or broken equipment; and lack of information and communications technology for basic program planning and monitoring. The HIV/AIDS crisis has exacerbated these conditions, straining limited health resources and facilities. In support of national strategies and Emergency Plan goals, the United States is addressing these barriers by supporting such activities as construction (for example, of additional space at an existing health facility for counseling and testing); renovation; procurement of equipment, supplies, furniture, and vehicles; and financing as needed for expanded HIV/AIDS service delivery under the Emergency Plan.

Improving laboratory infrastructure and capacity has been a specific focus of the Emergency Plan. To meet Emergency Plan goals, an estimated 30 million to 100 million people in focus countries will require HIV testing.

The Emergency Plan not only purchases antiretroviral drugs like these at a clinic in Haiti but also supports the delivery mechanisms and infrastructure development necessary to provide effective AIDS treatment.

Yet in most of these countries, existing laboratories lack equipment and trained staff, as well as established quality control procedures to help ensure the reliability of testing. Emergency Plan staff have worked in all focus countries to help strengthen their capacity to diagnose HIV and related infections. One priority is to support the use of rapid HIV tests. These tests, which require minimal equipment and can be reliably performed by lay counselors, can dramatically expand a country's capacity to perform HIV testing. Emergency Plan staff have worked with laboratory experts in focus countries to evaluate these tests, have trained more than 3,100 people in HIV testing and have helped provide oversight to ensure that the testing was reliable. Thanks to these efforts, nearly 2,200 sites in focus countries used rapid HIV tests and nearly 1.3 million people benefited from HIV testing in fiscal year 2004.

A second laboratory component critical to the success of the Emergency Plan is the monitoring of HIV-related immunosuppression (e.g., CD4 count). This testing is necessary for determining when a person needs to start HIV treatment and to monitor that therapy. Emergency Plan staff have worked with national staff in focus countries to provide advice in the purchase of appropriate equipment, provide training, and strengthen the relevant quality control systems. In fiscal year 2004, 335 additional laboratories developed the capacity to conduct the necessary immunological or hematological testing.

In fiscal year 2005, the Emergency Plan will continue its efforts to strengthen laboratory capacity in focus countries. As a result, more people will learn their HIV infection status, and physicians will be able to reliably determine which patients will benefit from HIV treatment and to monitor the success of that therapy.

Quality Assurance, Logistics, and Commodity Procurement

Many focus countries lack adequate systems and resources to operate a safe, secure and reliable supply chain management system (SCMS) for procuring pharmaceutical and other products needed to provide care and treatment of people with HIV/AIDS and related infections. The scale and intent of the Emergency Plan and the national strategies it supports have brought renewed focus to this need. SCMS are necessary to procure, store, distribute, and use high-quality products. These systems include not only the actual purchase of product but also oversight of national drug regulatory bodies and other agencies within host governments to ensure there is appropriate quality assurance. The United States is committed to working collaboratively with host governments to enhance their SCMS activities.

Currently, many focus countries lack adequate national strategies. During the first year of the Emergency Plan, U.S. implementing partners provided technical assistance to host government agencies, helping them with procurement, logistics, and strategies to prevent stock-outs of key commodities. The Emergency Plan has supported multiple in-country assessments of SCMS capacity and needs. Through an interagency process that included in-country consultations, a new SCMS contract is being competed that will provide countries with an enhanced ability to receive key technical assistance on all aspects of the supply chain process. The purpose of the project is to establish and operate a secure, reliable, and sustainable SCMS to procure and deliver pharmaceuticals, including antiretroviral drugs, and other products and services needed to provide lifesaving HIV/AIDS care and treatment in under-resourced settings. Also included will be the design, development, and implementation of

Building a Quality Supply Chain Management System

The Emergency Plan has issued a request for application for a supply chain management system (SCMS). The SCMS contractor will work with host government agencies to enhance forecasting, procuring, delivering, and reporting on procurements and deliveries; provide capacity-building services; and conduct quality assurance activities that ensure the development, implementation, and/or maintenance of proper standards for the delivery of such services, including monitoring, guidance, oversight, and mentoring through site visits, technical assistance and performance evaluation, and periodic review by regulatory bodies and funding entities. All activities related to the SCMS contractor must comply with U.S. and host-country laws and regulations. Specifically, the organization will be required to:

- Develop and maintain a program management capability to ensure the effective and efficient delivery of contract services and the achievement of performance standards contained in the contract
- Develop and maintain a competitive and transparent capability to procure required commodities that:
  - Fully complies with all applicable U.S. contracting laws and regulations
  - Leverages volume purchasing to achieve significant reductions in the current costs of supplies
  - Achieves the lowest prevailing price worldwide

A key component of the SCMS contract will be working with national drug regulatory authorities to:

- Establish and maintain a quality assurance program to obtain and manage the required documentation and verify that supplies meet contractual and product specifications
- Provide freight-forwarding and warehousing services that promote the efficient, safe, and secure handling and delivery of procured supplies
- Establish in-country support teams to help field programs estimate and secure their supply needs, ensure the delivery of commodities to service sites, and create needed in-country expertise in supply chain management
- Develop a comprehensive management information system to provide current information about all aspects of the HIV/AIDS supply chain

improved systems for forecasting, procurement, storage, distribution, and performance monitoring of HIV/AIDS pharmaceuticals and other commodities and supplies. As a necessary tool for ensuring sustainability, the project emphasizes the capacity building of local essential supply chain management personnel to strengthen the quality and expand the reach of effective HIV/AIDS interventions.

The project is initially designed to target activities in the 15 focus countries, but it is also the intent of the United States to help other countries with U.S.-supported HIV/AIDS programs develop appropriate SCMS capabilities to fight the HIV/AIDS epidemic. Requests for the services of this project will be field-driven, in consultation with host governments. Once services are in place and fully functional, the contract may also be tasked with support for HIV/AIDS programs funded by other governments and donor entities, typically on a fully cost-reimbursable basis. Thus programs receiving support from the Global Fund to Fight AIDS, Tuberculosis and Malaria or other entities will also be able to use this mechanism.

Health commodities required for HIV/AIDS prevention, treatment, and care programs will be procured in collaboration with host governments. Categories of commodities will include but are not limited to:

- Antiretroviral drugs
- Other pharmaceuticals and medical items (other than contraceptives) needed to provide care and treatment to people with HIV/AIDS and related infections
- Laboratory and other supplies for performing tests related to the provision of care and treatment to people with HIV/AIDS and related infections
- Other medical supplies needed for the operation of HIV/AIDS treatment and care centers, including products needed in PMTCT programs (this may include breast milk substitutes if used in a manner consistent with USAID guidance)
- Pharmaceuticals and health commodities (not including food) needed for the provision of palliative care and pain management
- As needed and deemed appropriate by supervising national and U.S. officials, laboratory and clinic equipment, equipment needed for the transportation and care of HIV/AIDS supplies, and other equipment needed to provide prevention, care, and treatment of HIV/AIDS described above

At full scale, it is expected that the contract will cost about $25 million per year and be able to forecast, procure and deliver from $500 million to $800 million in HIV/AIDS drugs and related commodities per year. Proposals were due February 16, 2005, with an expected award in May 2005.

Ambassador Tobias meets with Gerard Latortue, the Prime Minister of Haiti, and Josette Bijoux, the Minister of Health, to discuss ways the Emergency Plan can support Haiti's national HIV/AIDS strategy.

"AIDS is an individual tragedy for all who suffer and a public health catastrophe that threatens the future of many nations."

President George W. Bush
June 23, 2004

Chapter 6

Strengthening Bilateral Programs Worldwide

Every nation, large or small, developed or developing, is vulnerable to the threat of HIV/AIDS. No nation is protected by geography or political boundaries. With the knowledge that turning the tide against global AIDS requires a global fight, the President's Emergency Plan for AIDS Relief (PEPFAR/Emergency Plan)) encompasses HIV/AIDS programs in 96 countries in addition to the 15 focus countries. The Emergency Plan targets $4 billion over five years to support HIV/AIDS programs in these countries, including international research. Recognizing that an effective global strategy to combat the pandemic must respond to the diversity of the global HIV/AIDS challenge, the Emergency Plan is committed to strengthening U.S. Government-supported HIV/AIDS programs and promoting strong leadership in all of the countries in which it works.

The Emergency Plan committed significant resources - $437 million in fiscal year 2004 - to sustain and expand ongoing U.S. assistance to HIV/AIDS programs in these 96 additional countries. The Office of the U.S. Global AIDS Coordinator (OGAC) has promoted consistent HIV/AIDS policies and programs across our continuing bilateral prevention, care, and treatment initiatives with the aim of harmonizing bilateral programs with the principles and intent of the Emergency Plan. To date, strategic planning and budgeting for U.S. Government programs outside of the focus countries have remained the responsibility of the implementing agencies, which do so

Strengthening Bilateral Programs

Goal

Apply best practices in prevention, treatment, and care, and improve coordination, management, and accountability across all U.S. Government bilateral HIV/AIDS programs

Strategies

- Strengthen quality and capacity of prevention, treatment, and care programs worldwide
- Strengthen coordination, management, and accountability of U.S. Government programs worldwide, and ensure their consistency with the principles of the Emergency Plan

within the framework of the U.S. Global AIDS Strategy and under OGAC leadership.

Bilateral programs are making significant progress. The Emergency Plan seeks to develop lessons learned from the rapid scale-up of national integrated prevention, treatment, and care programs in the focus countries, and from U.S. interagency coordination, to strengthen prevention, care, and treatment interventions worldwide. Several features of the Emergency Plan in focus countries have taken hold in other bilateral programs. Interagency teams have been formed to undertake joint planning and programming, especially in countries with significant HIV/AIDS prevalence. OGAC has begun to collect data from these countries using the same measures and indicators used in the focus countries. While the data collection systems in the countries outside of the 15 focus countries do not yet produce the optimum level of information, improving these systems will be a key focus of ongoing strategic information activities. Moreover, as best practices are identified across programs, they will be shared with other programs facing similar challenges.

Results

Prevention

Through its bilateral programs, the U.S. Government supports programs and builds capacity for countries to prevent the spread of HIV. Such programs include addressing medically and sexually transmitted HIV, preventing mother-to-child transmission, and promoting the ABC approach. Stigma and discrimination remain challenges worldwide, greatly impacting the quality of life of those infected and affected by HIV/AIDS. Access to needed support mechanisms, education, treatment for HIV-related illnesses, prevention of violence against women, and the ability to seek and maintain employment are all affected by stigma and discrimination in a society.

Using the Power of Television to Share Prevention Knowledge with Zimbabwean Youth

Reaching youth with prevention messages depends on using effective channels of communication. In Zimbabwe, as in many nations, television is an important part of young people's lives.

The Emergency Plan supports *Studio 263,* a locally produced TV series for youth focused on the social issues surrounding HIV/AIDS. *Studio 263* - the number is Zimbabwe's international dialing code - encourages youth to question social norms and behavior patterns that may increase the risk of transmitting HIV. The drama aims to help youth understand the risks and responsibilities associated with sexual activity, especially HIV/AIDS and unwanted pregnancy.

Key HIV prevention messages in *Studio 263* include the importance of delaying the onset of sexual activity, the related themes of self-control and self-respect, and understanding love and friendship. The importance of HIV testing and serostatus knowledge is also a frequent theme.

According to the Zimbabwe All Media Products Survey (ZAMPS), *Studio 263* is the most popular TV show in Zimbabwe, especially among youth, with 86 percent of 11- to 29-year-olds reporting having watched the drama within the last seven days and 62 percent reporting having seen every episode. ZAMPS reports that these messages influenced 48 percent of 15- to 19-year-old viewers to delay the onset of sexual activity, 33 percent of 25- to 29-year-olds to seek voluntary counseling and testing services, and 26 percent of 25- to 29-year-olds to discuss HIV testing with their spouse or partner.

Studio 263 is clearly a valuable tool in the Emergency Plan's efforts to keep young Zimbabweans safe.

Helping Make Blood Safe in Cambodia

In Cambodia, medical transmission of HIV through unsafe blood is a challenging issue. The basic infrastructure to ensure a safe blood supply is not available except in a few densely populated areas. In 2002, only 12 of the 24 provinces had either a blood transfusion center or a blood depot (where blood can be safely stored for transfusion). In provinces with no blood facilities, blood was transfused without having been screened for HIV. As a result, Cambodia had:

- The highest HIV prevalence among blood donations in Asia
- The lowest level of donations (1.9/1000) compared to 5/1000 in other developing countries
- A dependency on family donations (many of whom are paid donors), which presents an increased risk for transmitting HIV and other infections

The President's Emergency Plan has worked in collaboration with the World Health Organization (WHO) to address these challenges in Cambodia. The United States has:

- Provided funds to support a full-time blood safety specialist to work with the government's National Blood Transfusion Center (NBTC)
- Helped the NBTC develop a nationwide blood safety policy
- Supported the expansion of blood safety activities by extending transfusion centers to 19 of the 24 provinces
- Provided blood donor recruitment education and support to increase the percentage of voluntary donors
- Purchased, through WHO, a bloodmobile for outreach to faith-based organizations such as pagodas to increase the number of volunteer donors
- Established a laboratory quality control program to support the National Laboratory of Public Health in ensuring quality testing of blood
- Provided training to 117 laboratory technicians and provincial hospital directors in blood safety techniques
- Decreased the seroprevalence in blood donors from 2.2 percent in 2002 to 1.8 percent in the first six months of 2004, primarily through increasing the number of volunteers through outreach to school students and monks

On June 14, 2004, the U.S. Government and WHO cosponsored the first ever World Blood Day celebration where major donors were recognized and the bloodmobile purchased with U.S. Government funds was unveiled. The Minister of Health was among the first to donate blood at this new mobile unit.

Treatment

As in the Emergency Plan's focus countries, other bilateral HIV/AIDS programs are challenged in their ability to provide treatment to people with HIV/AIDS. In addition to the focus countries, there are 10 countries in Africa, Asia, and the Caribbean that have launched U.S. Government-financed treatment programs since the beginning of the President's Emergency Plan, including a significant program in China. More than 135 service outlets in these countries are providing treatment.

Care

Care for orphans and vulnerable children is a key component of a compassionate response to HIV/AIDS throughout the world. The Emergency Plan's bilateral programs outside of the focus countries have included 240 programs targeted to orphans and vulnerable children. As described in chapter 3 of this report, programs seek to strengthen the ability of families and communities to care for orphans and vulnerable children and to ensure that these children receive basic nutrition, education, and housing.

Overcoming Obstacles to Bring Hope to HIV-Positive People in China

The Emergency Plan has been instrumental in China's effort to implement its national antiretroviral treatment (ART) program, which the Chinese government reports has already reached more than 10,000 patients in 160 communities during its first 18 months of operation. As part of this effort, the Emergency Plan supported the development of the *Free ARV Treatment Manual* and assisted in the development of a national database system for patients on ART.

In addition, an Emergency Plan-sponsored study found an average ART adherence rate of less than 70 percent. To help improve patient adherence to ART, two projects were launched. The first supported the rapid distribution of a video-based adherence promotion program targeting patients and primary health care providers in all villages with an ART program. The second was a pilot program using "directly observed therapy" (DOT) workers to ensure that people living with HIV/AIDS in Henan province follow their ART regimen as prescribed. The initial success of the DOT approach has resulted in a recommendation by the Henan government to use DOT for all ART patients in China.

To address a major limitation of AIDS treatment in a country where the majority of patients live in rural villages and the few clinicians specializing in AIDS care and treatment are based in distant urban centers, a rural training center was launched in 2004 in Anhui. This center, based in Lixin County, the third most affected county in China, now has a U.S. AIDS specialist training county-level physicians using a mini-residency model. The goal of this effort is to place a clinician trained in AIDS care and treatment in the majority of China's most heavily affected counties over the next two years.

Orphans and vulnerable children receive care and support at the Mercy Center, an Emergency Plan-supported orphanage in Bangkok, Thailand.

Even in countries where the epidemic is not widespread in the general population, it is important that care be made available to those who are affected. Chapter 3 also describes how the Emergency Plan supports the continuum of care from the time of diagnosis with HIV infection until death, including counseling and testing to make the diagnosis of HIV infection.

Collecting information on best practices in providing quality care to orphans and vulnerable children and people living with HIV/AIDS received much attention in fiscal year 2004 and will continue to receive attention. These practices include assessing optimal packages of services, home- and community-based care programs, training for providers, and many others. Lessons learned from the scale-up of care programs in the focus countries are being applied in other bilateral programs of the Emergency Plan.

Capacity Building

The President's Emergency Plan for AIDS Relief is committed to improving and amplifying the HIV/AIDS response worldwide. The U.S. Government supports appropriate policy development and system strengthening for host-country HIV/AIDS responses across the globe,

capitalizing on its expertise in technical assistance and capacity building for quality improvement and sustainability of programs. In countries where the U.S. Government provides assistance, public and private sector institutions across all categories of HIV/AIDS response receive technical assistance for policy development, including policies aimed at reducing stigma and discrimination and other capacity-building activities.

In fiscal year 2004, the U.S. Government trained people to prevent the medical transmission of HIV, provide PMTCT services to pregnant women and their infants, deliver HIV-related palliative care, conduct HIV counseling and testing, and perform necessary laboratory tests. In addition, the U.S. Government took a leadership role in training country staff in monitoring and evaluation, surveillance, and health management information systems, as well as policy, capacity building, and stigma and discrimination reduction programs. The investment in capacity building through bilateral programs reflects the United States' commitment to helping nations increase their ability to respond to both current and future HIV/AIDS challenges and establish programs that are sustainable in the long term.

Increased Financial Commitments

In addition to the 15 focus countries targeted for dramatically scaled-up resources (home to nearly half of the world's HIV-positive people), the Emergency Plan continues to track and respond to rising needs in countries with the potential for explosive epidemics, such as China, India, and Russia, as well as countries like Angola, Swaziland, and Lesotho, all struggling to contain their epidemics.

In fiscal year 2004, acting on the recommendation of an interagency team of experts, the U.S. Global AIDS Coordinator provided an additional $25.5 million to seven countries, including India, Russia, Cambodia, Swaziland, and Lesotho, and to five regional programs covering an additional 20 countries.

In India, the U.S. Government increased its commitment to fighting HIV/AIDS by nearly 25 percent from fiscal year 2003 to fiscal year 2004. India has the largest HIV/AIDS program ($36 million, including research, in fiscal year 2004) supported by the U.S. Government outside the 15 focus countries.

In Russia, the U.S. Government increased its commitment to fighting HIV/AIDS by nearly 50 percent from fiscal year 2003, with funds increasing in fiscal year 2004 to more than $10 million. U.S.-funded projects addressed a wide range of problems associated with the epidemic, including prevention, treatment, and reducing

Supporting a Continuum of Care for People Living with HIV/AIDS in Cambodia

A new Emergency Plan-supported collaborative initiative in Moung Russey, Cambodia, provides a continuum of care for people living with HIV/AIDS. The term "continuum of care" refers to a comprehensive package of activities including counseling and testing, clinical care for opportunistic infections, antiretroviral therapy, care for HIV/tuberculosis comorbidities, prevention of mother-to-child transmission services, and psychosocial support. To make these available, the United States is working with district health services, the national government, local community members, including people living with HIV/AIDS, and international and local nongovernmental organizations (NGOs).

In 2004, these partners implemented specially designed services in Moung Russey, providing testing and counseling for 999 people (with an HIV rate of 30 percent); outpatient diagnostic and treatment services for 395 people living with HIV/AIDS; and antiretroviral treatment for 81 people living with HIV/AIDS. In addition, NGOs make home care visits throughout the week. An important component of the continuum of care is the day care center, where people living with HIV/AIDS gather voluntarily for peer support, education on prevention and treatment, and self-care activities such as nutrition, exercise, and meditation.

HIV/AIDS-related stigma. Since 2003, the Department of State has programmed more than $2 million for HIV/AIDS vaccine research, including identification of a novel vaccine platform technology, in conjunction with Russia's former Weapons of Mass Destruction Institutes.

The U.S. Government's commitment of $37 million in fiscal year 2004 for bilateral health assistance to China for HIV/AIDS and other diseases has had an impressive impact on U.S.-Chinese health cooperation. The Chinese government is actively engaging U.S. officials and medical professionals for help in designing and improving the nation's health care infrastructure.

Sub-Saharan Africa remains by far the most affected region, and the Emergency Plan's commitment there also extends beyond the focus countries. Emergency Plan budgets for several countries in this region increased, with budgets for Lesotho and Swaziland increasing by as much as 150 percent between fiscal years 2003 and 2004.

Finally, the United States remains by far the largest contributor to the Global Fund to Fight AIDS, Tuberculosis and Malaria, which is now active in 130 countries. In 2004, the United States' contribution made up one-third of all contributed Global Fund resources; thus, roughly one-third of the $352 million the Global Fund has approved in two-year projects for China, India, and Russia - or approximately $117 million - is attributable to U.S. contributions.

Strengthening Coordination, Management, and Accountability: Ensuring Consistency with Emergency Plan Principles

The President's Emergency Plan offers a fresh opportunity to implement consistent HIV/AIDS policies and ensure a coordinated U.S. Government approach across all of our bilateral prevention, care, and treatment initiatives. The Global AIDS Coordinator has provided program and policy guidance to all U.S. missions with HIV/AIDS programs, urging them to adopt integrated interagency strategies wherever U.S. resources are used. Strategies may include prevention, treatment, care, and technical assistance, as well as U.S. leadership and advo-

Facilitating Partnerships and Capacity Building in Brazil

In addition to directly providing U.S. resources, the Emergency Plan also seeks to facilitate relationships that will help combat HIV/AIDS. In 2004, the Brazilian National AIDS Program requested the U.S.-based National Association of State and Territorial AIDS Directors to help establish a bilateral exchange program between state and city program directors to share experiences and lessons learned in HIV/AIDS prevention and care, with a particular emphasis on program monitoring and evaluation (M&E). U.S. and Brazilian sites were matched as follows:

- Laredo City Health Department (Texas) and Campo Grande Municipal STD/AIDS Program
- Louisiana City Office of Public Health and Manaus Municipal STD/AIDS Program
- Massachusetts State Department of Public Health and Pernambuco State STD/AIDS Program
- New York State AIDS Institute and Sao Paulo State STD/AIDS Program
- San Francisco City Department of Public Health and Curtitiba Municipal STD/AIDS Program

In addition, with support from the Emergency Plan, the Ministry of Health in 2004 provided technical assistance through projects such as MONITORAIDS, an innovative Web-based information system; M&E certificate- and master's-level courses to develop mid-level M&E practitioner capacity (to date scarce in Brazil); and the establishment of M&E "centers of excellence." With Emergency Plan support, five centers have been established in different regions of Brazil. M&E capacity will be developed further through the twinning relationships between U.S. and Brazilian state and municipal health departments listed above.

cacy to reduce stigma and diplomacy to increase host government engagement.

Specific guidance included:

- Adopting the OGAC leadership model by creating interagency teams under mission management leadership
- Developing integrated strategies with specific and accountable goals, closely coordinated with host governments and other major donor partners
- Supporting accountability by promoting and providing the technical assistance needed for effective measure-

South African traditional healers, Ambassador Jendayi Frazer, and the South African Surgeon General celebrate the opening of a new military HIV/AIDS treatment and research site supported by the Emergency Plan.

Protecting Societies by Protecting Their Troops

In many areas of the world, to be a soldier is to be at high risk of HIV/AIDS. When troops become infected in large numbers, they are likely to infect surrounding civilian populations. In addition, military readiness is compromised - posing a threat to security and stability. In 70 countries around the world, the U.S. Department of Defense (DoD) is meeting these challenges by working with host-nation militaries to implement Emergency Plan programs to protect militaries.

The nation of Sierra Leone has suffered greatly from war in recent years. With support from the Emergency Plan through DoD, the Republic of Sierra Leone Armed Forces (RSLAF) has begun to show strong leadership in the fight against HIV/AIDS. RSLAF has developed and implemented a national strategy for addressing HIV/AIDS among troops, including naming a national focal person for HIV/AIDS prevention and care within the military. Monthly training seminars are now offered to all units deployed in the field, with more than 30 peer educators trained to work with soldiers in the field, and there are plans to train more. A troop sensitization program, or "road show," is helping to reach a broad audience. RSLAF has adopted a national HIV/AIDS policy that includes confidential screening of all potential recruits and care for HIV-positive soldiers and their spouses. Counseling, testing, and care are also available to all pregnant women receiving care at military clinics in Freetown.

Angola is recovering from a decades-long civil war. To serve troops there, the Emergency Plan has supported the Charles R. Drew University of Medicine and Science, a historically black U.S. institution, in developing a military HIV/AIDS program with DoD. A behavioral surveillance tool to assess high-risk behaviors, train health care workers in clinical surveillance, and develop behavioral interventions to educate new recruits on HIV risk behavior and prevention options is central to the program. This program has trained approximately 36,000 personnel, made counseling and testing available, and initiated a mass awareness campaign of HIV prevention using billboards, posters, and brochures. The program's success was profiled in the PBS documentary *AIDS Warriors*.

Through the work of DoD, the Emergency Plan is working with nations around the world to protect their troops - and their societies at large.

Supporting the Dominican Republic's National Response

Working within the Dominican Republic's national strategy, the Emergency Plan supported 12 outpatient care and treatment centers for HIV-positive people in 2004, laying the foundation for broader access to quality treatment and care services. The Emergency Plan also supported establishment of an integrated care unit in the Ministry of Health, helping to set and oversee the implementation of national AIDS treatment and care norms and providing training to improve the unit's financial and management capacity.

Another element of the Emergency Plan in the Dominican Republic, as in many other nations, is coordination of bilateral HIV/AIDS resources with those of the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and other donors under the "Three Ones" agreement (see chapter 7, "Strengthening Multilateral Action"). Country-level coordination includes U.S. leadership on the Global Fund's country coordinating mechanism.

ment and evaluation systems to monitor program results with quantified goals

- Employing targeted prevention interventions that include the successful ABC model (Abstinence, Be Faithful, and, as appropriate, correct and consistent use of Condoms) and other prevention activities such as programs to increase testing and improve blood safety

- Encouraging and strengthening faith- and community-based organizations as vital partners for U.S. HIV/AIDS programs to ensure a wide reach of programs, particularly at the community level and in hard-to-reach places, and to ensure long-term sustainability

- Fostering the development of sustainable health care networks by developing and expanding prevention, care, and treatment programs in concert with local governments and ministries of health, which maintain basic health care networks in most countries

In addition, as part of the significantly enhanced accountability of HIV/AIDS programs introduced by the Emergency Plan, interagency strategic information teams worked this past year to identify strategies and indicators to better track and monitor activities in bilateral HIV/AIDS programs outside of the focus countries. Based on the indicators developed for the focus countries, implementation of this coordinated monitoring and evaluation effort will greatly improve program planning and accountability.

Physicians and researchers led by Dr. Bill Pape (second from left) at the GHESKIO Center in Port-Au-Prince, Haiti. GHESKIO tested more than 53,000 people for HIV/AIDS and provided antiretroviral treatment to more than 1,800 AIDS patients in eight months through the collaborative support of both the Emergency Plan and the Global Fund.

"We're fully engaged in this global fight against AIDS - I mean fully engaged. Our nation took the lead in founding the Global Fund. We remain the world's largest contributor to the Fund. We're setting the example for others to follow. That's what a leader does. America leads so that others will follow."

President George W. Bush
June 23, 2004

Chapter 7
Strengthening Multilateral Action

The challenge of global HIV/AIDS requires sustained cooperative effort from host and donor nations, as well as international, national, and community organizations, employing their comparative strengths and resources. A key element of U.S. leadership under the President's Emergency Plan for AIDS Relief (PEPFAR/Emergency Plan) is to promote a comprehensive response by building international commitment to coordinated action to address HIV/AIDS at the country level.

Limited resources must be used efficiently to avoid duplication and achieve maximum impact. All contributors must work within the context of host country HIV/AIDS strategies, with a deliberate eye to building capacity and transferring responsibility for a sustained long-term response. This chapter focuses on Emergency Plan accomplishments in strengthening such coordinated action.

Strengthening Multilateral Action

Goal

Ensure a comprehensive and amplified response to global HIV/AIDS through leadership, engagement, and coordination with multilateral institutions and international organizations

Strategies

- Coordinate programs to ensure a comprehensive and efficient response and capitalize on the comparative advantage offered by each organization, including targeting organizational strengths to unique challenges
- Promote evidence-based policies and sound management strategies
- Encourage expanded partnerships that build local capacity

Strengthening International and Country-Level Coordination

The dramatic leadership commitment of the United States has greatly increased resources available to combat the HIV/AIDS pandemic and has brought coordination of strategies, implementation, and monitoring and evaluation to the forefront. The United States has been a partner and a facilitator of such coordination with host nations, other donors, and international partners in the fight against HIV/AIDS. The Emergency Plan has pursued initiatives to further cooperation among headquarters organizations and, even more critically, at the country level where HIV/AIDS services are being delivered.

The "Three Ones"

U.S. collaboration with key organizations includes a close partnership with the consortium of 10 United Nations agencies making up the Joint United Nations Program on HIV/AIDS (UNAIDS). The Emergency Plan has built on a long-standing effort by UNAIDS to establish principles for cooperation that make use of the comparative advantages of international partners and maximize resources by allowing for different but coordinated approaches to combat the pandemic.

In April 2004, OGAC, working with UNAIDS, the World Bank, and the U.K. Department for International Development (DfID), organized and co-chaired a major international conference in Washington for major donors and national partners to consider and adopt key principles for supporting coordinated country-driven action against HIV/AIDS. These principles became known as the "Three Ones" - *one* national plan, *one* national coordinating authority, and *one* national monitoring and evaluation system in each of the host countries in which organizations work. Rather than mandating that all contributors do the same things in the same ways, the Three Ones facilitate complementary and efficient action in support of host nations. Inherent in the principles is the shared recognition of the urgent need for action that supports inclusive national ownership and clear accountability.

In a historic global agreement, all major stakeholders and donors, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, endorsed these principles and committed themselves to their country-level implementation. The support of the United States and the United Kingdom were instrumental in bringing the agreement about, and the respective U.S.-U.K. national efforts remain central to its implementation.

UNAIDS is working with the United States and other partners to produce regular progress reports about the implementation of the Three Ones that will highlight success stories and address those countries that have not fully put the principles into practice. The first results matrix should be completed in early 2005.

As part of U.S. implementation efforts, U.S. missions in the Emergency Plan focus countries now include progress reports on coordination efforts in all country operational plans. Field staff recognize that the Three Ones are espe-

The "Three Ones" - Supporting One National HIV/AIDS Framework

Vietnam adopted its national strategy for HIV/AIDS just this year. Through its participation in the international HIV Technical Working Group and the Community of Concerned Partners (a committee of donors working to harmonize support organized through the auspices of UNAIDS and the United Nations Development Program), the United States worked with other international donors and UNAIDS to provide support and feedback during Vietnam's development of its national strategy. Since the adoption of the strategy, the United States has worked closely with stakeholders, including the government, civil society groups, other donors, foundations, UNAIDS, and other U.N. entities, to develop programs consistent with its framework. These coordinating activities are supported not only with U.S. participation but also with Emergency Plan funds. The United States will seek opportunities to further refine the national action framework by, for example, encouraging openness to nongovernmental organizations that have not previously been engaged and by seeking communication and transparency among all parties involved in HIV/AIDS activities in Vietnam.

cially relevant for those countries where the United States has substantially increased its HIV/AIDS assistance. OGAC has urged all posts to work with host governments to facilitate, where they do not already exist, the creation of inclusive national AIDS authorities and to adopt national strategies in collaboration with donors and civil society groups.

The "Three Ones" - Supporting One National AIDS Coordinating Authority

In the government of Namibia (an Emergency Plan focus nation), the National Multisectoral AIDS Coordinating Committee is responsible for the coordination and overall implementation of the national response. It brings together the policy and program offices of the government, donors, nongovernmental organizations, and other stakeholders. To support this national authority, the United States has an office within the Ministry of Health and Social Services, where the authority is housed, which enables U.S. personnel to provide technical support in a very cooperative fashion.

All 15 of the Emergency Plan focus countries now have such national authorities. A crucial role still remains, however, for the United States, UNAIDS, and other donors to play in contributing to a national AIDS authority's ability to set priorities and policies and in helping it monitor progress fully, inclusively, and transparently. The United States has set an example in this regard by supporting broad partnership forums where all stakeholders, including people living with AIDS, can participate in the work of the national AIDS coordinating authority.

Monitoring and evaluation is also an area where donor coordination is essential. There can be no real accountability without solid monitoring and evaluation; at the same time, multiple and duplicative reporting requirements can overburden those entities already struggling to meet HIV/AIDS service needs. The Three Ones provided renewed impetus to ongoing efforts to standardize monitoring and program evaluation activities.

Under the principle of one agreed country-level monitoring and evaluation system, the United States is committed to supporting national efforts to establish a single functional data collection and analysis system at the country level that meets the needs of both donors and program implementers. Discussed in more detail in chapter 9 ("Improving Accountability and Programming"), the United States is helping national institutions build capacity to track, monitor, and evaluate results while also working to streamline national and international indicators to improve systems for assessing progress against the HIV/AIDS pandemic and minimizing management and reporting burdens for host nations. Major accomplishments in 2004 included developing plans with WHO, UNAIDS, and the Global Fund for 1) the creation of joint monitoring and evaluation systems in 2005; 2) the establishment of a central technical support body for monitoring and evaluation; 3) jointly developed estimation methods and data release dates; and 4) coordinated evaluation plans.

The "Three Ones" - Supporting One Country-Level Monitoring and Evaluation System

Rwanda provides an example of the United States' commitment to this principle. The Emergency Plan is providing substantial support to the two governmental entities that oversee strategic information related to HIV, enabling them to plan, coordinate, and monitor the national response. The United States is funding an update of the national monitoring and evaluation plan, financial management training for government and nongovernmental organization personnel, capacity building for program evaluation, and production of progress reports for international donors. The United States is also providing information technology equipment, staff training, and connectivity at decentralized sites across Rwanda.

Strengthening International Partnerships

The Global Fund to Fight AIDS, Tuberculosis and Malaria

Multilateral organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria play vital roles in the fight against the HIV/AIDS pandemic, organizing across countries and sectors to create innovative financing mechanisms, pool expertise, and serve special populations and needs. The United States was instrumental in the creation of the Global Fund, with President Bush making its founding pledge. Collaboration with the Fund is underlined in the Emergency Plan's strategy.

The United States leads the world in contributions to the Fund, with $1.08 billion in contributions as of January 30, 2005, and has pledged a total of $2.12 billion from the inception of the Fund through 2008 (with cumulative contributions not to exceed 33 percent of total contributions to the Fund, beginning in fiscal year 2004). The United States accounts for 35.6 percent of total pledges and 32.5 percent of contributions to the Fund as of February 2, 2005.

In January 2003, then U.S. Secretary of Health and Human Services Tommy Thompson was elected Chairman of the Fund's Board, giving the United States special leadership responsibility through April 2005. Secretary Thompson traveled throughout the world on behalf of the Fund, enlisting and engaging governments, the private sector, and nongovernmental organizations to support the Fund's efforts to combat the global pandemic.

The launch of the Emergency Plan and the congressionally mandated 33 percent cap on U.S. Global Fund contributions have been important catalysts to encourage other donors to increase financial support for the Fund. That cap requires that cumulative U.S. contributions through 2008 never exceed 33 percent of total contributions to the Fund, beginning in fiscal year 2004. As of July 31, the date set by Congress for annual "snapshots" to determine the allowable level of U.S. contributions, other donors had only contributed enough for the United States to contribute $427 million of the total $547 million appropriated for 2004. As a result, the U.S. Global AIDS Coordinator, Ambassador Randall L. Tobias, decided to extend the deadline for an additional two months, giving the Global Fund additional time to raise the resources necessary to draw down the $547 million appropriated for 2004. Together with Secretary Thompson, Ambassador Tobias contacted the Group of Eight and other donors to urge that they accelerate and increase their contributions to allow the maximum possible amount from the United States. The Fund also made direct high-level approaches to leaders such as U.K. Prime Minister Tony Blair. Even private citizens got involved, contributing nearly a million dollars, in amounts from a few dollars to many thousands.

As a result of these efforts, during this two-month grace period the Fund received additional contributions totaling $67 million, allowing a final fiscal year 2004 U.S. contribution of $459 million. Although the United States was not able to make its maximum allowable pledge, the momentum generated by this challenge generated an additional $67 million for the Global Fund from other donors, and $33 million from the United States, for a total of $100 million that the Fund might not otherwise have received.

As the Global Fund has matured, Emergency Plan support has been important in extending the reach of its projects to 130 countries and amassing billions of dollars in pledges and contributions. As with bilateral U.S. efforts under the Emergency Plan, accountability in implementing local efforts is key to the Fund's success and the foundation upon which the Fund was conceived. Much of the United States' work with the Fund in fiscal year 2004 has therefore focused on supporting the Fund in being true to this founding principle. In addition, the United States and the Fund have identified important ways to coordinate and strengthen U.S. bilateral efforts and Fund activities.

In coordination with Fund staff, the United States has continued its long-term efforts to improve the Fund's capacity to monitor program performance and results. In October 2004, Emergency Plan and Global Fund staff jointly developed a monitoring and evaluation toolkit for use by both programs, which will assist the Fund in mak-

ing performance-based decisions on grant renewals. In addition, the United States helped design an early warning system to alert Fund partners, both bilateral and multilateral, when grant performance appears to be faltering. Of top priority in 2005 will be devising better means for partners to provide effective targeted assistance to improve such grants. Such program monitoring and response mechanisms will become increasingly important as the Global Fund prepares to launch a fifth round of grant proposals in March 2005, with Board approval of proposals slated for September 2005.

In June 2004, the Fund's Board approved nearly $1 billion in funding for the first two years of operations of a fourth round of Global Fund grants. As mandated by the Emergency Plan's authorizing legislation, the United States is also required to conduct a parallel technical review of Global Fund grant proposals. Fiscal year 2004 was the first year in which this provision was required, carried out through the establishment of a U.S. interagency task force comprising both headquarters and field staff from dozens of countries implementing HIV/AIDS programs. The interagency team's independent review of each Fund project resulted in the contribution of U.S. technical expertise and field knowledge to strengthen grant agreements. Numerous concerns were identified, including potential overlap of Fund and U.S. programs in several countries. Recommendations were made and submitted to the Fund's Board for approval. In many instances these suggested changes were incorporated in the final grant agreements.

Given potential overlap indicated by grants in Emergency Plan focus countries, including Tanzania, Ethiopia, and Kenya, the United States intensified efforts to identify such overlap in coordination with Fund staff and adjust grants accordingly. Coordination efforts have been improved by increasing membership and participation by U.S. personnel within the Global Fund's country coordinating mechanisms (CCMs), which coordinate and oversee the implementation of Fund projects.

The United States has also used its seat on the Global Fund's Board to maximize the participation of civil society within CCMs, in particular with the addition in 2004 of a requirement that CCMs must include representatives of people living with the diseases. In several countries where capacity is very limited, local U.S. personnel have also provided assistance to help the CCMs function more effectively.

Ambassador Tobias and Dr. Lee Jong-wook, Director General of the World Health Organization.

The World Health Organization

The United States works closely with the World Health Organization (WHO) to support the implementation of evidence-based policies and sound management, including implementation within its "3 by 5" initiative. WHO provides technical leadership and has a critical role to play in establishing norms and standards for a wide range of areas within the international public health response to HIV/AIDS. As a member state with considerable expertise in HIV/AIDS, the United States has been intimately involved in formulating HIV/AIDS-related policy and guidelines, actively participating in the World Health Assembly - where Emergency Plan policy often informs the discussion - and partnering with WHO and host countries to adapt and implement such policies.

Specific collaborations in fiscal year 2004 included developing recommendations for the expansion of HIV testing - an important component of combating the disease - with an emphasis on integrating HIV testing services into routine clinical care. Collaborations with WHO also resulted in significant advances in policy and action regarding medical transmission, including injection and blood safety. For example, the United States supported

WHO in providing technical assistance to countries developing national blood safety plans. As a result, some countries, including Tanzania, are close to achieving a nearly 100 percent HIV-free blood supply. The United States and WHO also worked together to formulate strategies for joint TB/HIV activities at the international, national and subnational levels. In June and September 2004, the United States, WHO, and other partners sponsored TB/HIV surveillance meetings in which nine focus countries (Botswana, Côte d'Ivoire, Ethiopia, Haiti, Kenya, Mozambique, South Africa, Tanzania, and Zambia) developed plans for improved TB/HIV surveillance. The Emergency Plan now supports ongoing technical assistance for plan implementation.

Human capacity development is a major priority for both the Emergency Plan and WHO. Preliminary discussions early in fiscal year 2004 have now led to coordinated activities to provide the training and technical assistance necessary to provide sustained responses to national epidemics. In countries such as Mozambique, the Emergency Plan and WHO are jointly conducting comprehensive human capacity development assessments to identify specific strategies to address long-term human resource needs. Collaborations on building capacity in the area of strategic information have been particularly successful, making considerable progress in achieving standard definitions and reporting on HIV/AIDS-related activities.

Building on its strong international alliances in the fight against AIDS, the United States will increasingly put such cooperation to work in the rapid expansion of prevention, care, and treatment services worldwide, promoting the adoption of established best practices across all areas of bilateral and multilateral action.

Partnering with Other Bilateral Donors

The United States has partnered closely with other donor nations to pursue joint strategies on HIV/AIDS. In November 2003, President Bush and U.K. Prime Minister Blair, with Ambassador Tobias present, launched a Special Joint Task Force on HIV/AIDS to strengthen cooperative efforts in five African countries severely

Collaboration with the United Kingdom

U.S.-U.K. collaboration at the country level is extensive. Examples include:

Ethiopia. With leadership from the United States and the United Kingdom, a multifaceted HIV/AIDS donor forum was formed to facilitate bilateral cooperation in financing, identifying vulnerable groups, and monitoring and evaluation efforts in support of the national HIV/AIDS strategy.

Kenya. The two countries jointly financed a management study of the National AIDS Control Council, the key national authority for AIDS, and encouraged the host government to reinforce its ownership of this body. In addition, the U.K. Department for International Development directly assisted the U.S. mission in overcoming initial procurement bottlenecks for medications and test kits that were slowing implementation of the Emergency Plan.

Uganda. The United States and the United Kingdom led other development partners in jointly supporting a study on human resources for HIV/AIDS in the health sector. The results were useful both in the formulation of the U.S. country operational plan and in the development of Uganda's national health sector strategic plan.

Before participating in an HIV/AIDS roundtable, President George W. Bush and British Prime Minister Tony Blair meet at 10 Downing Street, November 20, 2003.

affected by HIV/AIDS - Ethiopia, Kenya, Uganda, Nigeria, and Zambia. The Task Force was established to focus and reinforce bilateral efforts in these countries, enlisting other donors and host governments as well. Coordinated U.S.-U.K. cooperation is targeted to expanding prevention activities, providing wide access to care and treatment, and building a skilled force of health care workers, with a focus on the comparative strengths of each nation in its international HIV/AIDS programming.

Another important donor with whom the United States collaborates on the country level is the Netherlands. In September 2003, President Bush and Dutch Prime Minister Balkenende agreed to cooperate in HIV/AIDS prevention, treatment and care in countries where both the Netherlands and United States had significant bilateral programs. These nations currently include Ghana, Zambia, Rwanda, and Ethiopia. The cooperation agreement was a first step in a joint initiative between two of the world's largest donors for HIV/AIDS and contributed to the impetus for substantial increases in the Dutch international contribution to the fight against the HIV/AIDS pandemic. U.S.-Dutch field collaboration includes working together in:

- **Ghana** to develop and implement a landmark workplace treatment and prevention program that delivers services to tens of thousands of workers and their families. The initiative now has 31 participating private sector companies, 16 of which are already implementing programs.

- **Rwanda** to jointly facilitate funding of community projects that address HIV/AIDS prevention and mitigation. The United States and the Netherlands also have joint private sector programs for HIV prevention and treatment for those already infected. The United States supports PharmAccess, a Dutch consortium working with local companies, and the Bralirwa brewery in a joint venture with Heineken, Rwanda's largest non-state employer and a model for other companies.

- **Zambia** to support the Zambian Central Board of Health as it grapples with the HIV-related TB epidemic. The Netherlands is shifting its support for individual nongovernmental organizations to broaden support for institutional capacity building in nongovernmental and community-based organization networks to better mesh with the Emergency Plan's country strategy.

Key Challenges and Future Directions

As in its bilateral programs, the Emergency Plan has made it a priority to avoid wasteful duplication or counterproductive effort in its multilateral programs with fellow donors and international organizations. Just as accountability is a fundamental principle of Emergency Plan strategy, the world community must insist on the greatest possible degree of accountability for each dollar spent by all donors. And just as the Emergency Plan commits to supporting, strengthening and expanding the work of national governments and community organizations, the world community must continue to deepen local ownership and sustainability of programs by reinforcing national strategies.

Akebe Oqubay, the mayor of Addis Ababa, opted to be publicly tested for HIV/AIDS immediately following Ambassador Tobias' challenge to local leadership to be tested and reduce stigma.

"HIV/AIDS, you see, is a challenge, it's a direct challenge to the compassion of our country and to the welfare of not only our nation but nations all across the globe. It's really one of the great challenges of our time."

President George W. Bush
June 23, 2004

Chapter 8
Engendering Bold Leadership

A key objective of the President's Emergency Plan for AIDS Relief (PEPFAR/Emergency Plan) is to engender bold leadership and additional resources from other countries, entities and individuals for the fight against global HIV/AIDS. Leadership from every sector is necessary to combat stigma, denial, and discrimination; spur action; and mobilize resources from the public and private sectors. Leadership is also necessary to confront negative cultural patterns, including gender inequity, that contribute to the spread of HIV/AIDS.

The leadership demonstrated by President Bush in launching the Emergency Plan, and the United States' commitment to combating global HIV/AIDS that it represents, has helped strengthen leadership worldwide. Former Secretary of State Colin L. Powell never missed an opportunity to raise HIV/AIDS awareness and advocate for an amplified global response with audiences ranging from leaders of foreign nations to youth groups in severely affected countries. Following his example, U.S. Ambassadors also took up the cause, using their unique access and relationships within host countries to urge greater action. Worldwide, and in the focus countries in

Leadership

Strategies

The range of strategies the United States is pursuing to engender bold leadership in the fight against HIV/AIDS includes:

- Engaging heads of state, other government officials, community leaders (including people living with HIV/AIDS), and religious leaders to generate multisectoral leadership and responses to HIV/AIDS in severely affected nations
- Using tools of public diplomacy and communications to inform and engage new partners, including media, business, labor, and the public, and to advocate for greater leadership worldwide in the fight against the HIV/AIDS pandemic
- Using diplomatic interventions in bilateral and multilateral forums with donor nations and engaging private entities to raise additional resources for global AIDS

particular, government at every level has renewed its focus on HIV/AIDS, while civil society leaders and groups are also taking action against HIV/AIDS in their communities.

Since its inception, OGAC has pursued a variety of strategies to engage diverse audiences throughout the world in the fight against HIV/AIDS, including those in severely affected nations, donor and potential donor nations, and the American people, whose generous compassion has made the Emergency Plan possible. These strategies include outreach to government and community leaders, religious and civil society groups, and people living with HIV/AIDS in severely impacted nations; use of the tools of public diplomacy and communications to reach wider audiences and engage new partners; and active diplomacy to raise more resources for the fight against global AIDS.

Helping Traditional South African Leaders Combat HIV/AIDS

Fostering and supporting indigenous leadership is a major focus of the Emergency Plan. In South Africa, traditional leaders play an important role in society. The country's constitution recognizes traditional leaders as an embodiment of the people's way of life and as custodians of their customs, traditions and cultures. Traditional leaders therefore have tremendous potential to lead their constituencies in responding to threats such as HIV/AIDS, which is believed to affect more people in South Africa than in any other country.

Traditional healers in South Africa welcome an American delegation to their rural community in Kwazulu-Natal province.

In rural communities across the country, the Emergency Plan is supporting a unique leadership-building partnership, the Traditional Leaders HIV/AIDS Human Rights and Advocacy Program. The United States is collaborating with South Africa's National Department of Health, the Nelson Mandela Foundation, and the National Traditional Leaders' Forum. The program has implemented workshops on HIV/AIDS attracting more than 500 traditional leaders and 70 key government stakeholders, including representatives from South Africa's Departments of Agriculture, Social Development, and Health.

This training in advocacy and human rights is helping traditional leaders become powerful allies in the fight against HIV/AIDS. Many now deliver messages aimed at helping their constituents protect themselves and their loved ones from HIV infection. Many traditional leaders are also speaking out to protect the rights of people living with and affected by HIV/AIDS while promoting the quality care and support they need.

The partnerships promoted between traditional leadership and government representatives also lead to progress on the HIV/AIDS epidemic. Representatives from key government departments attending the workshops learn that traditional leaders are powerful entry points for service delivery in rural communities. Several months into the program, 40 percent of workshop participants had already established partnerships to serve basic needs including food security, income for unemployed families, and care for people living with HIV/AIDS.

Leaders in all areas of society have roles to play, and the Emergency Plan is helping South Africa's traditional leaders make the most of their opportunity to lead on HIV/AIDS.

Following a visit to a counseling and testing center in Mozambique, Ambassador Tobias answers local reporters' questions about the President's Emergency Plan.

Promoting Leadership by Government and Community Leaders

In nations suffering from the HIV/AIDS pandemic, leadership from the top levels of government is essential for an effective response. Leaders who have scorned stigma in favor of compassion and care for those infected or affected, and who have been bold in addressing the AIDS crisis, have made an impact on the disease in their countries and offered hope of turning the tide. The U.S. Global AIDS Coordinator, Ambassador Randall L. Tobias, and other U.S. Government leaders and staff have met with the heads of state or government of Botswana, Côte d'Ivoire, the Dominican Republic, Ethiopia, Guyana, Kenya, Mozambique, Nigeria, Rwanda, India, and Thailand, and with senior ministers and health officials from many countries receiving U.S. Government bilateral assistance. These relationships helped build country-level support for implementing the Emergency Plan and supported hard-hit nations in mobilizing their own campaigns against HIV/AIDS.

In hard-hit nations, leadership at the community level is crucial in the fight against HIV/AIDS. Such leadership ensures that messages about HIV/AIDS reach communities at every level, reinforced through forums including churches, mosques, schools, and community associations. The Emergency Plan has made a particular effort to encourage and support community leaders in responding to the pandemic. Ambassador Tobias and in-country U.S. Government staff have engaged community leaders as diverse as religious leaders, traditional healers, people living with HIV/AIDS, popular culture leaders, business executives, and sports icons in leading grassroots efforts against HIV/AIDS.

Ambassador Tobias and U.S. personnel have particularly highlighted the need for community and national leadership in fighting stigma. One of the worst impacts of stig-

Supporting National Leadership in Promoting Testing and Defeating Stigma

On a visit to the Emergency Plan focus country of Ethiopia, Ambassador Tobias was invited to join the Mayor of Addis Ababa, an influential figure in Ethiopia, to "cut the ribbon" at a new U.S.-supported counseling and testing center. To draw the attention of community leaders to their role in eliminating stigma, Ambassador Tobias mentioned that he had been tested himself the day before, in another center in Ethiopia. He urged the local leaders to do the same, and then to make it known that they had been tested.

In response, the Mayor of Addis Ababa announced that he was going to be tested himself following the ceremony, and he encouraged all the other political leaders there to do the same. The local media had treated Ambassador Tobias' test the day before as an interesting curiosity. But when the mayor of the capital city, one of the most important people in the country, was tested - and publicly said so - the story was heavily covered by the local media. Because of his leadership example, the effects multiplied as more and more leaders publicly stepped forward to be tested in the days that followed.

From a local leader's small gesture of leadership and rejection of stigma, many Ethiopians learned of the importance of HIV testing. Encouraging this kind of indigenous leadership is a hallmark of the President's Emergency Plan.

ma is its deterrent effect on those in need of HIV testing and counseling. Increasing testing is central to the effectiveness of HIV prevention and treatment efforts, yet those who seek testing are often stigmatized. In this area, leadership can have a tremendous impact. In both private and public forums, Ambassador Tobias has urged leaders to speak out against discriminatory attitudes and in favor of compassion and care for those infected or affected. In keeping with the "lead by example" intent of the Emergency Plan, Ambassador Tobias and U.S. Government in-country staff have publicly sought HIV testing, inviting local media and officials to be present, and, at times, participate. The public attention generated by these events has helped promote testing and defeat stigma.

Speaking Out for "Access for All" at the Bangkok International AIDS Conference

The theme of the XIV International AIDS Conference in Bangkok, Thailand, was "Access For All," emphasizing the need for rapid progress in making lifesaving antiretroviral medicines available in the developing world. This philosophy is central to the President's Emergency Plan, and the United States welcomed the opportunity for the world to come together to meet this goal.

Ambassador Tobias's plenary lecture at Bangkok, "The Fight Against Global AIDS: What Do We Need to Do Differently?," called on the world community to put past differences aside and come together in a spirit of unity to defeat HIV/AIDS. The speech, forcefully delivered after being delayed by protesters, brought extensive worldwide press coverage to America's call for unity in the world's response to the pandemic.

While in Bangkok, Ambassador Tobias also met with other leaders in the fight, including people living with HIV/AIDS, and visited U.S.-supported HIV/AIDS services providers in Thailand. He also met with some of the harshest critics of U.S. leadership on global AIDS, defending the urgent U.S. response to the crisis and advocating bolder leadership from the world community to make "Access for All" a reality.

Promoting Leadership Through Public Diplomacy and Communications

Increased worldwide and multisectoral commitment is essential to defeating global HIV/AIDS. U.S. Government leaders have reached out directly to a variety of domestic and international audiences through local and international print, radio, and television media; speaking engagements; and conferences.

Emergency Plan World AIDS Day activities exemplify this approach. For World AIDS Day 2003, Ambassador Tobias accompanied former Secretary of Health and Human Services Tommy Thompson to six countries in Africa as part of a 100-member delegation that included governmental and nongovernmental representatives. Former Secretary of State Colin Powell taped World AIDS Day messages that appeared in several African countries and at World AIDS Day events including benefit concerts in Moscow and Kiev. U.S. Ambassadors penned opinion pieces that appeared in at least 39 countries and more than 60 print and Web-based publications. For World AIDS Day 2004, OGAC developed and coordinated the placement of domestic World AIDS Day opinion pieces by former Secretary Powell and Secretary of Labor Elaine Chao and a piece jointly authored by Ambassador Tobias and UNAIDS Executive Director Peter Piot. With heavy media coverage, Ambassador Tobias participated in World AIDS Day forums at the National Press Club and the Woodrow Wilson Center in Washington with Dr. Piot of UNAIDS and other leaders. In addition, Ambassador Tobias participated in digital video conferences with media from Russia, France, and Australia; met with Washington-based reporters from Japan and Latin America; and provided interviews to BBC outlets to reach international audiences.

OGAC has looked for every opportunity to raise the AIDS issue on the agendas of international opinion leaders. For example, in collaboration with Under Secretary for Global Affairs Paula Dobriansky, Ambassador Tobias addressed a group of women ambassadors to the United

Bringing Global HIV/AIDS Awareness to Wall Street

On October 13 the opening bell of the New York Stock Exchange bell rang with an unusual purpose - to summon the business community to offer leadership on HIV/AIDS. Ambassador Tobias, himself a former CEO, was joined for this event by senior leaders from eight corporations - DaimlerChrysler, Ford Motor Company, 3M, Becton Dickinson, Getty Images, FedEx, Viacom, and Hewlett Packard - that have led the way in responding to HIV/AIDS. Before proceeding to the bell podium, the leaders discussed their experiences in fighting AIDS and shared ideas for involving other businesses in fighting the pandemic.

The ringing of the opening bell is a familiar image in the world of business. The Stock Exchange estimates that the bell-ringing is viewed live by millions of people around the world every day. On most days, business executives ring the bell in order to publicize their companies.

After Ambassador Tobias rang the bell, the trading floor rapidly returned to its usual chaotic state. But perhaps this unusual interlude provided the inspiration for a few business leaders to decide that their companies would join the fight.

Drawing the attention of the business community to global HIV/AIDS, Ambassador Tobias rings the bell of the New York Stock Exchange with leaders of companies that have made fighting HIV/AIDS a priority.

States, focusing on issues affecting women and girls. U.S. Government leadership has engaged religious leaders worldwide, including senior leadership at the Holy See. At the Council of the Americas, Ambassador Tobias encouraged heightened commitment and increased openness from Western Hemisphere leaders in dealing with the pandemic.

By participating in multilateral events, including UNAIDS, UNICEF, and World Bank conferences and the XIV International AIDS Conference in Thailand, Ambassador Tobias has strengthened the call for international action and collaboration, advocating for an unprecedented global response. Through these efforts, international audiences heard clear messages about the need for the world to come together in fighting the HIV/AIDS pandemic and the need for every nation to play its part.

Encouraging the commitment of private sector leaders, globally as well as domestically, has also been a key priority of OGAC. In hard-hit nations, businesses have a unique capability to assist workers and their families in protecting themselves against HIV/AIDS and accessing appropriate treatment and care. Globally, the private sector must be mobilized to bring both its resources and innovations to the fight against the HIV/AIDS pandemic.

U.S. missions implementing the Emergency Plan have formed dozens of innovative local partnerships with business and industry associations that bring resources and community leadership to the fight against the epidemic in their countries. U.S. Government leadership has engaged private sector leaders in developing strategies to combat HIV/AIDS at forums such as the Global Business Coalition on HIV/AIDS, composed of activist CEOs addressing HIV/AIDS, and the Initiative for Global Development, a network of business executives devoted to mobilizing private sector leaders for economic development in poor nations. With these efforts, participation from the private sector has continued to grow; for example, several large European media firms have joined the Global Business Coalition and are lending their communication expertise to the fight against HIV/AIDS.

Engendering Leadership in the Private Sector

The Emergency Plan supports the Department of Labor in promoting HIV/AIDS initiatives in the workplace. In India, the country team has had substantial success in the state of Jharkand in a project working with seven enterprises to train 40 master trainers who will in turn train enterprise employees.

One of the companies is McNally Bharat Engineering Ltd., where there has been enormous support for the project. Company officials were originally skeptical of the project and questioned why their enterprise was singled out in the province. They also felt that the employees, all highly educated with a background in engineering, did not need HIV/AIDS training. In time, the HIV/AIDS project staff convinced them the company was not being targeted because of suspected infection but because it would be able to serve as an example for the rest of the region.

McNally Bharat volunteered to hold the first training of master trainers, and 10 of its employees volunteered to be master trainers. These 10 master trainers are now educating 200 employees about HIV/AIDS. The company also adopted the region's first corporate HIV/AIDS policy in April 2004. The other six participating enterprises in the region, seeing the positive progress of McNally Bharat, have increased their training schedules, with two now in the process of adopting a company-wide HIV/AIDS policy.

The U.S. Department of Labor has been a key implementing partner in promoting private sector HIV/AIDS initiatives under the Emergency Plan, reaching out to ministries of labor, employers, and labor leaders to improve responses to the HIV/AIDS pandemic. In Vietnam, the Emergency Plan supported training and technical assistance to Colgate-Palmolive managers to help the company quickly establish a workplace policy that protected its HIV-positive employees and eliminated mandatory testing. The company will promote anonymous voluntary testing; care and support services for its employees; and ongoing employee education activities. Colgate-Palmolive recently stated that it views its HIV/AIDS program as a model to replicate in its other branches throughout Asia, including those in China, Thailand, India, and Nepal.

In addition, the increasing number of funding agencies, implementing partners, and other organizations undertaking workplace-related HIV/AIDS activities internationally has led to a growing recognition of the need for leadership, information sharing, coordination, and collaboration of private sector efforts. The biannual Roundtable on HIV/AIDS in the International Workplace, jointly sponsored by OGAC, the U.S. Department of Labor's Bureau of International Labor Affairs, and the U.S. Agency for International Development's Bureau for Global Health, encourages the expansion of effective private sector partnerships and related workplace HIV/AIDS initiatives by sharing lessons learned, identifying opportunities for new partnerships, and addressing specific implementation challenges.

The President's historic Emergency Plan reflects - and depends on - the compassion and commitment of the American people. Knowing that the fight against the HIV/AIDS pandemic will take years to win, U.S. Government leaders have especially engaged the compassion of Americans to develop domestic constituencies and new partners in support of the U.S. Government's efforts to combat AIDS internationally. At the National Conference of Mayors, Ambassador Tobias urged local leaders to get involved in the global HIV/AIDS fight through mechanisms such as "sister city" relationships with cities in hard-hit nations. U.S. Government leaders have reached out to special affinity groups in the United States, encouraging their leadership in America's efforts against the pandemic. Among the groups addressed were Haitian-Americans, Vietnamese-Americans, the Africa-America Institute, faith-based communities, the International Women's Forum, and the National Association of Women Judges. Through his participation in an Indiana University conference that highlighted the work of the University's treatment program in Kenya, Ambassador Tobias brought media attention to the contributions American institutions can make.

Promoting Leadership for Increased Donor Resources and Commitment

Leadership from other donor governments is indispensable for effective action in the fight against the HIV/AIDS pandemic. Beyond the operational challenges, it is imperative that the global community respond with additional resources for fighting global HIV/AIDS. The U.S. Government calls on fellow donor nations, and potential donor nations, to meet this humanitarian crisis with human compassion.

There has been a clear global increase in resources being dedicated to this fight, due in large part to U.S. initiative, but the emergency demands more from the world as a whole. The high-level launch of the Emergency Plan generated heavy media coverage globally. The urgency and scope of the President's historic initiative to turn the tide against global HIV/AIDS created diplomatic momentum that encouraged announcements by other donors, including the United Kingdom, Italy, Canada, Australia, and the Netherlands, of substantial increases during 2004. In some cases, nations doubled or tripled their budgets for international AIDS relief.

At the Special Summit of the Americas, held January 12-13, 2004, in Monterrey, Mexico, leaders from the 34 democratic countries of the Western Hemisphere pledged to fight corruption, spur growth, reduce poverty, and improve education and health in the region. To implement this commitment, the leadership agreed to provide antiretroviral treatment for HIV/AIDS to all who need it, with a goal of treating at least 600,000 individuals by the end of 2005. In November 2005, leaders from the Western Hemisphere will once again meet for the Summit of the Americas in Mar el Plata, Argentina, with the theme of "Creating Employment to Confront Poverty and Strengthen Democratic Governance." The U.S. Government is working closely with the Pan American Health Organization and other countries in the hemisphere to encourage an HIV/AIDS initiative aimed at fighting stigma and discrimination through workplace programs.

The United States and European Union (EU) partners have also built on the opening provided by the EU's

Ambassador Tobias meets with President Joaquim Alberto Chissano of Mozambique to encourage strong indigenous leadership in the fight against HIV/AIDS.

Dublin Conference, hosted by Ireland as EU President. With U.S. encouragement, the EU has taken initial steps to address the HIV/AIDS technical and resource needs of the EU's new Eastern European member states, which lost access to outside development assistance upon their entry to the EU. The succeeding EU President, the Netherlands, also included a major focus on HIV/AIDS and donor coordination of HIV/AIDS programs at the country level. The United Kingdom will continue to focus on Africa and HIV/AIDS during its Group of Eight presidency in 2005.

Ultimately, the key to reducing the scourge of HIV/AIDS in the developing world, especially in Africa, is assertive leadership on the part of political and social leaders in the countries most affected. This leadership must include a commitment to use indigenous as well as donor resources to educate and empower individuals to prevent transmission of the disease; to provide access to quality antiretroviral treatment and palliative care; and to reduce the stigma associated with HIV/AIDS in order to mitigate its impact on economies, societies, communities, families, and individuals.

With support from the Emergency Plan, Namibia is developing the technological infrastructure necessary to support a comprehensive health management information system.

> "We ought not to be measured on how much money we move, we ought to be measured on how many lives we save."
>
> President George W. Bush
> June 23, 2004

Chapter 9

Improving Accountability and Programming

Accountability for results is a cornerstone of the President's Emergency Plan for AIDS Relief (PEPFAR/Emergency Plan) and serves as the basis for program and policy development, implementation, and improvement. Fiscal year 2004 program accomplishments in prevention, capacity building, care, and treatment provide critical information for future funding cycles, mid-course program adjustments, and the identification of best practices in the field.

Collecting and analyzing HIV/AIDS data for program accountability and improvement in the developing world poses certain strategic information challenges. Tracking patients and maintaining records is particularly difficult in under-resourced settings. Often, over-extended physicians and other health practitioners focus on delivering the best quality services as quickly as possible, with little time to focus on patient record-keeping. A key contributor to patient record-keeping and timely information-sharing is a robust health management information system infrastructure. In many of the focus countries, lack of such an infrastructure presents a challenge to both routine monitoring and program evaluation efforts.

In response to these challenges, the Emergency Plan has begun implementation of key strategic information systems identified in the U.S. Five-Year Global HIV/AIDS Strategy. Such strategies include the improvement of surveillance activities to ensure a clearer understanding of the epidemic; accurate reporting to enhance program accountability; design and upgrade of information management systems to support patient tracking and program monitoring activities; and prioritization and coordination of special studies across countries. In addition, the Office of the U.S. Global AIDS Coordinator (OGAC) has engaged in a number of activities to build country capacity for strategic information and to enhance coordination and cooperation across U.S. Government agencies and external donor organizations, such as UNAIDS, WHO, and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Surveillance Information to Track HIV Incidence, Prevalence, and Mortality

Enhanced surveillance efforts improve our understanding of the epidemic. Surveillance provides knowledge of

where cases are concentrated, and among whom, and allows tracking of program impacts and outcomes. For example, in Guyana, uncertainty remains about important aspects of the epidemic, such as prevalence, both overall and among certain high-risk groups. To address this, complementary data collection efforts are under way, including behavioral surveillance surveys, AIDS indicator surveys, antenatal clinic surveillance, and most-at-risk population surveys. Survey results will be used to help target future funding and make midcourse program shifts.

Surveillance efforts are also providing improved information for Emergency Plan programs in Botswana. One effort focuses on improving the tracking of TB cases through an electronic TB register. This system has been successful and Botswana reported more than 10,000 HIV-positive individuals receiving TB care and treatment in an AIDS palliative care setting during fiscal year 2004.

Key fiscal year 2004 outcomes of HIV surveillance efforts also include improved methods for estimating and projecting HIV prevalence and incidence, an improved definition for AIDS case reporting, and development of methods for antiretroviral drug resistance surveillance. A number of baseline data collection activities were undertaken, establishing baselines for measuring changes in the pandemic over time.

Program Reporting and Monitoring Mechanisms

In fiscal year 2004, each focus country followed OGAC's newly established central reporting process. Components include five-year strategic plans to set long-range vision, annual country operational plans to map out specific program activities and related budgets, and biannual and annual reports to document program results. In a number of countries, the Emergency Plan has organized monitoring and evaluation coordinating committees to ensure coordination of the planning and implementation of country HIV reporting systems with existing health information efforts. For example, in Botswana, the United States supports the HIV Response Information Management System to enhance monitoring, reporting, and use of data in decision-making. Such data will help target use of U.S. funds and measure progress toward the 2-7-10 goals in the 15 focus countries. By mid-2004, all U.S. missions allocated resources to enable them to report first-year treatment accomplishments.

Health Management Information Systems

The emphasis on health management information systems (HMIS) in the Emergency Plan has a threefold purpose: 1) to assist in the collection of core indicator data; 2) to improve country capacity to collect client-level and clinical service information that will assist in daily management of individual patient care; and 3) to improve capacity to collect facility-, district-, and country-level information that will assist with clinic and program management. Emergency Plan HMIS activities are spearheaded by a multi-agency workgroup that facilitates the design of country-level management information systems. These integrate separate HIV information systems (including patient management, laboratory services, logistics management, program indicators, and HIV facility-based management information systems) into broader regional or national health information systems. The HMIS workgroup helps improve the quality and capacity of data storage systems, data flow, and use of data for decision-making.

A number of countries have already seen improvements in their information systems. In Ethiopia, for example, Emergency Plan funding is facilitating the adoption of a national monitoring and evaluation plan and framework in site-level database systems for prevention of mother-to-child HIV transmission, TB, antiretroviral treatment, and counseling and testing, and is also expanding public health information systems to all Ministry of Health offices. To begin this work, U.S.-supported program staff created operations manuals for implementers, developed database formats, and trained information officers, 400 to 600 of whom will be trained by early 2005.

In Namibia, the Emergency Plan is also working with the National Planning Commission, the Ministry of Health, the United Nations Development Program, and others to improve reporting of estimates and projections on the impact of HIV/AIDS on key demographic and health

This computer is part of a site-level database system in an Ethiopian counseling and testing site. With Emergency Plan support, the system will help ensure the accuracy and accessibility of patient records.

indicators. The Emergency Plan is providing technical assistance to the central statistics office and the monitoring and evaluation unit in the Ministry of Health.

In Botswana, the President, his cabinet, and other stakeholders have advocated a centralized computer-based information management system. The current system produces quarterly paper-based reports on program implementation at the national and district levels. It is highly dependent on information inputs from sources such as government and private health sectors, institutions, individuals, and financiers and donors across Botswana. U.S. support will allow for further development of the framework and full implementation of monitoring and evaluation services for all sectors by 2006.

An example of how focus countries are benefiting from tools developed in the United States comes from Uganda, where Emergency Plan funds are being used to adapt and test the U.S. Health Resources and Services Administration's CAREWare, an electronic medical record and reporting system first developed to track HIV patients in the United States.

Key accomplishments in fiscal year 2004 included publication in May of a concept paper, *Developing Facility-Based Management Information Systems*, which describes the strategy for achieving Emergency Plan HMIS objectives. Three countries - Haiti, Côte d'Ivoire, and Mozambique - initiated HMIS planning and assessment in fiscal year 2004. Recommendations and action steps were developed for each country and are in various stages of implementation. Five additional U.S. missions are anticipated to participate in the HMIS planning and assessment process in fiscal year 2005. An HMIS Assessment Guide has been developed to assist U.S. missions that have not yet initiated an HMIS assessment. An inventory was also developed to support U.S. missions that plan to use software in the management of patients receiving ART. This inventory describes about a dozen software packages, including their functions, system specifications, availability, and suitability to various settings. Two of the software tools, the CAREWare tool for patient care and management and the Epi-Info data analysis tool of the Centers for Disease Control and Prevention (CDC), were modified to make them more suitable for Emergency Plan requirements. In fiscal year 2005, a new area of focus for the inventory will be laboratory information systems. Additionally, software packages currently supported by Emergency Plan funds, including CAREWare and the UNAIDS Country Response Information System, will be updated and/or enhanced. Enhanced support and management of geographical information systems activities is anticipated, as well as support to WHO for its HealthMapper and Service Availability Mapping projects.

Identifying Best Practices

Identifying evidence-based best practices is a core principle of the Emergency Plan. Through determining key evaluation questions, monitoring methods and results, and evaluating programs and activities on the ground, the Emergency Plan is ensuring program reliability, determining critical areas of program success, and seeking opportunities for program improvement.

In 2004, OGAC convened a standing subcommittee on targeted evaluations under its Scientific Steering Committee. This group of U.S. Government program implementers, evaluators, and research scientists has agreed upon critical evaluation questions for the first year of Emergency Plan implementation and conducted a technical review for proposed targeted evaluation activi-

ties in the fiscal year 2005 country operational plans. Based on input from this technical review, OGAC will determine the need for centralized mechanisms for technical assistance to countries implementing studies and address gaps in the evaluation agenda.

Joint U.S. Government Planning

Strategic information staff at U.S. Government agencies, including the U.S. Agency for International Development (USAID), the Department of Health and Human Services, the Department of Defense, the Census Bureau, and the Peace Corps have worked together to transform their formerly disparate surveillance, HMIS, targeted evaluation, and monitoring and evaluation activities. They have produced an annual joint activity plan and budget focused on improving strategic information capacity in both Emergency Plan focus countries and other countries. Through this effort, U.S. Government agencies have combined complementary strengths, such as CDC's HIV surveillance experience and USAID's population survey experience, to update HIV epidemic impact and outcome information, provide technical assistance, and build capacity in the field.

Through coordinated strategic information planning, in fiscal year 2004 U.S. Government agency headquarters and country teams achieved the following:

- Substantially contributed to international efforts to coordinate the monitoring and evaluation objective under the "Three Ones" strategy (see chapter 7) by establishing one country monitoring and evaluation effort.

- Participated in UNAIDS strategic information reference groups and hosted a meeting in Washington to harmonize 2004 program reporting information. The reference groups coordinated data measurement definitions and common support of management information systems and related standards. They also harmonized the interpretation of the quality of international treatment numbers.

- Partnered with WHO, UNAIDS, the World Bank, and the Global Fund in the effort to improve the quality of HIV/AIDS strategic information. The results of these partnerships include harmonizing 2004 country treatment numbers, expanding HIV surveillance guidelines, and agreeing to draft common HIV management information standards in 2005.

- Established an annual planning and results reporting system for use within the U.S. Government - the Country Operational Plan and Reporting System. This Web-based information system allows for the annual entry and updating of Emergency Plan country operational plans, semiannual reports, and budget information by the focus country teams. Information is now available and can be rapidly searched and reported by key factors and areas of interest to the program, including partner and partner type, program area, geographic coverage, women's issues, indicator targets, and budget.

- Took a leadership role in planning, funding, and participating in a number of joint international donor-sponsored training and capacity building efforts, including in-depth strategic information staff training in Atlanta, surveillance training in Ethiopia, and a joint HMIS country planning meeting in Tanzania.

Table 9.1 - Strategic Information: FY04 Capacity Building Results

Country	Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	Focus country strategic information team hired and organized
Botswana	71	X
Côte d'Ivoire	187	X
Ethiopia	588	X
Guyana	65	X
Haiti	460	X
Kenya	1,286	X
Mozambique	304	X
Namibia	371	X
Nigeria	690	X
Rwanda	319	X
South Africa	2,044	X
Tanzania	315	X
Uganda	1,471	X
Vietnam	273	X
Zambia	856	X
Total	**9,300**	

In addition, U.S. missions in focus countries have established strategic information functions with staff for program reporting and gathering surveillance impact and outcome information.

Table 9.1 summarizes the results of capacity building efforts for strategic information in Emergency Plan focus countries during 2004.

International Coordination

The Emergency Plan's strategic information system is being guided by internationally agreed indicators developed by WHO, UNAIDS, and the United States. Such worldwide coordination is part of ongoing efforts to harmonize data and reporting systems across donors. Donors are working together to streamline how they require affected nations to submit proposals, manage programs, and report strategic information. Ensuring compatibility among donor requirements enables recipient nations to face fewer burdens. With the United States in a leadership role, donors are working to come up with better systems to collect high-quality data.

Beginning in 2004 and continuing into 2005, OGAC pursued harmonization efforts with WHO, UNAIDS, and the Global Fund. In late 2004, senior strategic information managers from the Global Fund and Emergency Plan drafted plans for coordination in four new systems areas - joint monitoring and evaluation systems (to be created in 2005); a central technical support body for monitoring and evaluation; jointly developed estimation methods and data release dates; and coordinated evaluation plans. Additionally, data confidentiality and international data collection protocols were discussed and are now being established and reinforced. To ensure that data systems are suited to resource-poor settings and enable easy data sharing, in 2005 the Global Fund and OGAC have agreed to:

- Communicate system guidelines to grantees and countries
- Develop guidance on data storage, confidentiality, and transmission standards based on initial guidelines
- Coordinate with WHO on national estimates
- Share data on subrecipients and assess overlap

The Emergency Plan, the Global Fund, WHO, and UNAIDS have also agreed to an ongoing dialogue with regard to study results and epidemiologic estimates. Donors saw a need to coordinate national WHO and UNAIDS epidemiologic estimates to enhance consistency in reporting, with attention to clarifying what the estimates can include and how they relate to Emergency Plan and Global Fund epidemiologic data. Among the needs are consistent estimates of people on ART and how to attribute the contributions of various donors.

Donors also recognized a need for coordination on information collected about funded programs. Plans for the future include:

- Sharing of common data on focus countries
- Comparing subrecipients in focus countries
- Meeting with WHO/UNAIDS to specify content and dates for national estimates
- Jointly analyzing reported Emergency Plan/Global Fund data
- Analyzing and issuing a joint statement on high-level results
- Preparing a comparative article on figures, problems with data, data comparison challenges, and estimates

Multiple evaluators across donor organizations are working to better determine what evaluations to undertake and how to conduct them. Areas for coordination to be worked out include development of baselines against historical data, the potential impact of interventions on infections averted, and mortality and disease outcomes.

Key Challenges and Future Directions

The future of HIV strategic information systems holds many challenges, particularly in countries that lack basic transmission and storage capacity for health information, have few trained strategic information personnel, and must cope with the operations and demands of multiple donors. Major Emergency Plan efforts in 2005 will focus first on building U.S. Government systems within countries for monitoring partner accountability and reporting. Headquarters workgroups will assist missions in the Emergency Plan's focus countries as they issue reporting guidelines and audit and store program and budget data from partners. Discussions are also under way among U.S. agencies to explore harmonizing their existing HIV reporting systems in other nations where the Emergency Plan is at work. As it pursues these activities, the United States will also continue and expand its coordination of strategic information with other donors.

President George W. Bush emphasized the importance of effective management of the Emergency Plan in his speech on compassion and HIV/AIDS at People for People in Philadelphia, Pennsylvania, June 23, 2004.

> "We're moving a lot of money … I want to make sure the money is actually spent wisely …"
>
> President George W. Bush
> June 23, 2004

Chapter 10
Implementation and Management

Implementation and Management

Goal

Efficient, effective, and accountable use of resources

Achievements in Fiscal Year 2004

- Created a unified U.S. Government HIV/AIDS team at headquarters and field levels
- Published a unified U.S. Government strategy for global HIV/AIDS
- Developed unified U.S. Government five-year strategies and operational plans in each of the 15 focus countries
- Developed a unified reporting mechanism for results-based assessments
- Obligated $673.9 million in 15 focus countries supporting nearly 1,200 partners
- Obligated $1.3 billion for central programs supporting 15 focus countries and HIV/AIDS assistance to 96 additional countries, international research, and international partners

A Unified U.S. Government HIV/AIDS Team

President Bush's Emergency Plan for AIDS Relief (PEPFAR/Emergency Plan) is a bold call for action abroad and an equally bold call for a "new way of doing business" here at home. Under the leadership of the U.S. Global AIDS Coordinator, new structures and systems were established at every level of the U.S. Government working in international HIV/AIDS to ensure a unified strategic approach to combating the epidemic abroad. The primary implementing departments and agencies of the U.S. Government - the Departments of State, Defense, Health and Human Services, Commerce, and Labor; the U.S. Agency for International Development; and the Peace Corps - have heeded the Coordinator's call to "leave their uniforms at the door" and come together in the common cause of turning the tide against the HIV/AIDS pandemic. Although this is an ongoing process, the achievement of a single U.S. approach to global HIV/AIDS within the first year of implementation is extraordinary. It is a testament to the dedication and compassion of program and management technical experts and administrators throughout the implementing departments and agencies.

Strong leadership is required to ensure a unified U.S. approach to global HIV/AIDS. To that end, at the headquarters level the U.S. Global AIDS Coordinator chairs a weekly policy team of principals from the lead implementing agencies. The Assistant U.S. Global AIDS Coordinator chairs a weekly meeting of deputy principals to manage specifics related to program implementation. To ensure that the Emergency Plan incorporates the most advanced technical thinking, there are interagency technical working groups for care and treatment, prevention, orphans and vulnerable children, human capacity development, and strategic information, as well as a scientific steering committee. Although a Chief Operating Officer has not yet been named, technical working groups are already functioning in human resources and acquisitions and assistance. Each of the technical and operations working groups is co-chaired by representatives from various implementing agencies and includes field representatives. In addition to formulating technical guidance and providing direct support to field programs, these working groups have streamlined differences among agencies on reporting requirements, policies, and regulations.

In each focus country, the U.S. Ambassador leads an interagency HIV/AIDS team that includes all of the implementing departments and agencies in-country. This unified U.S. Government in-country team ensures a unified strategy and voice in working with host governments and local nongovernmental partners. In many of the focus countries, there are also interagency technical working groups that relate to host governments and nongovernmental partners. Thanks to the commitment of U.S. personnel in the field, the implementation of highly functional interagency teams in-country has been a remarkable first-year achievement. Because the U.S. Government now speaks with one voice on HIV/AIDS, interactions with host governments and nongovernmental partners have become more efficient and effective. In many countries, high-level Emergency Plan advisory committees have been formed to ensure a close working relationship between the U.S. Government and host-country counterparts responsible for directing the national strategy. For example, in Nigeria, the Minister of Health and the U.S. Ambassador chair a joint Nigerian-U.S. Emergency Plan working group. In Uganda, the U.S. Ambassador has convened a multisector Emergency Plan advisory group chaired by a former Prime Minister. These relationships complement U.S. participation in donor groups that support national strategies and further ensure that the Emergency Plan is fully coordinated with the national HIV/AIDS strategy.

To ensure constant communication between interagency teams at headquarters and interagency teams in the field, the Office of the U.S. Global AIDS Coordinator (OGAC) has established feedback and exchange processes. An interagency Core Team, with a coordinator in OGAC, serves as a liaison between the field and headquarters. The Core Team structure contributes to the strategy of a unified U.S. Government approach to combating the HIV/AIDS pandemic. The Core Team is fully informed of OGAC policy as well as country programs, facilitating the flow of information between countries and headquarters. The Core Team also provides technical assistance and support in program and management areas, including the identification and provision of specialized technical assistance beyond the scope of the Team members.

In order to share learning and offer feedback across all levels of program implementation and management, country team representatives, led by their Ambassadors, and OGAC leaders met in Johannesburg, South Africa, in June 2004 to take stock and plan next steps. This forum provided the opportunity for a rich exchange on programmatic and management issues and enabled countries and headquarters to learn from each other. Several important actions to improve the Emergency Plan were instituted as a result of this meeting. Countries asked for clearer and more consistent communication from Washington on policy and implementation issues. This resulted in *News to the Field*, a weekly e-mail that provides the latest information, guidance, and news from headquarters. Issues addressed are often generated from questions from field missions which are raised through the Core Teams.

The Global AIDS Coordinator recognizes that clear and transparent communication outside the U.S. Government is also essential. During fiscal year 2004,

OGAC worked with departments and agencies to overcome technical and administrative obstacles to developing a comprehensive, transparent Web site fully accessible to all, with the expectation that the site will be functional in the third quarter of 2005.

A Unified U.S. Government Strategy

On February 23, 2004, one month after the first congressional appropriation of resources for the President's Emergency Plan, the Coordinator submitted to Congress the U.S. Five-Year Global HIV/AIDS Strategy. The Strategy set forth in detail the goals of the Emergency Plan and strategies for achieving those goals, and it guided the Emergency Plan activities in fiscal year 2004 described throughout this report. All U.S. embassies have received the Global Strategy, and the Coordinator has sent cables to the U.S. Ambassador in every country with a bilateral HIV/AIDS program requesting that their programs be aligned with the five-year strategy. Guidance has also been provided to all bilateral programs to facilitate the incorporation of Emergency Plan goals and strategies in the Department of State Mission Performance Plans.

In addition, the U.S. Ambassador in each of the 15 focus countries led country teams in the preparation of a five-year country strategy, submitted in October 2004, to guide country operational plans toward the Emergency Plan's five-year goals. These results-oriented strategies are based on the Five-Year Global Strategy, and were developed with U.S. partners in-country so that they 1) reflect unique challenges and opportunities for each focus country; 2) ensure support of host-country HIV/AIDS strategies; 3) effectively build on the comparative advantage of U.S. Government expertise; and 4) complement other donors' programs.

Now that the Emergency Plan is well into its first year of program implementation, OGAC plans to hire a contractor to provide an independent non-financial audit and evaluation of in-country implementation of select programmatic aspects of the Emergency Plan. This audit will help the Coordinator determine how well Emergency Plan strategy and policy guidance is being implemented in the field and identify what additional support OGAC can provide to implementing agencies and other partners to assist them in implementation of the Emergency Plan. The programmatic aspects that will be examined include the delivery of HIV/AIDS treatment, care, and prevention assistance, including implementation of the ABC approach to HIV/AIDS prevention. The contractor will also examine the involvement of host governments, the private sector, and nongovernmental entities, including faith-based organizations, in the design and delivery of Emergency Plan assistance.

Ambassador Tobias congratulates members of the U.S. interagency Emergency Plan task force in Kenya on their excellent fiscal year 2004 country operational plan at a meeting in Johannesburg on Emergency Plan implementation issues.

A Unified U.S. Government Operational Plan in Each Focus Country

Under the guidance of the global and country strategic plans, an annual country operational plan (COP) is developed, defining annual targets and the programs to achieve those targets during the coming fiscal year. The U.S. Ambassador in each focus country submits a unified U.S. Government COP, which includes budgetary requests for all field-based planning of U.S. HIV/AIDS resources to be utilized in that country. The COP outlines the prevention, treatment, and care activities of each partner and includes specific targets for those activities. The COPs include centrally funded activities and targets, with resource allocations for these activities determined centrally. The COP also includes 15 budget categories to allow for the collection of key data. The

COP format provides the means by which the performance of each partner can be followed for each activity described in the document/database.

A comprehensive COP review process was also established for fiscal year 2005 based on lessons learned from the review process for fiscal year 2004. This well-defined interagency process incorporates technical, management, and policy analysis and strong communication with field programs. The relevant areas of each COP were reviewed initially by the interagency technical review teams according to previously established criteria they had developed. This assured consistency between the Global Strategy and the country five-year strategy, as well as adherence to sound technical approaches for both program areas and management. The entire COP was then reviewed more broadly by a programmatic team, according to previously established review criteria, chaired by a member of the interagency deputy principals. Following intensive discussions of the findings of the technical and programmatic reviews with the country teams, the programmatic review teams submitted standardized recommendations and comments to a principals review committee chaired by the Coordinator and with participation from principals of the implementing departments and agencies. The Coordinator made final decisions regarding funding of country program activities under the COPs and communicated these to the Ambassadors. These comprehensive reviews have significantly broadened and deepened the unity of the U.S. Government's strategy for HIV/AIDS. They also served to outline the priority technical and management issues to be addressed in the upcoming year.

A Unified Reporting Mechanism for Performance-Based Assessments

A fundamental aspect of the Emergency Plan is results-based programming and funding. Decisions regarding annual country allocations and approval for continued funding of individual partners and activities will be made based on performance against the targets set by the country teams and partners in the COP and approved by the Coordinator in consultation with principals from the implementing departments and agencies.

An important innovation for facilitating such performance-based management has been the development and implementation of a fully electronic Web-based COP (see appendix VI). Developed following an evaluation of experiences with the fiscal year 2004 COPs, the electronic COP was first used for fiscal year 2005 COPs. The electronic COP feeds into a comprehensive database also developed as a result of the fiscal year 2004 COP process, with significant input from implementing agencies. The database is a powerful tool that enables both countries and headquarters to manage, track, and adjust program activities and resource allocation to maximize results.

Implementing Departments and Agencies for the President's Emergency Plan For AIDS Relief

Department of State

The U.S. Global AIDS Coordinator reports directly to the Secretary of State. At the direction of the Secretary, the Department of State's support for the Office of the Global AIDS Coordinator (OGAC) includes providing human resources services; tracking budgets within its accounting system; transferring funds to other implementing agencies; and providing office space, communication, and information technology services. Chiefs of Mission provide essential leadership to interagency HIV/AIDS teams in the focus countries and, along with other U.S. officials, engage in policy discussions with host-country leaders to generate additional attention and resources for the pandemic and ensure strong donor coordination. The Coordinator has also created the President's Emergency Plan for AIDS Relief Small Grants Programs to make funds available for Ambassadors to support local projects developed with extensive community involvement, targeted at the specific needs of the host country, and developed in coordination with local nongovernmental organizations and municipalities. The Department's programs under the FREEDOM Support Act and the Support for Eastern European Democracies Act also contribute to combating the HIV/AIDS pandemic under the Emergency Plan. The Department also implements a variety of diplomatic initiatives and other community-based HIV/AIDS programs through its embassies in 162 countries. Most of these activities focus on prevention. Embassies also use the tools of public diplomacy to reach out through print and electronic media, facilitate exchange programs, and engage new partners.

Department of Health and Human Services (HHS)

HHS is responsible for all U.S. domestic HIV/AIDS programs and has a long history of HIV/AIDS work within the United States. Under the Emergency Plan, through its Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), Health Resources and Services Administration (HRSA), and Food and Drug Administration (FDA), HHS implements prevention, care, and treatment programs in developing countries and conducts HIV/AIDS research. HHS field staff also work with the country coordinating mechanisms of the Global Fund to Fight AIDS, Tuberculosis and Malaria to improve implementation of Global Fund grants and programs and their coordination with U.S. Government programs.

Examples of HHS programs and activities follow:

- Since its inception in 2000, the CDC Global AIDS Program's highly trained physicians, epidemiologists, public health advisors, virologists, and other laboratory scientist have provided technical assistance in 25 country programs (including the 15 Emergency Plan focus countries) and four regional offices around the world. Now, on behalf of the Emergency Plan CDC works to mitigate the effects of HIV/AIDS, TB, malaria, and other diseases around the world, by collaborating with diverse partners to provide technical assistance in the areas of prevention; laboratory capacity building; surveillance and infrastructure development; and care, support, and treatment.

- NIH supports a comprehensive program of basic, clinical, and behavioral research on HIV infection and its associated opportunistic infections, co-infections, and malignancies. This research will lead to a better understanding of the basic biology of HIV, the development of effective therapies to treat it, and the design of better interventions to prevent new infections, including vaccines and microbicides. NIH supports an international research and training portfolio that encompasses more than 90 countries and is the lead federal agency for biomedical research on AIDS.

- HRSA builds human capacity for scaling up care and treatment based on its more than 15 years of experience in providing quality comprehensive HIV/AIDS care to underserved communities. Strategies are implemented through activities such as twinning, training and technical assistance,

rapid roll-out of antiretroviral drugs, mentoring for nursing leadership, and enhancement of the continuum of palliative care.

- FDA is implementing a new expedited review process to ensure the U.S. Global AIDS Coordinator can buy safe and effective antiretroviral drugs for the Emergency Plan at the lowest possible prices. FDA's medical reviewers, scientists, and inspectors are uniquely qualified to do this work.

- The Office of Global Health Affairs in the Office of the Secretary coordinates all of the HHS agencies to be sure all of the Department's resources are working effectively and efficiently under the leadership of the Global AIDS Coordinator. The Office also provides staff support to the U.S. delegation to the Global Fund and to Global Fund Board Chair Tommy Thompson.

U.S. Agency for International Development (USAID)

USAID currently supports the implementation of Emergency Plan HIV/AIDS programs in nearly 100 countries, through direct in-country presence in 50 of them and through seven regional programs in the rest. As a development agency, USAID has focused for many years on strengthening primary health care systems to prevent and more recently treat a number of communicable diseases, including HIV/AIDS. Under the Emergency Plan, USAID works with governments, nongovernmental organizations and the private sector to provide training, technical assistance, and commodities, including pharmaceuticals, to reduce the transmission of HIV/AIDS and provide care and treatment to people living with HIV/AIDS. As the HIV/AIDS epidemic in most countries outside of the focus countries is still limited to high-risk groups, USAID focuses considerable resources on reducing high-risk behaviors in high-risk groups and the general population.

USAID is uniquely positioned to support multisectoral responses to HIV/AIDS that address the widespread impact of HIV/AIDS outside the health sector in high-prevalence countries. In these countries, USAID is supporting programs in areas such as agriculture, education, democracy, and trade that link to HIV/AIDS and mutually support the objective of reducing the impact of the pandemic on nations, communities, families, and individuals.

Under the Emergency Plan, USAID also supports a number of international partnerships (such as the International AIDS Vaccine Initiative and UNAIDS); provides staff support to the U.S. delegation to the Global Fund to Fight AIDS, Tuberculosis and Malaria; and works with local coordinating committees of the Global Fund to improve implementation of Fund programs and their complementarity to U.S. Government programs. Finally, USAID supports targeted research, development and dissemination of new technologies (including microbicides), and packaging and distribution mechanisms for antiretroviral drugs.

Department of Defense

The Department of Defense (DoD) implements a number of Emergency Plan programs by supporting HIV/AIDS prevention, care, treatment, strategic information, human capacity development, and program and policy development in host militaries and civilian communities in more than 70 countries encompassed by the Emergency Plan. These activities are accomplished through direct military-to-military assistance, engagement of nongovernmental organizations, and universities. Under the Emergency Plan, in addition to supporting a broad spectrum of military-specific HIV prevention programs, infrastructure assistance (including laboratory space, equipment, and training), and care activities, the DoD HIV/AIDS Prevention Program hosts a one-month HIV/AIDS training program for military clinicians providing HIV-related care. DoD international HIV/AIDS programs support six clinical trial and vaccine research sites and have established permanent laboratory and research capabilities in nine countries. Under its humanitarian assistance programs, DoD also provides rudimentary construction to support civilian HIV programs.

Department of Labor

The Department of Labor implements Emergency Plan projects that target the workplace for prevention education and strengthen the response to HIV/AIDS by providing technical assistance to governments, employees, and labor leaders. Under the Emergency Plan, the Department also supports an international assistance program to reduce workplace stigma and discrimination against people living with HIV/AIDS. Another extensive international technical assistance program focuses on child labor and works with the International Labor Organization, UNICEF, and nongovernmental and faith-based organizations to implement programs targeting HIV-affected children forced to work and children involved in prostitution. The International HIV/AIDS Workplace Education Program (IHWEP) works with leaders of business, government, and labor to combat HIV/AIDS through prevention education and promotion of antidiscrimination policies. The program focuses on three major components:

- **Education -** Increasing awareness and knowledge of HIV/AIDS by focusing on a comprehensive workplace education program, including the ABC approach and linkages with testing, counseling, and other support services

- **Policy -** Improving the workplace environment by helping business, government, and labor develop and implement workplace policies that reduce stigma and discrimination associated with HIV/AIDS

- **Capacity -** Building capacity within employer associations, government, and trade unions to replicate workplace-based programs in other enterprises; improving worker access to testing, counseling, and other supportive HIV/AIDS services

Peace Corps

The Peace Corps implements Emergency Plan programs in 10 of the 15 Emergency Plan focus countries - Botswana, Zambia, Namibia, South Africa, Mozambique, Kenya, Tanzania, Uganda, Haiti, and Guyana. The Peace Corps posts in these countries are using Emergency Plan resources to enhance their HIV/AIDS programming and in-country training; field additional Crisis Corps and Peace Corps volunteers specifically in support of Emergency Plan goals; and provide targeted support for community-initiated projects.

The Peace Corps is uniquely positioned as a grassroots capacity-building organization to play an essential role in any country strategy aimed at combating HIV/AIDS. Peace Corps involvement in the Emergency Plan acts as a catalyst as Peace Corps volunteers provide long-term capacity development support to nongovernmental, community-based, and faith-based organizations with particular emphasis on ensuring that community-initiated projects and programs provide holistic support to people living with and affected by HIV/AIDS. Peace Corps volunteers also aim to develop the necessary management and programmatic expertise at recipient and beneficiary organizations to ensure long-lasting support, particularly in rural communities.

Department of Commerce

The Department of Commerce has provided and continues to provide in-kind support to the President's Emergency Plan for AIDS Relief aimed at furthering private sector engagement by fostering public-private partnerships. Recent activities include:

- Presentations to industry trade advisory committees on HIV/AIDS with discussions on how the private sector can contribute

- The creation and dissemination of sector-specific strategies for various industries (e.g., consumer goods, oil and extractives, health care) detailing to companies concrete examples of how the private sector can be engaged in HIV/AIDS

- Departmental support for various private sector activities such as the Business-Higher Education Forum and events with the Global Business Coalition on HIV/AIDS

- Regular meetings with multilateral organizations such as the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria to discuss how the Department has been able to reach out to businesses and industry and what other organizations might do

- Regular contact with dozens of companies working in an HIV/AIDS capacity around the world to discuss coordination and identify opportunities for public-private partnerships

The U.S. Census Bureau, within the Department of Commerce, is also an important partner in the Emergency Plan. Activities include assisting with data management and analysis, survey support, estimating infections averted, and supporting mapping of country-level activities.

The President's Emergency Plan for AIDS Relief Sources of Funding

(dollars in millions)

	2004 Enacted	2005 Enacted
USAID	**1,117**	**815**
Child Survival HIV/AIDS[1]	513	347
Other Accounts HIV/AIDS, TB and Malaria	52	51
Child Survival TB and Malaria	154	169
Child Survival Global Fund*	398	248
HHS	**762**	**577**
CDC HIV/AIDS[2]	136	135
NIH HIV/AIDS Research[3]	317	332
CDC TB and Malaria	11	11
Mother and Child HIV/AIDS Prevention Initiative*	149	0
NIH Global Fund*	149	99
DOL	**10**	**2**
DOD	**4**	**7**
STATE	**1**	**2**
Foreign Military Finance	1	2
U.S. Global AIDS Coordinator's Office	**488**	**1,374**
Global HIV/AIDS Initiative*	488	1,374
TOTAL, GLOBAL HIV/AIDS, TB & MALARIA	**2,382**	**2,778**
TOTAL, GLOBAL HIV/AIDS	**2,217**	**2,598**

1 $170 million in CSH funding for the focus countries has been moved to the Global AIDS Coordinator's Office for FY 2005.

2 Excludes administrative expenses for CDC programs that are centralized beginning in FY 2005 and shown comparably in FY 2004. Includes CDC research whose budget may change depending on actual research projects.

3 Funding for NIH research is estimated for FY 2005 and may change depending on actual research projects.

* New resources for the Emergency Plan

The President's Emergency Plan for AIDS Relief Uses of Funding

(dollars in millions)

Programs	FY 2004 ENACTED ($ Millions)
Focus Countries*	845
Other Bilateral Programs	437
IAVI, UNAIDS, MICROBICIDES	71
Global Fund	547
HIV/AIDS Research	317
TB and Malaria	165
Total Emergency Plan	2,382

*FY 04 number does not include $11M FY 03 carryover

Allocation of Funding to Focus Countries

(dollars)

Country	FY 04 Enacted Country-Managed Programs	FY 04 Enacted Central Programs	FY 04 Total Enacted	FY 05 Planned Country-Managed Programs	FY 05 Planned Central Programs	FY 05 Total Planned
Botswana	17,870,871	6,506,869	24,377,740	35,329,129	7,737,106	43,066,235
Côte d'Ivoire	13,035,496	11,287,871	24,323,367	26,164,505	13,176,753	39,341,258
Ethiopia	40,990,732	6,995,688	47,986,420	61,359,268	8,664,485	70,023,753
Guyana	9,326,543	2,873,662	12,200,205	14,153,457	4,008,979	18,162,436
Haiti	20,326,735	7,726,409	28,053,144	40,372,798	7,379,056	47,751,854
Kenya	71,359,718	21,221,348	92,581,066	115,140,281	20,871,243	136,011,524
Mozambique	25,528,206	11,860,141	37,388,347	48,221,038	6,455,537	54,676,575
Namibia	21,185,762	3,087,924	24,273,686	36,013,835	3,701,072	39,714,907
Nigeria	55,491,358	15,433,724	70,925,082	84,358,642	24,500,660	108,859,302
Rwanda	27,973,778	11,326,683	39,300,461	41,072,725	10,223,053	51,295,778
South Africa	65,424,371	23,966,052	89,390,423	106,675,630	25,424,338	132,099,968
Tanzania	45,791,174	24,837,665	70,628,839	84,208,827	20,716,384	104,925,211
Uganda	80,579,298	10,178,127	90,757,425	112,818,223	11,517,249	124,335,472
Vietnam	17,354,885	0	17,354,885	25,000,000	0	25,000,000
Zambia	57,933,801	23,852,837	81,786,638	84,745,140	30,174,081	114,919,221
Total	**570,172,728**	**181,155,000**	**751,327,728**	**915,633,498**	**194,549,996**	**1,110,183,494**

USAID's FY 2004 HIV/AIDS Research

The U.S. Agency for International Development (USAID) has been a leader in fighting HIV/AIDS globally since 1986. One of the key components of USAID's HIV/AIDS program has been to conduct biomedical and operational research to develop and evaluate new tools for providing antiretroviral therapy, preventing HIV transmission, and caring for people living with AIDS.

The major focus of USAID's research is to address needs for program implementation in resource-limited settings. USAID-funded research is comprehensive, from identifying a program problem to research and efficacy verification, to field testing and full implementation in developing countries.

Treatment

Antiretroviral Therapy

There are many complex issues related to the introduction and impact of antiretroviral therapy. USAID invested in three learning sites to study the introduction of AIDS treatment in low-resource settings. Two of these sites are now completely integrated into the Emergency Plan. The third site (Ghana) is not an Emergency Plan focus country, but is built into the national strategy and is scaling up with resources from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Ongoing studies of methods to improve treatment adherence are under way and providing useful information. A training manual for treatment adherence, developed for one of the studies, is now widely disseminated.

Preventing Mother-to-Child HIV Transmission (PMTCT)

USAID has been working to develop single-dose packaging options to improve access to nevirapine among newborns at risk of HIV through mother-to-child transmission. Over the past year, two main packaging options have been researched to determine drug stability, mothers' acceptance, and relative cost. USAID has also supported research that produced practical information on infant feeding and HIV transmission. Results have further supported the hypothesis that exclusive breastfeeding, as opposed to mixed feeding, decreases the risk of mother-to-child transmission. Additionally, studies are continuing in several countries to determine the feasibility and effectiveness of integrating PMTCT services with other maternal and child health services. Also under way are targeted evaluations of innovative approaches that use temporary clinics, peer psychosocial support, and traditional birth attendants to improve access and use of PMTCT services.

Prevention

"Abstinence, Be faithful, and, as appropriate, correct and consistent use of Condoms" (ABC) Approach

USAID has carried out pioneering studies in behavior change for successful HIV prevention, including a recently funded six-country study on the ABC approach, and has published an important paper analyzing the success of the ABC approach in Uganda. New studies are being planned to optimize ABC implementation interventions for youth and at-risk groups.

Male Circumcision

Clinical trials are currently underway to review whether male circumcision has a protective effect on HIV transmission. USAID is supporting research in Haiti, Kenya, South Africa, and Zambia to learn more about issues of safety and complications, acceptability and feasibility, and the logistical issues involved in developing pilot demonstration services for safe and affordable male circumcision and male reproductive health programs.

Injection Safety

HIV transmission in the health care setting can occur through unsafe injections and other unsafe medical practices. USAID has supported practical research and targeted evaluations in injection safety in several ways. First, baseline data were collected to evaluate interventions to reduce unsafe injections and injection-related injuries. Second, medical centers provided data on the reasons why injections are currently used; this information will help forecast injection safety commodity needs and develop strategies to reduce inappropriate use of injections. Additionally, preliminary informal evaluations of health care workers' attitudes toward single-use devices indicate overwhelming support. Lastly, following a favorable evaluation of the approach, USAID is bundling an injectable contraceptive commodity with auto-disable syringes and safety boxes. USAID is currently evaluating single-dose prepackaged injection systems for contraceptives as a way to further increase safety.

Care

Nutrition

HIV infection affects nutrition by reducing dietary intake and through nutrient malabsorption and complex metabolic alterations that culminate in weight loss and wasting. USAID is implementing research on the effectiveness of providing food supplements on adherence to antiretroviral treatment and return for HIV care; cost and feasibility of incorporating food and nutrient supplements into antiretroviral treatment programs; and formulation of food and nutrient supplements for children and adults living with HIV/AIDS.

Orphans and Vulnerable Children

USAID has 102 programs in 27 countries in support of orphans and vulnerable children. In 2004, USAID helped provide technical support to local nongovernmental organizations conducting community-level research to improve interventions for children affected by HIV/AIDS. In South Africa, a study is currently investigating new roles for early childhood development practioners participating in programs for children affected by HIV/AIDS. A study in Tanzania is evaluating how programs can best address the needs of older primary caregivers and will field test a rapid assessment tool to identify the care and support needs of orphans and vulnerable children in their communities. In India, USAID is supporting research to evaluate the needs of children affected by HIV/AIDS in foster care.

Biomedical Research

Microbicides

In 2004, USAID continued to support the development of microbicides (female-controlled chemical barriers to prevent transmission of the AIDS virus). USAID supported several microbicide development projects, most notably, the scaling up for large-scale clinical trials of three microbicide candidates.

Vaccines

USAID continued to support the development of vaccines, an essential technology for preventing transmission of HIV. USAID's grant to the International AIDS Vaccine Initiative contributed to the ongoing development of two vaccine candidates as well as the Initiative's core immunology laboratory and primate facilities.

Appendix V

Update on the HHS/NIH AIDS International Research Program for the OGAC Strategic Plan

The U.S. Department of Health and Human Services/National Institutes of Health (HHS/NIH) response to the AIDS pandemic requires a unique and complex multi-institute, multidisciplinary global research program. HHS/NIH has developed a comprehensive biomedical and behavioral research program to better understand the basic biology of HIV, develop effective therapies to treat and control HIV disease, and design interventions to prevent new infections from occurring. Perhaps no other disease so thoroughly transcends every area of clinical medicine and basic scientific investigation, crossing the boundaries of the HHS/NIH Institutes and Centers. HHS/NIH-sponsored HIV/AIDS research continues to provide the important scientific foundation necessary to design, develop and evaluate new and better vaccine candidates, therapeutic agents and regimens, and prevention interventions.

Since the early days of the epidemic, HHS/NIH has supported research efforts in countries affected by HIV and AIDS. Beginning in 1984 with a research project in Haiti and the establishment of Project SIDA in 1985 in what was then Zaire, HHS/NIH has maintained a strong international AIDS research portfolio. HHS/NIH has expanded its research effort to encompass approximately 90 countries around the world. It is important to point out that the majority of HHS/NIH international AIDS research funds support U.S-based AIDS researchers to conduct research in collaboration with scientists in international settings. Some funds are awarded directly to investigators in foreign research institutions. Results of this research benefit not only the people in countries where the research is conducted but people affected by HIV/AIDS worldwide.

HHS/NIH FY 2006 Plan for HIV-Related Research and AIDS Research Priorities

In accordance with the HHS/NIH Revitalization Act of 1993, the Office of AIDS Research (OAR) has developed the HHS/NIH FY 2006 Plan for HIV-Related Research and the fiscal year 2006 HHS/NIH comprehensive AIDS research budget. One component of the overall document is the strategic plan for international AIDS research. The international research plan shapes HHS/NIH investments in biomedical and behavioral AIDS research and provides the framework to translate critical research findings to benefit populations desperately in need around the world, particularly in resource-constrained countries. The plan serves as the framework for developing the annual HHS/NIH AIDS research budget; for determining the use of HHS/NIH AIDS-designated funds; for tracking and monitoring AIDS-related expenditures; and for informing the scientific community, the public, and the AIDS-affected community about HHS/NIH AIDS research priorities.

HHS/NIH-sponsored international research includes efforts to develop HIV vaccine candidates and chemical and physical barrier methods, such as microbicides, to prevent sexual transmission; behavioral strategies targeted to the individual, family, and community to alter risk behaviors associated with sexual activity and drug and alcohol use; drug and non-drug strategies to prevent mother-to-child HIV transmission; therapeutics for HIV-

related co-infections and other conditions; and approaches to using antiretroviral therapy in resource-poor settings.

In fiscal year 2006 HHS/NIH's overarching priority is on the discovery, development, and preclinical testing of additional HIV vaccine candidates. The evaluation of an AIDS vaccine will require extensive testing in the United States and in international settings where there is a high incidence of HIV. Priority is placed on moving promising vaccine candidates into large-scale clinical trials to evaluate their potential for efficacy.

Key HHS/NIH AIDS International Research Program Activities

- The Partnership for AIDS Vaccine Evaluation (PAVE) was established as a voluntary consortium of U.S. government agencies (HHS/NIH, HHS/CDC, and DoD) and key U.S. government-funded organizations, including the International AIDS Vaccine Initiative (IAVI), involved in the development of HIV/AIDS preventive vaccines and the conduct of HIV vaccine clinical trials. The goal of PAVE is to achieve harmonization and increased operational and cost efficiencies in the development and clinical evaluation of HIV vaccine candidates.

- HHS/NIH has served in a lead role in the formation of the Global Enterprise for HIV/AIDS Vaccine Development, a consortium for accelerating HIV vaccine development formally endorsed by the Group of Eight nations. The strategic plan for the vaccine enterprise was published on January 18, 2005. (http://www.plosmedicine.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0020025)

- As part of the vaccine enterprise, HHS/NIH is currently soliciting for a Center for HIV/AIDS Vaccine Immunology (CHAVI) which will establish a "virtual" vaccine center. This initiative is expected to be partnered with other private and foreign country initiatives. An award is expected in 2005.

- The HIV Prevention Trials Network (HPTN) is a worldwide collaborative clinical trials network that develops and tests the safety and efficacy of non-vaccine interventions designed to prevent HIV transmission. HPTN carries out its mission through a network of investigators from more than 24 international sites partnered with a leadership group comprising three U.S.-based institutions. HPTN has sites in Africa, Asia, and North and South America.

- The HIV Vaccine Trials Network (HVTN) is a coordinated global network for the conduct of HIV vaccine clinical trials at U.S. and international sites. HVTN conducts phase I, II, and III clinical trials, from evaluating candidate vaccines for safety and the ability to stimulate immune responses to testing vaccine efficacy.

- The Comprehensive International Program for Research on AIDS (CIPRA) provides direct funding of foreign investigators. It is designed to provide long-term support and enhance developing-country capabilities to conduct research relevant to their populations. CIPRA supports research and development in institutions to develop practical, affordable, and acceptable methods to treat HIV/AIDS in adults and children.

- The Adults AIDS Clinical Trials Group (AACTG) is a network of clinical sites at major medical centers and academic institutions that conduct Phase I, II, and III clinical trials of drug regimens for HIV disease and its complications in adults. AACTG has 34 sites in the United States and 12 international sites.

- The Pediatric AIDS Clinical Trials Group (PACTG) is a global network that conducts phase I, II, and III clinical trials of regimens to treat HIV infection and its complications in neonates, infants, children, adolescents, and pregnant women. PACTG has 39 sites in the United States and 14 international sites.

- The AIDS International Training and Research Program (AITRP) supports HIV/AIDS and related TB international training for health scientists, clinicians, and allied health workers from developing countries. The primary goal of this program is to build biomed-

ical and behavioral research capacity for the prevention of HIV/AIDS and related TB infections. AITRP supports grants to U.S. academic and medical institutions, which have developed working relationships with institutions in collaborating countries. AITRP helps to facilitate research efforts supported by other NIH institutes and centers and to establish long-term collaborations between U.S. and international researchers.

- HHS/NIH international AIDS programs provide important support for 1) developing research sites through establishment of stable, targeted cohorts, development of recruitment strategies, and enhancement of laboratory, clinical, and data management capabilities; 2) increasing the number of scientists, clinicians, and health care workers trained in basic, clinical, and behavioral research, data management, and ethical considerations; 3) developing research collaborations; and 4) transferring appropriate clinical and laboratory technologies.

COPRS Data System

The Emergency Plan Country Operational Plan and Reporting System (COPRS) is a two-step planning and reporting process. The first step is the development of the country operational plan (COP), which defines activities to be implemented during the fiscal year, along with the associated activity descriptions, funding levels, indicator targets, implementing partners, etc. The second step is the development of the semiannual or annual progress report, which documents results achieved and funds obligated by activity defined in the COP.

Data Entry

The data entry component of the COPRS is a Web-based, password-protected data collection system. The primary data collection efforts are twofold. One is the collection of financial information that consists of numerical information about dollars requested (planning documents) or obligated (reporting documents); characteristics of the organizations (i.e., U.S. Government partners) that receive the funds; and characteristics of the activities to be conducted with those funds.

Partner Organizations

In terms of the characteristics of the organizations that receive the funds, we are able to gather data both about the type of organization (faith-based organization, non-governmental organization, private contractor, university, host-country government agency, or multilateral organization) and the locality of the organizations (i.e., whether it is local/indigenous or not). This information is gathered not just for the prime partners that the U.S. Government works with, but also for subpartners that are also receiving funding.

Activities

With regard to the characteristics of the activities, the system is able to gather several different pieces of information. The activities are broken down by the 15 different program areas in which the Emergency Plan works. Additionally, there are 16 different activity categories which cut across all of the program areas (e.g., training, human resources, logistics, quality assurance and supportive supervision, infrastructure, strategic information, etc.). Information is gathered on the amount of funding to be programmed for each of these activity categories in order to allow for analysis of where our resources are going. Finally, data are also gathered on the specific region/province within the country where the particular work is occurring, in order to allow mapping of our activities.

Financial Data

Financial data collection occurs three times a year. First is the gathering of planned financial information for the coming year, the COP. Second and third are the submission of the semiannual and annual progress reports. These reports collect information on financial obligations to date for the fiscal year and are due after the first six months of the fiscal year and at the end of the fiscal year, respectively. The progress reports are structured to provide obligations against funds requested for each activity as submitted in the COP.

Indicators

The second data collection effort filled by the COPRS is the collection of indicator/target information. This information is collected at the same three points in time as the financial information. In the COP, the U.S. Government in-country missions submit targets for a prescribed list of indicators that they plan to reach over the coming fiscal year. In the semiannual and annual progress reports, the focus countries submit information on results achieved to date in the fiscal year, based on the same indicator set for which targets were submitted in the COP.

Several different indicator/targets are collected by the Emergency Plan. National level indicators/targets relate to the overall goals of the Emergency Plan, the 2-7-10 goals. Program level indicators are an Emergency Plan predetermined set of indicators for each of the 15 program areas defined by the Emergency Plan. These indicators/targets monitor progress on specific U.S. Government-supported activities.

In addition, there are outcome/impact indicators. The outcome/impact indicators are also a prescribed set of indicators and are used to measure joint progress with other international donors. These indicators are monitored only in the progress reports. The indicators and targets are not requested in the COPs.

Pursuant to Section 104A of the Foreign Assistance Act of 1961, as amended by Section 301(a)(2) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (P.L. 108-25), the Office of the Global AIDS Coordinator has requested from the relevant executive branch agencies a description of efforts made by each relevant executive branch agency to implement the policies set forth in section 104(B), "Assistance to Combat Tuberculosis," and 104(C), "Assistance to Combat Malaria," a description of the programs established pursuant to such sections, and a detailed assessment of the impact of programs established pursuant to such sections. The relevant executive branch agencies will be providing this information under separate cover.

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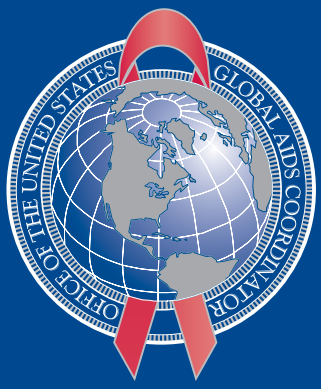
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