ACTION TODAY, A FOUNDATION FOR TOMORROW:

THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF

Second Annual Report to Congress

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Cover photo:

Nkonzo, a participant in the U.S.-supporterd "Men As Partners" program, practices what he preaches so he can serve as a role model to his younger brother, Mzwakhe. This is Nkonzo's story as related to staff at the U.S. Embassy in Pretoria, South Africa.

Supporting My Family with Love and Respect

One quiet evening in Soweto, a loud bang on our door frightened us. We knew it was him—my father. We didn't want to let him in or he'd beat up my mother. He demanded, "Vulani, vulani!" (Open up!) We froze. My mother, sisters, brothers and I didn't know what to do.

He used to come home smiling. Whenever we heard his knock, we knew he had gifts for us and threw open the door for him. I was his first-born, so he spent extra time with me. I don't know what happened to that kind father. Now his life is ruled by alcohol and led to a divorce. He disappeared.

I kept all those childhood memories with me. When I was 16, my Mom passed away after giving birth to my youngest brother, Mzwakhe. No one knew why or what happened. I was still trying to get used to her not being around when my eldest brother (from another father)—our family's sole breadwinner—got shot and died delivering food for the bakery where he worked.

I became a hermit. I earned money by doing "izikorobho" (painting, tiling and things like that). I found a way to survive. I had to grow up on my own, but I wanted to be there for Mzwakhe. Today, I spend time with him, helping him with his homework, taking him to parks and sharing with him what I do at work—teach men to respect women. He believes in me. He looks up to me as a father figure.

And it's funny. Our father showed up after many years. Strangely, I managed to find peace with him. We have become friends, but he has no say in my life. He lost his job, so I give him money. I support four sisters, three brothers, nieces and nephews by planning ahead to pay for rent, food and services. Ten of us live in our four-room house and draw water from an outdoor tap. A brother and I sleep in a shack we built outside. My family and I manage. And we love each other.

I'm helping my eldest sister adjust to being HIV-positive. She denied it when she first found out. But I took her to the hospital. They said she also had tuberculosis, so she got treatments. She's feeling so well, she's looking for a job to support her two children. I look beyond her status and see her as my sister—someone good, caring, loving. I'm proud of her and the strength and courage she shows.

Three years ago a friend invited me to a workshop in my neighborhood, called "Men As Partners." I eventually realized what was wrong in my life, how I could change and what kind of man I want to be. I asked the organizers if I could work with them, even as a volunteer. I became a peer educator, talking to others in my age range about important things, especially gender roles. A guy will tell you he's got HIV or is hurting his Mom or partner or another woman in his life… men need someone they trust so they open up. Yesterday, my best friend admitted his father is violent to his own mom. He'd never talked about it before. Guys who have experienced domestic violence have the choice of stopping it and preventing it also.

People need to do all things as equally as possible. Nobody should be favored or prejudiced by gender, but given an equal chance at home, school and work. Each and every role is meant for both people. Let's understand and accept that and treat each other with respect, fairness and love.

In my job and personal life, I help South Africans learn why it's important to treat women with respect. We should treat everybody respectfully, regardless of gender. This concept is not a goal for me, but a way of life.

I've started a youth group at my church. We deal with threats of daily life. Many people are afraid of getting AIDS. I tell them to abstain from sex before marriage and stick with one partner after marriage. Not everybody finds this message easy to live, but we talk about ways to avoid sexual compromises. Some guys tell us we're crazy and don't know what we're talking about. Others accept it and live safer lives. I hope life will be better when Mzwakhe grows up.

To all of you who have lost your role models, it's up to us to put a stop to this, because someday, we, too, may become fathers. Fathers, be positive role models for your children, especially your sons. You are their spirit, hope and inspiration.

They say a man can change his stars through the help of God. I will be a star for Mzwakhe.

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United States Department of State

Washington, D.C. 20520

February 8, 2006

Dear Senator/Representative:

On behalf of President Bush, it is my privilege to submit to you the Second Annual Report of the President's Emergency Plan for AIDS Relief (PEPFAR/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.

President Bush promised to lead the fight against global HIV/AIDS in 2003 with the launch of the Emergency Plan – $15 billion to fight the disease in over 120 countries around the world. With your support, America has followed through on this commitment, and now leads the world's nations in its level of support for the fight.

This financial commitment is accompanied by ambitious goals, including support for prevention of 7 million new infections, support for treatment for 2 million HIV-infected people, and support for care for 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children, in 15 of the world's hardest-hit nations. To reach these goals, the Emergency Plan is implementing the most complex and diverse prevention, treatment and care strategy in the world. We are also holding ourselves to unprecedented levels of accountability for results, because President Bush made it clear that "business as usual" was not an option.

People are alive today because the United States has turned its words into action. At the time President Bush announced the Emergency Plan, only an estimated 50,000 people in all of sub-Saharan Africa were receiving life-extending antiretroviral treatment. Yet after just two years of implementation, PEPFAR supported treatment for approximately 401,000 people in the 15 focus nations (395,000 of them in the 12 sub-Saharan African focus nations), as well as approximately 70,000 additional people in other nations.

In the first two years of the initiative, approximately 3.2 million women received PEPFAR-supported services to prevent mother-to-child transmission of HIV, and an estimated 47,100 infant HIV infections were prevented. The Emergency Plan also reached over 42 million people with evidence-based community outreach prevention efforts in the 15 focus countries in fiscal year 2005.

In fiscal year 2005, PEPFAR supported care for nearly 3 million people in the focus countries, including over 1.2 million orphans and vulnerable children and over 1.7 million people living with HIV/AIDS. Over the first two years of implementation, the Emergency Plan provided support for HIV counseling and testing services for over 9.4 million people in the focus countries.

The President's strategy of partnership with our host nations is one of the keys to these unprecedented results. By

working with host nations to build quality healthcare networks and increase capacity, we are laying the foundation for nations and communities to sustain their efforts against HIV/AIDS long after the initial five years.

U.S. leadership is making a tremendous difference in the fight against HIV/AIDS, and I believe that every American can be proud. 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 second Annual Report of the President's Emergency Plan for AIDS Relief is dedicated to the late Major Joseph Haydon Jr., United States Army, and all United States Government staff – as well as the staff of host governments and local partners – who have contributed to the remarkable achievements described in these pages.

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, the Substance Abuse and Mental Health Services Administration, and the Office of Global Health Affairs), and the Peace Corps.

Acronyms and Abbreviations

AB	Abstain, Be faithful
ABC	Abstain, Be faithful, and, as appropriate, correct and consistent use of Condoms
AEI	African Education Initiative
ANC	Antenatal clinic
ART	Antiretroviral treatment
ARV	Antiretroviral drug
CCM	Country coordinating mechanism
CDC	Centers for Disease Control and Prevention
COP	Country Operational Plan
COPRS	Country Operational Plan and Reporting System
CY	Calendar year
DBS	Dried blood spot
DfID	Department for International Development (U.K.)
DoD	Department of Defense (U.S.)
DOT	Directly observed therapy
FBO	Faith-based organization
FDA	Food and Drug Administration
FY	Fiscal year
HHS	Department of Health and Human Services (U.S.)
HMIS	Health management information system
HRSA	Health Resource and Services Administration
IAVI	International AIDS Vaccine Initiative
IDU	Injecting drug user
IOM	Institute of Medicine (U.S.)
M&E	Monitoring and evaluation
MIS	Management information systems
MoH	Ministry of Health
NGO	Non-governmental organization
NIH	National Institutes of Health
NPI	New Partners Initiative
OGAC	Office of the U.S. Global AIDS Coordinator
OI	Opportunistic infection
OVC	Orphans and vulnerable children
PCR	Polymerase chain reaction
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief (Emergency Plan)
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child HIV transmission

SI	Strategic information
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commission for Refugees
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

President George W. Bush smiles as he looks back at Thandazile Darby and her two children, 4-year-old Lewis, and 5-year-old Emily. The South African visitors, along with their physician, Dr. Helga Holst, were guests at the Dwight D. Eisenhower Executive Office Building Thursday, Dec. 1, 2005, for the President's remarks on World AIDS Day.

"The United States Congress and the American people have been generous in this effort, and Americans can know that their generosity is making a significant difference."

President George W. Bush
World AIDS Day
December 1, 2005

Executive Summary

The global HIV/AIDS pandemic has been a destroyer of hope, casting the shadow of suffering and death upon families, communities, and even nations. In much of the developing world, hope for the future has been a victim of this scourge.

At last, however, hope has begun to be reborn. Around the world, partnerships between the President's Emergency Plan for AIDS Relief (PEPFAR/Emergency Plan) and host nations are proving that there is hope of winning this fight – even in the most difficult places.

President Bush's announcement of PEPFAR in 2003, it is now clear, marked a turning point in the worldwide response to HIV/AIDS. The Emergency Plan represents historic leadership in terms of financial resources: no nation has ever undertaken a larger international health initiative directed at a single disease. With the strong support of Congress and the American people, the United States leads all international partners in its financial commitment to the fight. In fiscal year 2005, the United States committed approximately $2.8 billion to the Emergency Plan, up from $2.4 billion in fiscal year 2004, the first year of implementation. President Bush has requested, and Congress has appropriated, approximately $3.2 billion for fiscal year 2006, keeping the Emergency Plan on track to meet the President's five year, $15 billion commitment.

Yet money alone can never defeat HIV/AIDS, nor bring about the societal transformation needed in nations devastated by the pandemic. The Emergency Plan thus invests in partnerships with host nations to build locally-led HIV prevention, treatment and care strategies. As President Bush put it, "This effort is succeeding because America is providing resources and Africans are providing leadership. Local health officials set the strategy and we're supporting them."

In the world's hardest-hit nations, HIV/AIDS will be a tragic fact of life for many years to come. The fight against it will succeed today, and be sustainable tomorrow, only if the local population takes ownership. PEPFAR is working in partnership with host nations to bring high quality programs to scale today, while supporting the

With Emergency Plan support, Bright Futures, a network of people living with HIV/AIDS (PLWHA) in Vietnam, is helping PLWHA and family members to live positively.

development of sustainable local capacity for these programs to continue in the future.

The Emergency Plan's efforts to build high quality, sustainable programs in fiscal year 2005 took place through bilateral programs in 123 countries, and in additional countries through support for multilateral efforts. Bilateral programs include a special emphasis on 15 focus countries in Africa, the Caribbean, and Asia that together account for approximately one-half of the world's 40 million HIV infections.[1] In these focus countries over 5 years, the Emergency Plan has set goals of supporting prevention of 7 million new infections, supporting treatment for 2 million HIV-infected people, and supporting care for 10 million individuals, including orphans and vulnerable children as well as people living with HIV/AIDS.

To reach these ambitious goals, the Emergency Plan is implementing the most complex and diverse prevention, treatment and care strategy in the world. The lessons learned from the intensive application of the Emergency Plan strategy in the focus countries are now being extended to other PEPFAR nations, helping to fuel transformation of HIV/AIDS responses in nations around the world.

Across all activities, accountability is a hallmark of PEPFAR. When the United States undertook the Emergency Plan, our nation did not promise good intentions, but results – and accountability for achieving them. Accountability depends on accurate information. The Emergency Plan is thus investing heavily in the tools needed to ensure that accurate information on results is gathered and fully utilized by the Emergency Plan and its host nations.

After two years of the Emergency Plan, there can be no doubt that the action of the United States has produced results. These results may be measured in numbers, but what these numbers represent are children, women, and men who are alive today because of America's action.

Results

Prevention

Slowing the rate of new HIV infections is the most difficult challenge facing the world in the fight against HIV/AIDS. The U.S. is rising to this challenge with support for the most diverse portfolio of HIV/AIDS prevention strategies of any international partner. Strategies include the ABC approach (Abstain, Be faithful, correct and consistent use of Condoms where appropriate) developed in Africa to prevent sexual transmission; prevention of mother-to-child transmission (PMTCT); prevention of medical transmission through blood safety and safe medical injections programs; and programs that focus on intravenous drug users, on HIV-discordant couples, on women, on men, and on alcohol abuse, among other key issues. The United States has also maintained its position as the global leader in HIV/AIDS research and innovations, with an emphasis on developing safe and effective vaccines and microbicides.

Growing evidence of all three of the ABC behaviors, and of corresponding reductions in HIV prevalence in certain countries, highlight the importance of support for ABC programs to prevent sexual transmission of HIV. In the focus countries in fiscal year 2005, PEPFAR supported balanced, evidence-based ABC community outreach

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

Peer educators in South Africa receive training with PEPFAR support. People from the community can be particularly effective in reaching fellow community members with HIV prevention education.

activities that reached over 42 million people.

PEPFAR supported PMTCT services for over 1.9 million women during the reporting period, including antiretroviral prophylaxis for over 122,600 women, averting an estimated 23,400 infant infections. In the first two years of the Emergency Plan overall, approximately 3.2 million women received PEPFAR-supported PMTCT services, with over 248,000 women receiving antiretroviral prophylaxis, preventing an estimated 47,100 infant HIV infections to date.

Addressing the special vulnerability of women to HIV/AIDS is a key focus of prevention and other activities. Across all program areas in the focus countries in the reporting period, PEPFAR implementing partners reported that 203 program activities sought to address violence and coercion, 305 activities sought to address male norms and behaviors, 105 activities promoted increased legal protection for women, and 107 activities sought to increase women's access to productive resources.

The Emergency Plan devoted 28 percent of all focus country program funding to prevention in fiscal year 2005.

Treatment

At the time President Bush announced the Emergency Plan, only an estimated 50,000 people in all of sub-Saharan Africa were receiving life-extending antiretroviral treatment (ART). Yet at the end of just two years of implementation, the Emergency Plan supported treatment for approximately 401,000 people in the 15 focus nations, including 395,000 in the 12 sub-Saharan African focus nations. PEPFAR has also provided support for treatment for approximately 70,000 additional people through U.S. bilateral programs in other nations, for a worldwide total of approximately 471,000 people receiving bilateral treatment support from the United States.

Quality assurance, essential in the context of treatment, is a key focus of Emergency Plan efforts, with major investments in strengthening systems to ensure quality. High-quality generic antiretroviral drugs (ARVs) are increasingly used in PEPFAR-supported programs. 15 generic products, including four pediatric formulations, are now eligible for purchase by Emergency Plan programs under the expedited U.S. Government ARV review process established in 2004.

Highlighting PEPFAR's commitment to pediatric treatment, approximately 7 percent of those receiving treatment at U.S.-supported sites in the focus countries in fiscal year 2005 were children – a number that is expected to rise as pediatric programs are scaled up in the coming

Ambassador Tobias meets with Dr. Peter Mugyenyi at the Joint Clinical Research Center in Uganda. With Emergency Plan support, Dr. Mugyenyi has been able to reach vastly expanded numbers of Ugandans with life-extending antiretroviral treatment.

years. In terms of gender equity in services, approximately 60 percent of ART clients whose gender was reported were women.

In fiscal year 2005, PEPFAR devoted 46 percent of focus country program funding to support for treatment.

Care

As the numbers of orphans and vulnerable children (OVCs) and people infected with HIV continue to grow, the Emergency Plan is urgently scaling up support for effective interventions. In fiscal year 2005, PEPFAR supported care for nearly 3 million people in the focus countries. This number included over 1.2 million orphans and vulnerable children and over 1.7 million people living with HIV/AIDS.

Nilsa and Celsa lost their parents to AIDS. With care from a volunteer with a PEPFAR-supported faith-based organization in Mozambique, they are able to remain in school and pursue their dreams.

Counseling and testing is a key gateway to treatment and care for people living with HIV/AIDS, as well as an important venue for prevention education. To date, the Emergency Plan has provided support for HIV counseling and testing services for over 9.4 million people in the focus countries. Of these, over 6.6 million received services in fiscal year 2005 – over 1.9 million in PMTCT settings and over 4.6 million through other counseling and testing activities. An estimated 69 percent of those counseled and tested in all settings were women.

Care activities received 26 percent of Emergency Plan program funding in the focus countries in fiscal year 2005.

Building Capacity

An intensive focus on helping communities and nations develop their own capacity for sustainable, high-quality HIV/AIDS interventions remains essential. Many developing countries face common barriers to expanding and sustaining responses. While supporting the intensive scale-up of prevention, treatment, and care now, PEPFAR is a vital partner with host nations as they develop tools to sustain responses in the future.

Supporting the development of the institutional capacity of the civil society sector in host nations is a key strategy for sustainability. Approximately 82 percent of all implementing partners in fiscal year 2005 were indigenous organizations. PEPFAR is pursuing strategies to drive this number even higher in coming years. Faith- and community-based organizations, including ones that have not previously worked with the U.S. Government, bring key strengths to the HIV/AIDS fight. The New Partners Initiative, launched by President Bush on World AIDS Day 2005, will help PEPFAR expand and diversify its partner base.

The leadership of host governments is critical for an effective national response to HIV/AIDS. The Emergency Plan is partnering with ministries of health, national HIV/AIDS coordinating authorities, and other governmental entities to foster multisectoral, intensive national responses. Over 20 percent of host country partners during the reporting period were public sector entities. In many countries, the fragile but growing private sector also has important contributions to make to the fight, and PEPFAR is intensifying efforts to build public-private partnerships.

The Emergency Plan is providing focused support for the development of human capacity to deliver HIV/AIDS services. In fiscal year 2005, the Emergency Plan supported training or retraining for more than 536,000 service providers (with individuals being trained in multiple

areas in certain cases). This total included support for training or retraining of approximately:

- 267,600 individuals in prevention of sexual transmission
- 28,600 individuals in prevention of mother-to-child transmission (PMTCT)
- 20,300 individuals in prevention of medical transmission
- 36,500 individuals to support antiretroviral treatment

Capacity-building and quality assurance are hallmarks of the Emergency Plan. PEPFAR works with host nations to support training for health care personnel, such as this laboratory technician in Tanzania.

- 74,800 individuals to care for orphans and vulnerable children
- 86,300 individuals to care for HIV-positive people
- 22,200 individuals to provide counseling and testing (in addition to those trained in PMTCT)

Strengthening essential health care systems through health care network and infrastructure development is another key to sustainability. In the reporting period, PEPFAR worked with its governmental and nongovernmental partners to support a minimum of 14,900 service sites in the focus countries. Among these sites were 2,500 PMTCT service outlets, 600 sites that carry out blood safety activities, 800 treatment sites, 6,800 palliative care sites, and 4,200 sites for counseling and testing in settings other than PMTCT.

PEPFAR also supports health system development in the areas of laboratories, clinical quality assurance, and procurement of commodities. The new Partnership for Supply Chain Management will assist host nations in growing their capacity to assure the quality of ARVs and other commodities.

Many developing nations face deficits in the areas of surveillance, reporting, evaluation, and other areas of strategic information needed for accountability and program improvement. In fiscal year 2005, the Emergency Plan supported training or retraining of approximately 17,900 individuals in the focus countries in strategic information.

Another area of continuing focus is "wraparound" programs. Through these programs, PEPFAR coordinates with and leverages resources from other agencies and sectors, such as nutrition and education, to promote comprehensive and effective responses.

Beyond the Focus Countries

The Emergency Plan encompasses all existing and new U.S. Government international HIV/AIDS activities. Bilateral programs operate in 123 countries, including the 15 focus countries and 108 additional countries. Of the $15 billion over five years that President Bush committed to the Emergency Plan, $5 billion represents support for HIV/AIDS programs in these 108 additional countries, as well as support for international research, international partnerships (including the Global Fund), and other activities.

In its first year, PEPFAR established a Five-Year Global AIDS Strategy for achieving the President's goals; since then, the strategy has been implemented in the focus countries. In fiscal year 2005, similar communication,

coordinated strategic planning, resource allocation and evaluation mechanisms began to be extended formally to bilateral HIV/AIDS programs in the other 108 countries. After an interagency development process, the Emergency Plan issued general policy guidance for programs in all nations receiving bilateral resources, in order to ensure consistency of all bilateral programs with PEPFAR principles.

In fiscal year 2005, PEPFAR directed $293 million to HIV/AIDS program activities in these 108 nations. Five countries received more than $10 million, 13 received between $5 and $10 million, 20 received between $1 million and $5 million, and 70 received less than $1 million. Going forward, requirements for reporting and documentation are dependent upon fiscal year 2005 HIV/AIDS funding levels. Nations that received over $10 million – Cambodia, India, Malawi, Russia, and Zimbabwe – will have requirements most similar to those of the focus nations.

The Emergency Plan supports HIV counseling and testing – a crucial gateway to prevention, treatment, and care. In Angola, soldiers receive testing through a military-to-military program supported by PEPFAR.

India remains the largest Emergency Plan program outside the focus nations, with over $26 million in support in fiscal year 2005, up from approximately $17 million in fiscal year 2003. PEPFAR funding for Russia in fiscal year 2005 was almost $14 million, or about twice the level in fiscal year 2003. Emergency Plan coordination with China continues to expand.

Emergency Plan bilateral programs support a range of prevention, treatment, and care activities and capacity-building in the group of 108 countries. In addition to the 15 focus nations, for example, 17 other nations have launched U.S.-financed treatment programs since the beginning of the Emergency Plan, and PEPFAR has provided support for treatment for 70,000 people in these nations.

This bilateral support is in addition to support provided by the United States through the Global Fund, to which the United States remains the largest contributor, having provided approximately one-third of its funding through fiscal year 2005. Roughly one-third of results achieved by the Global Fund worldwide are thus attributable to U.S. contributions.

Multilateral Leadership

The United States, as a founding member of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and its first and largest donor, continues to play a leadership role in ensuring its success. The United States has already contributed nearly 50 percent more to the Global Fund in just three years than President Bush's 2003 pledge of $1 billion over five years – a contribution that is in addition to massive U.S. bilateral efforts.

In contrast to some nations, for which the Fund may be the most viable mechanism for matching HIV/AIDS resources to needs in the developing world, the U.S. contribution to the Fund is just one part of a diverse portfolio of investments in HIV/AIDS. In the near term, the most effective use of U.S. resources is through bilateral programs, but support for the success of the Fund is a key part of the overall Emergency Plan strategy. Particularly for nations without strong bilateral programs, the Fund provides a vital mechanism to increase financial commitments to the global HIV/AIDS fight.

At the country level, PEPFAR works to coordinate its bilateral programs with those of the Global Fund under the Three Ones principles for cooperation, under which international partners have agreed to support one national HIV/AIDS framework, one national coordinat-

ing authority, and one country-level monitoring and evaluation system in each host nation. In the focus countries, where the United States has committed resources intended to bring prevention, care and treatment programs up to national scale, coordination with the Fund based on comparative advantages is a central focus. Outside the focus countries, PEPFAR bilateral support and technical assistance leverage Fund financing and help to bring prevention, care and treatment programs up to full national scale. Recognizing the importance of U.S. technical assistance to the success of the Global Fund, approximately $14 million is being directed to partners in the field worldwide to provide technical assistance to Fund grantees. These funds will fill a critical need expressed by many grantees and support the success of their grants.

In addition to funding and support for implementation at the country level, the Emergency Plan also offers leadership to assist the Global Fund in such areas as achieving maximum effectiveness, operating with appropriate transparency and accountability, maintaining its performance-based funding approach and unique financing role, and supporting country-driven processes and participation. PEPFAR also coordinates programs under the Three Ones principles with UNAIDS, the World Health Organization, and others, and has been a co-sponsor of a number of activities in support of the Three Ones with UNAIDS and other partner nations.

Conclusion

Many doubted that HIV/AIDS programs could ever be successful on a broad scale in the world's poorest nations.

After two years of the Emergency Plan, it is clear that high-quality programs can work – and are working – in many of the world's most difficult places. On World AIDS Day 2005, President Bush welcomed a South African mother, son, and daughter to the White House. All three are HIV-positive – and all three are alive and well, thanks to the extraordinary efforts of those in their country who developed their treatment program and the support of the United States. This was one family among millions that have been touched in just the first two years of PEPFAR.

Through the President's Emergency Plan, the American people are partners with families, communities, and nations that are reclaiming their future.

A traditional healer in South Africa speaks with a patient. Traditional healers are receiving training on HIV/AIDS counseling and testing and prevention messages with support from the Emergency Plan. The project will soon train them in supporting adherence to antiretroviral treatment.

"We're working with our partners to expand prevention efforts that emphasize abstinence, being faithful in marriage, and using condoms correctly. This strategy – pioneered by Africans – has proven its effectiveness, and America stands behind the ABC approach to prevention."

President George W. Bush
World AIDS Day
December 1, 2005

Chapter 1

Critical Intervention in the Focus Countries: Prevention

Prevention Summary

Five-Year Goal in the 15 Focus Countries

Prevent 7 million infections by 2010

Progress Achieved through September 30, 2005

- Supported community outreach activities to over 42 million people to prevent sexual transmission
- Supported prevention of mother-to-child transmission for approximately 3.2 million women, and antiretroviral prophylaxis for 248,100 women, averting an estimated 47,100 infant HIV infections (cumulative for fiscal years 2004 and 2005)
- Supported training or retraining of over 316,000 people in provision of prevention services
- Supported approximately 3,100 service sites for prevention of mother-to-child transmission and blood safety

Allocation of Resources in Fiscal Year 2005

$294 million to support prevention in focus counties (28 percent of total focus country resources for prevention, treatment, and care)

The challenges facing the developing world in seeking long-term solutions to prevent the transmission of HIV are daunting. The latest UNAIDS report indicates the highest number of infections ever – over 40 million worldwide, including approximately 5 million new infections in 2005. Many nations face rapidly growing epidemics even as HIV/AIDS is reducing average life spans. Approximately 50% of the world's HIV-infected people live in the 15 focus nations of the Emergency Plan.

These indicators remind us that prevention represents the only long-term, sustainable solution to turn the tide against HIV/AIDS. Treatment and care are necessary, vital, life-extending services that greatly mitigate the impact of HIV infection and AIDS. But unless the world can reduce the number of new infections, we will be running a race we cannot win.

Despite the alarming realities of the pandemic, there is also a growing basis for hope. Recent evidence from Kenya, Zimbabwe, Caribbean nations, and others shows

that people have begun to change their behavior in ways that make them safer.

Support for sustainable change, in places with generalized epidemics of the type found in most PEPFAR focus countries, requires comprehensive, multisectoral, complex prevention activities that reach as much of society as possible, while still meeting the needs of people who face especially elevated risks. Yet effective prevention cannot be indiscriminate – it must be high-quality and evidence-based. Only quality programs produce long-term changes in infection rates – the ultimate metric of success.

Effective prevention must be sustainable – community-owned, people living with HIV/AIDS (PLWHA)-inclusive, gender-sensitive, responsive to local culture and tailored to local circumstances. These activities should also be linked to care and treatment programs, as well as to other parts of the health care system like tuberculosis (TB) services and family planning sites, as part of a comprehensive national response to HIV/AIDS.

Efforts directed at sexual transmission are crucial, particularly in the focus countries, where most infections are sexually transmitted. PEPFAR also focuses on activities that address non-sexual modes of transmission such as intravenous drug use, mother-to-child transmission, unsafe blood, and unsafe medical injections. In these areas too, quality and sustainability are guiding principles.

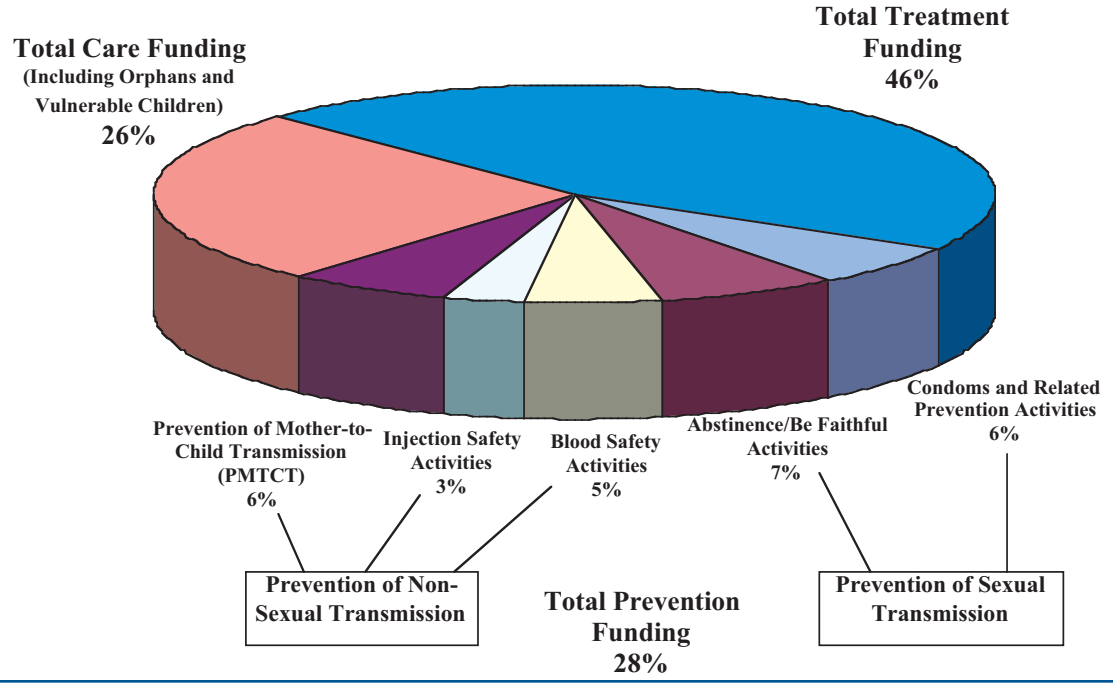
This chapter describes the efforts of the Emergency Plan in the focus nations, where PEPFAR is working within national strategies to identify and scale up interventions that meet the challenges of quality and sustainability. In our second year, we are pleased to note significant progress.

Reflecting the Emergency Plan goal of continuous program refinement, prevention activities are generating information on best practices. This information is rapidly put to use, guiding programming decisions to ensure that PEPFAR support goes to interventions that are of high quality and are sustainable.

Prevention of Sexual Transmission of HIV

The PEPFAR focus nations, with the exceptions of Vietnam and (to a lesser extent) Guyana, have epidemics

Figure 1.1 - Prevention: The U.S. President's Emergency Plan for AIDS Relief
FY 2005 Funding for Prevention, Treatment, and Care in the Focus Countries



that are not heavily concentrated within easily-identified risk groups. While some subgroups have higher levels of HIV prevalence than others, these nations' epidemics are generalized, affecting broad cross-sections of society, and the predominant mode of transmission is sexual activity. In these settings, any sexual exposure can be high-risk activity.

Generalized epidemics are often accompanied by growing awareness of HIV, its effects, and its modes of transmission. Yet it has become clear that awareness of HIV by itself does not necessarily lead to changed behavior – a situation that might be described as "awareness fatigue." Awareness of HIV in many of the hardest-hit nations has grown dramatically in recent years, yet infection rates have not necessarily fallen accordingly – highlighting the need to continually improve prevention efforts.

Many countries have now embarked on a difficult new stage of the fight against HIV. They are moving to balance campaigns to promote awareness of HIV with a broader public health approach that provides people with comprehensive information, services, and support that will enable them to make healthy decisions about how to protect themselves. Indeed, providing people with this level of information, support and services is not merely good public health practice – it can help promote the democratic value of personal responsibility that leads to healthy behaviors.

The national strategies of many host nations included the ABC approach (Abstain, Be faithful, correct and consistent use of Condoms where appropriate), delivered in culturally-sensitive ways, even before the advent of the Emergency Plan.

New evidence from Kenya and other nations suggests that behavior change in the face of HIV/AIDS is possible. The Kenyan Ministry of Health estimates that HIV prevalence has dropped markedly in recent years. While the causes are undoubtedly complex, this decline correlates with a broad reduction in sexual risk behavior. Among the findings:

- Increased male faithfulness, as measured by the percentage of men who report more than one sexual partner in the preceding year (in the key 20-24 age group, the percentage dropped from over 35 percent in 1998 to less than 18 percent in 2003)

- Delayed sexual debut among young women (with median age of sexual debut rising from 16.7 in 1998 to 17.8 in 2003)

- Among both teenage boys and girls, high levels of both primary abstinence (with a minority of boys and girls in the 15-17 age group, and a minority of girls in the 18-19 age group, reporting any prior sexual activity) and secondary abstinence (in both age groups, a minority of those who reported prior sexual activity reported any sexual activity in the last year)

- Increased condom use among women who engage in risky activity (the number of women who reported condom use in their last higher-risk sexual encounter rose from 16 percent to 24 percent from 1998 to 2003)

In Zimbabwe, UNAIDS reports that HIV prevalence among pregnant women declined from 26% in 2002 to 21% in 2004. The report attributes the decline to higher levels of condom use with casual partners (86% among men and 83% among women) and reductions in the number of sexual partners. As Dr. Peter Piot of UNAIDS remarked with respect to these two countries, "[T]he declines in HIV rates have been due to changes in behaviour, including increased use of condoms, people delaying the first time they have sexual intercourse, and people having fewer sexual partners." Put another way, each of the ABC behavior changes took place in these countries.

Among the other countries with generalized epidemics and evidence of ABC behavior change at the national or subnational level are Ethiopia, Zambia, South Africa, Haiti, and Tanzania. More work is needed to understand these data, and to identify which interventions may have influenced them. Fundamentally, however, it is clear that people in some countries have begun to change their

sexual behavior in ways that reduce their risk of infection. It is thus urgent to identify and scale up initiatives to help even more people choose healthy behaviors.

PEPFAR supports host nations' efforts to scale up interventions that incorporate the ABC messages. PEPFAR supports an evidence-based, public health approach that provides information so people can decide how to protect themselves: the only 100 percent effective way to avoid HIV is to abstain or to be faithful to a single, HIV-negative partner, while correct and consistent use of condoms reduces risk by approximately 80-90 percent. With that knowledge, if one chooses risky behavior, condoms must be available to that person.

The ABC Guidance

In 2005, the Emergency Plan issued formal guidance to country teams and partners on implementation of ABC activities. The guidance may be found online in its entirety at www.pepfar.gov. The PEPFAR-supported ABC approach employs population-specific interventions that emphasize abstinence for youth and other unmarried persons, 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 places them at risk for transmitting or becoming infected with HIV. PEPFAR-supported programs may include all three of the ABC messages, or a subset of them, as appropriate.

The ABC approach is distinctive in its targeting of specific populations, the circumstances they face, and behaviors within those populations for change. This targeted approach results in a comprehensive and effective prevention strategy that helps individuals personalize risk and develop tools to avoid risky behaviors under their control.

Abstinence programs encourage unmarried individuals to abstain from sexual activity as the best and only certain way to protect themselves from exposure to HIV and other sexually transmitted infections (STIs). Abstinence until marriage programs are particularly important for young people, as approximately half of all new infections occur in the 15- to 24-year-old age group. Delaying first sexual encounter can have a significant impact on the health and well-being of adolescents and on the progress of the epidemic in communities. In many of the countries hardest hit by HIV/AIDS, sexual activity begins early and prior to marriage. Surveys show that, on average, slightly more than 40 percent of women in sub-Saharan Africa have had premarital sex before age 20; among young men, sex before marriage is even more common. A significant minority of youth experience first sex before age 15. Internationally, a number of programs have proven successful in increasing abstinence until marriage, delaying first sex, and achieving "secondary abstinence" — returning to abstinence — among sexually experienced youth.

These programs promote the following:

- Abstaining from sexual activity as the most effective and only certain way to avoid HIV infection;
- The development of skills for practicing abstinence;
- The importance of abstinence in eliminating the risk of HIV transmission among unmarried individuals;
- The decision of unmarried individuals to delay sexual debut until marriage; and
- The adoption of social and community norms that support delaying sex until marriage and that denounce cross-generational sex; transactional sex; and rape, incest, and other forced sexual activity.

Be faithful programs encourage individuals to practice fidelity in marriage and other sexual relationships as a critical way to reduce risk of exposure to HIV. Once a person begins to have sex, the fewer lifetime sexual partners he or she has, the lower the risk of contracting or spreading HIV or other STIs. Some of the most significant gains in Uganda's fight against HIV are a result of specific emphasis on, and funding of, programs to promote changes in behavior related to fidelity in marriage, monogamous relationships, and reducing the number of sexual partners among sexually active unmarried persons. Uganda's President Museveni, along with local religious groups and other nongovernmental organizations (NGOs), promoted a consistent message of partner reduction and fidelity, which contributed to a significant decline in the number of sexual partners among both men and women in Uganda.

Through workplace and prevention programs, the Emergency Plan is supporting efforts to provide prevention resources, such as condoms and education on being faithful, to miners like these men in Chingola, Zambia.

Be faithful programs promote the following:

- The elimination of casual sexual partnerships;
- The development of skills for sustaining marital fidelity;
- The importance of mutual faithfulness with an uninfected partner in reducing the transmission of HIV among individuals in long-term sexual partnerships;
- HIV counseling and testing with their partner for those couples that do not know their HIV status;
- The endorsement of social and community norms supportive of refraining from sex outside of marriage, partner reduction, and marital fidelity, by using strategies that respect and respond to local cultural customs and norms; and
- The adoption of social and community norms that denounce cross-generational sex; transactional sex; and rape, incest, and other forced sexual activity.

Correct and consistent Condom use programs support the provision of full and accurate information about correct and consistent condom use reducing, but not eliminating, the risk of HIV infection; and support access to condoms for those most at risk for transmitting or becoming infected with HIV. Behaviors that increase risk for HIV transmission include engaging in casual sexual encounters, engaging in sex in exchange for money or favors, having sex with an HIV-positive partner or one whose status is unknown, using drugs or abusing alcohol in the context of sexual interactions, and using intravenous drugs.

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. Other high-risk persons or groups include men who have sex with men (MSMs) and workers who are employed away from home. Existing research demonstrates that the correct and consistent use of condoms significantly reduces, but does not eliminate, risk of HIV infection. Studies of sexually active couples for example, in which one partner is infected with HIV and the other partner is not, demonstrate that latex condoms provide approximately 80-90 percent protection, when used consistently.

Condom use programs promote the following:

- The understanding that abstaining from sexual activity is the most effective and only certain way to avoid HIV infection;
- The understanding of how different behaviors increase risk of HIV infections;
- The importance of risk reduction and a consistent risk-reduction strategy when risk elimination is not practiced;
- The importance of correctly and consistently using condoms during every sexual encounter with partners known to be HIV-positive (discordant couples), or partners whose status is unknown;
- The critical role of HIV counseling and testing as a risk-reduction strategy;
- The development of skills for obtaining and correctly and consistently using condoms, including skills for vulnerable persons; and
- The knowledge that condoms do not protect against all STIs.

In nations which have epidemics that are still highly concentrated in certain population groups, effective outreach can help to keep the epidemic contained in combination with other interventions and referrals to other services, such as counseling and testing.

Best Pratices
Namibia: In the *shebeens* of Rehoboth, "Try and You Will See"

The Peace Corps assigned Megan Sweat as a volunteer to Rehoboth in December 2004 with the aim of trying to engender greater community involvement in the fight against HIV/AIDS. Working within the Community Mobilization Program supported by the Emergency Plan and implemented through USAID, Megan focused on strengthening the organization and commitment of the Rehoboth Eastern Community Action Forum (RECAF), a group of community members concerned about the threat of HIV/AIDS. Since that time, Megan and RECAF have worked directly with Ditsa-I-Mu ("Try and You Will See" in the Damara language), a group of out-of-school young people who live in the most marginalized area of Rehoboth, where the majority of the young people are unemployed or employed part time. When Megan started working in Rehoboth, Ditsa-I-Mu consisted of 10 eager young people who wanted to do something about HIV/AIDS, but knew little about the disease and even less about how to reach out to their community.

With the support and encouragement of Megan and the USG-supported RECAF, membership in the Ditsa-I-Mu has grown to 25 people, most of whom meet on a daily basis to discuss HIV/AIDS and methods for community outreach. Ditsa-I-Mu started to visit informal neighborhood bars (known as *shebeens*) in the community, where the group members talk frankly about HIV/AIDS and the increased dangers posed by excess drinking, risky sex and other dangerous behavioral practices. The group has also received funding for drama and song awareness programs and travels to schools, church youth groups, and community events and activities singing and speaking about HIV/AIDS and behavior change. The group has become a respected force in the community and a focal point of HIV/AIDS efforts.

The partnership of the USG and these community groups has helped transform a group of young people from being potential victims of HIV/AIDS to being active, effective mobilizers who are building the capacity of their community to win this fight.

In contrast, in places with generalized epidemics like most of the PEPFAR focus nations, those at high risk include both defined high-risk populations and all individuals who choose to engage in risky activity. PEPFAR's ABC guidance supports the range of activities needed to reach these different populations with specific outreach, comprehensive prevention messages, and condom information and provision.

Abstinence and behavior change for youth is identified as one of three priority intervention areas. Under the guidance, young people who have not had their sexual debut must be encouraged to practice abstinence until they have established a lifetime monogamous relationship. For those youth who have initiated sexual activity, returning to abstinence must be a primary message of prevention programs. Marketing campaigns that target youth and encourage condom use as the primary intervention are not appropriate for youth, and the Emergency Plan will not fund them. (For this same reason, Emergency Plan funds may not be used to actively promote or provide condoms in school settings, but may be used in schools to support programs that deliver age-appropriate "ABC" information for youth.) In summary:

- Emergency Plan funds may be used in schools to support programs that deliver age-appropriate "AB" information to young people age 10-14
- Emergency Plan funds may be used in schools to support programs that deliver age-appropriate "ABC" information for young people above age 14
- Emergency Plan funds may be used to support integrated ABC programs that include condom provision in out-of-school programs for youth identified as

engaging in or at high risk for engaging in risky sexual behaviors

- Emergency Plan funds may not be used to physically distribute or provide condoms in school settings

- Emergency Plan funds may not be used in schools for marketing efforts to promote condoms to youth

- Emergency Plan funds may not be used in any setting for marketing campaigns that target youth and encourage condom use as the primary intervention for HIV prevention

Another priority area for intervention under the ABC guidance is *promoting healthy norms and behaviors,* confronting the roots of HIV/AIDS-promoting behaviors such as multiple casual sex partnerships, cross-generational and transactional sex, forced sex, the unequal status of women, and the sexual coercion and exploitation of young people. Activities in this area include as goals:

- Educating parents to improve parent-child communication on HIV, sexuality, and broader issues such as limit-setting through parent-teacher groups, local associations, and faith-based groups

- Training local religious and other traditional leaders in HIV concerns and supporting them in publicizing the risks of early sexual activity, sex outside of marriage, multiple partners, and cross-generational sex

- Supporting youth-led community programs to help youth, their parents, and the broader community personalize the risk associated with early sexual activity, sex outside of marriage, multiple partnerships, and cross-generational sex

- Supporting media campaigns that reinforce and make abstinence, fidelity, partner reduction, HIV counseling and testing, and other safer behaviors legitimate options and standards of behavior for both youth and adults

- Developing and training mentors for youth who lack sufficient parental or other adult supervision, including training in messages for HIV prevention

- Organizing campaigns and events to educate local communities about sexual violence against youth and strengthen community sanctions against such behaviors

- Implementing workplace programs for older men to stress male sexual and familial responsibility, and school-based programs for younger males to provide education about preventing sexual violence

- Promoting the use of testing and counseling services, including developing innovative strategies to encourage and increase HIV testing, such as routine testing where appropriate

- Training health care providers, teachers, and peer educators to identify, counsel, and refer young victims of rape, incest, or other sexual abuse for other health care

- Coordinating with governments and nongovernmental organizations (NGOs) to eliminate gender inequalities in the civil and criminal code and enforce existing sanctions against sexual abuse and sexual violence.

A third area for priority interventions is *prevention of HIV infection in the most at-risk populations.* PEPFAR funds activities that target at-risk populations with specific outreach, services, comprehensive prevention messages, and condom information and provision. Populations facing special risks – which in some cases are especially difficult to reach with services – include commercial sex workers and their clients, sexually active discordant couples, substance abusers, mobile male populations, MSMs, PLWHAs, and those who have sex with an HIV-positive partner or one whose status is unknown.

The experiences of Thailand, Cambodia, Dominican Republic, Senegal, and other countries illustrate that

targeted efforts to promote condom use with specific high-risk groups can prevent concentrated epidemics from maturing into generalized epidemics.

In generalized epidemics, such targeted approaches remain crucial but must be augmented by balanced ABC approaches that can reach broader audiences in order to provide information to those who may be engaging in risky activity, such as having sex with a partner whose status is unknown.

In addition to support for approaches directed at ending risky behavior, the Emergency Plan supports effective new approaches to serve groups at high risk through a combination of the following:

- 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 routine testing where appropriate
- Promoting and supporting substance abuse prevention and treatment targeting HIV-infected 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

HIV and Alcohol

Sexual risk-taking behaviors associated with alcohol use are prevalent in many of the nations severely affected by HIV/AIDS. The association between alcohol use (misuse, abuse and dependence) and increased risks for HIV transmission is of growing concern in many countries. Reports indicate that HIV-positive individuals with alcohol problems delay HIV testing and entering into care, and have problems complying with antiretroviral treatment (ART) if their alcohol dependence is not addressed.

The Emergency Plan is monitoring data trends in this area and designing interventions to respond. A study of 1,630 HIV-positive men in Zambia showed that only 36 percent had not consumed alcohol in the past year. Forty percent reported drinking twice weekly or more often, one-third being intoxicated weekly, and one-tenth drinking daily. The Kenya Demographic and Health Survey (2003) reported that HIV prevalence was 19 percent among women who had consumed alcohol but only 9 percent among women who had not.

These data trends suggest that risk of HIV infection may be exacerbated by the consumption of alcohol. In order to address this, the Emergency Plan is supporting such interventions as working with *shebeens* (neighborhood bars) in Namibia (see accompanying story). Activities to reach individuals who consume alcohol with HIV prevention information, counseling and testing, and referrals to other needed services are being scaled up in many PEPFAR-supported countries.

To ensure that USG programs are supporting effective alcohol and HIV prevention programming, the Emergency Plan supported an Africa regional meeting for in-country USG teams in August 2005 entitled, "Alcohol, HIV risk behaviors and transmission in Africa: Developing Programs for the United States Emergency Plan for AIDS Relief." Participants shared lessons learned and offered assistance to one another in order to support and expand such prevention activities. In fiscal year 2006, PEPFAR will fund specific interventions to address the alcohol-HIV nexus, and will support targeted evaluations to develop lessons learned from the most effective programs.

- Promoting correct and consistent condom use during high-risk sexual activity

- Media interventions with specially tailored messages appropriately targeted to specific populations

At the same time, quality prevention efforts must reflect the variety of factors that affect people's ability to negotiate the A, B, and C elements – such as gender issues and alcohol abuse. The Emergency Plan is working to ensure that interventions reflect these complex realities.

Results: Rapid Scale-Up

In fiscal year 2005, the Emergency Plan continued to expand its support for host nations' efforts to prevent sexual transmission of HIV – the leading source of new infections in the focus countries and many other nations.

Fiscal year 2005 funding for activities to prevent the sexual transmission of HIV in the focus countries totaled approximately $141 million, of which approximately $76 million (approximately 53 percent) was for abstinence and faithfulness (AB) activities. When all prevention resources are considered (including those for activities focused on non-sexual modes of transmission), approximately 26 percent of total prevention funding in the focus countries was for AB programs.

Emergency Plan-supported community outreach activities that promoted abstinence and faithfulness reached almost 25 million individuals. As a subset of these activities, approximately 8 million individuals – primarily youth – were reached by activities that promoted abstinence as their primary behavioral objective.

While PEPFAR continues to support targeted mass media activities, country teams no longer provide esti-

Table 1.1 - Prevention: FY05 Prevention of Sexual Transmission Results

Country	Number of individuals reached with community outreach HIV/AIDS prevention activities that promote abstinence and/or being faithful[1]	Number of individuals reached with community outreach HIV/AIDS prevention activities that promote condoms and related services[2]	Total
Botswana [3]	53,700	56,000	109,700
Cote d'Ivoire	43,900	110,400	154,300
Ethiopia	3,324,200	424,400	3,748,600
Guyana	155,500	35,200	190,700
Haiti	345,700	266,500	612,200
Kenya	3,248,500	2,312,500	5,561,000
Mozambique	994,600	808,700	1,803,300
Namibia	209,200	102,100	311,300
Nigeria	1,890,300	824,000	2,714,300
Rwanda	732,500	269,300	1,001,800
South Africa	3,967,500	4,122,500	8,090,000
Tanzania	5,636,600	4,002,500	9,639,100
Uganda [4]	3,639,200	3,606,400	7,245,600
Vietnam[5]	265,500	165,200	430,700
Zambia	354,800	835,400	1,190,200
Total	**24,862,000**	**17,941,100**	**42,802,800**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.

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 focus on individual behavior change or may address relevant social and community norms.

[2] Condoms and related HIV/AIDS prevention includes behavior change activities, outside of those promoting abstinence and being faithful, that are aimed at preventing HIV transmission. Examples include 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.

[3] The number of people reached through community outreach AB programs declined from FY04 to FY05 in Botswana. This is in large part due to the award of new contracts and grants in FY05 that began implementation after the reporting period ended, and to programs that experienced contractual problems, which affected their reach.

[4] The number of people reached through community outreach programs in Uganda declined from FY04 to FY05. Due to improved data quality procedures, which reduced duplication in the results reported, and to the absence of results from the Ministry of Health, which were included in the FY2004 results, but have not yet been made available for FY2005.

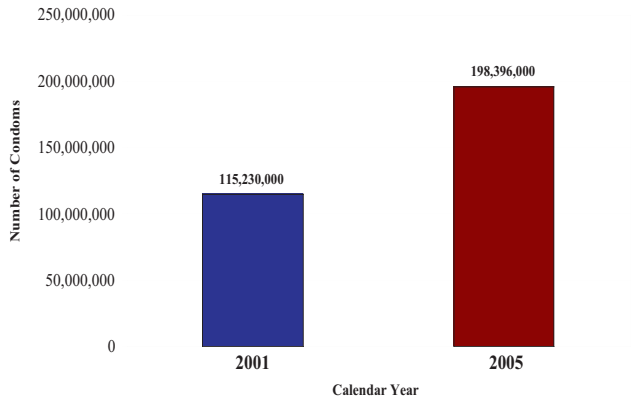
[5] In FY2004, Vietnam was not an Emergency Plan focus country and reported all community outreach prevention results under the "Other Prevention program area". In FY2005, in accordance with Emergency Plan reporting requirements, community outreach results are split between the AB or Other Prevention program areas.

Table 1.2 - Prevention: FY05 Prevention of Sexual Transmission Capacity Building Results

Country	Number of individuals trained or retrained to provide HIV/AIDS prevention activities that promote abstinence and/or being faithful[1]	Number of individuals trained or retrained to provide condoms and related services[2]	Total
Botswana	900	900	1,800
Cote d'Ivoire	200	200	400
Ethiopia	39,600	7,600	47,200
Guyana	1,200	400	1,600
Haiti	3,500	2,800	6,300
Kenya	19,500	35,100	54,600
Mozambique	12,300	1,500	13,800
Namibia	2,200	1,200	3,400
Nigeria	11,600	1,300	12,900
Rwanda	7,100	1,900	9,000
South Africa	14,900	18,800	33,700
Tanzania	14,000	2,700	16,700
Uganda	9,000	8,400	17,400
Vietnam	1,500	8,500	10,000
Zambia	36,900	1,900	38,800
Total	**174,400**	**93,200**	**267,600**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.
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 focus on individual behavior change or may address relevant social and community norms.
[2] Condoms and related HIV/AIDS prevention includes behavior change activities, outside of those promoting abstinence and being faithful, that are aimed at preventing HIV transmission. Examples include 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.

Figure 1.2 - Prevention: USG Total Condoms shipped to Focus Countries, 2001 & 2005



Source: USAID, January 23, 2006

Table 1.3 - Prevention: USG Total Condoms shipped by Focus Country, 2001 & 2005

Country	CY 2001	CY2005
Botswana	0	5,367,000
Cote d'Ivoire	0	528,000
Ethiopia	71,292,000	69,597,000
Guyana	0	0
Haiti	0	12,105,000
Kenya	0	0
Mozambique	4,524,000	16,968,000
Namibia	0	0
Nigeria	234,000	3,204,000
Rwanda	0	3,891,000
South Africa	21,420,000	0
Tanzania	0	18,582,000
Uganda	7,140,000	47,007,000
Vietnam	0	10,344,000
Zambia	10,620,000	10,803,000
Total	**115,230,000**	**198,396,000**

Note: Numbers above 1,000 are rounded to nearest 1,000
Source: USAID, January 9, 2006

mates of numbers of persons reached by these activities. The Emergency Plan has concluded that such estimates are insufficiently accurate to be useful and is focusing on obtaining and analyzing behavior change impact data rather than program output data.

Emergency Plan funding in fiscal year 2005 for condoms and related prevention strategies directed at people who engage in high-risk activity in the focus countries totaled approximately $66 million, reaching almost 18 million people with community outreach activities. This funding represented over 46 percent of funding for activities focused on sexual transmission. When all prevention resources are considered (including those for activities focused on non-sexual modes of transmission), approximately 22 percent of total prevention funding in the focus countries was for condoms and related prevention activities.

Most United States Government (USG)-supported condoms were purchased and shipped through the mechanism of USAID's Commodity Fund, which achieves economies of scale and obtains low prices that allow funds to go farther. USG condom procurement levels to host countries depend upon a variety of factors, including whether the government procures condoms directly or asks international partners such as the USG to do so. Total USG-supported procurement of male and female condoms to focus countries in calendar year (CY) 2005 was estimated by USAID in January 2006 to have been over 198 million – up from approximately 115 million for these nations in 2001. It should be noted that projections

Prevention for Positives

The Emergency Plan weaves HIV prevention into every aspect of services in order to ensure success in preventing new infections. One of the most critical steps in prevention is the adoption of behaviors that prevent the spread of infection by people who are living with HIV/AIDS. Indeed, PLWHA networks and individuals continue to be outstanding leaders in the area of prevention and have made great strides in working within and outside service delivery systems to help turn the tide of the epidemic.

Many countries with generalized HIV epidemics where PEPFAR works are characterized by high rates of multiple and concurrent sexual partnerships and sero-discordance among married couples. While countries such as Kenya, Uganda, Ethiopia and Zambia have experienced changes in indicators of risk behavior, such as a reduction in the number of sexual partners and an increase in the age of first sex, there remains an elevated risk of HIV transmission in all countries among the general population if prevention is not addressed among those who are living with HIV/AIDS.

Prevention for positives and the integration of prevention into treatment and care are key priorities within the USG's overall approach to prevention. Emergency Plan partners work with PLWHA to ensure positive living – including making healthy decisions – and work within health care systems to ensure that prevention information, counseling and commodities (including condoms) are provided to clients.

In Uganda, this focus on prevention for positives has become a hallmark of USG programming. Recent data from the AIDS Information Center main branches indicate that 94% of 135,000 counseling and testing clients in the last three years were unaware of their partners' HIV status. With USG support, interventions were designed to encourage couples to be tested together, to encourage mutual disclosure within couples, and to support preventive behaviors, such as faithfulness in relationships and condom use for discordant couples. To support integration of prevention into care and treatment, clients who are receiving ART or other services are also provided with prevention counseling and information. The programs fully incorporate PLWHA and work with support groups and networks to make sure that healthy choices for prevention are seen as part of healthy living.

of planned condom procurement for the current year and future years may fluctuate as countries change their orders, and that projections may also differ from numbers that are ultimately shipped. Factors that may lead to such variability include changes in condom inventories in-country (e.g., overstocks that lead countries to request delay of further shipments), changes in the capacity of condom manufacturers, and host government regulatory issues that may delay condom shipments.

USG procurements have risen over this 2001-2005 time period in 10 focus nations (in the others, such as Guyana, Kenya, Namibia, and South Africa, government policies often mandate that condoms be procured by the government directly or by other specified entities, though USG funding typically supports these procurements in other ways). In Uganda, for example, USG condom procurement rose from approximately 7 million in 2001 to over 47 million in 2005.

Sustainability: Building Capacity

In support of the array of approaches described above, PEPFAR focuses on building capacity for behavior change interventions at the community level, where activities can best be tailored to local circumstances. Emergency Plan activities support peer educators in reaching youth, parents, faith communities, and other leaders, and in managing their activities and maintaining

Best Pratices

Rwanda: Supporting soldiers in keeping themselves – and others – safe from HIV

As the mist slowly rises up the volcano in the background, Rwandan soldiers descend from the surrounding hills, their boots caked with mud. They belong to units that patrol Rwanda's borders with the Democratic Republic of Congo and Uganda. Today they walked for around an hour to this PEPFAR-supported mobile counseling and testing center at Kinigi to be educated about HIV prevention and learn their status. "I have wanted to do this for a long time. For many years we have been hearing how important it is to get tested for HIV, but we never have the time to get tested. My unit is more than a day's walk to the nearest health center," notes Sgt. Adrien Muhgamrire.

An educator shows pictures and talks about HIV prevention with the soldiers of Rwanda's 63rd Battalion.

On arrival, the soldiers gather into groups to receive information about preventing HIV/AIDS. A counselor presents a series of paintings that illustrate the issues surrounding HIV, encouraging questions from the soldiers. A picture showing a pretty girl and a soldier elicits laughter, followed by questions and comments.

Another group of men gather to see and discuss a mobile video unit screening which explores the themes of fidelity, partner reduction and condom use. Some of the videos have been made by other soldiers during 'Club Anti-SIDA (AIDS)' activities, designed for the whole military community regardless of their HIV status. The soldiers watch a variety of videos covering the ABCs of HIV prevention (Abstinence, Being faithful, and correct and consistent use of Condoms). Testimonies from soldiers living with HIV, as well as dramatized sketches performed by soldiers are also featured.

accountability and quality. In South Africa and Ethiopia, for example, peer educators working with faith communities provide outreach, support and links to HIV-related services. In the fifteen focus countries, over 174,000 people were trained or retrained in promoting abstinence and/or faithfulness.

Outreach to people who may be socially marginalized is most credibly conducted by local organizations close to those they serve. For example, in Vietnam PEPFAR supports peer outreach to commercial sex workers, linked with job training and skill development to help women leave prostitution. The Emergency Plan is supporting local organizations with training and capacity-building in order to help them reach out with effective, evidence-based strategies. In fiscal year 2005, PEPFAR helped to lay a foundation for sustainability by supporting training or retraining for over 93,000 people in the provision of condoms and related prevention services.

Key Challenges and Future Directions

Ensuring consistent quality across a wide range of locally-tailored prevention activities is crucial. The Emergency Plan thus supports efforts to develop indicators that measure the quality of processes, in addition to outcome indicators. Both are yielding information essential for program management. For further information, see the chapter on Improving Accountability and Programming.

Next, the soldiers participate in a group counseling session to prepare them for what will happen during the individual counseling and testing session. A 2001 survey revealed that people who suspected they were HIV-positive were reluctant to get tested. As a result, programs focus on the benefits of getting tested, and the medical services available for those who test positive. Each soldier spends around 15 minutes with a counselor who completes a questionnaire regarding the soldier's sexual habits. The counselor provides the soldier with condoms and also tells him where he can buy condoms in the future. After this, the counselor takes a blood sample, and the soldier only needs to wait 30 minutes to receive the results from the same counselor.

Staff Sgt. Innocent Birinda is pleased to be getting tested today, since he says he is ready to look for a wife, and many families suspect soldiers of being HIV-positive. Like many of his fellow soldiers, he is very well informed about HIV. Another soldier in his company tested HIV-positive, and he stresses that they all "live together, sleep together, with no problem, no difference".

For the men that receive the news that they are HIV-positive, the counselor recommends that they meet with their medical officer to arrange for a transfer to the Kanombe Military Hospital in Kigali, where they will receive additional blood tests. The soldiers will have access to antiretroviral treatment if their blood test results warrant it. The soldiers are assured that their lives will continue, with no change in their duties or responsibilities. Counselors also focus on 'prevention for positives,' encouraging HIV-positive soldiers to use condoms and arrange HIV testing for their wives and children.

Mobile counseling and testing responds to the needs of people who cannot access a fixed health facility. Marcel Sebagabo, Head of the Public Health Department for the Rwandan military, reports that the military are more comfortable being tested in a military setting, and as a result 80% of those offered counseling and testing come to get tested. The U.S. Department of Defense plays an important role in training and supporting the personnel working both at the Kanombe Military Hospital in Kigali and the field support staff such as the Battalion Medical Officers.

Sgt. Adrien Muhgamrire leaves Kinigi today with the good news that he is HIV-negative. Today he participated in the 'Club Anti-SIDA' activities and he plans to return in a couple of weeks for the next meeting. Before heading into the hills, the club practices their new song, which a soldier translates, "We fight against AIDS, then we stay strong, we serve our country, we protect our families and we are careful and loyal."

Strengthening the knowledge base of effective behavior change interventions is a challenge, due in part to limited understanding of the factors that influence sexual behavior. PEPFAR monitoring and evaluation of activities and results is helping to grow the knowledge base and allow for adjustment of programming decisions.

Girls and young women remain disproportionately vulnerable to HIV transmission, and PEPFAR programs are addressing this vulnerability. For further information, please see the chapter on Gender and the text box at the end of this chapter.

Sexual coercion, exploitation, and violence remain major issues, and a growing number of PEPFAR activities focus on men and boys in order to break this cycle. The Emergency Plan also reaches out to faith communities, supporting them in addressing this issue.

Schools offer unique venues for reaching large numbers of youth with prevention messages, and PEPFAR is increasing its investment in school-based prevention activities. These include activities that involve parents, strengthening the impact while supporting families.

Partner reduction and mutual faithfulness hold great promise for reducing rates of infection, and the Emergency Plan is working with a broad range of partners to support the "Be faithful" component of ABC activities. Working with men in particular is crucial for reducing sexual violence and coercion that put women and girls at risk for HIV. PEPFAR prevention programs are including a greater emphasis on men in their ABC efforts. For example, in South Africa the Men as Partners program works with men to help change social norms and promote healthier behaviors, such as eliminating concurrent sexual partnerships.

Ensuring full participation of PLWHA in prevention is a key and continuing challenge, and the Emergency Plan is supporting activities to help these communities receive the full benefit of outreach through various PLWHA networks. In Kenya, networks of teachers living with HIV/AIDS and KENERELA, a network of individuals from the faith community living with or personally affected by HIV/AIDS, have made substantial progress in reducing stigma and promoting prevention strategies within their communities and workplaces.

Stigma, discrimination, and marginalization of groups that face especially high risks remain serious obstacles to effective prevention, and PEPFAR activities seek to combat these persistent problems.

Reaching discordant couples – who account for a large share of all infected persons in some high-prevalence countries – is a major need. Because faithfulness to a partner whose status is unknown is not a sufficient risk reduction strategy, the Emergency Plan supports linkage of prevention activities to counseling and testing. (See the "Prevention for Positives" text box.)

Shortages of well-trained prevention workers are a major barrier to outreach in the developing world, and PEPFAR supports training activities as well as linkages to existing networks.

Alcohol is gaining growing recognition as a factor in HIV transmission, and Emergency Plan programs have begun to address it directly. In August 2005 the Emergency Plan held an African regional meeting on alcohol, HIV and risk behaviors to help USG country teams identify evidence-based best practices to incorporate into their program planning for fiscal year 2006. (See the "HIV and Alcohol" text box.)

Meeting the range of needs of injecting drug users (IDUs) is a difficult challenge, particularly in Vietnam, as well as outside the focus countries in Asia, Eastern Europe and Russia. (It is also notable that PEPFAR is monitoring growth in IDU transmission in sub-Saharan Africa). The Emergency Plan has scaled up activities that address the needs of IDUs, such as peer outreach, links to relapse centers and helping HIV-positive drug users access treatment and other support services. The Emergency Plan has also completed policy guidance to assist the field in programming for this important population.

The Emergency Plan and Refugees

Many PEPFAR nations, including some focus countries, have significant refugee populations. Refugees are persons who are outside their country of origin and cannot return owing to a well-founded fear of persecution because of their race, religion, nationality, political opinion or membership in a particular social group. The Geneva Convention of 1951 established the United Nations High Commissioner for Refugees (UNHCR) in order to protect and assist refugees and others.

Studies have suggested that HIV prevalence among refugees is typically lower than that of general surrounding populations, yet their displacement, and the disruption of their normal lives, put them at risk for HIV/AIDS. The U.S. recognizes the vulnerability and the need for adequate services to be provided to refugees. These people are often forced to live in refugee camps located in remote areas, with poor access to roads and other health and social services. This isolation also poses challenges for food security and provision of HIV/AIDS services.

In fiscal year 2005, the Emergency Plan supported HIV/AIDS interventions in the areas of prevention, treatment, and care, including services supported through the U.S. Department of State Bureau of Populations, Refugees and Migration. In Kenya, women at the Kukuma camp are able to access prevention of mother-to-child transmission (PMTCT) and other counseling and testing services. In Zambia, more than 24,000 refugees at the Mwange camp now receive a variety of prevention services. At the Sherkole camp in Ethiopia, approximately 16,000 refugees are now able to obtain counseling and testing. In Tanzania, women in all refugee camps are now able to access PMTCT programs.

In collaboration with host governments, international partners, and other U.S. Government agencies, PEPFAR will continue to emphasize prevention to ensure that the current low prevalence among refugee populations is maintained and even reduced. The Emergency Plan will continue to work to identify unmet HIV/AIDS needs of refugees in order to ensure that they are met.

In order for the Emergency Plan to be successful in meeting its prevention goals, validated new technologies and research findings must be rapidly incorporated. PEPFAR works with USG implementing agencies, including HHS/CDC, HHS/NIH and research divisions of USAID, to monitor such emerging prevention areas as male circumcision, female-controlled prevention technologies and microbicide development. The Emergency Plan contributed approximately $97 million for microbicide research efforts in fiscal year 2005. As data emerges regarding the potential protective effect of male circumcision (such as from a recent randomized control trial in South Africa that found 60% fewer infections in the group of men who were circumcised), the Emergency Plan has responded by convening a Scientific Advisory Board to review data and develop draft recommendations. While its work continues, the fiscal year 2006 Country Operational Plan (COP) for Kenya, for example, includes funding for activities to explore the acceptability and feasibility of promotion of male circumcision in that country to prepare for scale-up of programmatic activities should data from ongoing studies conclude that such intervention would be advisable.

Prevention of Non-Sexual Transmission of HIV

Prevention of Mother-to-Child Transmission (PMTCT)

Results: Rapid Scale-Up

In the focus countries, the Emergency Plan provided approximately $66 million in fiscal year 2005 funding for comprehensive programs to provide HIV testing for pregnant women, prevention services for those who test HIV-negative, and antiretroviral drug (ARV) prophylaxis to

HIV-positive women and their newborn children to prevent transmission.

PMTCT programs encompass a wide range of critical interventions, including:

- Scaling up PMTCT programs by rapidly mobilizing resources
- Providing technical assistance and expanded training for health care providers on: appropriate antenatal care; safe labor and delivery practices; infant-feeding counseling and nutrition support; and malaria prevention and treatment
- Strengthening referral links to family-centered antiretroviral treatment (ART) programs, so that eligible HIV-infected mothers, children, and fathers can access life-saving therapy together
- Networking with nutrition, child survival, and family-planning programs to improve overall HIV-free survival among children born to HIV-positive mothers
- Ensuring effective supply chain management of the range of PMTCT-related products and equipment
- Expanding access to short-course preventive ARVs while also assisting countries in developing plans to scale up the implementation of more effective combination prophylaxis regimens
- Providing technical assistance to countries in strengthening national PMTCT monitoring systems and revising national PMTCT guidelines to reflect best practices
- Strengthening systems to improve the postnatal follow-up for HIV-exposed infants, including piloting of polymerase chain reaction (PCR) testing, which enables the identification of HIV-infected infants who are in need of care and treatment
- Strengthening referrals for HIV testing for partners of HIV-positive women identified in antenatal clinics

As noted, PMTCT encounters provide a key opportunity to provide HIV counseling and testing to pregnant women. The PMTCT services indicator for fiscal year 2005 was clarified to ensure that a woman was only

Women wait in the maternity ward of St. Francis Hospital in the Kilombero District of Tanzania to receive PMTCT services.

counted as receiving PMTCT services if she was counseled and tested and received her test result. PMTCT services are thus crucial to the Emergency Plan's efforts to increase the numbers of women provided with counseling and testing.

The Emergency Plan has provided support for PMTCT interventions for approximately 3.2 million women to date, including over 1.9 million women in fiscal year 2005. Of these, over 248,000 (including over 122,000 in fiscal year 2005) received mostly short-course preventive ARVs, preventing an estimated 47,100 infections of newborn children to date, including over 23,000 in fiscal year 2005. For additional information on PMTCT programs, see the chapters on Children and Care.

Sustainability: Building Capacity

In addition to supporting host governments in building the capacity to operate PMTCT programs, the Emergency Plan supported training or retraining of over 28,000 people in the provision of PMTCT services, and supported approximately 2,500 service outlets that provide the minimum package of PMTCT services.

Table 1.4 - Prevention: FY05 Prevention of Mother to Child Transmission[1] Results

Country	Number of pregnant women receiving PMTCT services			Number of pregnant women receiving ARV prophylaxis			Total estimated infant infections averted[4]
	Number receiving upstream system strengthening support[2]	Number receiving downstream site-specific support[3]	Total	Number receiving upstream system strengthening support[2]	Number receiving downstream site-specific support[3]	Total	
Botswana	33,000	4,500	37,500	6,900	900	7,800	1,500
Cote d'Ivoire	0	22,800	22,800	0	1,900	1,900	400
Ethiopia	0	23,600	23,600	0	1,000	1,000	200
Guyana	0	6,900	6,900	0	95	95	18
Haiti	3,800	56,000	59,800	85	600	685	100
Kenya	24,600	318,400	343,000	1,600	19,400	21,000	4,000
Mozambique	16,800	71,200	88,000	1,800	4,200	6,000	1,100
Namibia	0	12,100	12,100	0	2,500	2,500	500
Nigeria	16,900	58,300	75,200	400	1,000	1,400	300
Rwanda	82,100	50,800	132,900	4,000	3,200	7,200	1,400
South Africa	457,700	75,900	533,600	12,700	18,300	31,000	5,900
Tanzania	41,100	133,300	174,400	1,000	5,800	6,800	1,300
Uganda	48,200	201,800	250,000	2,200	9,100	11,300	2,100
Vietnam	0	70,700	70,700	0	200	200	38
Zambia	0	127,400	127,400	0	23,700	23,700	4,500
Total	**691,200**	**1,233,700**	**1,957,900**	**30,700**	**91,900**	**122,600**	**23,400**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100

Footnotes:

[1] PMTCT programs provide the minimum package of PMTCT services as appropriate, including: HIV counseling and testing for pregnant women, ARV prophylaxis for HIV-positive pregnant women to prevent transmission, counseling and support for safe infant feeding practices, and family planning counseling or referral.

[2] 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, protocol and curriculum development.

[3] Number of individuals reached through downstream site-specific support includes those receiving services at U.S. Government-supported service delivery sites.

[4] The number of infant infections averted was calculated by multiplying the total number of pregnant women who received ARV prophylaxis (upstream and downstream) by the efficacy rate of ARV prophylaxis, currently estimated to be 19%.

Table 1.5 - Prevention: Cumulative Prevention of Mother to Child Transmission[1] Results, FY04-FY05

Country	Number of pregnant women receiving PMTCT services			Number of pregnant women receiving ARV prophylaxis			Number of estimated infections averted[2]		
	FY04	FY05	Total	FY04	FY05	Total	FY04	FY05	Total
Botswana	30,500	37,500	68,000	2,000	7,800	9,800	400	1,500	1,900
Cote d'Ivoire	24,900	22,800	47,700	1,900	1,900	3,800	400	400	800
Ethiopia	6,600	23,600	30,200	200	1,000	1,200	38	200	200
Guyana	5,700	6,900	12,600	67	95	200	13	18	31
Haiti	28,000	59,800	87,800	500	700	1,200	95	100	200
Kenya	333,700	343,000	676,700	16,600	21,000	37,600	3,200	4,000	7,200
Mozambique	36,100	88,000	124,100	2,300	6,000	8,300	400	1,100	1,500
Namibia	7,800	12,100	19,900	1,300	2,500	3,800	200	500	700
Nigeria	22,900	75,200	98,100	600	1,400	2,000	100	300	400
Rwanda	49,300	132,900	182,200	2,800	7,200	10,000	500	1,400	1,900
South Africa	487,300	533,600	1,020,900	76,000	31,000	107,000	14,400	5,900	20,300
Tanzania	42,800	174,400	217,200	1,800	6,800	8,600	300	1,300	1,600
Uganda	131,200	250,000	381,200	6,600	11,300	17,900	1,300	2,100	3,400
Vietnam	1,200	70,700	71,900	0	200	200	0	38	38
Zambia	63,300	127,400	190,700	12,800	23,700	36,500	2,400	4,500	6,900
Total	**1,271,300**	**1,957,900**	**3,229,200**	**125,500**	**122,600**	**248,100**	**23,700**	**23,400**	**47,100**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100

Footnotes:

[1] PMTCT programs provide the minimum package of PMTCT services as appropriate, including: HIV counseling and testing for pregnant women, ARV prophylaxis for HIV-positive pregnant women to prevent transmission, counseling and support for safe infant feeding practices, and family planning counseling or referral.

[2] The number of infant infections averted was calculated by multiplying the total number of pregnant women who received ARV prophylaxis (upstream and downstream) by the efficacy rate of ARV prophylaxis, currently estimated to be 19%.

Table 1.6 - Prevention: FY05 Prevention of Mother to Child Transmission[1] Capacity Building Results

Country	Number of USG-supported service outlets providing the minimum package of PMTCT services	Number of health workers trained or retrained in the provision of PMTCT services
Botswana	12	100
Cote d'Ivoire	44	200
Ethiopia	100	4,900
Guyana	46	75
Haiti	60	1,900
Kenya	900	3,100
Mozambique	51	500
Namibia	79	900
Nigeria	42	800
Rwanda	64	1,600
South Africa	400	8,400
Tanzania	200	2,200
Uganda	300	2,700
Vietnam	7	500
Zambia	200	700
Total	**2,500**	**28,600**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.
Footnotes:
[1] PMTCT programs provide the minimum package of PMTCT services as appropriate, including: HIV counseling and testing for pregnant women, ARV prophylaxis for HIV-positive pregnant women to prevent transmission, counseling and support for safe infant feeding practices, and family planning counseling or referral.

Key Challenges and Future Directions

PEPFAR activities reach women with antenatal care services, including home-based services, through community outreach. Even in resource-poor settings, including rural areas, interventions reach women with comprehensive information, provide rapid HIV testing and enable women to access ARVs to reduce risks of transmission. For example, in Mozambique clinical staff reach out to clients who opt to deliver at home. Home births are a common occurrence in many countries, and outreach ensures that mothers and newborns have access to PMTCT services and are linked to the appropriate follow-up care and support services. Ensuring that all women who visit antenatal clinics receive the option of an HIV test through pre-test counseling is a goal. By promoting the routine offer of HIV testing, so that women receive testing unless they elect not to receive it, the Emergency Plan has helped to increase the rate of uptake among pregnant women from low levels to around 90% at many sites. The focus in the coming year is to support countries to scale up this "opt-out" approach at as many sites as possible, allowing many more women to be reached while improving health worker performance and efficiency.

The Emergency Plan has also made progress through expanding the use of rapid HIV tests among HIV-positive women, thereby allowing many more women at PMTCT sites to receive their test results. Rapid testing is now being offered at many PEPFAR-supported PMTCT sites, and plans are to continue to scale up this best practice in the coming year. In addition, many PMTCT sites in such countries as Kenya, South Africa and Uganda are offering partner testing within their PMTCT programs.

New state-of-the-art combination regimens have recently been developed that can reduce transmission from over 30% to around 2%, and a focus of the Emergency Plan in the coming year will be to assist countries in scaling up these highly effective regimens to many more PMTCT sites and thereby to avert many more infant infections.

Linking HIV-positive pregnant women and their family members to a continuum of care and treatment services continues to be a very high priority for PEPFAR-supported programs, as they focus on developing and implementing adaptable and replicable models of HIV primary care for women and families. In addition, linking PMTCT to family planning programs is an important objective.

Emergency Plan activities also seek to strengthen postnatal follow-up and care for HIV-exposed infants, focusing on improving infant-feeding practices among HIV-positive mothers. These efforts promote exclusive infant feeding practices and provide nutritional support to enable the cessation of breastfeeding as soon as replacement feeding can be provided in a feasible and safe way.

Expanding the ability to effectively treat HIV-exposed infants, including increasing the availability of PCR diag-

nostic testing, will continue to be a priority as successful pilot approaches are scaled up in the coming year. Many countries utilize PEPFAR funds to help procure PCR machines, enabling earlier infant diagnosis. For example, the McCord Hospital in South Africa provides PCR testing at six weeks of age, allowing for improved pediatric care to those in need.

Helping the majority of mothers – who are found to be free of HIV – and their partners take prevention steps is another key focus of interventions. In Uganda, a group of HIV-positive men – ADMACHA – provides dramatic presentations at antenatal clinics encouraging husbands to be supportive partners and help prevent the spread of HIV.

Personnel and health systems issues remain serious, and PEPFAR supports efforts to train providers and systematize procurement of testing supplies and ARVs.

A medical technician draws blood at a facility in Guyana. Emergency Plan funds are helping to support the national blood transfusion service.

Prevention of Medical Transmission of HIV

Results: Rapid Scale-Up

Blood transfusions and unsafe medical injections continue to account for some infections in the focus countries, and addressing these issues requires major health system changes and advancements. While all of these nations are responding, their responses are at different stages, and PEPFAR is lending support tailored to the needs of each host nation. Total Emergency Plan funding for medical transmission activities in the focus countries in fiscal year 2005 was approximately $86 million.

To reduce the risks of blood transfusions, the Emergency Plan supports national programs to improve the quality

Table 1.7 - Prevention: FY05 Medical Transmission[1] Capacity Building Results

Country	Number of service outlets/programs carrying out blood safety activities	Number of individuals trained or retrained in blood safety	Number of individuals trained or retrained in injection safety
Botswana	0	89	1,600
Cote d'Ivoire	4	400	300
Ethiopia	12	30	900
Guyana	10	30	300
Haiti	26	500	900
Kenya	42	700	900
Mozambique	100	33	900
Namibia	4	100	400
Nigeria	12	3,100	200
Rwanda	43	0	600
South Africa	27	1,500	100
Tanzania	5	300	2,100
Uganda	200	800	2,700
Vietnam	0	0	300
Zambia	100	400	98
Total	**600**	**8,000**	**12,300**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.
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).

Best Pratices
Kenya: Investments in safe blood supply have broad impact

The 1998 terrorist attack on the U.S. Embassy in Nairobi revealed severe deficiencies in Kenya's blood supply system. One element of the USG response to this tragedy was funding for improvement of both the capacity and the quality of this vital component of the public health infrastructure. American funding strengthened the National Blood Transfusion Service (NBTS) and allowed construction of six Regional Blood Transfusions Centres (RBTC).

With the advent of the President's Emergency Plan, Kenya is capitalizing on earlier USG investments and implementing a multifaceted strategy to establish a national system that meets the need for safe blood. There has been over a 50% increase in blood collected from low-risk volunteer donors and screened for HIV, syphilis, and hepatitis B and C.

The program in place today includes: training of health workers to reduce the number of unnecessary transfusions; provision of essential commodities such as blood bags; work with the Kenya Red Cross Society and Hope Worldwide to educate and mobilize voluntary donors through community- and faith-based organizations; support for distance learning for laboratory technicians; a transfusion medicine course to train RBTC directors; and in-service training for over 100 NBTS personnel.

Due to these capacity-building investments, the share of Kenya's estimated annual demand for safe blood that could be met with screened units has increased from approximately 40 percent in 2004 to over 60 percent in 2005. In 2006, it is expected that over 80 percent of demand will be met with fully screened blood from voluntary donors.

PEPFAR investments are producing system-wide benefits. While safe blood is associated with reduced transmission of HIV, it is noteworthy that high rates of anemia associated with malaria in children and complications of pregnancy account for 75% of the annual demand for transfusions in Kenya. Emergency Plan contributions to safe blood serve not only to prevent HIV infections, but to reduce maternal and child morbidity and mortality as well.

of blood supplies through improved policies, infrastructure, commodity procurement, and management. In fiscal year 2005, the Emergency Plan–supported approximately 600 blood safety service outlets or programs in the focus nations.

Addressing the challenges of medical injection safety, PEPFAR supports efforts to reduce the number of injections and to make them safer, through programs to improve provider practices and reduce community demand for injections, strengthen supply of appropriate injection commodities, and facilitate safe disposal of injection equipment and supplies, especially sharps. The Emergency Plan supported procurement of over 89 million syringes for injection safety in the focus countries in fiscal year 2005.

The Emergency Plan also supports training of health workers, including training in universal medical precautions to reduce their risk of blood-borne infections. In the focus nations in fiscal year 2005, PEPFAR supported training or retraining for approximately 8,000 people in blood safety and over 12,000 in medical injection safety.

Many health workers who become infected due to medical transmission benefit from Emergency Plan-supported post-exposure prophylaxis (PEP) treatment interventions to prevent exposure from progressing to infection, helping to maintain the fragile health workforce of the developing world.

Sustainability: Building Capacity

The Emergency Plan goal of sustainability through support for locally-owned responses is reflected in the

Emergency Plan's approach to blood and injection safety. Support was channeled largely to national governmental initiatives to implement and manage distribution and logistics systems on which medical transmission prevention relies.

As noted above, the Emergency Plan also made significant investments in training of health care workers and managers of blood safety and medical injection safety activities. In two districts in Zambia, after interaction with clinical managers, new infection prevention practices were put into place, such as protective gear for housekeepers and orderlies and a color-coded bin system for marking hazardous waste material.

The Emergency Plan also supports "south-to-south" technical assistance, facilitating the sharing of lessons learned and best practices among host nations. For example, Kenya's blood safety program (see accompanying story) has won global recognition and has served as a model for many other countries in Africa.

Key Challenges and Future Directions

The new Partnership for Supply Chain Management, discussed in the chapter on Building Capacity for Sustainability, will help to address the significant commodity procurement challenges in the medical transmission area by strengthening supply chains, allowing for bulk purchasing and improved forecasting.

Shortages of personnel trained in blood safety and medical injection safety remain a major concern, and PEPFAR is supporting host nation efforts to expand training in safe injection techniques, as well as universal medical precautions and infection control.

Accountability: Reporting on the Components of Prevention

The First Annual Report to Congress of the Emergency Plan described the ways in which U.S. support is provided. Where partnership limitations or technical, material or financial constraints require it, the Emergency Plan, or another international partner, may support every aspect of the complete package of prevention, treatment, or care services at a specific public or private delivery site, in coordination with host-country national strategies.

Downstream support

In many areas, the Emergency Plan will coordinate with other partners to leverage resources at a specific site, providing those essential aspects of quality services that others cannot provide due to limited technical and/or financial circumstances. For example, in some settings components of services are provided to specific sites through the host-country government or other international partners such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, while the Emergency Plan may contribute other essential services, training, commodities, and infrastructure. "Downstream" site-specific support refers to these instances where the Emergency Plan is providing all or part of the necessary components for quality services at the point at which services are delivered.

Upstream support

Beyond the site-oriented downstream components of services, support is required to provide other critical elements, which may include the training of physicians, nurses, laboratory technicians, other health care providers, and counselors or outreach workers; 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 services. This coordination and leveraging of resources optimizes results while limiting duplication of effort among international partners, 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 sustainable network systems for prevention, treatment, and care.

Attribution challenges due to country-level collaboration

The Emergency Plan supports national HIV/AIDS treatment strategies, leveraging resources in coordination with

host-country multisectoral organizations and other international partners to ensure a comprehensive response. Host nations must lead a multisectoral national strategy for HIV/AIDS for an effective and sustainable response. International partners 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 international partners are not desirable or sustainable. In such an environment, attribution is complex, including both upstream and downstream activities, often with multiple partners supporting the same sites to maximize comparative advantages. PEPFAR is conducting audits of its current reporting system to refine methodologies for the future, and continues to assess attribution and reporting methodologies in collaboration with other international partners.

Prevention reporting conventions

To account for Emergency Plan prevention programming, in-country partners total all of the programs, services, and activities aimed at preventing HIV transmission. These include community outreach programs to promote abstinence, faithfulness, correct and consistent condom use, and other behavior change to support avoidance or reduction of HIV risk behaviors; community mobilization for HIV testing; and PMTCT 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 OGAC.

Addressing the Vulnerabilities of Women and Girls

As discussed in detail in the chapter on Gender, women and girls face special vulnerability to HIV/AIDS. This is due both 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.

These same factors make prevention activities for women particularly challenging – and particularly essential. These factors contribute to such prevention challenges as:

- Stigma, making women vulnerable to infection and preventing them from accessing services
- Transactional sex – often as a survival mechanism
- Male norms that accept unfaithfulness, casual sex, and cross-generational sex
- Patterns of coercion, violence, and rape
- Sex trafficking, abuse, and exploitation
- Women's lack of access to income
- Laws that may afford women insufficient protections

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
- Increase women's ability to negotiate safer practices

See the chapter on Gender for further discussion of Emergency Plan activities to support women and girls.

Condom shipments are tracked by a central database within the USG. Estimates of persons reached by mass media programs, however, are no longer reported, as such estimates are not sufficiently reliable to be useful.

To account for programs addressing medically transmitted HIV, in-country partners identify programs that support a national blood program, including policy development, infrastructure, equipment, and supplies; donor recruitment activities; blood collection, distribution and supply chain logistics, testing, screening, and transfusion; waste management; training; and management to ensure a safe and adequate blood supply. In addition, they identify programs that support policy development, training, waste management systems, advocacy, and other activities that promote medical injection safety, including activities to reduce inappropriate injections, improve distribution and supply of appropriate injection equipment, and promote appropriate disposal of injection equipment and related supplies.

Country teams monitor activities aimed at providing the minimum package of PMTCT services, including counseling and testing for pregnant women; preventive ARV 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.

The Emergency Plan has funded the MEASURE Evaluation Project, discussed in the chapter on Improving Accountability and Programming. This collaboration will result in:

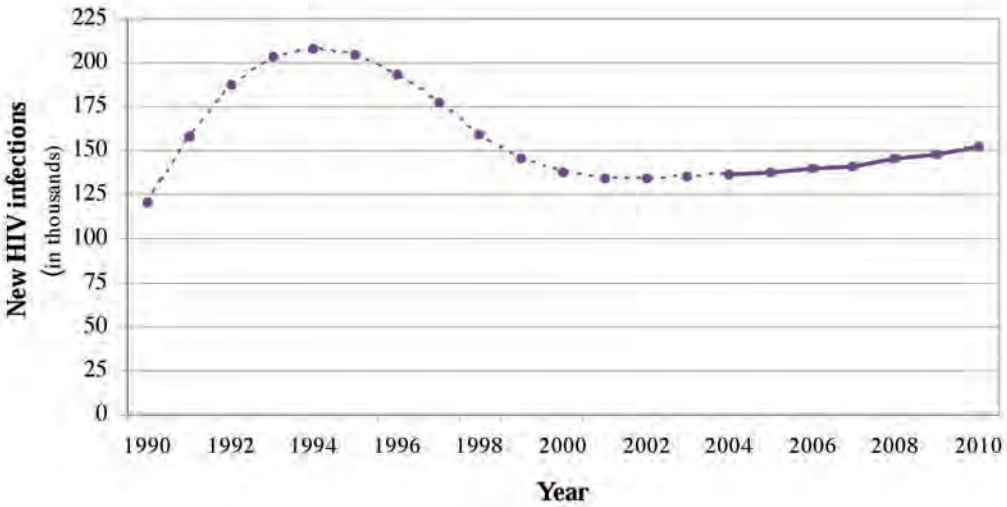
- Data quality audit guidance for program-level indicators
- Best practices for program-level reporting
- Implementation of data standards guidance in select countries

These products will help PEPFAR develop systems and processes that contribute to long-term, sustainable, high-quality HIV/AIDS monitoring and evaluation capacity in host nations.

Estimating infections averted

The number of infections averted as a result of expanded programs must be estimated through modeling since it cannot be measured directly (i.e., by definition, it is a non-event). For the purpose of estimating progress towards reaching the global target of 7 million HIV

Figure 1.4 - Prevention: New HIV Infections for Kenya: 1990 to 2010
Historical and Projected Estimates



--- Pre-Emergency Plan trend
— Projected trend in absence of Emergency Plan

Source: U.S. Census Bureau, unpublished estimates
Note: Estimates are subject to change as models are refined.

infections averted by the year 2010, the U.S. Census Bureau will prepare baseline projections of HIV incidence for each of the focus countries using pre-Emergency Plan data for the years 2004 through 2010. This baseline will then serve as the reference for future comparisons.

As an example, the figure above shows the baseline trend of new HIV infections for Kenya. The figure shows the historical trend in new HIV infections from 1990 to 2003 and the baseline estimates for 2004 to 2010.

Trends in HIV prevalence can be used to estimate trends in HIV incidence and the number of infections averted. Since it takes several years to detect changes in prevalence trends, this can only be done on a periodic basis. In this approach, prevalence trends will be established for each country using data through 2003. In 2006 these prevalence trends will be re-estimated for those countries with additional surveillance data available for 2004 and 2005 and estimates of new HIV infections will be made. The difference in the trends in new HIV infections, baseline versus new data, will represent the net impact of all program changes since the start of the Emergency Plan.

The Census Bureau will provide estimates of HIV infections averted during 2006 for those countries that report new HIV prevalence estimates. These estimates will be included in the January 2007 report to Congress.

The Emergency Plan has supported treatment for approximately 471,000 people worldwide in 2005, including this mother and child in Guyana. The family also participates in counseling and nutrition activities and receives home care visits three times a month.

"Before the Emergency Plan for AIDS Relief, only 50,000 people of the more than 4 million people in sub-Saharan Africa needing immediate AIDS treatment were getting medicine – think about that, only 50,000 people. After two years of sustained effort, approximately 400,000 sub-Saharan Africans are receiving the treatment they need."

President George W. Bush
World AIDS Day
December 1, 2005

Chapter 2

Critical Intervention in the Focus Countries: Treatment

Antiretroviral treatment (ART) is more than drugs – it represents hope. To people who have understood their HIV infection to be a death sentence, treatment promises a future.

Thanks to the urgent efforts of dedicated partners – both governmental and nongovernmental – in the field, and with support from the Emergency Plan, this hope is reaching a growing number of people.

Just two years into the initiative, the Emergency Plan is now partnering with host nations to support treatment for approximately 401,000 people in the 15 focus nations, and 70,000 people in the rest of the world, for a total of 471,000 people worldwide.

In achieving this success, the Emergency Plan has moved faster than any other bilateral or multilateral initiative to support the expansion of HIV/AIDS services using a network model of care to bring life-extending treatment to

Treatment Summary

Five-Year Goal in the 15 Focus Countries

Support antiretroviral treatment (ART) for 2 million HIV-infected individuals

Progress Achieved through September 30, 2005

- Supported ART for approximately 401,000 people in the focus countries
- Supported training or retraining of approximately 36,500 people in providing quality ART services
- Supported approximately 800 ART sites

Allocation of Resources in Fiscal Year 2005

$482 million to support ART in focus countries
(46 percent of total focus country resources for prevention, treatment, and care)

areas that are among the world's most difficult to serve. This success is rapidly transforming the social landscape in many of the world's hardest-hit nations, and it is an achievement to celebrate.

Yet it is not enough to scale up quickly. In the area of treatment, it is particularly essential that programs maintain the highest quality. Because treatment is complex, quality treatment has many elements. Antiretroviral drugs (ARVs) are one of these critical elements. The quality, safety and efficacy of formulations must be ensured, and ARVs and other needed commodities must travel to treatment sites via a secure and reliable supply chain.

Medical care must also be of high quality for treatment to be effective: those administering and monitoring treatment must be well-trained in the nuances of complex regimens. The unique dosing needs of children receiving ART must be considered on an individual basis. There must be effective integration of treatment with prevention and care services. Outreach to communities to support people on treatment and support adherence is also essential for quality programs.

The effects of poor quality treatment go beyond simple waste of scarce resources. Poor quality treatment means increased risk of morbidity and mortality for individual patients. Just as importantly, it can lead to widespread development of toxicity and transmission of viruses resistant to current treatment. The Emergency Plan is thus devoting intensive resources to strengthen the systems necessary to ensure that the treatment offered to HIV-positive people in the developing world is of high quality.

A second threat to the hope that ART scale-up brings is the threat that treatment will become unavailable in the future. When managed with ART, HIV is a chronic condition, and patients who begin therapy must maintain it for the rest of their lives. If people on ART lose their access to medications, they will die.

Sustainability for the indefinite future is thus also critical for ART efforts, and as with all HIV/AIDS responses, this can only be guaranteed by local leadership and ownership. For this reason, the Emergency Plan focuses support on helping host nations develop critical network systems. PEPFAR partners with these nations, supporting them as they harness the resources of their own societies to build capacity to treat their people for the long term.

Results: Rapid Scale-Up

ART – including ARV drugs and services, as well as laboratory support – received approximately $470 million in Emergency Plan funding in fiscal year 2005, or 46 percent of total focus country resources for prevention, treatment and care activities.

Defining Support for ART

What does it mean to provide support for ART? That is a complicated question because comprehensive 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; physical 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 drugs (ARVs) themselves.

Because there are so many elements of quality ART, the cost of ARV drugs is estimated to be around 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 no longer the fundamental obstacle to treatment that they once were. This reality highlights the importance of all the components required to provide quality ART.

For an explanation of "downstream" and "upstream" support, see the Accountability section at the end of this chapter.

Figure 2.1 - Treatment: Number of Individuals Receiving ART in the 15 Focus Countries
(Total of Both Upstream and Downstream USG-Supported Interventions)

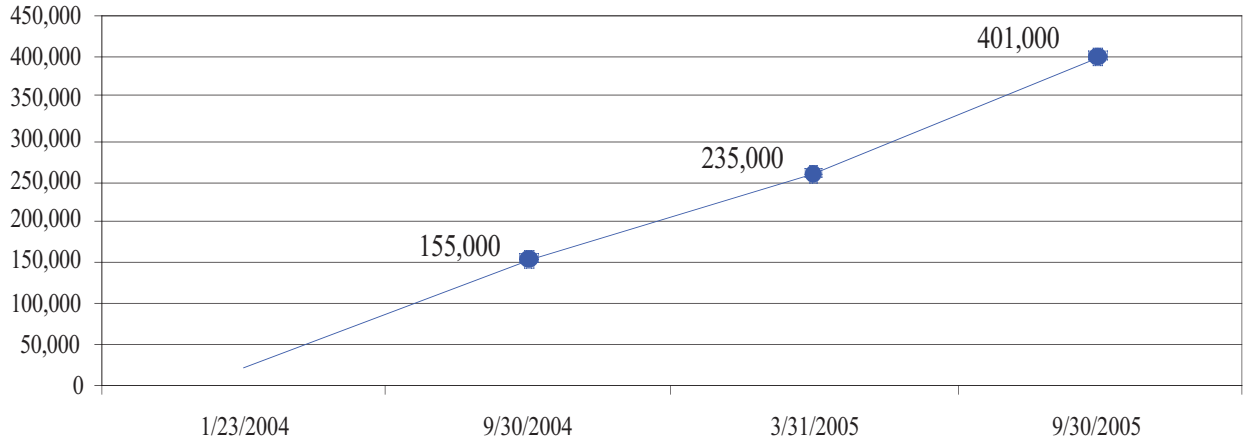


Table 2.1 - Treatment: FY05 Progress Toward Emergency Plan Target of 2 Million Individuals Receiving Treatment

Country	Emergency Plan 5 Year target	Total number of individuals reached[1]	Percentage of 5 Year target met
Botswana	33,000	37,300	113%
Cote d'Ivoire	77,000	11,100	14%
Ethiopia	210,000	16,200	8%
Guyana	2,000	800	40%
Haiti	25,000	4,300	17%
Kenya	250,000	44,700	18%
Mozambique	110,000	16,200	15%
Namibia	23,000	14,300	62%
Nigeria	350,000	28,500	8%
Rwanda	50,000	15,900	32%
South Africa	500,000	93,000	19%
Tanzania	150,000	14,700	10%
Uganda	60,000	67,500	113%
Vietnam	22,000	700	3%
Zambia	120,000	36,000	30%
All countries	**2,000,000**	**401,000**	**20%**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.
Footnotes:
[1] 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- supported service delivery sites.

Best Practices
Namibia: A hospital integrates high-quality treatment with prevention and care

Since the USG-supported Shanamutango Center in Onandjokwe Lutheran Hospital started to offer ART in November 2004, 1,371 people have been enrolled in treatment, including 330 children who represent more than 24% of all patients. Quality is a hallmark of the site: the patient flow inside the center is well-organized, saving time and effort for patients, and considerable efforts are undertaken to ensure that patients are monitored and supported to adhere to ART regimens. This involves extensive hospital inquiries, home visits by hospital staff, telephone calls and counseling, and direct communications with patients and their treatment supporters. The Center also relies upon an accurate filing system and critical patient management software that facilitate access to service data, including pharmaceutical dispensing and drug stock records. According to the preliminary results of a pilot study, patient enrollment and ability to access ART is having a significant positive effect on morbidity and mortality. This, in turn, is shortening the number and overall duration of admissions to the hospital and minimizing associated costs to an already taxed hospital budget.

Families benefit from linkage of the treatment program to the hospital's PMTCT program. From January to September 2005, 371 women were newly enrolled for PMTCT at this center, and an additional 469 children were enrolled and followed up regularly with prophylaxis against opportunistic infections, clinical follow-up and laboratory investigations. Among them, 12 children "graduated" – that is, their HIV test at the age of 18 months was negative. Additionally, since starting rapid testing at two sites inside the hospital, 4,536 rapid tests were done in the last 4 months of the reporting period, saving a substantial amount of money. In the maternity ward, 94% of delivering mothers had unknown HIV status before introduction of rapid testing; now this percentage has declined to only 10%. As more patients have been tested and made aware of their HIV status, more have been enrolled in PMTCT programs and placed on ART when eligible, and more protection has been provided to babies of HIV-positive mothers.

Through cooperation with other USG partners under the Emergency Plan, Shanamutango also leverages the assistance of community counselors and psychologists, as well as a home-based care network. Through ongoing training of staff from the hospital and district clinics, activities at this Center are generating lessons learned that can be applied elsewhere in Namibia.

As a result of this unprecedented commitment to partnership with host nations, PEPFAR supported ART for approximately 401,000 people in the focus countries through September 2005. Of these people, approximately 249,000 benefited from site-specific "downstream" support, while approximately 152,000 benefited from "upstream" support for national health care networks and systems for ART provision. (These categories of support are explained in the Accountability section at the end of this chapter.) Of those receiving downstream support, approximately 171,000 began treatment during fiscal year 2005, while the remainder continued treatment previously begun.

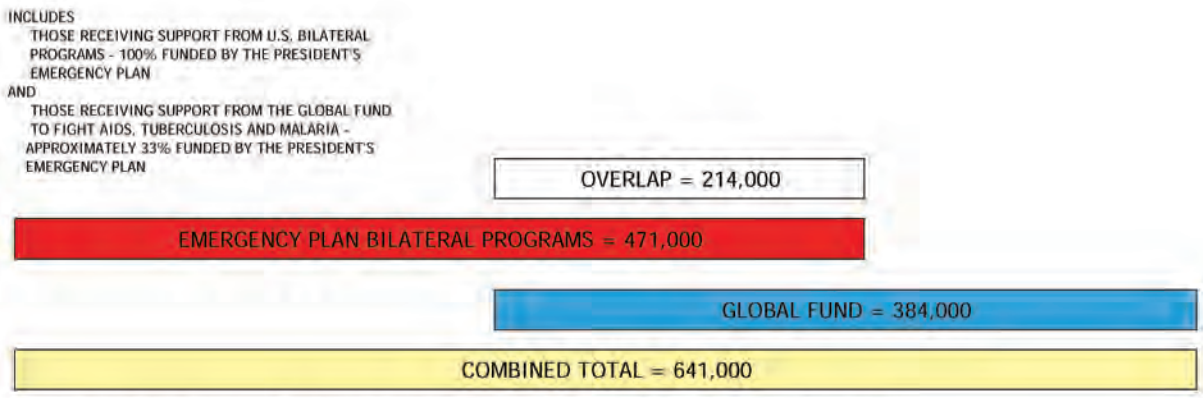
The Emergency Plan features a growing commitment to pediatric AIDS treatment, and of those receiving ART at downstream sites for whom partners reported age, approximately 7 percent were children. This number is likely understated, as many partners are still developing systems – with PEPFAR support – to report adult or child status in all data. Further information on the challenges and early results in the area of pediatric AIDS treatment may be found in the chapter on Children.

The Emergency Plan is also committed to ensuring full participation of women in treatment activities, and is working with implementing partners toward the goal that all patients served be reported by gender. At downstream

Table 2.2 - Treatment: FY05 Overall Results			
Country	**Number of individuals receiving upstream system strengthening support for treatment[1]**	**Number of individuals receiving downstream site-specific support for treatment [2]**	**Total number of individuals reached[1]**
Botswana	37,300	0	37,300
Cote d'Ivoire[2]	0	11,100	11,100
Ethiopia	0	16,200	16,200
Guyana	0	800	800
Haiti	0	4,300	4,300
Kenya	9,800	34,900	44,700
Mozambique	12,100	4,100	16,200
Namibia	1,000	13,300	14,300
Nigeria	9,600	18,900	28,500
Rwanda	2,100	13,800	15,900
South Africa	52,800	40,200	93,000
Tanzania	3,300	11,400	14,700
Uganda	17,900	49,600	67,500
Vietnam	0	700	700
Zambia	6,100	29,900	36,000
All countries	**152,000**	**249,000**	**401,000**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.
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, protocol and curriculum development.
[2] Number of individuals reached through downstream site-specific support includes those receiving services at U.S. Government-supported service delivery sites.
[3] Reliable data to capture non-duplicated upstream results are not yet available in Cote d'Ivoire. The acute exacerbation of the political crisis between November 2004 and March 2005 delayed the establishment of effective national planning, coordination and monitoring and evaluation systems. Although the Emergency Plan supports systems-strengthening, we are unable to estimate the number of people reached through upstream support and the total number of people reached is likely an underestimate. The Emergency Plan team is working with the national authorities and development partners to obtain national data.

Figure 2.2 - Treatment: People Receiving Treatment with Support from the President's Emergency Plan for AIDS Relief in FY2005



Treatment data for the Emergency Plan bilateral programs provided by the Office of the U.S. Global AIDS Coordinator
Treatment data for the Global Fund programs provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria

sites where implementing partners reported results by gender, 60 percent of those receiving PEPFAR-supported ART were women and 40 percent were men.

Beyond the 15 focus countries, the Emergency Plan also supported ART for approximately 70,000 people through bilateral programs in 17 other nations, for a total of approximately 471,000 people worldwide receiving ART with PEPFAR support.

The Emergency Plan is working to support the implementation of effective monitoring and evaluation systems across USG implementing partners in support of national monitoring and evaluation systems. This is assisting in-country teams and implementing partners to monitor and improve delivery of services and, in particular, adherence to therapy. In Uganda, for example, PEPFAR has implemented a comprehensive monitoring and evaluation (M&E) system across some of its treatment partners, allowing the partners and USG to have a snapshot of partner-level data on key quality-specific indicators such as the retention of patients on ART and adherence to preventive care guidelines (such as the use of cotrimoxazole). This approach has yielded valuable information for both PEPFAR and its partners, and the USG is now planning to expand it to other partners in Uganda. Other innovative M&E programs are being developed in focus countries for use in them and beyond.

The U.S. is also the largest donor to the Global Fund. The Global Fund has reported that it supported ART for 384,000 people globally as of the end of 2005. Of those, 214,000 received support from both the bilateral and multilateral resources of the Emergency Plan, as shown in Figure 2.2.

Sustainability: Building Capacity

While helping host nations rapidly scale up high-quality treatment today, the Emergency Plan is also supporting them in building the capacity and instituting the systems to expand treatment in the future.

Training in ART services for health care workers is a major focus; in fiscal year 2005, the Emergency Plan supported training or retraining for approximately 36,500 service providers in the focus countries. These efforts range from lecture format to bedside mentoring and include on-the-job training and other strategies to support those trained in remaining at their posts.

Strengthening sites for quality ART provision is critical: this includes addressing deficits in infrastructure, laboratory capacity, and procurement and distribution of ARVs and other commodities. The Emergency Plan supported approximately 800 ART service sites in the focus countries in the reporting period, and the new Partnership for Supply Chain Management, described in the chapter on Building Capacity for Sustainability, will make a major contribution to meeting procurement and distribution challenges for ARVs and other commodities needed for quality treatment. PEPFAR support for laboratory capacity – including equipment, training, and quality control – is also helping nations improve their ability to monitor individuals' response to care and treatment and make better informed clinical judgments.

Moving beyond a hospital- and clinic-based model for provision of ART will also help make services more widely available and sustainable, and PEPFAR is supporting development of a widening range of treatment settings. Strengthening linkages under the network model so that patients have access to seamless prevention, treatment and care services is also a priority. This is particularly important for persons with TB, OVCs, and mothers, among others.

Emergency Plan-supported activities involve networks of people living with HIV/AIDS (PLWHA) to support treatment literacy and adherence, fostering quality as well as sustainability.

Antiretroviral drugs as a component of antiretroviral treatment

Low-quality or inappropriately prescribed ARVs can do more harm than good in the fight against HIV/AIDS. Drug interactions often alter the preferred first-line therapy, as in the case of those treated for HIV and TB simultaneously, many of whom cannot use their nations' preferred first-line regimens. Drug resistance and toxicity are already increasing in nations as ART becomes widely

Best Practices
Uganda: High quality treatment for the poorest

As Uganda scales up HIV care and treatment programs, the great challenge is to make services available to the poor and disadvantaged, who make up over 70 percent of the country's population. With Emergency Plan funding, Reach Out Mbuya, a faith-based organization serving a Kampala neighborhood, is providing comprehensive, holistic care to poor people using a clinic/home-based model of service delivery.

Rose Namukasa with her two children receive treatment from Reach Out, which now provides treatment for 800 HIV+ clients and care for over 1,800 clients and their families.

Ms. Rose Namukasa was a 37-year-old widow caring for her four children and two orphaned relatives when she arrived at the Reach Out clinic in 2002. HIV-positive with active TB and too poor to access private medical care, Rose was at high risk of contracting other opportunistic and possibly fatal infections. She recounts her journey from sickness and destitution to health and strength through three stages. At first, she felt desperation as the unemployed head of a family that had come to Kampala to escape the conflict in northern Uganda. But after deciding to undergo HIV testing at Reach Out, she was able to accept her HIV positive status and learn how to follow a treatment regimen. The final stage of her transformation is her improved health and her employment as a community antiretroviral treatment (ART)/TB treatment supporter (CATTS) at Reach Out. She now looks forward with hope to rebuilding her life and planning a future for her family.

Reach Out is now able to provide treatment to 800 HIV positive clients and care for over 1,800 clients and their families. The Reach Out comprehensive service delivery model combines clinic care by nurses, who work under a doctor's supervision, with home-based follow-up linked to a network of community workers, 80 percent of whom are HIV-positive clients themselves. Clients are provided extensive counseling on ART adherence and every client is visited at home for an assessment of their psychosocial environment. In addition, the CATTS conduct weekly visits for pill counts, health assessments and general assistance. Reach Out also offers its clients nutrition support, microfinance loans, school fees for dependent children, and training in income–generating activities.

With Emergency Plan support, Reach Out has developed a comprehensive HIV/AIDS care and treatment service delivery model at a low cost that has saved and transformed lives. As Rose Namukasa can testify, Reach Out has shown a community that there is hope for people living with AIDS, even for the poor.

available, making it increasingly crucial that a broad formulary be available.

The Emergency Plan remains committed to funding the purchase of the lowest-cost ARVs from any source, regardless of origin, whether copies, generic, or branded, as long as those drugs are proven safe, effective, and of high quality, and their purchase is consistent with international law.

To meet the need for rapid identification of drugs proven to be safe, effective, and of high quality, the Food and

Table 2.3 - Treatment: FY05 Capacity Building Results		
Country	**Number of USG-supported sites providing treatment**	**Number of health workers trained or retrained, according to national and/or international standards, in the provision of treatment**
Botswana[1]	0	75
Cote d'Ivoire	33	100
Ethiopia	108	1,500
Guyana	7	100
Haiti	20	500
Kenya	182	3,600
Mozambique	15	94
Namibia	28	400
Nigeria	24	2,300
Rwanda	62	1,000
South Africa	135	15,000
Tanzania	33	2,200
Uganda	86	7,600
Vietnam	23	900
Zambia	44	1,100
Total	**800**	**36,500**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.
Footnotes:
[1] In FY2004, the USG funded one site in Botswana to deliver ART. This site continues to deliver ART; however, in FY2005 the Botswana program received only upstream support from the USG and is therefore not reported here.

Drug Administration of the Department of Health and Human Services (HHS/FDA) introduced in May 2004 an expedited process whereby drugs from anywhere in the world, produced by any manufacturer, could be rapidly assessed for purchase under PEPFAR.

Approved or tentatively approved drugs are determined to meet standards equal to those established for the U.S., ensuring that no drug purchased for use in PEPFAR programs abroad falls below standards for U.S. families. Through December 2005, 15 new generic formulations received approval or tentative approval from HHS/FDA under the expedited review established in May 2004, including four pediatric formulations. By late 2005, at least four focus countries had begun to import HHS/FDA approved generics. As a side benefit, the process developed for PEPFAR has also expedited availability of generic versions of ARVs whose U.S. patent protection has expired.

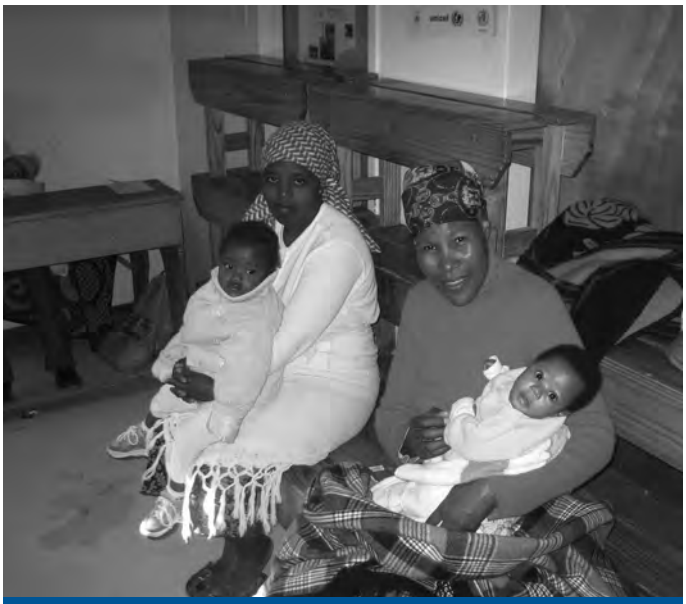
Some host nations, however, require additional review that can delay or prevent implementing partners from using ARVs that have been found safe and effective by HHS/FDA. HHS/FDA conducted a workshop for host

Table 2.4 - Treatment: FY05 Laboratory Capacity Building Results		
Country	**Number of USG-supported laboratories with the capacity to perform HIV tests, CD4 tests and/or lymphocyte tests**	**Number of individuals trained or retrained in the provision of lab-related activities**
Botswana	2	54
Cote d'Ivoire	9	60
Ethiopia	82	800
Guyana	2	16
Haiti	35	200
Kenya	200	500
Mozambique	3	33
Namibia	5	5
Nigeria	46	200
Rwanda	10	300
South Africa	4	23
Tanzania	41	522
Uganda	200	2,500
Vietnam	41	100
Zambia	200	400
Total	**900**	**5,700**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.

governments on this issue in September 2005, and is engaging in additional outreach efforts to inform drug regulatory officials about the process that leads to approval or tentative approval of generic anti-retroviral agents, and to keep them informed about the current list of such drugs. This collaboration will hasten the in-country approval process.

The USG has also worked with multilateral partners. HHS/FDA has signed a confidentiality agreement with the World Health Organization (WHO) Secretariat to hasten the inclusion on the prequalification list at WHO of generic antiretroviral drugs approved or tentatively approved by HHS/FDA, and such ARVs have begun to be added to the drug list maintained by the WHO pre-qualification project. The Global Fund to Fight AIDS, Tuberculosis and Malaria now recognizes HHS/FDA tentative approval as approval by a "stringent regulatory authority," which means Global Fund resources may go to purchase HHS/FDA tentatively approved generic anti-retroviral drugs.



Women and their babies wait at the Queen Elizabeth II Hospital in Maseru, Lesotho. The hospital works in partnership with the U.S. and Lesotho governments to provide a variety of PMTCT and pediatric AIDS services including treatment.

Key Challenges and Future Directions

Reaching HIV-positive children with ART is a major challenge, due in large part to the difficulty of infant

Figure 2.3 - Treatment: Generic HIV/AIDS Formulations Made Eligible for Purchase by PEPFAR Programs Under the HHS/FDA Expedited Review Process, through December 2005

Drug	Company	Date of FDA Approval or Tentative Approval
Didanosine (200mg, 250mg, 400mg delayed release capsules)	Barr Laboratories	Approved 12/03/04
Fixed dose Zidovudine (300mg)/lamivudine (150mg) co-packaged with Nevirapine (200mg)	Aspen Pharmacare	Tentatively Approved 1/25/05
Lamivudine (150mg and 300mg tablets)	Aurobindo Pharma	Tentatively Approved 6/15/05
Lamivudine (150mg tablets)	Ranbaxy Laboratories	Tentatively Approved 5/27/05
Nevirapine (200mg tablets)	Ranbaxy Laboratories	Tentatively Approved 6/20/05
Nevirapine (200mg tablets)	Aurobindo Pharma	Tentatively Approved 6/20/05
Efavirenz (600mg tablets)	Aurobindo Pharma	Tentatively Approved 6/24/05
Stavudine (30mg and 40mg capsules)	Aurobindo Pharma	Tentatively Approved 7/1/05
Fixed dose Lamivudine (150mg)/Zidovudine (300mg) tablets	Aurobindo Pharma	Tentatively Approved 7/7/05
Zidovudine (300mg tablets)	Ranbaxy Laboratories	Tentatively Approved 7/13/05; Approved 9/19/05
Zidovudine (300mg tablets)	Aurobindo Pharma	Tentatively Approved 8/25/05; Approved 9/19/05
Zidovudine (oral solution 50mg/5ml)	Aurobindo Pharma	Tentatively Approved 9/7/05; Approved 9/19/05
Lamivudine (10mg/ml oral solution)	Aurobindo Pharma	Tentatively Approved 11/8/05
Stavudine (oral solution 1mg/mL)	Aurobindo Pharma	Tentatively Approved 12/21/05
Nevirapine (oral suspension 50 mg/5 mL)	Aurobindo Pharma	Tentatively Approved 12/27/05

Pediatric AIDS Treatment

Approximately 640,000 children under age 15 become infected with HIV each year worldwide. As is discussed at length in the chapter on Children, preventing, diagnosing and treating pediatric HIV/AIDS all present daunting challenges. Yet these activities are essential because, without treatment, the majority of infected children die before they are two years of age.

The limited capacity of health systems in resource-poor nations affects pediatric HIV/AIDS treatment, as it does a range of other health issues. Diagnosis of children – especially the young children most likely to be infected – is complex and expensive. Technologies to improve pediatric diagnosis are not yet widely available, and shortages of trained health workers are a major problem.

Long-term combination ART for children also poses special challenges. ARVs are often unavailable in pediatric formulations, and they are often much more costly than adult drugs. Pediatric regimens can be difficult to follow because of the complexity of dosing by weight. Furthermore, storage and packaging of pediatric formulations require reliable electricity to maintain temperature control.

The Emergency Plan has brought U.S. leadership to bear on the pediatric HIV/AIDS crisis, as part of the U.S. response to the overall emergency. With governmental and nongovernmental host country and international partners, the U.S. Government is scaling up a family-based approach to treatment – one integrated with prevention and care efforts – for children infected with HIV/AIDS. As part of these efforts, four generic ARVs for children have received tentative approval through HHS/FDA under the expedited review process established for PEPFAR. The Emergency Plan's efforts in this area are discussed at length in the chapter on Children.

diagnosis of HIV. The Emergency Plan has launched a major effort to meet and overcome this and other obstacles and is greatly expanding its pediatric treatment efforts. For more information, see the chapter on Children.

Ensuring adherence to ART is a critical challenge the Emergency Plan is working to confront. The Emergency Plan is expanding support for population-based testing for resistance and toxicities in order to adjust treatment, as well as laboratory support for testing to determine when a person needs to begin HIV treatment and to monitor that therapy.

Quality is also being addressed with a number of system-strengthening approaches, including monitoring and evaluating programmatic indicators, on-site supervision, and district, national, and international ART program reviews. The Emergency Plan's interagency ART Technical Working Group has guided such efforts, and the information is now being used to improve programs.

In Rwanda and other focus countries, PEPFAR provides the government with intensive technical assistance to ensure treatment quality, supporting such activities as equipment procurement, review and development of operating procedures, improvement of store management, and management and information systems.

One promising approach to meeting the challenge of reaching HIV-positive people with ART is public-private partnerships. Among these are workplace efforts, through which PEPFAR is partnering with employers to support ART for their employees and their families. In some cases, the Emergency Plan conducts training while the employer procures the ARVs. A number of U.S. Embassies have demonstrated leadership by instituting ART workplace programs for their own employees.

Human capacity constraints remain a serious impediment to ART scale-up, exacerbated by the "brain drain" of health workers from many focus nations to developed countries and the toll HIV/AIDS has taken on health

Best Practices
HIVQUAL: A tool for treatment quality improvement

As treatment services are scaled up, the Emergency Plan is focusing on quality. Program managers and Ministries of Health need to be able to systematically assess and improve the quality of treatment and care services. One way to improve quality is through the HIVQUAL project, a pilot that involves building capacity in facility performance measurement, quality improvement, and infrastructure development. The HIVQUAL approach is based on the concept that quality management programs should reflect a balance between quality improvement and performance measurement and be built upon a foundation of programmatic support and infrastructure. This organizational approach to quality management emphasizes the development of systems and processes to support quality improvement activities involving clinic staff and consumers with support from agency leadership. These structural features are designed to be sustainable even when staff turnover is high or organizational affiliations change.

Four principles guide the methodology of the HIVQUAL Project: 1) ongoing quality improvement activities improve patient care; 2) performance measurement lays the foundation for quality improvement; 3) infrastructure supports systematic implementation of quality improvement activities; 4) indicators to measure performance are based on clinical guidelines or formal group decision-making methods. HIVQUAL builds capacity to support clinical data collection and analysis at the clinic level, linking these activities to systems building that improve processes and outcomes of care. HIVQUAL is designed to strengthen systems for documentation, permitting monitoring of appropriateness of care and development of capability for self-assessment. HIVQUAL, which was piloted by the USG in Thailand, is planned in fiscal year 2006 in Uganda, Nigeria and Mozambique, and if successful will be more widely used in the future.

workers. ART requires training, which the Emergency Plan is working to provide through innovative school and on-the-job methods.

Despite the shortage of health workers, some countries are reluctant to expand responsibility for ART administration and monitoring beyond physicians. The Emergency Plan has been working with governments to promote the "network system," which seeks to allocate highly trained health workers – such as physicians with specialized training – to referral centers where their level of training is essential, while allowing non-physicians trained in ART to administer treatment at field sites. The soaring demand for ART in resource-poor nations requires a flexible health workforce, and PEPFAR supports policy initiatives to permit such flexibility. This topic is discussed further in the chapter on Building Capacity for Sustainability.

The geographic dispersal of PLWHA, with many in remote rural areas, provides a key challenge in making ART available to those who need it. PEPFAR efforts to reach rural populations include innovative models, as well as expansion of the network system and outreach to community- and faith-based providers. A home-based care (HBC) model for delivery of ARTs is also being used successfully in many settings; in Rwanda, the CHAMP program involves community-based organizations to provide HBC. There are training manuals on HBC and a network system that links HBC to services in the area, including pediatric services.

Quality ART programs depend on secure and reliable ARV supply chains, with risks of interruption a dangerous threat to ART programs. The new Partnership for Supply Chain Management, discussed in the chapter on Building Capacity for Sustainability, will do much to ensure that this is maintained even when local circumstances become difficult.

Another key challenge is coordination with other international partners. ARV supply challenges faced by Haiti in 2005 demonstrated the benefit of close cooperation among partners such as PEPFAR, the Global Fund, and the World Bank. The Emergency Plan has supported

Best Practices
Zambia: Network model improves accessibility and quality of ART

Providing antiretroviral treatment (ART) services in rural areas continues to be a challenge for the Government of Zambia and its international partners. While ART services are more easily managed in the capital of Lusaka and other urban centers, reaching the rural areas requires transportation, cold chain logistics and most importantly, human resources. Even in towns and cities, the long journey from an outlying clinic to a central hospital can be difficult for a referred individual.

People wait at Letita District Hospital, in Zambia's Central Province, where HIV outreach clinics have been established through District Health Management Teams.

With support from the Emergency Plan, the Zambia Prevention Care and Treatment (ZPCT) partnership is responding to the government's request for equity of services for clients in rural and urban areas. In the five northern provinces of Zambia (Central, Copperbelt and the very rural Northern, Northwest and Luapula provinces), ZPCT is providing ART in 24 districts, reaching many rural areas. Even with these more widespread services, the lack of trained doctors to initiate ART beyond provincial or district hospitals remains a barrier. As a result, patients often travel long distances to hospitals on public transportation that they can hardly afford, only to face long waiting lines upon arrival. All of these factors increase the difficulty of accessing ART and, once ART is begun, of adhering to the ART drug regimen.

With USG support, ZPCT has worked closely with the Ministry of Health and the Central, Provincial and District Boards of Health to address these challenges and improve access to ART using the network system. For example, referral hospitals, laboratories and pharmacies have been renovated to accommodate the increased number of patients. In addition, a referral system has been developed to bring CD4 samples from patients to the laboratory, reducing further travel for poor Zambians. These actions have streamlined patient flow within facilities – and from one facility to another – thereby improving the overall quality of care that ART patients receive.

In Central and Copperbelt Provinces, ZPCT is assisting District Health Management Teams (DHMTs) and referral hospitals to manage the HIV/ART outreach clinics established at health centers. Doctors from hospitals or the DHMTs travel to the health centers on specific days to organize the clinics. Depending on the capacity of the health center, ARVs are either stored on site or brought in from the referring hospital on specific clinic days. The doctors then initiate ART services and care services, such as treatment for opportunistic infections (OIs), for new clinics and mentor the clinics to manage follow-up visits and to assist patients seeking ART services on days when doctors are not present.

Theresa Chiyaka, Clinician and head of the ART Clinic at the Chipokota Mayamba Health Centre in the Ndola District of the Copperbelt said of the program: "When ART services started in November 2004 at Chipokota Mayamba, patients could only be seen by the doctor once a week, but after ZPCT trained us in ART/OI, clients can now walk into our clinic any time from Monday to Friday to access ART services. This has really improved patient access to services in that they don't have to see the doctor for everything, including OIs that we are now able to manage on our own (and) follow-up of clients on ART."

PEPFAR's partnership with Zambia's public sector through ZPCT has increased access to ART services for rural patients, reduced transportation time and costs, and decreased waiting times. With services being provided to clients in their communities under the network model, ART adherence and follow-up has significantly improved.

nations that have moved to country-level unified procurement and distribution systems, such as Rwanda.

Accountability: Reporting on the Components of Treatment

The First Annual Report to Congress of the Emergency Plan described the ways in which U.S. support is provided. Where partnership limitations or technical, material or financial constraints require it, the Emergency Plan, or another partner, may support every aspect of the complete package of prevention, treatment, or care services at a specific public or private delivery site, in coordination with host-country national strategies.

Downstream support

In many areas, the Emergency Plan coordinates with other partners to leverage resources at a specific site, providing those essential aspects of quality services that others cannot provide due to limited technical and/or financial circumstances. For example, in some settings components of services are provided to specific sites through the host-country government or other international partners such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, while the Emergency Plan may contribute other essential services, training, commodities, and infrastructure. "Downstream" site-specific support refers to these instances where the Emergency Plan is providing all or part of the necessary components for quality services at the point at which services are delivered.

Upstream support

Beyond the site-oriented downstream components of services, support is required to provide other critical elements, which may include the training of physicians, nurses, laboratory technicians, other health care providers, and counselors or outreach workers; 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 services. This coordination and leveraging of resources optimizes results while limiting duplication of effort among partners, 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 prevention, treatment, and care.

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). The USG has provided significant contributions to the development and implementation of national systems for training, quality assurance, and guidelines applied to clinical delivery of ART, HIV laboratory, and monitoring and evaluation of the ART program. These contributions strengthen 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 the chapter on Strengthening Multilateral Action). In working with major partners, including the Global Fund, WHO, and UNAIDS, 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.

Attribution challenges due to country-level collaboration

The Emergency Plan supports national HIV/AIDS treatment strategies, leveraging resources in coordination with host-country organizations and other international partners to ensure a comprehensive response. Host nations must lead a multisectoral national strategy for HIV/AIDS for an effective and sustainable response. International partners 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 international partners are not desirable or sustainable. In such an environment, attribution is complex, including both upstream and downstream activities, often with multiple partners supporting the same sites to maximize comparative advantages. PEPFAR is conducting audits of its current reporting system to refine methodologies for the future, and continues to assess attribution and reporting methodologies in collaboration with other partners.

Treatment reporting conventions

During this reporting period, to account for Emergency Plan treatment programming, in-country partners 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 supported by the U.S. Government's contribution to national, regional, or local activities.

Reporting by gender and age

The Emergency Plan requirement that ART service sites report on the gender and adult/child status of those served, in order to ensure that ART activities are reaching women and children, will become mandatory for all partners in fiscal year 2006.

This girl in the Nurturing Orphans of AIDS for Humanity (NOAH) program in South Africa has hope for a brighter future.

"[P]eople who know they can be treated are more likely to seek testing... And we're working with our partners to expand compassionate care - especially for the millions of children made orphans by this cruel disease."

President George W. Bush
World AIDS Day
December 1, 2005

Chapter 3

Critical Intervention in the Focus Countries: Care

Emergency Plan support is not limited to activities to keep people from being infected with HIV and to keep people who become infected alive. PEPFAR also supports societies in developing comprehensive responses that address the impact of HIV/AIDS. Only responses that address the full range of HIV/AIDS-related challenges will fully enable nations to move from despair to hope.

The focus nations of the Emergency Plan are places in which this need is especially great. Approximately half of the over 40 million people currently living with HIV/AIDS worldwide live in the 15 focus countries of PEPFAR. Of the over 14 million children orphaned or made vulnerable by HIV/AIDS, at least 8 million live in the focus countries. In most of the focus nations, the inadequate availability of care for those infected and affected by the virus is placing additional stresses on social bonds that are already severely frayed. Solutions that are of high quality – and that can be sustained for the long term – may be all that protect these societies from unraveling altogether.

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

Progress Achieved through September 30, 2005
Supported care for nearly 3 million people, including:

- Care for over 1.2 million orphans and vulnerable children
- Care for over 1.7 million people living with HIV/AIDS, including over 368,000 who received care and treatment for tuberculosis
- Supported counseling and testing for over 9.4 million people to date, including over 6.6 million in fiscal year 2005, through prevention of mother-to-child transmission and other counseling and testing activities
- Supported training or retraining of approximately 75,000 individuals to care for orphans and vulnerable children in fiscal year 2005
- Supported training or retraining of over 86,000 individuals to care for people living with HIV/AIDS and approximately 6,800 service sites
- Supported training or retraining of over 50,000 individuals to provide counseling and testing and over 6,600 service sites through prevention of mother-to-child transmission and other counseling and testing activities

Allocation of Resources in Fiscal Year 2005
$274 million to support care for orphans and vulnerable children and people living with HIV/AIDS and for counseling and testing in settings other than prevention of mother-to-child transmission (26 percent of total focus country resources for prevention, treatment, and care)

Perhaps the most obvious manifestation of HIV/AIDS in many countries is the large number of orphans and vulnerable children (OVCs). Orphans are defined as children under age 15 who have lost a mother, a father, or both, and vulnerable children are those affected by HIV through the illness of a parent or principal caretaker.

Many communities have traditional family-based care approaches for children, such as care by grandparents, but even extended family and social structures are being stretched beyond their capacity as they are now overwhelmed by the sheer number of children who are in need of care. Orphans are forced into roles they are not yet prepared for, placing them at high risk of HIV infection.

Also straining these societies are the large numbers of people living with HIV/AIDS (PLWHA) in need of care. Both those not yet in need of antiretroviral treatment (ART) and those who are receiving it require basic health care, social, spiritual and emotional support, and in some cases, end-of-life care. Again, many communities' current resources for meeting the needs of PLWHA are inadequate to the task.

In many cases, caring for family, friends, and children infected and affected by HIV/AIDS consumes energies and resources needed for survival. Communities may abandon or reject those who need care, creating hopelessness that undermines all efforts to mobilize communities – and nations – to respond.

A related challenge is increasing the number of people who learn their HIV status. In some surveys, only 10% of people know their HIV status – yet when asked, a majority say that they would like to know. Counseling and testing is an entry point to care and treatment, and is also a crucial opportunity for prevention education – for those who are infected and their partners, and also for those who are not infected. Yet counseling and testing remain stigmatized and utilized by far too few people in nations hard-hit by HIV/AIDS.

The Emergency Plan thus works in concert with national strategies in the following areas, which collectively are considered "care" for PEPFAR purposes:

- Support basic needs of orphans and vulnerable children

Figure 3.1 - Care: Number of Individuals Receiving Care in the 15 Focus Countries
(Orphans and Vulnerable Children and Palliative Care)

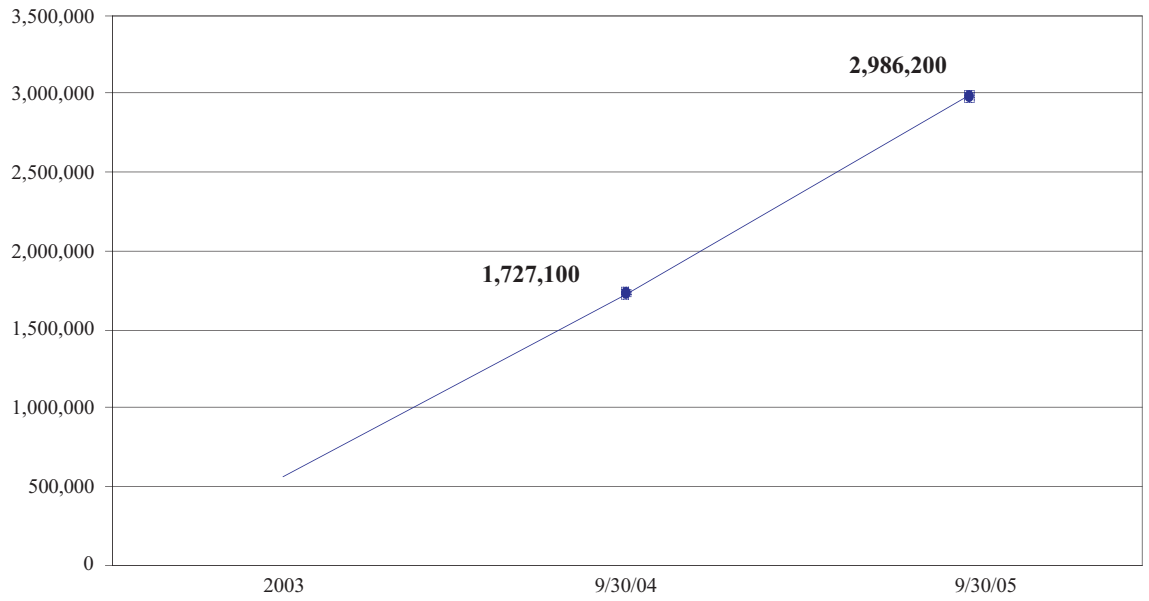


Table 3.1 - Care[1]: FY05 Progress Toward Emergency Plan Target of 10 Million Individuals Receiving Care (including OVC and Palliative Care activities)			
Country	**Emergency Plan 5 Year Target**	**Total number receiving care services[2]**	**Percentage of Year 5 Target Met**
Botswana	165,000	69,800	42%
Cote d'Ivoire	385,000	33,800	9%
Ethiopia	1,050,000	264,100	25%
Guyana	9,000	6,200	69%
Haiti	125,000	57,100	46%
Kenya	1,250,000	397,000	32%
Mozambique	550,000	187,500	34%
Namibia	115,000	146,300	127%
Nigeria	1,750,000	67,900	4%
Rwanda	250,000	89,700	36%
South Africa	2,500,000	548,200	22%
Tanzania	750,000	413,000	55%
Uganda	300,000	371,200	124%
Vietnam	110,000	13,100	12%
Zambia	600,000	321,300	54%
All countries	**10,000,000**	**2,986,200**	**30%**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.
Footnotes:
[1] Care includes the areas of Palliative Care Basic Health Care & Support and 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, protocol and curriculum development and those receiving services at U.S. Government-supported service delivery sites.

- Support care for people living with HIV/AIDS (Palliative Care)
- Support counseling and testing for HIV

Orphans and Vulnerable Children

The Emergency Plan supports varied interventions to help communities mobilize to care for their own children and families affected by HIV/AIDS. Community and faith-based peer support can be crucial for growing children and adolescents faced with both the normal challenges for their age and heavy economic, psychosocial and stigma burdens.

OVC services include caregiver training, access to education, economic support, targeted food and nutritional support, legal aid, medical care, psychological and emotional care, and other social and material support. These services are summarized in the text box on the following page, and are described in further detail in the chapter on Children.

OVCs themselves face elevated risk of HIV infection, and PEPFAR supports efforts to expand HIV counseling and testing, which are an entry point to care and treatment. In addition, the Emergency Plan recognizes that meeting the needs of children with HIV can also serve as a way to build relationships with their caregivers, who may themselves be in need of services.

Results: Rapid Scale-Up

In fiscal year 2005, Emergency Plan funding for care services for OVCs totaled over $62 million in the focus countries – approximately 6 percent of prevention, treatment, and care resources.

PEPFAR-supported activities reached over 1.2 million OVCs during the reporting period. This figure is in addition to OVCs receiving antiretroviral treatment through USG programs, as described in the chapters on Treatment and Children. Over 815,000 of the children who received care services were beneficiaries of downstream support at the site of service, while the remainder received upstream support through USG contributions to national, regional, and/or local activities such as training, systems strengthening, and policy and protocol develop-

Table 3.2 - Care: FY05 Orphans and Vulnerable Children[1] Results			
Country	**Number of OVCs receiving upstream system-strengthening support[2]**	**Number of OVCs receiving downstream site-specific support[3]**	**Total**
Botswana	0	5,800	5,800
Cote d'Ivoire[4]	0	7,900	7,900
Ethiopia	0	45,400	45,400
Guyana	0	5,200	5,200
Haiti	1,400	15,200	16,600
Kenya	65,000	155,400	220,400
Mozambique	0	108,000	108,000
Namibia	75,800	25,000	100,800
Nigeria[5]	0	3,500	3,500
Rwanda	0	29,700	29,700
South Africa	43,200	64,400	107,600
Tanzania[6]	250,000	36,400	286,400
Uganda	20,300	73,300	93,600
Vietnam	0	1,000	1,000
Zambia[7]	0	188,200	188,200
Totals	**455,700**	**764,400**	**1,220,100**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.
Footnotes:
[1] OVC activities are aimed at improving the lives of children and families directly affected by AIDS-related morbidity and/or mortality.
[2] 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, protocol and curriculum development.
[3] Number of individuals reached through downstream site-specific support includes those receiving services at U.S. Government-supported service delivery sites.
[4] Reliable data to capture non-duplicated upstream results are not yet available in Cote d'Ivoire. The acute exacerbation of the political crisis between November 2004 and March 2005 delayed the establishment of effective national planning, coordination and monitoring and evaluation systems. Although the Emergency Plan supports systems-strengthening, we are unable to estimate the number of people reached through upstream support and the total number of people reached is likely an underestimate. The Emergency Plan team is working with the national authorities and development partners to obtain national data.
[5] National level data on the number of OVCs reached through upstream support are not available for Nigeria. Downstream results are lower than FY2004 due to the close-out of a large OVC program and delayed selection and start-up of new OVC project activities.
[6] The number of OVCs served in Tanzania represents a large increase from the results reported in FY04, due to increased upstream support to develop a National Framework for the Care of Most Vulnerable Children and a National Action Plan for OVCs.
[7] The number of OVC served in Zambia during FY2005 declined from that reported in FY04, due to the close-out of a major OVC project in FY05. Although the second phase was launched in FY05, the project began awarding scholarships to OVC after the end of the fiscal year.

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

- Strengthening the capacity of families to identify, locate, protect, and care for OVCs by prolonging the lives of parents and caregivers and by providing therapeutic, economic, psychosocial, and other risk reduction support to OVCs 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 OVC access to essential services, including education, vocational training, health care, case management, birth registration, legal services, 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 OVCs 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 and reduce stigma and discrimination
- Helping OVCs acquire the skills and knowledge to protect themselves from HIV infection

Thokozani (left), whose mother has AIDS, receives vegetable seeds for his family garden from Nestar Twala (right), a Child Care Forum worker, outside his new home in South Africa. The program has also negotiated a waiver of Thokozani's school fees and helped the family find new housing.

ment. Definitions for these terms are provided in the Accountability section at the end of this chapter. Of those receiving downstream support whom partners reported by gender, 52 percent were girls and 48 percent were boys.

Sustainability: Building Capacity

The Emergency Plan seeks to support communities, families, and OVCs themselves in accessing the full range of supportive resources available to them. These resources include those funded by PEPFAR, but also include those provided by a range of other sources (including other USG programs).

Among the most important potential long-term sources of support for OVC care are national governments. Strengthening citizens' ability to work with – and, when necessary, demand – effective responses from their governments is a key Emergency Plan strategy for building sustainability in OVC responses.

Further laying the foundation for sustainable responses, the USG supported the training of over 74,000 community or family caregivers in the focus nations during fiscal year 2005, helping them to access time- and labor-saving technologies and income-generating activities, and connecting children and families to health and social services where available.

Table 3.3 - Care: FY05 Orphans and Vulnerable Children[1] Capacity Building Results

Country	Total number of individuals trained or retrained to provide OVC care
Botswana	600
Cote d'Ivoire	300
Ethiopia	4,500
Guyana	92
Haiti	2,000
Kenya	10,900
Mozambique	21,500
Namibia	1,700
Nigeria	200
Rwanda	1,100
South Africa	7,700
Tanzania	3,200
Uganda	12,900
Vietnam	400
Zambia	7,700
Total	**74,800**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.
Footnotes:
[1] OVC activities are aimed at improving the lives of children and families directly affected by AIDS-related morbidity and/or mortality.

Key Challenges and Future Directions

Scaling up support to families and communities

It is usually ideal for orphaned children to remain in family settings within their communities. In hard-hit communities, however, families' capabilities are already stretched to the breaking point by poverty and, in many cases, AIDS within the family itself. Continued stigma against children and caregiving families makes the ideal situation still more difficult to achieve.

The Emergency Plan thus continues to concentrate its efforts on strengthening families and communities, working with community- and faith-based organizations to identify promising models and bring them to scale. For example, in Rwanda an Emergency Plan partner started what is known in Kinyarwanda as the Nkundabana (I Love Children) project. The project is specially designed for child-headed households, with assistance

Best Practices
Mozambique: Small program has quick impact on female orphans, vulnerable children, single mothers

With funds provided through the Emergency Plan, the U.S. Embassy in Mozambique is able to support a number of very small-scale initiatives by local organizations working to mitigate the transmission and the effects of HIV/AIDS. In 2005, this Quick Impact Program strengthened the efforts of a dozen partners. One of them, Action for Community Development, works in Dondo in Sofala province, which has the highest HIV prevalence rate in Mozambique. This organization developed a plan to boost the income of orphans and vulnerable children (OVCs) and single mothers affected by HIV/AIDS by hiring a dressmaker to train older female orphans and single mothers in dressmaking and other handiwork that has a local market. The training was provided at the Macação Primary School, since about 70% of the children benefiting from the program were students at this school.

When the school introduced a school uniforms requirement for the new academic year in January 2005, the existing income–generating activity for HIV/AIDS-affected girls and women was incorporated into the on-site manufacture of the school uniforms, with additional skills training provided with USG support. USG funds also directly purchased fabric to manufacture the uniforms for 30 OVCs. Participating girls and women now make and sell ribbons, kitchen towels, bread bags, aprons, embroidery, crochet work, and bead work; they also sew seams and buttons for school uniforms. Because the program is located on site at the school, the participating girls and young women feel more integrated in school and the community. The dressmaking schedules were adapted to ensure that the beneficiaries stay in school. "There was a change in my life here at school. I received school supplies (and) food. And I learned how to make embroideries and work with beads. We already bought some fabric in the house and started doing a few embroideries," says Antónia, one participating girl.

provided by volunteers within the community. These volunteers receive training in active listening, nutrition, HIV/AIDS and hygiene, and provide the children with needed support and assistance.

Quality of programs for orphans and vulnerable children

Because OVC services are delivered by organizations working at the family and community levels, quality assessment poses special challenges. The Emergency Plan is contributing to the effort to meet these challenges.

The USG is supporting host government efforts to develop standard packages of OVC services and program monitoring and evaluation. In Kenya, the government and international partners have collaborated to create an OVC quality package that includes six essential services that must be provided in every OVC program (health, education, nutrition, psychosocial support and protection). PEPFAR supports host government initiatives to develop national policies, protocols, and guidelines. USG supports dissemination of these to communities, as well as efforts to inform communities of the rights of their OVCs.

Addressing the special vulnerability of girls

As noted in the chapters on Prevention and Gender, girls in the developing world often face special vulnerability to the HIV/AIDS pandemic and its effects. This vulnerability can be greatly compounded for girls who are orphaned, losing their means of economic and social support and protection. Such girls are at high risk of abuse and exploitation, violence, transactional and cross-generational sex – all pathways to HIV/AIDS infection. In addition, girls often bear the burdens of care for families impacted by the disease as primary care providers. Girls are typically the first to lose access to school, as resources are diverted to provide care for persons in household infected with HIV.

Because of this special vulnerability, the Emergency Plan focuses special attention on female OVCs and their distinctive issues. In Zambia, the PEPFAR-funded RAPIDS project supports community care coalitions that focus on issues such as providing support and supplies for children, especially girls, who have dropped out of school due to

Education and HIV/AIDS

"Education, especially for girls, is an important part of our campaign to increase understanding of how HIV can be prevented and how it can be treated. Educated girls are more likely to know what HIV is and how to avoid it."
First Lady Laura Bush, September 15, 2005

For too many children, education has been a casualty of the HIV/AIDS pandemic. Millions of children face enormous obstacles to schooling. In families where one or both parents are chronically ill or have died, there is often little money to pay for school fees and other related expenses. HIV-associated illnesses often increase family health care expenses while inhibiting the ability to earn an income. Children, especially young girls, are often required to care for sick family members. Additionally, the grief a child experiences in anticipating or seeing their parents die inhibits a child's ability to concentrate on learning, even if able to attend school. Many teachers have been infected with HIV/AIDS, and their illnesses and deaths have forced schools to close and class sizes to explode.

Students in Uganda enjoy community and educational activities that teach abstinence and faithfulness as part of the PIASCY program.

Yet schooling remains an essential element of a robust individual and societal future, and partnerships with the education sector provide important opportunities to fight back against the pandemic. PEPFAR supports programs in schools that offer important prevention education for youth, while also linking with other programs to address difficulties in the educational sector due to HIV/AIDS. Partnerships to ensure that children affected by AIDS have access to education, and that schools are a safe resource center for these children, are also central to the Emergency Plan approach.

An example of effective prevention education in the schools is Uganda's Presidential Initiative on AIDS Strategy for Communicating to Youth (PIASCY). PIASCY has developed, printed and distributed teacher's guides to all schools in the country; trained teachers to deliver age-appropriate life skills messages (including abstinence and faithfulness messages in primary schools); and piloted a guidance and counseling program to provide teachers with the skills to assist orphans and vulnerable children (OVCs) within the school setting. The PIASCY program is national, covering nearly 15,000 schools in Uganda and helping to prepare the next generation to remain safe from HIV/AIDS. PEPFAR also supports the Window of Hope teacher and student HIV/AIDS manuals in Namibia and Ghana, which teach behavior change and combat stigma.

The Emergency Plan "wraps around" other organizations that promote access to education for those affected by and infected with HIV/AIDS, leveraging a comprehensive response for OVCs. A key example is with USG's African Education Initiative (AEI), implemented through USAID. The goal of AEI is to improve educational opportunities for Africa's children so that they may lead happier, healthier lives, and become productive members of society.

In June of 2005, President Bush recognized the importance of AEI by doubling the funding for the initiative. Over the next four years, the United States will provide $400 million for AEI to train half a million teachers and provide scholarships for 300,000 young people, mostly girls. Many partner programs are already in place with the Emergency Plan and AEI. The Ambassador's Girls Scholarship program is working with PEPFAR teams in Zambia and Mozambique to provide scholarships to OVCs and other marginalized children. USAID education staff in Zambia are collaborating with the PEPFAR team in-country to develop a pilot program focusing on ensuring school opportunities for OVCs. In Malawi, PEPFAR coordinates with a School Fees Reform Program, decreasing the cost of education and enabling 20,000 OVCs in the Dowa district to attend school.

Another example of promising partnerships is the HERO (Help Educate at-Risk Orphans and Vulnerable Children) program. With almost $3 million leveraged through the United Nations Association of the United States of America (UNA-USA), support through AEI, and linkages with PEPFAR in-country programs, funds will support necessary school-based programs for OVCs, initially in South Africa, Namibia and Ethiopia. With increased funding for AEI, additional resources will be available to create new and scale up existing educational programs for HIV/AIDS–infected and affected youth.

the death of a parent. These groups are also helping to end the practice of early marriage, which has grown as young orphaned girls have come to be viewed as a burden by their own families.

Working with other sectors and partners for a multisectoral approach

The Emergency Plan recognizes the broad array of challenges facing OVCs and supports a coordinated, holistic approach, with linkages to programs that meet key needs of OVCs in such areas as:

- Food
- Education
- Vocational training
- Protection
- Emotional support
- Substance abuse prevention and treatment

In many cases successful programs are ones in which the Emergency Plan interventions link or "wrap around" critical support to other sectors. Examples of wraparound programs in the area of education with which the Emergency Plan coordinates support are found in the accompanying text box.

Leveraging partners and resources

Like the other aspects of the HIV/AIDS emergency in a given nation, the OVC crisis requires more resources than the USG alone can contribute. The Emergency Plan recognizes that the ability and willingness of host governments to marshal all resources available to them – not only those of outside partners – for an effective response must be fostered. The USG is thus working with host governments, while coordinating with other international partners, the private sector, and communities themselves, to ensure development of sustainable systems that fully recognize and meet the needs of children, including those affected by HIV/AIDS.

Care for People Living with HIV/AIDS (Palliative Care)

For HIV-positive people, the need for care extends throughout the continuum from diagnosis with HIV infection until death. This entire spectrum of care for PLWHA is known as palliative care, under definitions developed by PEPFAR based on those of the U.S. Department of Health and Human Services and the World Health Organization. In the United States, palliative care is sometimes used in a much more narrow sense, to refer only to end-of-life care. The broader definition used by the Emergency Plan, however, is the one customarily used in Africa and much of the rest of the world.

An often-overlooked reality of HIV/AIDS care is that many people infected with HIV at a given time do not meet the clinical criteria for antiretroviral treatment. Of the over 40 million HIV-positive people living worldwide at present, it is estimated that about 6.5 million currently need ART.

Farmers in Eldoret, Kenya raise crops for a unique program, "HAART and Harvest," in conjunction with the Moi Teaching and Regional Referral Hospital and the University of Indiana. The program includes a working farm that provides food for PLWHA and their families.

In any case, the health care needs of the HIV-positive individuals who do not yet need treatment are different from those of people without HIV. While their basic health care needs may be similar, HIV-positive individuals may also require symptom management, treatment or prevention of opportunistic infections, social, spiritual and emotional support, and compassionate end-of-life care.

The Emergency Plan focuses on integrating prevention for PLWHA with care and treatment services. Prevention is a crucial component of PEPFAR and important regardless of one's sero-status, helping to ensure positive living, including the prevention of new HIV infections. These efforts are further discussed in the chapter on Prevention.

In addition to efforts to work with PLWHA to prevent transmission of HIV, another PEPFAR focus is prevention of opportunistic infections (OIs) and other diseases. The Emergency Plan supports such interventions as cotrimoxazole to prevent diarrhea and other OIs, insecticide-treated bed nets to prevent malaria, clean water vessels, condoms and, where appropriate, isoniazid to prevent tuberculosis (TB).

Best Practices

Uganda: Constructing a seamless web of effective prevention, treatment, and care

With support from the Emergency Plan, the AIDS Support Organization (TASO) in Uganda is providing comprehensive, holistic care using a clinic- and home-based model of service delivery. Rural communities are severely limited in their ability to access needed services. To meet the care needs of isolated communities, TASO has integrated prevention, care and treatment services. TASO approaches the family unit as an entry point for services, and the home as a venue for HIV counseling and testing and prevention education. TASO provides services such as weekly home visits by lay workers in lieu of clinic visits; access to cotrimoxazole prophylaxis, multivitamins and medications, including antiretroviral therapy (ART), and treatment for tuberculosis (TB)-HIV/AIDS co-infection; and ART adherence counseling. TASO's efforts are providing outlying populations with comprehensive clinical care.

One of the common threats faced by patients suffering from HIV/AIDS is exposure to common infections, so TASO introduced cotrimoxazole prophylaxis as part of its palliative care services. This intervention produced a 46% reduction in mortality, and 30-70% reductions in incidences of malaria, diarrhea, and hospitalization. By improving the health and well-being of program beneficiaries, the intervention helped to reduce the pressure on the strained health care system.

The integrated care package also included multivitamins and treatment for TB-HIV co-infection. Multivitamins have been associated with a reduction in mortality rates among people living with HIV/AIDS. Additionally, the provision of INH prophylaxis for 6-12 months to TB/HIV co-infected individuals has been associated with a 60% decrease in active TB and a possible 20% reduction in mortality. By providing multivitamins and treatment for TB/HIV co-infection, TASO has helped to improve overall health and reduce mortality rates among program beneficiaries.

Poor hygienic conditions adversely impact both HIV-positive people and their communities at large. To improve hygienic conditions, TASO designed a home care package that includes the provision of an inexpensive and locally produced Safe Water Vessel and a chlorine water treatment kit, allowing for storage of purified water in the home. Since diarrhea is six times more common among people living with HIV than among the general population, the ability to provide clean drinking water to the family as a whole is crucial.

With support from the Emergency Plan, TASO is providing rural Ugandans with quality comprehensive care – and building an evidence base to support an effective response that can be sustained in the future. The success of this project is also yielding valuable information on best practices that can inform efforts in Uganda and other PEPFAR countries.

Basic Palliative Care Services Provided Through the Emergency Plan

Palliative care comprises a broad range of services including physical, psychological, spiritual 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 drug therapy, 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
- Spiritual care
- HIV/AIDS prevention services

Some countries are beginning to standardize their approach and are working with implementing partners to ensure that all HIV-positive people receiving services, even if they are not eligible for ART, receive a "basic preventive care package" that provides a number of these lifesaving interventions. These interventions benefit all HIV-positive individuals whether they have begun ART or are not yet in need of it. When people receive ART without other needed care, they fail to reap the full clinical benefit of ART.

The Emergency Plan provides support for an interdisciplinary, holistic range of palliative care services. These services are listed in the accompanying text box.

Results: Rapid Scale-Up

In fiscal year 2005, the Emergency Plan committed $121 million for care for PLWHA in the focus countries. With these resources, palliative care was supported for approximately 1.7 million people. Approximately 12 percent of resources for prevention, care and treatment activities in the focus countries were devoted to palliative care for people living with HIV/AIDS.

Emergency Plan support is provided for a variety of interventions at different levels within the network model (including home-based care programs, as well as health care sites that deliver services). In addition, support is provided to fill 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.

Over 50 percent of HIV-infected people in many areas of the focus nations are co-infected with TB – a deadly airborne disease and a leading cause of death in those living with HIV/AIDS. Of those infected, approximately 10% per year develop active TB. It is vital to treat people with TB to prevent illness and death, as well as to prevent its spread to others. The Emergency Plan thus monitors activities dedicated to people living with HIV/AIDS-TB co-infection.

The Emergency Plan supported TB care and treatment for approximately 369,000 co-infected people in the focus countries during fiscal year 2005. The priority is diagnosis and treatment of active TB (including directly observed therapy, or DOTS), with support also provided

Best Practices
Kenya: Integration of HIV and TB diagnostic testing results in improved ART access

HIV and poverty drive the tuberculosis (TB) epidemic in Kenya, with a ten-fold increase in registered TB cases since 1987. In the eastern slums of Nairobi, an epicenter of the dual HIV/TB epidemic, the Eastern Deanery of the Nairobi Catholic Diocese has provided health care through seven clinics since the early 1990s. In 2001, a partnership between the Eastern Deanery AIDS Relief Program (EDARP), the Kenya National Leprosy and TB Program (NLTP) of the Ministry of Health, and HHS/CDC established integrated HIV and TB services in these clinics. Initially, TB patients were referred to freestanding counseling and testing centers; however, only one in eight patients referred for counseling and testing actually sought testing.

To improve uptake and better integrate the services, in 2003 physicians assistants began to provide diagnostic counseling and testing at the time of TB diagnosis. Despite this change in procedure, many TB patients were not tested for HIV. With Emergency Plan support, the program began in 2004 to routinely offer HIV counseling and testing to all outpatients believed to have TB. Nurses conducted the testing, using simple HIV rapid tests done in the presence of the patients.

Of 1,917 patients offered HIV counseling and testing over 19 months, 85% accepted during their initial clinic visit – and nearly all of those who came for follow-up due to active TB eventually accepted testing. The expansion of testing has accompanied the rapid expansion of care and antiretroviral treatment (ART) in the program, helping to identify patients who are eligible to start ART.

Lessons learned from this project have informed national policy and strategy, serving as a model for integrating TB and HIV services. The USG team estimates that offering testing to the 400,000 patients believed to have TB annually in Kenya can be expected to result in 300,000 accepting testing, potentially leading to 100,000 referrals for HIV care per year. The majority of these people would be eligible for ART. Manpower constraints in TB clinics have slowed the application of these lessons throughout the country, but they have informed the Kenya National Guidelines for HIV Testing in Clinical Settings and established a best practice model that is now being duplicated around the country. Offering diagnostic testing for HIV and TB routinely at the first patient contact is more acceptable to patients, more efficient for staff, and results in better management of both diseases.

This advance is making a difference for people in the slums of Nairobi. Salome Majuma (name and details changed to protect her identity) is a woman in her early 40's who was diagnosed with HIV and TB in May 2004. At the time of diagnosis, she began her 8 month course of TB treatment and cotrimoxazole prophylaxis to prevent other opportunistic infections. In February 2005 she began ART and visits the clinic monthly to collect her medications, provided with Emergency Plan support. Her tuberculosis is now cured and her health improved – offering a hopeful future.

for diagnosis and treatment of latent TB infection to prevent the development of active disease, and for general TB-related care. Of all adults and children who received TB care, 179,400 received it at USG-supported delivery sites, while the remainder received support through contributions to national, regional, and local programs.

Sustainability: Building Capacity

The Emergency Plan focuses on supporting the expansion of networks of health care providers and linking them to home-based care programs in order to support sustainable care for people living with HIV/AIDS. PEPFAR efforts focus on building the capacity of community- and faith-based groups, which have played a leading role

Table 3.4 - Care: FY05 Palliative Care[1] Results						
Country	Number of HIV-infected individuals who received palliative care/basic health care and support			Number of HIV-infected individuals who received palliative care/TB treatment and care		
	Number receiving upstream system strengthening support[2]	Number receiving downstream site-specific support[3]	Total	Number receiving upstream system strengthening support[3]	Number receiving downstream site-specific support[4]	Total
Botswana	30,000	7,300	37,300	26,400	200	26,600
Cote d'Ivoire[4]	0	24,500	24,500	0	1,400	1,400
Ethiopia	0	185,700	185,700	0	33,000	33,000
Guyana	0	700	700	0	200	200
Haiti	6,600	32,100	38,700	0	1,800	1,800
Kenya	21,000	92,500	113,500	0	63,200	63,200
Mozambique	26,700	52,700	79,400	0	0	0
Namibia	0	31,200	31,200	0	14,300	14,300
Nigeria	0	31,200	31,200	0	33,200	33,200
Rwanda	2,100	56,900	59,000	600	400	1,000
South Africa[5]	5,800	281,400	287,200	139,300	14,100	153,400
Tanzania	75,000	51,200	126,200	0	400	400
Uganda	17,900	241,000	258,900	4,500	14,300	18,800
Vietnam	0	11,800	11,800	0	300	300
Zambia	0	111,900	111,900	18,700	2,600	21,300
Totals	**185,100**	**1,212,100**	**1,397,200**	**189,500**	**179,400**	**368,900**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.

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] 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, protocol and curriculum development.

[3] Number of individuals reached through downstream site-specific support includes those receiving services at U.S. Government-supported service delivery sites.

[4] Reliable data to capture non-duplicated upstream results are not yet available in Cote d'Ivoire. The acute exacerbation of the political crisis between November 2004 and March 2005 delayed the establishment of effective national planning, coordination and monitoring and evaluation systems. Although the Emergency Plan supports systems-strengthening, we are unable to estimate the number of people reached through upstream support and the total number of people reached is likely an underestimate. The Emergency Plan team is working with the national authorities and development partners to obtain national data.

[5] As South Africa invested in improved data quality efforts, there was less overlap among partners which reduced duplication in results counted by multiple partners. The decline in total number of people receiving palliative care/basic health care and support services in South Africa from FY04 to FY05 is due largely to improved data quality.

in home-based care in many countries. USG in-country teams have found that even small grants can be very empowering for these grassroots organizations, allowing them to expand their services and advocate for increased community and national commitment to people living with HIV/AIDS.

Building the capacity of networks of PLWHA to provide care is another key element of PEPFAR's work in this area. Their involvement in palliative care helps build sustainable systems that respond fully to the challenges PLWHA face.

Recognizing the long-term importance of appropriate national policies on care for people living with HIV/AIDS, the Emergency Plan has supported policy development initiatives. Another focus is strengthening referral systems to services beyond medical needs for people living with HIV/AIDS.

USG support was provided for training of over 86,000 palliative care providers in the focus countries in fiscal year 2005, while approximately 6,800 sites received support for personnel, infrastructure development, logistics, strategic information services, and other components of quality care.

Key Challenges and Future Directions

Human capacity

As in other areas of HIV/AIDS response, inadequate human capacity remains a major challenge to ensuring quality of care for PLWHA, with nurses and other health care providers in desperately short supply in many nations.

For lay workers and volunteers who provide palliative care as well as professional health care workers, there is a need to expand and improve training, and strengthened supervision systems and appropriate incentives are essential. With PEPFAR support, South Africa's Hospice

Table 3.5 - Care: FY05 Palliative Care[1] Capacity Building Results

Country	Number of USG-supported service outlets or programs providing palliative care	Total number of individuals trained or retrained to provide palliative care
Botswana	2	3,700
Cote d'Ivoire	64	200
Ethiopia	740	8,900
Guyana	14	200
Haiti	58	2,000
Kenya	1,800	8,600
Mozambique	130	800
Namibia	300	1,500
Nigeria	100	1,000
Rwanda	800	8,900
South Africa	1,200	24,100
Tanzania	100	2,800
Uganda	1,100	13,900
Vietnam	132	2,100
Zambia	300	7,600
Totals	**6,800**	**86,300**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.
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.

Palliative Care Association was able to strengthen its financial and technical capacity, increasing its ability to provide high quality outreach and services to people living with HIV/AIDS. To expand this initiative throughout the region, PEPFAR has also supported the African Palliative Care Association (APCA), as described in the chapter on Building Capacity for Sustainability.

To ensure quality, the Emergency Plan supports efforts to strengthen supervision of lay health workers by professionals where possible. Initiatives to provide incentives to volunteers, including remuneration, also receive support, helping to strengthen care networks. Key training programs include pre-service training for future health care professionals and in-service training for current health workers.

Addressing key policies that limit care

National policies in some countries prevent health aides, including nurses, from engaging in key activities for care of people living with HIV/AIDS. Given the centrality of nurses to care in the developing world, it is essential for quality care that nurses become HIV experts who may develop capabilities to provide medication. In collaborative efforts with host governments, advanced practice nursing is a priority for Emergency Plan policy development efforts.

Holistic physical, psychological, and supportive end-of-life care remains a relatively recent innovation in many nations. Opioids, which may be one element of such care, and can be essential for pain relief, are often not registered for pain relief for AIDS patients by national governments. Working with host governments, PEPFAR continues to offer strong support to efforts to improve end-of-life care policies as well as programs.

Also critical is dissemination of the "basic preventive care packages" developed by the Emergency Plan under national strategies, offering services such as medications to prevent opportunistic infections, bed nets to prevent malaria, and clean drinking water.

Addressing burden on women and girls

The burden of caregiving for PLWHA falls disproportionately on women and girls, exacting an emotional, physical, and financial toll on a group with limited access to resources.

The Emergency Plan thus supports efforts to make comprehensive, high-quality care available at the community level, with links to broader health networks. These initiatives augment policy advocacy on behalf of women and community outreach to involve men in caregiving, thus reducing the burdens on women and girls. For example, countries such as Uganda and Zambia have established programs that provide legal protection and education for women and orphans at the community level, focusing on issues such as inheritance rights.

Food and nutrition

In 2005, the Emergency Plan created an interagency technical working group on food and nutrition that includes the Office of the U.S. Global AIDS Coordinator (OGAC), USAID, HHS, and the U.S. Department of Agriculture (USDA), and developed policy guidance

One Woman's Story
Zambia: From HIV-positive to positive about life

Mary-Gorretti Banda (known as "MG") is a service provider, outreach worker, and mentor all in one. She can most often be found at Minga Mission Hospital where she is an HIV/AIDS counselor and coordinator of three hospice wards while also leading a massive home-based care outreach effort. Her work is part of SUCCESS, a broad spectrum palliative care program supported by the Emergency Plan.

MG's past has brought her to this work. During her married life, her husband decided to take two more wives. MG, being first wife, was devastated by her husband's decision but had little choice in the matter, as local tradition allows men to have more than one wife. She decided to remain in her matrimonial home, despite being the least "loved" among the three wives, and rarely had sex with her husband. MG's husband became sick and eventually died of what seemed to be AIDS, and MG worried that she too could be infected. MG's two co-wives suffered from health symptoms similar to her late husband's, and within one year, both died. Would MG be next in line?

Mary–Gorretti (smiling in back), who is HIV-positive, works at Minga Hospital's hospice section and now coordinates the hospital's home-based care activities.

After the deaths, MG went for an HIV test and learned that she was HIV-positive. Her first reactions were fear, bitterness, depression, and denial. Watching HIV positive patients coming to Minga Hospital for help, however, MG soon wondered how she could assist them and herself. When the hospice program at Minga Hospital was launched, MG decided to take courses in counseling and testing and attend HIV/AIDS workshops, and she began to work in the hospice section of the hospital. Eventually she became Minga Hospital's home-based care coordinator as well as a counseling and testing advisor and hospice coordinator. MG now spends weeks on end in the field caring for others infected by HIV/AIDS just like herself, and she estimates that her counseling center can test as many as 200 people a month.

Mary-Gorretti Banda has truly transformed being HIV-positive into being positive about life. The Emergency Plan has made a difference for MG, who remarked, "Through my participation in the hospice and outreach activities, I have come to accept my status, take care of myself, and better understand the HIV/AIDS pandemic."

which is now being finalized for incorporation into the care activities of USG teams in the field. The guidance clarifies that the Emergency Plan supports appropriate assessment, monitoring, and counseling on the nutritional needs of people living with HIV/AIDS.

Emergency Plan teams work to leverage food and nutrition resources from other USG sources, such as USAID's Title II program and USDA's Food for Progress program, among others. In addition the Emergency Plan seeks to leverage food from other sources, including the World Food Program and the private sector. The Emergency Plan will also expand collaboration with host governments as they increase their own efforts to provide for their populations.

Community support for care, including involvement of people living with HIV/AIDS

The Emergency Plan strongly supports efforts to include PLWHA in the provision of care, helping to address the human capacity shortfall in developing countries while ensuring that care activities are conducted in ways that respond to the needs of PLWHA. USG country teams are reaching out to groups of PLWHA, including them in the design and implementation of care programs, and providing funding for a growing number of support groups in all focus country programs. PEPFAR also supports associations that reach out to the most highly stigmatized individuals, for example, men who have sex with men, and injecting drug users in Vietnam. In Kenya, faith-based organization (FBO) leaders who are living with HIV provide outreach to members of the faith community to help reduce stigma, while providing education and a system of support. In addition, PEPFAR is supporting a variety of efforts to help communities confront the challenge of providing care and support.

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 palliative care. The Partnership for Supply Chain Management established in fiscal year 2005 and described at length in the chapter on Building Capacity for Sustainability will help to ensure the quality of these items.

HIV Counseling and Testing

The Emergency Plan has led the way in supporting the expansion of access to HIV/AIDS prevention, treatment and care in the developing world. Yet one of the key limiting factors is people's lack of knowledge of their HIV status.

A person unaware of his or her HIV-positive status will not begin life-saving treatment, or care that can prevent opportunistic infections, and may not take all possible prevention steps to avoid spreading infection. Counseling and testing are key gateways to prevention, care and treatment.

Large numbers of people must be tested for PEPFAR to meet its ambitious care and treatment goals in the focus countries. Yet the numbers receiving counseling and testing today remain far short of what is needed, and the consequences of this shortfall affect all other efforts to combat HIV/AIDS.

A key current barrier to counseling and testing is lack of routine availability in health care settings, including TB and sexually transmitted infection (STI) clinics – among the most important venues for testing people who are more likely than the general population to be infected. Other obstacles include distance of patients from facilities, and inadequate access to providers, rapid tests, and laboratory services. Sustainable programs must overcome these obstacles while also ensuring that services provided are of high quality. Compounding all these challenges, stigma and discrimination against those thought to be HIV-positive remain significant in many nations.

The Emergency Plan is moving with the urgency and innovation that are commensurate with this extraordinary challenge. A growing number of best practices for sustainable, quality counseling and testing have been identified. PEPFAR is working with country teams and partners to bring these to scale as quickly as possible, using locally-appropriate approaches that can be sustained in the future.

Zach Stednick, a Peace Corps volunteer in Onipa, Namibia, works in partnership with the community to spread the word on the importance of counseling and testing.

Best Practices

Tanzania and Namibia: U.S. and host nation militaries bring leadership and teamwork to the fight

Each August, an estimated 2 million people attend the week-long annual Agriculture and Industry Fair known as "Nane Nane" in the southern Tanzanian town of Mbeya. This year, the U.S. Department of Defense (DoD), using Emergency Plan resources, worked with 11 local partners to staff counseling and testing and educational booths at the fair. About 300,000 people explored the booths, and 700 sought testing. The partner organizations gave educational speeches from a grandstand built specially by the Tanzania People's Defense Force, and presented dramas, dances, songs, and testimonies throughout the week. They also staffed all-day counseling and testing booths, contributing "runners" to take blood samples to the referral hospital lab. Due to the overwhelming number of clients, one night they were forced to conduct group counseling and take 50 clients to the Regional Hospital to finish the testing.

Out of the 700 tested, 9.4% were positive and given referrals to support groups and care and treatment centers. Significantly more males than females were tested, and 85% were between the ages of 19-28. The Tanzania Minister of Transportation and Communication, Professor Mark Mwandosya, hailed the partnership of the American and Tanzanian governments, and encouraged all attendees to work together to control HIV/AIDS. The remarkable range of partners was among the most impressive aspects of the event. The 11 local partners were faith- and community-based organizations providing HIV services in the Southern Highlands. The partners collaborated so well that they decided, with the encouragement of DoD and the Walter Reed HIV/AIDS Foundation, to form a network of local non-governmental organizations in Mbeya region. The network meets on the last day of each month to share information on best practices in the field, while planning, implementing and evaluating programs to address HIV/AIDS in the Southern Highlands of Tanzania.

In a number of countries DoD is collaborating with ministries of defense to develop leadership in HIV prevention for military personnel. In Namibia, the DoD-sponsored Military Action and Prevention Program in the Namibian Defense Force sponsored a base commanders' seminar, which forty-eight senior line officers attended. The seminar encouraged open discussion about the threat of HIV to military readiness and national security, and the responsibility of commanders to provide opportunities and encouragement for participation of soldiers in HIV prevention activities and testing. In Namibia and other Emergency Plan countries, an encouraging sign is the involvement of senior officers in the development of policies regarding HIV-positive troops and their future in military service – a previously taboo subject.

Because prevention of mother-to-child transmission (PMTCT) services include counseling and testing, PMTCT activities are among the most effective ways to increase women's access to these services. As described further in the chapters on Prevention and Children, PMTCT encounters also serve as an entry point for provision of prevention, treatment, and care services.

In addition to PMTCT efforts, other innovative PEPFAR initiatives include support for expansion of diagnostic counseling and testing in other health care settings in Botswana, Kenya, and Tanzania. A major expansion of rapid testing has been supported in Namibia, while couples counseling is being supported in a number of focus countries. In Uganda and Botswana, door-to-door testing of entire districts is being supported, with promising results.

The Emergency Plan is also supporting laboratory quality improvement, which is a key element of effective testing programs, through training and other efforts. Support is also provided for the expansion of rapid HIV testing.

Table 3.6 - Care: FY05 Counseling and Testing Results (in settings other than PMTCT)			
Country	**Number of individuals receiving upstream system-strengthening support[1]**	**Number of individuals receiving downstream site-specific support[2]**	**Total number of individuals receiving counseling and testing in settings other than PMTCT**
Botswana	71,200	61,500	132,700
Cote d'Ivoire[3]	0	23,700	23,700
Ethiopia	55,400	335,100	390,500
Guyana	0	11,700	11,700
Haiti	2,300	126,300	128,600
Kenya	97,700	404,900	502,600
Mozambique	36,600	96,100	132,700
Namibia	11,900	65,000	76,900
Nigeria	11,900	98,000	109,900
Rwanda	165,200	145,400	310,600
South Africa[4]	718,500	185,800	904,300
Tanzania	282,100	242,300	524,400
Uganda	466,200	633,100	1,099,300
Vietnam	0	37,300	37,300
Zambia	200,000	68,000	268,000
All countries	**2,119,000**	**2,534,200**	**4,653,200**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.
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, protocol and curriculum development.
[2] Number of individuals reached through downstream site-specific support includes those receiving services at U.S. Government-supported service delivery sites.
[3] Reliable data to capture non-duplicated upstream results are not yet available in Cote d'Ivoire. The acute exacerbation of the political crisis between November 2004 and March 2005 delayed the establishment of effective national planning, coordination and monitoring and evaluation systems. Although the Emergency Plan supports systems-strengthening, we are unable to estimate the number of people reached through upstream support and the total number of people reached is likely an underestimate. The Emergency Plan team is working with the national authorities and development partners to obtain national data.
[4] The large increase relative to FY2004 in the number of people counseled and tested as a result of upstream USG support in South Africa is partly due to scale up of counseling and testing services, but also partly due to a change in the data source from FY2004 to FY2005. It is believed that the data source currently being used to track the numbers of people counseled and tested is more accurate than what had been used in the past.

These efforts are described at length in the chapter on Building Capacity for Sustainability.

Results: Rapid Scale-Up

To date, the Emergency Plan has provided support for HIV counseling and testing services for over 9.4 million people in the focus countries. Of these, over 6.6 million received services in fiscal year 2005 – over 1.9 million in PMTCT settings and over 4.6 million through other counseling and testing activities.

Of the over 6.6 million counseled and tested in fiscal year 2005, over 3.7 million received these services with downstream PEPFAR support at USG-supported sites, while the remainder were supported through upstream PEPFAR support for 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). Definitions for upstream and downstream support are provided in the Accountability section at the end of this chapter.

Zambian Defense Forces watch a performance by a traveling HIV/AIDS drama troupe.

Reflecting the importance of counseling and testing to achieving the goals of the Emergency Plan, approximately $64 million, or 6 percent, of focus country prevention, treatment and care resources in fiscal year 2005 were committed to PMTCT services, while $90 million, or about 9 percent, were committed to other counseling and testing activities.

Table 3.7 - Care: Cumulative Counseling and Testing Results, FY04-FY05

	FY04	FY05	Cumulative C&T to date
Number of women receiving C&T through PMTCT[1]	1,017,000	1,957,900	2,974,900
Number of individuals receiving C&T in other settings[2]	1,791,900	4,653,200	6,445,100
Total	**2,808,900**	**6,611,100**	**9,420,000**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.
Footnotes:
[1] In FY04 only, it was assumed that 80% of women receiving PMTCT services were counseled and tested.
[2] In FY05, the PMTCT indicator was clarified, so that women were only counted as receiving PMTCT services if they were counseled, tested, and received their test results.

Table 3.8 - Care: FY05 Counseling & Testing Capacity Building Results (in settings other than PMTCT)

Country	Number of USG-supported sites providing counseling and testing in settings other than PMTCT	Total number of individuals trained or retrained in counseling and testing in settings other than PMTCT
Botswana	32	30
Cote d'Ivoire	54	200
Ethiopia	800	2,200
Guyana	15	88
Haiti	74	1,400
Kenya	500	2,200
Mozambique[1]	52	100
Namibia	200	1,200
Nigeria	200	1,500
Rwanda	72	800
South Africa	1,000	3,800
Tanzania	100	700
Uganda	700	6,200
Vietnam	61	400
Zambia	300	1,400
Total	**4,200**	**22,200**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.
Footnotes:
[1] In FY04, voluntary counseling and testing sites in Mozambique received upstream USG support, which was provided to Mozambique's national voluntary counseling and testing program. This central support included USG-supported procurement of all of the test kits Mozambique used in FY2004 as well as development of protocols, guidelines, training curricula, and a range of related technical support without which the expansion would not have occurred. In FY05 the level of central support in the area of C&T was not as extensive. Therefore, for FY05, Mozambique reported only downstream USG-supported sites.

PEPFAR continues to work to overcome challenges to reach women with much-needed services. Approximately 69 percent of those who received USG-supported counseling and testing services in fiscal year 2005 were female. This figure includes all PMTCT clients, as the PMTCT services indicator for fiscal year 2005 was clarified to ensure that a woman was only counted as receiving PMTCT services if she was counseled and tested and received her test result. For clients receiving non-PMTCT counseling and testing at a downstream USG-supported site and whom implementing partners reported by gender, 53 percent were women. This percentage was then applied to those who received upstream support as well.

Sustainability: Building Capacity

The Emergency Plan has continued to make progress in partnering with host nations to make counseling and testing a centerpiece of efforts to bring national responses to scale – but much more effort is needed. Emergency Plan teams have worked with host governments and other partners to integrate counseling and testing into routine health care, as must be done to reach the large numbers who require testing if the tide is to be turned.

In the focus countries in fiscal year 2005, the Emergency Plan provided support for training of approximately 50,800 individuals in counseling and testing (including 28,600 in PMTCT and approximately 22,200 in other counseling and testing services). PEPFAR also supported approximately 6,700 service sites (including 2,500 PMTCT sites and 4,200 other counseling and testing sites).

Key Challenges and Future Directions

Bolstering sustainable activities to increase the number of people who learn their HIV status

Given the challenge involved in rolling out counseling and testing on the massive scale needed, it is critical to focus efforts on people with a higher likelihood of HIV infection than the general population. This must be done without neglecting efforts to ensure access for the population at large, especially in countries with generalized epidemics.

Table 3.9 - Care: FY05 Total Counseling and Testing Capacity-Building Results						
Country	Number of USG-supported sites other than PMTCT	Number of USG-supported PMTCT sites	Total	Number of health workers trained or retrained in PMTCT services	Number of individuals trained or retrained in counseling and testing in settings other than PMTCT	Total
Botswana	12	32	44	100	30	130
Cote d'Ivoire	44	54	98	200	200	400
Ethiopia	100	800	900	4,900	2,200	7,100
Guyana	46	15	61	75	88	200
Haiti	60	74	100	1,900	1,400	3,300
Kenya	900	500	1,400	3,100	2,200	5,300
Mozambique[1]	51	52	100	500	100	600
Namibia	79	200	300	900	1,200	2,100
Nigeria	42	200	200	800	1,500	2,300
Rwanda	64	72	100	1,600	800	2,400
South Africa	400	1,000	1,400	8,400	3,800	12,200
Tanzania	200	100	300	2,200	700	2,900
Uganda	300	700	1,000	2,700	6,200	8,900
Vietnam	7	61	68	500	400	900
Zambia	200	300	500	700	1,400	2,100
Total	**2,500**	**4,100**	**6,600**	**28,600**	**22,200**	**50,800**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.
[1] In FY04, voluntary counseling and testing sites in Mozambique received upstream USG support, which was provided to Mozambique's national voluntary counseling and testing program. This central support included USG-supported procurement of all of the test kits Mozambique used in FY2004 as well as development of protocols, guidelines, training curricula, and a range of related technical support without which the expansion would not have occurred. In FY05 the level of central support in the area of C&T was not as extensive. Therefore, for FY05, Mozambique reported only downstream USG-supported sites.

Making diagnostic testing a part of health care interactions is among the most efficient and sustainable ways of accomplishing this goal. Accordingly, the Emergency Plan has sharply increased its support for routine voluntary counseling and testing in programs for pregnant women, clinics that treat TB or STIs, hospitals, and other health care settings. In addition, as prevention is being integrated into care and treatment services in places such as Kenya and Uganda, clients receiving treatment services are asked about disclosure and partner testing.

As noted above, a variety of other locally-designed initiatives have shown very promising results, including partner testing for couples, home-based testing (including testing of family members), mobile testing, hotlines linking callers to testing sites, and others.

The Emergency Plan has taken special efforts to ensure that women receive counseling and testing without stigma and discrimination, and that they have full access to care and treatment as needed. Many of the initiatives described have helped to achieve these goals, including testing for pregnant women in health care settings, partner testing, and activities to reduce stigma and cultural barriers that inhibit women's access to services. Integration of counseling and testing into family planning clinics is a priority, and routine testing within PMTCT programs has proven a highly effective means of linking women to needed treatment and care.

One requisite of quality in counseling and testing programming is that those tested actually receive their test results. Long delays in obtaining test results, however, have led many who are tested not to return for their results. The increasing availability and quality of rapid tests is thus one of the most encouraging developments

in the fight to expand counseling and testing, and PEPFAR continues to strongly support country teams and partners' inclusion of rapid tests in their plans. A number of host nations and partners have moved to rapid testing in recent years with USG support.

Ensuring quality in counseling and testing

Widely available, high-quality testing requires testing kits in very great numbers. The Emergency Plan's new Partnership for Supply Chain Management, described in detail in the chapter on Building Capacity for Sustainability, will help host nations to ensure uninterrupted supplies of high-quality test kits.

High quality in counseling is perhaps even more difficult to ensure than quality in testing. Counseling for those who test negative is an area that has tended to receive insufficient attention, wasting critical opportunities for prevention efforts. The Emergency Plan is thus supporting efforts to expand and improve training of counselors and to ensure that they are able to offer appropriate prevention information.

Accountability: Reporting on the Components of Care

The First Annual Report to Congress of the Emergency Plan described the ways in which U.S. support is provided. Where partnership limitations or technical, material or financial constraints require it, the Emergency Plan, or another international partner, may support every aspect of the complete package of prevention, treatment, or care services at a specific public or private delivery site, in coordination with host-country national strategies.

Downstream support

In many areas, the Emergency Plan will coordinate with other partners to leverage resources at a specific site, providing those essential aspects of quality services that others cannot provide due to limited technical and/or financial circumstances. For example, in some settings components of services are provided to specific sites through the host-country government or other international partners such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, while the Emergency Plan may contribute other essential services, training, commodities, and infrastructure. "Downstream" site-specific support refers to these instances where the Emergency Plan is providing all or part of the necessary components for quality services at the point at which services are delivered.

Upstream support

Beyond the site-oriented downstream components of services, support is required to provide other critical elements, which may include the training of physicians, nurses, laboratory technicians, other health care providers, and counselors or outreach workers; 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 services. This coordination and leveraging of resources optimizes results while limiting duplication of effort among partners, 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 prevention, treatment, and care.

Attribution challenges due to country-level coordination

The Emergency Plan supports national HIV/AIDS treatment strategies, leveraging resources in coordination with host-country multisectoral organizations and other partners to ensure a comprehensive response. Host nations must lead a multisectoral national strategy for HIV/AIDS for an effective and sustainable response. International partners 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 international partners are not desirable or sustainable. In such an environment, attribution is complex, including both upstream and downstream activities, often with multiple partners supporting the same sites to maximize comparative advantages. PEPFAR is conducting audits of its current reporting sys-

tem to refine methodologies for the future, and continues to assess attribution and reporting methodologies in collaboration with other partners.

Care reporting conventions

During this reporting period, results for PEPFAR care programming were determined by totaling all the programs, services, and activities aimed at optimizing quality of life for OVCs; at caring for patients and their families throughout the continuum of illness; and at diagnosing HIV-infection through counseling and testing, including through PMTCT activities.

Activities aimed at improving the lives of children and families directly affected by AIDS-related morbidity and/or mortality are counted as OVC 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. In-country partners 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 USG reporting and accounting systems by the grantees acquiring the goods.

The Emergency Plan has funded the MEASURE Evaluation Project, discussed in the chapter on Improving Accountability and Programming. This evaluation will provide:

- Data quality audit guidance for program-level indicators
- Best practices for program-level reporting
- Implementation of data standards guidance in select countries

Through the National Muslim Council of Kenya, Muslim women gather to discuss the stigma and challenges of HIV/AIDS. The women provide support and empower each other to make positive impacts within their communities.

"There is a deep need for the empowerment of women, and that begins with education. Educated young women have lower rates of HIV/AIDS, healthier families, and higher rates of education for their own children... We must give more girls in Africa a real chance to avoid exploitation and to chart their own future. Another important aspect of empowerment and the fight against AIDS is the legal protection of women and girls against sexual violence and abuse."

President George W. Bush
June 30, 2005

Chapter 4
Gender and HIV/AIDS: Responding to Critical Issues

Issues and Challenges

The President's Emergency Plan recognizes that social inequalities between women and men, which contribute to 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.

The number of women and girls living with HIV continues to grow rapidly. UNAIDS estimates that 46 percent of adults living with HIV worldwide now are women. In sub-Saharan Africa, the share is even higher – 57 percent. Adolescent girls continue to face especially high risks. In some countries, girls between the ages of 15 and 19 are infected at rates three to six times higher than boys their age. In addition to societal factors, another reason for this elevated risk is that 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. The interaction of this biological fact with the social fact of male behaviors and norms that put women at risk has proven to be deadly.

Among the harmful social norms and practices that increase the vulnerability of women and girls are 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 implications of these challenges are introduced in the chapter on Prevention.

As noted in the chapter on Care, women carry a disproportionate caregiving burden when family and community members become sick with AIDS or die. These burdens often fall on girls and young women, preventing them from obtaining education and the possibility of eco-

nomic empowerment. In addition, women who provide care – or who become known to be infected themselves – often face severe stigma.

The societal issues around gender and HIV/AIDS are complex, and in some cases the issues vary from one country to another, requiring different approaches. Addressing these challenges successfully, however, is critical to the achievement of the Emergency Plan's ambitious prevention, treatment, and care goals, and remains a high priority for PEPFAR.

If the world is to succeed in the effort to defeat HIV/AIDS, the soaring infection rates among women and girls simply must be reversed, and it is impossible to do this without addressing these enormous challenges.

In fiscal year 2005, PEPFAR created an interagency Technical Working Group on gender, and it is providing technical assistance to field programs in order to assist them in conducting gender analysis and providing support to strengthen successful, evidence-based interventions.

Results

Increasing gender equity in HIV/AIDS activities and services

The Emergency Plan is working to ensure that the activities it supports provide equitable access to services for both women and men and meet the unique needs of women and girls, including orphans and victims of sex trafficking, rape, abuse, and exploitation.

First Lady Laura Bush meets with women from the Mothers to Mothers-to-Be program in Cape Town, South Africa during her visit to Africa in July 2005.

The Emergency Plan is the only international HIV/AIDS program that requires reporting of data disaggregated by gender. This is vitally important, because without knowing who is accessing services, it is difficult to effectively develop gender-sensitive programs. For fiscal year 2005 in the focus countries, the gender of over 90 percent of clients served at downstream sites (those sites for which disaggregation by gender is possible) is known. The statistics in the following paragraphs refer to data from these activities.

An encouraging fact is that approximately 60 percent of those receiving antiretroviral treatment were women and 40 percent were men. Given that most people on U.S. Government (USG)-supported treatment live in Africa, where 57 percent of infected adults are women, ensuring equitable access to treatment is essential, and the Emergency Plan is a leader in making equitable access a reality.

In terms of prevention, approximately 3.2 million pregnant women (including over 1.9 million in fiscal year 2005) have accessed PEPFAR-supported prevention of mother-to-child transmission (PMTCT) services in the 15 focus countries. PMTCT services include HIV counseling and testing, providing an important entry point to HIV care and treatment for women and their family members.

Approximately equal numbers of females and males were reached by ABC prevention programs. A variety of approaches are being undertaken in these programs, many of which tailor messages and behavior change interventions to specific needs of boys, girls, women, and men — and also tackle harmful social norms that perpetuate gender inequalities. Given the role of male behaviors and social norms in HIV transmission, it is important to note that prevention work with men is crucial for reducing the vulnerability of women. Harmful norms also can increase vulnerability of men and boys by creating expectations of early sexual initiation, multiple partners,

risk taking, and use of aggression and control in relationships as signs of or to prove manhood.

Among all people who received PEPFAR-supported counseling and testing, approximately 69 percent were women, while approximately 31 were men. Of those who received HIV counseling and testing in downstream settings other than PMTCT, 53 percent were women, while 47 percent were men. (See the chapter on Care for further discussion of these figures.) The Emergency Plan is striving to ensure that women have equal access to counseling and testing services, not only through PMTCT services, but through a range of other PEPFAR-supported approaches, described in the chapter on Care. Among these approaches, the USG supports couples counseling and testing – an important strategy for reducing violence against women around their disclosure of their status. In order to promote a gender-sensitive approach, countries such as Uganda have worked to ensure that men receive their test results first in order to reduce the likelihood of men blaming women or acting out violently against them.

Among the orphans and vulnerable children (OVCs) served by PEPFAR activities, 52 percent were girls and 48 percent were boys. Ensuring that equal numbers of males and females have access to services does not by itself indicate that programming fully addresses gender issues, and therefore PEPFAR OVC programs are working towards including a greater focus on gender in their interventions. For example, in Zambia, Emergency Plan partners are working with the community to reduce potential violence towards OVCs, particularly adolescents, who are vulnerable and can fall victim to sexual coercion and rape.

One measure of equitable access is the extent to which men and women receive and access services. However, increasing availability of services for women and girls is just one component of the broader changes needed to reduce gender imbalance and promote gender equality. Programs must also address the barriers for women and men to receive information, access services, and adhere to treatment. Goals include improving hours of services and reducing costs of services to patients, ensuring greater gender equality in PEPFAR programming.

Reducing violence and coercion

Sexual and other forms of abuse against women fuel the spread of HIV in several ways. The practice or threat of sexual violence against women and girls puts them at increased risk of contracting HIV by creating situations in which women are unable to abstain or negotiate condom use. Fear of violence and rejection from partners, families, and communities keeps women from seeking HIV information, seeking counseling and testing for HIV, and receiving care and treatment. A woman can be at heightened risk of violence or rejection due to disclosing her positive status. The Emergency Plan supports activities to: change social norms and male violence against women; prevent violence resulting from HIV status disclosure through couples counseling and counseling on violence; strengthen policy and legal frameworks outlawing gender-based violence; and link HIV programs with community and social services, such as those to strengthen conflict resolution skills and to protect and care for victims.

In the focus countries during the reporting period, Emergency Plan implementing partners reported that 203 activities had a component that sought to address violence and coercion. Many of these activities are part of ABC efforts, as sexual coercion and violence create extreme challenges for girls and women to achieve these behaviors.

PEPFAR supports post-exposure prophylaxis (PEP) for rape victims in several countries, greatly reducing the risk of HIV infection. In Kenya, the Nairobi Women's Hospital Gender Violence Recovery Centre provides medical and psychosocial support for survivors of rape and sexual assault. In both Zambia and South Africa, USG partners are assisting women with concerted efforts to scale up sexual violence prevention services and PEP at both the local and national levels. Organizations are training healthcare providers in PEP provision, and the project has established a coordinated program with integrated post-rape services provided by pharmacists, police, and social workers. Furthermore, HIV-positive rape sur-

vivors are being referred to hospitals or clinics for ongoing clinical care and antiretroviral treatment (ART) assessment.

Alcohol contributes to sexual violence and assault against women, leading to HIV transmission. Emergency Plan activities focusing on alcohol abuse, discussed in the chapter on Prevention, are thus important for reducing both gender-based violence and HIV transmission.

Addressing male norms and behaviors

Emergency Plan prevention efforts recognize that deep-seated norms around male sexual behavior must be addressed in order to achieve the widespread behavior change necessary to curb the HIV epidemic. Practices such as multiple and concurrent 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. The Men as Partners program in South Africa trains non-governmental organizations (NGOs) in strategies for increasing male responsibility for HIV prevention, including working with traditional leaders to mobilize communities to challenge norms of masculinity that contribute to high-risk behavior.

To address these issues, PEPFAR implementing partners reported that 305 activities in the focus nations had a component specifically targeting men. Many of these activities target youth as well as adults, recognizing that

Best Practices

Kenya: Education leads tribal elders to support women's inheritance rights

In the wake of the HIV/AIDS epidemic, problems related to women's rights to property and inheritance in Kenya have escalated as women are widowed by AIDS. Through activities supported by the Emergency Plan, this critical issue has been brought to the attention of leaders in Nyanza Province, the region with the highest HIV prevalence and highest number of AIDS deaths in Kenya. In this province many women are widowed and have little access to food or shelter. Supporting their property and inheritance rights addresses one of their greatest areas of vulnerability, providing the stability needed to raise children and take care of their own needs.

In 2005, the Emergency Plan, through USAID's POLICY project, supported a workshop with the Kenya National Commission for Human Rights to address the problem of women's inheritance and rights of property in the Luo ethnic group in Nyanza. The workshops provided an opportunity for the Luo Council of Elders, women leaders, political leaders, the provincial administration, and local and national organizations to explore the inheritance problem. Community women presented their personal experiences of the discriminatory practices in their culture, as well as those in Kenyan law. The project organized eight participatory community workshops, where widows and orphans vividly described the experience of losing land and other inheritances.

The community meetings resulted in immediate alleviation of inheritance issues through traditional and local government structures. Prior to this Emergency Plan-funded project, the 150 elders from this community had never focused on women's rights. The Council of Elders now wants to restructure their organization to better address the plight of women and orphans and property ownership and inheritance. This work has helped to fundamentally shift the power dynamics between the sexes and lessen the ignorance and distortion within the Luo community, leading to a strong partnership in addressing the plight of women and orphans and vulnerable children. As of September 2005, the Luo Council of Elders reported that they have resettled over 20 women and their children back on their family lands. One elder who had initially objected to this project now proudly reports that he has helped to resettle four women. "I am now converted, thanks to this project," he stated. This has indeed been a fundamental cultural change – one that the Emergency Plan is working to replicate in many other places.

the seeds that lead to negative male behavior are often planted in youth.

In addition, the Emergency Plan supports PMTCT programs that encourage men's participation. For example, in Uganda, Kenya and South Africa, programs have begun to initiate partner testing within PMTCT settings.

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 supports 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. Implementing partners reported that 105 activities in the focus countries had such a component. In Kenya, the Federation for Women Lawyers helps people living with HIV/AIDS (PLWHA) on issues around property and inheritance as well as rape and sexual assault.

Empowering women to make healthy choices

The Emergency Plan supports interventions to enhance women's decision-making capacity in their personal lives and their capacity to provide leadership to community and national HIV/AIDS efforts. Support groups for women are valuable organizations that receive significant Emergency Plan support. For example, PEPFAR supports activities which link HIV-positive pregnant and postpartum women to psychosocial support groups run by peers. These support groups provide educational information on a range of topics from infant feeding to family planning, and provide a supportive space for women to talk with peers about coping with their HIV status.

A South African partner, Mothers To Mothers-To-Be (M2M2B), has created a support network with activities for pregnant women who have just learned their HIV status. The network helps to mentor, educate and encourage mothers to seek out ART, select the most appropriate feeding and family planning methods, and support women in their choice to disclose their HIV status and in coping with stigma. The Emergency Plan supports women's civil society organizations that provide leadership support for PLWHA – helping to build their organizational capacity to deliver services, and strengthening their linkages within broader health care networks.

Emergency Plan interventions are also linked to USG-supported family planning activities. For example, in Rwanda and Tanzania PMTCT programs train providers in family planning to help ensure that HIV-positive clients receive access to information and family planning services. The Emergency Plan also provides key support for expanding access to female-controlled methods of HIV/AIDS protection. PEPFAR-supported programs provide female condoms, and USG funding is contributing to research into microbicides, as noted in the chapter on Prevention.

Increasing women's access to income and productive resources

For many disadvantaged women and girls, transactional sex is one of the few options available for survival. The Emergency Plan supports efforts 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 the disease's impact. Programs also provide education and condoms to allow women who continue to engage in transactional sex to protect themselves.

The Emergency Plan supports income generation programs in India for women and girls infected and affected by HIV/AIDS.

Several programs, including public-private partnerships, are under way to address this critical issue. Additionally, linkages between Emergency Plan and other USG-supported education, economic development, and microfinance programs are being strengthened.

The USG supports activities targeting income generation development for women, helping women to mitigate the impact of HIV/AIDS on themselves and their families. The Emergency Plan also supports activities to help women develop alternatives to sex work, such as drop-in centers staffed by healthcare professionals and job placement and skill development support for women who wish to leave prostitution. These services are paired with male client interventions to reduce frequency of visits to commercial sex workers in a number of countries, such as Vietnam. Implementing partners reported 107 activities in the focus countries that addressed women's need for access to income and productive resources.

Future Directions

As programs mature and attention to quality of services grows, the need to focus on gender-related factors is becoming increasingly evident. The Emergency Plan's newly established Gender Technical Working Group will offer key technical assistance to field programs. PEPFAR will undertake expert consultations in order to expand its support for effective programs, developing evidence-based approaches to gender issues and taking them to scale. As part of this effort, the USG is refining its efforts to develop quantitative indicators and targets to ensure that the Emergency Plan is supporting effective approaches and to assess the contribution of such approaches to PEPFAR's goals.

It remains clear that reversing trends in infection rates among women and girls and ensuring that women receive equitable access to care and treatment services are critical factors in PEPFAR's ability to meet its goals,

Best Practices
Haiti: 'Other Choice' and 'Back to School' programs give women in prostitution new options

The Emergency Plan supports a growing range of programs and interventions in its fight against HIV/AIDS in Haiti. One of these programs, the Lakay Social Clubs, supports HIV/AIDS prevention services for commercial sex workers by offering income-generation and educational alternatives to prostitution. The Lakay project has two main objectives: reducing the incidence of sexually transmitted infections and HIV/AIDS among women in prostitution and their clients, and helping these women to abandon the sex trade.

To address the second objective, the "Other Choice" program provides commercial sex workers with socio-economic alternatives to prostitution. The program offers the women training courses in subjects such as cooking, sewing, computer skills, arts and cosmetology. With these new skills, the program assists women to find new jobs and abandon the sex trade. Former commercial sex workers are integrated into the "Other Choice" program as peer trainers, further enhancing the program's ability to reach other women who are still involved in prostitution.

Through September 2005, the Other Choice program trained more than 1,400 women, many of whom have partially or fully removed themselves from prostitution. In the coming year, PEPFAR will support evaluation of this and similar programs to determine the effectiveness of the training in helping women to leave prostitution.

The Other Choice program will also be extended to include a new strategy called "Back to School." This initiative will target young women who, often due to economic challenges at home, have abandoned school to enter prostitution. The program will support the reintegration of these adolescents into schools, and work to reduce the school-children-by-day/commercial sex worker-by-night phenomenon that has recently developed in many Haitian cities.

including the 2-7-10 goals in the focus nations. The Emergency Plan has thus supported a wide variety of gender-focused activities to tackle critical gender issues, and will continue to intensify support for the gender-sensitive approaches to programming described above. These activities focus not only on access to services, but also on empowerment of women through strengthened individual, family and community-level interventions. In addition, programs that focus on men and boys will continue to grow as they are critical to achieving both successful gender programs and to slowing the tide of HIV transmission. Ongoing efforts will continue to address central issues such as gender-based violence.

Ambassador Tobias embraces an orphan girl at the Lesotho Child Counseling Unit during his visit in July 2005. The program provides a variety of services to abused and orphaned children including shelter, education, community and youth activities, training, and life skills development. Emergency Plan funds are helping the organization to grow and reach more children with services.

"A few years ago, a little girl in Namibia was born to a mother and father who both had HIV; she had the disease, as well. The name her parents gave her translates as the phrase, "There is no good in the world." Months ago, the girl was very sick and losing weight and close to death. But today, she and her entire family are receiving life-saving medicine. Now she's a beautiful, shy, thriving six-year-old, with a new life ahead of her, and there's a little more good in the world."

President George W. Bush
June 30, 2005

Chapter 5

Children and HIV/AIDS: Responding to Critical Issues

For further discussion, see the Emergency Plan's September 2005 Report to Congress, "Focusing on Our Future: Prevention, Diagnosis, and Treatment of Pediatric HIV/AIDS," available at www.pepfar.gov.

Issues and Challenges

Approximately 2.3 million children under age 15 are living with HIV/AIDS, and a majority live in the 15 focus countries of the Emergency Plan. HIV-positive children are especially vulnerable: without treatment, the majority of infected children die before they are two years of age.

When prevention fails, the cost is enormous in terms of human suffering, and there are also many obstacles to providing pediatric HIV treatment, which is more complicated and expensive than adult treatment. This is particularly true among the youngest children, who are at the highest risk of death from AIDS, but are also difficult to diagnose and provide with appropriate antiretroviral (ARV) drug formulations.

In addition to those infected with HIV/AIDS, many more are orphans and vulnerable children (OVCs), with one or both parents dead or chronically ill as a result of AIDS. At least 8 million children have been orphaned by AIDS in the focus countries.

In addition to the tragedy an individual child may experience, the increasing needs of millions of vulnerable children are reducing the economic and social resources of families, communities, and entire societies. Inadequate care and protection of children could result in increased social disorder, with profound implications for future political stability. Orphans are especially vulnerable to recruitment by gangs and armed groups, and to exploitation as child labor or trafficking victims.

Without attention to education and vocational training, skills needed for economic development could be lost, condemning nations to continued poverty. One World Bank simulation of the economy of South Africa – a nation with a relatively developed economy – found that without effective intervention to meet the needs of OVCs, by 2020 the average household income would be less than it was in 1960 and would continue to decline thereafter.

Children have distinctive needs that must be addressed in a comprehensive, multisectoral way, with programs of high quality that can be sustained by families and communities for the long term. While there is much left to do, the Emergency Plan has brought an intensive focus to children and HIV/AIDS.

Challenges in meeting the needs of HIV-exposed children

The vast majority of pediatric infections can be prevented through the provision of highly effective preventive short-course ARV regimens. In the U.S., new pediatric HIV infections have decreased by over 95% since the implementation of combination prophylaxis regimens, with less than 50 pediatric HIV infections now reported to occur every year.

In the developing world, however, preventing, diagnosing and treating pediatric HIV/AIDS all present daunting challenges, and scaling up highly effective interventions to prevent mother-to-child transmission (PMTCT) has been challenging. The prevalence of HIV among pregnant women is rising and is above 30% in some regions. The limited capacity of health systems in resource-poor nations affects pediatric HIV/AIDS care, as it does a range of other health issues.

The most effective way to prevent HIV in children is PMTCT. Yet PMTCT is challenging in resource-limited settings, beginning with difficulty in getting pregnant women to access antenatal care and HIV prevention programs in the first place. Even when women are reached with prevention services, there are significant barriers of stigma, reluctance to return for HIV test results, issues related to delivering short-course preventive ARVs in situations where women have their babies at home, and transmission through breastfeeding in settings where replacement feeding is not safe and feasible

Because most HIV-positive children die before the age of 2 without intervention, early diagnosis is essential. Yet diagnosis of children – especially the young children most likely to be infected – is complex and expensive. The traditional tests used for adults are not effective until after the child is 18 months old. Technologies to improve pediatric diagnosis are not yet widely available, and shortages of trained health workers are a major problem.

Long-term combination antiretroviral treatment (ART) for children also poses special challenges. ARVs are often unavailable in pediatric formulations, and they are often much more costly than adult drugs. Pediatric regimens can be difficult to follow because of the complexity of dosing by weight, and few providers are trained in pediatric HIV treatment. Parents often need to reconstitute the formulation, making the instructions more complex, and the formulations often need refrigeration for storage. Treatment of infants is also sometimes subject to higher failure rates than older children due to difficulties in administering these formulations.

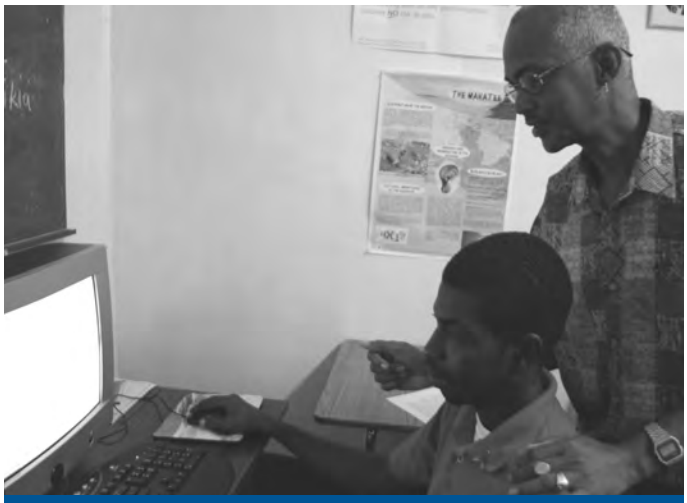
Communities do not always focus on the special issues of children with HIV/AIDS, whose parents may be ill or dead, and their caregivers often lack needed support. Even where there is a community response, older children in particular have issues that may be neglected.

Challenges in meeting the needs of orphans and vulnerable children

All children are vulnerable, simply by virtue of being children. Children whose parents become chronically ill or die from AIDS, however, face an especially daunting array of issues.

Dimensions of risk for children affected by HIV/AIDS may include:

- Survival vulnerability – poor health, nutrition and basic care



Orphans and other vulnerable children face many challenges, including academic vulnerability. At the Linden Care Foundation in Guyana, a student works on schoolwork with a staff member in the "Capacity Building Room."

- Economic vulnerability – loss of income and property, family and community fragility, inability to afford health care
- Academic vulnerability – leaving school due to lack of time, money, and hope for the future
- Psycho-social vulnerability – post-traumatic stress disorder, grief, burdens of caring for sick household members or younger children
- Exploitation vulnerability – abuse and exploitation due to loss of protective parents and community support

It is the interaction of a number of factors in a child's life that determine his or her level of vulnerability. Age and developmental level, gender, geography, and a complex array of social factors all interact to heighten or reduce a child's vulnerability, and effective responses must take these elements into account.

Because of the complex web of needs of OVCs, only some of which are directly addressed by prevention, treatment, and care programs, it is essential to coordinate with providers of resources that address the full range of issues. This coordination must take place among international partners and other providers of resources at both the national and community levels.

Activities must strengthen the capacity of those who take on the burden of caring for OVCs. Partnerships in support of families, communities, and community organizations are crucial. Perhaps the most fundamental way to protect children is to help their parents to stay alive through effective prevention, treatment and care interventions.

Results

The Emergency Plan has brought U.S. leadership to bear on the pediatric HIV/AIDS crisis, as part of the U.S. response to the overall emergency. With governmental and nongovernmental host country and international partners, the U.S. Government (USG) is scaling up a family-based approach to prevention, treatment and care for children infected with and affected by HIV/AIDS.

Table 5.1 summarizes fiscal year 2005 Emergency Plan results in providing a range of prevention, treatment and care services to children in the focus countries. (The terms "upstream" and "downstream," as used in this table and chapter, are defined in the Accountability sections at the end of the chapters on Prevention, Treatment, and Care.)

Support for pediatric HIV prevention

It is estimated that over 90% of childhood HIV infections result from transmission from mothers to their children during and soon after birth. Preventing childhood infections through PMTCT programs has been one of the highest priorities of the USG in the fight against AIDS. The President's International Mother and Child HIV Prevention Initiative launched some of the first programs in this critical area, and provided the foundation for current work under the Emergency Plan.

PMTCT programs offer preventive ARVs to mothers and infants to prevent HIV transmission to their babies during labor and delivery. While short course single-drug prophylaxis to mothers and infants beginning during the onset of labor can reduce transmission by over 40%,

Table 5.1 - Children: Summary of Child Prevention, Care, and Treatment Results in Focus Countries, 2003-2005

	October 2002 - March 2004	October 2003 - September 2004			October 2004 - September 2005			October 2003 - September 2005		
	2003	**FY04 upstream results[1]**	**FY04 downstream results[2]**	**2004 total results[3]**	**FY05 upstream results[1]**	**FY05 downstream results[2]**	**FY05 total results[3]**	**Upstream results: cumulative total of FY04 and FY05 results[1]**	**Downstream results: cumulative total of FY04 and FY05 results[2]**	**Total results: cumulative total of FY04 and FY05 results[3]**
Total number of infant infections averted[4]	6,400	14,700	9,100	23,700	5,800	17,500	23,400	20,500	26,500	47,100
Number of pregnant women receiving PMTCT services	355,300	671,100	600,200	1,271,300	724,200	1,233,700	1,957,900	1,395,300	1,833,900	3,229,200
Number of women receiving ARV prophylaxis for PMTCT	33,800	77,400	47,700	125,500	30,700	91,900	122,600	108,100	139,600	248,100
Number of OVCs served[5]	N/A	78,700	551,500	63,100	455,700	764,400	1,220,100	N/A	N/A	N/A
Total number of children (0-14) on ART[5]	N/A	N/A	4,800	4,800	N/A	17,700 **(7% of total ART patients)**	17,700	N/A	N/A	N/A

Notes:
Reporting in 2003 was for an 18-month period, from October 2002 through March 2004 as the (MTCT) Mother-to-Child-Transmission) Initiative was integrated into the Emergency Plan. Reporting in FY04 was from October 2003 through September 2004. There is thus some overlap in reporting during the months between October 2003 and March 2004. For this reason, results from the 2003 period are not included in Total Results for FY04.
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-supported service delivery sites.
[3] Total results are the sum of upstream and downstream results.
[4] The number of infant infections averted was calculated by multiplying the total number of pregnant women who received ARV prophylaxis (upstream and downstream) by the efficacy rate of ARV prophylaxis, currently estimated to be 19%. The same method was used to calculate total results for infant infections averted, and results are rounded to the nearest 100. Therefor, total results may not equal the sum of upstream and downstream results.
[5] It is assumed that there is substantial overlap in the OVCs served and the number of people on treatment from one fiscal year to the next. For this reason, cumulative totals are not present for the period between October 2003 and September 2005.

more effective combination regimens have now been developed which can reduce transmission from around 30% to as low as 2% in a non-breastfeeding population. The Emergency Plan has been working with countries to help them revise national guidelines to incorporate these more effective regimens and develop plans to scale up implementation in coming years.

Emergency Plan programs took the first step in addressing HIV/AIDS in environments where long-term ART was not available. These programs were also among the first to address the critical need to treat mothers and fathers who were sick with AIDS and needed long-term ART, as well as children who may have become infected in spite of short-course ARVs, in order to preserve families and prevent a generation from being orphaned.

PMTCT results to date are described in the chapter on Prevention. Beginning in fiscal year 2004, the first year of Emergency Plan implementation, emphasis was placed on supporting national strategies to expand PMTCT programs as well as ART for pregnant women and their families. This required strengthening health care systems, including infrastructure and human capacity, and improving monitoring of PMTCT programs. In fiscal year 2005, PEPFAR supported training for approximately 28,600 health care workers in PMTCT services, and provided support for approximately 2,500 PMTCT service sites in the focus countries.

Through September 2005, the Emergency Plan provided support for PMTCT services for approximately 3.2 million pregnant women, including over 1.9 million in fiscal year 2005 alone. Approximately 248,100 HIV-positive pregnant women in the focus countries have received short-course preventive ARVs, including 122,600 in fiscal year 2005.

Under internationally accepted standards for calculating infections averted, the Emergency Plan has supported

programs that have prevented the infection of approximately 47,100 estimated newborns, including approximately 23,400 in fiscal year 2005. In addition to short-course preventive ARVs, PEPFAR-supported PMTCT services include follow-up after birth to ensure that exposed children receive adequate diagnosis and treatment for opportunistic infections.

The Emergency Plan has continued to support countries in moving toward the routine offer of voluntary diagnostic HIV testing, sometimes called the "opt-out" approach, in PMTCT and other health care settings. Progress has also been made in increasing the proportion of women who receive their results through expanding rapid testing to many USG-supported PMTCT sites. As these approaches are scaled up, they will allow the Emergency Plan to reach many more women in future years.

Support for pediatric HIV diagnosis

The Emergency Plan is supporting host country efforts to make diagnostic tests more widely available, improve the capacity of laboratories, and ensure the availability of appropriate technologies for testing children. Efforts to expand a network of laboratory services to rapidly reach the largest possible number of children have initially emphasized development of national laboratory strategies, infrastructure renovations, training of personnel, and development of quality-assured laboratory services. Support has been, and continues to be, provided for these efforts in each of the focus countries.

The USG is supporting efforts to expand availability of polymerase chain reaction (PCR) tests, which can identify HIV-positive children before they are 18 months old and require less blood per test than older methods. In Namibia and other nations, the USG is pioneering the use of dried blood spot tests that can bring down costs and ease the burden of testing.

In addition, the Emergency Plan supports expanding information and training related to testing children and, where testing is not an option, improving clinical diagnosis based on symptoms. As with all Emergency Plan interventions, support is provided with an eye to long-term sustainability by developing local capacity and strengthening systems.

Support for pediatric HIV treatment

Because ARV doses are dependent on weight and other biologic factors that may differ for adults and children, pediatric ARV formulations are necessary, and the Emergency Plan is working to ensure their availability. As discussed in the chapter on Treatment, the USG has created an expedited review process for generic versions of ARVs, including pediatric formulations, and such products are being submitted for review and approval, providing additional sources of high-quality, inexpensive products. As of January 2006, four generic pediatric formulations had won approval or tentative approval from HHS/FDA and were thus available for use in Emergency Plan programs.

Children exposed to HIV or living with AIDS may require a broad range of additional health interventions. The Emergency Plan thus promotes a comprehensive package of other services to prevent infections that can lead to illness or death. This pediatric preventive care package includes life-saving interventions such as cotrimoxazole prophylaxis to prevent opportunistic infections and diarrheal disease; screening for tuberculosis and malaria; prevention of malaria using long-lasting insecticide-treated mosquito nets; and support for nutrition and safe water.

From the outset, the Emergency Plan has recognized the importance of supporting treatment for children and has required the dissaggregation of treatment data so that the number of children served can be determined. PEPFAR is the only major global HIV/AIDS program to require such reporting. Age-specific data are available only for programs for which the USG provides downstream support.

In fiscal year 2005, approximately 17,700 of 249,000 patients receiving ART with downstream PEPFAR support – or 7 percent – were children. This figure likely under represents the actual numbers, as there are a num-

One Young Woman's Story
Rwanda: "I Love Children" means support for a courageous child and her household

How can Marguerite Mukandayisenga, age 17, find the courage to smile, when her life has included such pain and loss? Over 50 family members, including her father, were killed during the Rwandan genocide of 1994. Marguerite and her mother were the only survivors. Her mother went on to have two more children, Maniriho (age 9) and Mushimimana (age 7), but no long term relationship developed with the fathers of the two boys. After the youngest was born, the children's mother became sick with AIDS. Marguerite left school to take care of her mother and run the house. The neighbors ostracized and isolated the family when they heard the news. Her mother joined an association of people living with HIV/AIDS that gave the family some financial assistance, but this support came to an end when she died in 2002. Marguerite became the head of the household, with no one to turn to for help.

Marguerite Mukandayisenga, 17, lives near Gitarama town, Rwanda, with her two brothers, age 9 and 7. She has cared for her brothers since her mother's death from AIDS, and has received assistance through the "I Love Children" program supported by the Emergency Plan.

Marguerite describes the loneliness she faced in the months following her mother's death. Neighbors forbid their children to visit the house. People refused to shake her hand and avoided being close to her. The house was in a terrible state, with a leaking roof and an insecure entrance. Marguerite's health started to deteriorate, with frequent bouts of diarrhea and malaria. Farming the small amount of land surrounding the house was a struggle, and there was never enough food to eat.

Two years ago, the situation changed. The Emergency Plan supported a partner in starting what is known in Kinyarwanda as the 'Nkundabana' (I love children) project, specially designed for child-headed households. Groups of child-headed households nominate a person from the community to be their supporter, known as the Nkundabana. Marguerite's group of houses nominated Pascasie Mukamusoni, who agreed to volunteer. Pascasie's role gives her prestige within the community and she is very proud of all the assistance she provides the children. She received training in HIV/AIDS, 'helpful active listening,' nutrition, and hygiene. She meets the children as a group once a week and visits their homes frequently.

On a visit to Marguerite's house, Pascasie proudly shows the improvements she has been able to make for the family. The project provided new doors, windows and a roof for the house, and Pascasie mobilized the local community to help install them. The children in other child-headed households were also mobilized to help.

With Pascasie's support, Marguerite found the courage to get tested for HIV and learned that she is HIV-positive. Three months ago she started to receive antiretroviral treatment, as well as treatment for tuberculosis and a prophylaxis for malaria. She is also receiving food on a monthly basis from the World Food Program. The Emergency Plan-supported project gave Marguerite a goat, and the manure it provides has resulted in a more productive garden. Her brothers are both going to school now and receive school uniforms and school supplies from the project. Marguerite herself finished literacy training, which qualifies her to start vocational training in tailoring. Marguerite is friends with the other children in her child-headed household association, and meets with them most days. They have created an income and loan club. Marguerite is very proud that she was able to borrow and repay a loan on a small initiative she had to sell vegetables.

As a friend appears through the door, Pascasie opens her arms to welcome her. Ernestine, 21, has been heading her own household for four years since her mother died. "Pascasie is like a mother to us, and without her we would be lost," says Ernestine, standing with her friend and her supporter, surrounded by a house full of life.

ber of sites that have not yet disaggregated patients by age.

Considering the constraints, these numbers represent important initial steps. There are still many more children who need help, and the USG plans to accelerate

progress in fiscal year 2006. Key initiatives include: establishing targets for children on treatment at the country level; working with international partners to ensure affordable pediatric ARV formulations and diagnostic techniques; training health care providers in pediatric treatment; and working at the community level to fight stigma and provide support to children and their caregivers.

Support for orphans and vulnerable children

Recognizing the central importance of preserving families, PEPFAR focuses on strengthening the capacity of families to identify, locate, protect, and care for OVCs by prolonging the lives of parents and caregivers. The Emergency Plan supports efforts – many by community- and faith-based organizations – to provide both immediate and long-term therapeutic and socioeconomic assistance to vulnerable households.

PEPFAR support for OVCs is discussed in detail in the chapter on Care. In fiscal year 2005, the Emergency Plan provided over $62 million in funding OVC activities in the focus countries, supporting care for over 1.2 million OVCs. Of these PEPFAR-supported children, over 815,000 received downstream support, while support for the remainder was provided through upstream PEPFAR contributions to national, regional, and/or local activities, such as training, systems strengthening, or policy development.

Care activities under the Emergency Plan emphasize strengthening communities to meet the needs of OVCs affected by HIV/AIDS, supporting community-based responses, helping children and adolescents meet their own needs, and creating a supportive social environment to ensure a sustainable response. The Emergency Plan supported training or retraining for approximately 74,800 individuals in caring for OVCs, promoting the use of time- and labor-saving technologies, supporting income-generating activities, 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, and the Emergency Plan supported 136 activities that included community-based initiatives for OVCs. PEPFAR activities seek to ensure OVC access to other essential services beyond traditional health partners and networks, reaching out to new partners to ensure a coordinated, multisectoral approach. Linkages have been established to basic care for physical survival (including health care and nutrition), economic support, education and vocational training, emotional support, and protection (including birth registration, inheritance protection, and protection from violence and exploitation). The Emergency Plan works with its governmental and nongovernmental partners to increase awareness, seeking to foster leadership that helps to create a supportive environment for OVCs.

Children are supplied with high protein energy supplements. These children are served by Community Care Coalitions, which also make monthly home visits throughout Chipata, Zambia.

Because OVCs are so numerous, the response must include the private sector and donors beyond the USG, and the Emergency Plan provides a vehicle for leveraging resources. While the Emergency Plan is focused on children orphaned and made vulnerable by AIDS, many nations have large numbers of orphans from other causes, and the Emergency Plan is working to foster comprehen-

One Young Man's Story
Botswana: Seychele, age 14

My mother died in 2002 when I was twelve years old and I was left under the care of my grandmother… While at school I was told that I was supposed to attend a five days life skill camp held at Maun Counseling Center on April 2003. Through the camp all the teachings came into my head and that was when I realized that these are the people I have been looking for. So I did not waste any time, during our tea break I contacted one of the counselors and he said he would help me. So I told him the story and went back. During the camp I learnt that "life does not go with the parent who passed away and one should face the fact that life is still there regardless of what might have happened and one should continue with life."

I also attended another camp in Toteng village in November 2004. From the camp I started teaching and telling those who were suffering from grief and loss that there is no giving up in life because you don't know what God's plans are, what might the future have for you... I want to learn and pursue my education without regret. I know I can stand in a gap for my peer age group. I have discovered (the) value of other people's life and I am willing to help my peers on overcoming issues of grief and loss of loved ones, vulnerability to HIV/AIDS, issues of stigma, career development and pursuit thereof, etc.

I am having big dreams for my future. I want to be someone who is helping his country and being someone who is important, trusted and honored by his own people.

sive responses at the community level. As donor commitment to OVCs grows, the U.S. has worked to bring stakeholders together under national OVC strategies, promoting coordination for effective delivery of resources.

Finally, the Emergency Plan seeks to ensure that governments protect the most vulnerable children through improved policy and legislation and by channeling resources to communities, particularly those with disproportionate numbers of OVCs with unmet therapeutic and service needs.

Future Directions

Despite encouraging progress, the challenges in meeting the needs of children at risk of, infected with, and affected by HIV/AIDS are significant. The Emergency Plan is taking steps on several fronts to address these challenges.

Incorporating a family-based approach and increasing the capacity of both adult treatment centers and maternal and child health programs to integrate pediatric HIV prevention, treatment and care is an important beginning. Stronger linkages among providers are key, as progress is made toward seamless PMTCT, treatment, care and community services for children and families.

Through supporting optimal infant feeding and nutrition, ensuring life-saving cotrimoxazole prophylaxis, and linking HIV infected children to core child survival interventions, PEPFAR will seek to ensure that as many as possible survive and can eventually access treatment.

A recently-created, interagency PMTCT/Pediatric AIDS Technical Working Group, drawing on leading USG experts in the area, has developed guidelines for focus countries for fiscal year 2006. These will help country teams to support high quality PMTCT and pediatric HIV programs by implementing more complex PMTCT regimens, improving the postnatal follow-up and diagnosis of infants, identifying treatment targets for children, systematizing infant and childhood HIV testing, and increasing access to treatment.

The Emergency Plan is working to improve assessment of the impact of ART on children and monitoring and evaluation of pediatric programs. Improving reporting of data by age will remain a high priority, and Country

Operational Plans for fiscal year 2006 allow for clearer attribution of which resources are devoted to pediatric programs.

Prevention

Given that PMTCT interventions can dramatically reduce rates of pediatric HIV, PEPFAR will continue to focus its efforts on scaling up high-quality PMTCT services. When one considers the complexity, difficulties, and costs involved in diagnosing and treating children with HIV, it is clear that providing universal access to quality PMTCT services is the most feasible long-term approach to mitigating the tremendous suffering that is being caused by pediatric HIV.

In this coming year PEPFAR efforts will focus on increasing the impact of PMTCT programs by continuing to scale up services, while actively assisting countries to implement the most effective interventions, including combination ARV prophylaxis regimens, rapid testing in antenatal clinics, and the routine offer of voluntary diagnostic HIV testing to all pregnant women (the "opt-out" approach).

Another key priority for PMTCT services is to improve postnatal follow-up of mothers and infants to prevent transmission through breastfeeding and ensure that mothers, fathers, and children enter into a long-term continuum of HIV treatment and care services after delivery. Stronger linkages to the larger health system are essential to ensure that HIV-exposed infants receive life-saving child survival interventions and mothers have access to family-planning services.

Treatment

As PMTCT services are scaled up, there is also an enormous need to scale up pediatric HIV treatment and care services. There are hundreds of thousands of children in immediate need of treatment services in the focus nations, and many of these children are exhibiting clinical symptoms of AIDS and can be rapidly identified through active case-finding in pediatric hospital wards and clinics.

Immediate efforts will focus on promoting active case-finding of such children, most of whom are older than two years and can be more easily diagnosed and treated than younger infants with currently available technology and pediatric formulations. At the same time, the Emergency Plan will continue to support development of systems to enable earlier diagnosis and the use of available clinical methods to diagnose HIV-infected infants.

Although PEPFAR is supporting rapid expansion of care and treatment for children, making liquid ARV formulations more widely available for young children who need treatment remains a high priority. Building on recent successes in this area, in 2006 the USG will work with other partners on this difficult issue. Ensuring that ARVs are available that are appropriate for children to take and easy for providers to dispense will also improve adherence to what will be a lifetime of treatment.

Care

An interagency Technical Working Group also guides PEPFAR efforts to meet the needs of OVCs. As the dramatic scale-up of OVC services takes place, ensuring that the services supported are of high quality is crucial. The Emergency Plan is working to identify and disseminate best practices based on age group, geographic location, gender, and degree of vulnerability.

Given that large-scale OVC programs are a relatively recent development, quality standards are still under development. The Emergency Plan will intensify efforts to develop consistent program indicators and improve monitoring and evaluation, and is supporting host nation partners in developing standard packages of services for OVCs.

Scaling up OVC support to meet the needs of the increasing number of children being affected by HIV/AIDS continues to be a major challenge, especially because many families in hard-hit communities are not in a position to take on additional children. Stigma and a lack of specialized expertise are also obstacles. The Emergency Plan is working through community- and faith-based organizations to bring best practices to scale.

Ensuring sustainability of care services for OVCs is another key challenge that PEPFAR is addressing by focusing resources at the community level. The Emergency Plan will also maintain its focus on improving coordination of care for OVCs at all levels: local, national, regional, and global.

A lab technician uses updated technology at the newly renovated National Blood Transfusion Center in Guyana, which was constructed and equipped with Emergency Plan support.

> "This effort is succeeding because America is providing resources and Africans are providing leadership. Local health officials set the strategy and we're supporting them."
>
> President George W. Bush
> June 30, 2005

Chapter 6
Building Capacity for Sustainability

The tragic reality is that the fight against HIV/AIDS in hard-hit nations will have to continue for the long term. This fight will only be sustainable if it is owned by the people of each country. In many nations, this will require an increase in response of a magnitude that can best be described as a transformation. The primary responsibility for achieving such dramatic change ultimately rests with the leadership and citizens of developing nations themselves. The U.S. Government (USG) and other international partners can play a vital and catalytic role, but outside resources for HIV/AIDS and other development efforts must be focused on transformational initiatives that are owned by host nations.

Local civil society organizations – including nongovernmental organizations (NGOs), faith-based organizations, community-based organizations, and the private sector – are crucial for this development, and are well-placed to identify the needs of their own country and devise strategies for meeting them. In addition to working with governments, the Emergency Plan thus focuses on supporting grassroots organizations, prioritizing funding to develop their capacity. A commitment to local ownership is

Human Resource Capacity Building

Results

In fiscal year 2005, the Emergency Plan supported training or retraining for more than 536,000 service providers (with individuals being trained in multiple areas in certain cases) and supported 14,960 service sites in the focus countries, including:

- Support for training of 267,600 individuals in prevention of sexual transmission
- Support for training of 28,600 individuals in prevention of mother-to-child transmission and 2,500 service sites
- Support for training of 20,300 individuals in prevention of medical transmission and 600 service outlets that carry out blood safety activities
- Support for training of 36,500 individuals to support antiretroviral treatment and 800 treatment sites
- Support for training of 74,800 individuals to care for orphans and vulnerable children
- Support for training of 86,300 individuals to care for HIV-positive people and 6,800 service sites
- Support for training of 22,200 individuals to provide counseling and testing (in addition to those trained in prevention of mother-to-child transmission) and 4,160 service sites

the basis for PEPFAR's focus on working with host nations and supporting their strategies to bring comprehensive national responses to scale.

At this point, international NGOs are indispensable partners in PEPFAR implementation, and there will always be more work to do in resource-poor settings. Yet we must support the building of sustainable, country-owned programs. Therefore, grant language for international NGO partners will require them to take steps to build local capacity, and the Emergency Plan will begin to require such partners to develop "exit strategies" – plans for reducing their own role and devolving responsibility to local people and organizations on a reasonable timeframe.

Review of annual Country Operational Plans (COPs) includes an evaluation of efforts to increase the number of indigenous organizations partnering with the Emergency Plan. This emphasis has led to impressive results: in fiscal year 2005, approximately 82 percent of Emergency Plan partners were local organizations. The progression toward reliance on local organizations, while challenging, is essential for PEPFAR to fulfill its promise to help host nations develop sustainable responses. As another step in the direction of sustainability, COPs for fiscal year 2006 were required to devote no more than 10% of funding to a single partner (with exceptions made for host government partners, commodity procurement, and "umbrella contractors" for smaller organizations). This requirement will help to expand and diversify PEPFAR's base of partners and facilitate efforts to reach out to new partners, particularly local partners – a key to sustainability.

Alongside efforts to support community capacity-building, enhancing the capacity of health care and other systems is also crucial for sustainability. Among the obstacles to these efforts in many nations are inadequate human resources and capacity, limited institutional capacity, and systemic weaknesses in such areas as: quality assurance; financial management and accounting; health networks and infrastructure; and commodity distribution and control. The Emergency Plan is intensively supporting national strategies to strengthen these critical systems. Across the focus countries in fiscal year 2005, partners reported that approximately 25 percent of activities had components that directly support health network development. Because building capacity goes hand-in-hand with expanding services, the previous chapters on Prevention, Treatment, and Care also summarize Emergency Plan efforts to ensure sustainability.

Financial capacity is another key issue. The capacity of host nations to finance HIV/AIDS efforts on the scale required varies widely. Many deeply impoverished nations are many years from being able to mount comprehensive programs with their own resources alone. Yet it is essential that these countries appropriately prioritize HIV/AIDS and do what they can to fight the disease with locally available resources, including financial resources. A growing number are doing so. Many other nations do have significant resources, and are in a position to finance much of their own HIV/AIDS responses. A growing number of these nations, also, are investing in fighting the disease on a scale commensurate with their financial capacity. In some cases, for example, host nations are procuring all or a portion of their own antiretroviral drugs (ARVs), while PEPFAR provides support for other aspects of quality treatment. Such developments within hard-hit nations are very positive for building sustainability in each country's fight against HIV/AIDS.

While HIV/AIDS is unmistakably the focus of PEPFAR, the initiative's support for capacity-building has important spillover effects that assist nations' broader efforts for sustainable development. Organizations whose capacity is expanded in order to meet USG fiduciary accountability requirements are also in an improved position to apply for funding for other activities or from other sources. Expanded health system capacity improves responses for diseases other than HIV/AIDS. Supply chain management capacity building improves procurement for health commodities generally. Improving the capacity to report on results fosters accountability, supporting the development of good governance and democracy. In a variety of ways, the Emergency Plan supports host nations in identifying their needs and in building the tools to address them in the future.

Building sustainable institutional capacity

Because of the intensive focus of the President's Emergency Plan on sustainability, many activities are intended to build the institutional capacity of local organizations to plan, implement, and manage HIV/AIDS programs. The Emergency Plan recognizes that all sectors of society, including governments, civil society institutions, and the private sector, must be involved.

The fiduciary accountability of local organizations is crucial to the Emergency Plan's effort to build capacity – and the Emergency Plan has made a major effort to provide technical assistance to partners in this area. An 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 USG. In fiscal year 2005, several focus countries used local "umbrella contractors," including those that serve as local fiduciary agents for the Global Fund to Fight AIDS, Tuberculosis and Malaria. The resources of the Twinning Center, described below, were also used to strengthen capacity in these areas.

The Emergency Plan has also begun to gather data in COPs and through results reporting on capacity-building. USG partner agencies are instructed to review partner performance in strengthening indigenous organizations as part of portfolio reviews conducted in the field, and the Emergency Plan will conduct a cross-country assessment of partner performance in this area to identify best practices and tools for measuring success. As noted above, in fiscal year 2006, in-country teams will devote no more than 10 percent of resources to a single partner unless one of several specified exceptions is satisfied, helping to broaden PEPFAR's partner base.

Host governments

The organizing structure, management, coordination, and leadership provided by capable, committed host governments are essential to an effective, efficient HIV/AIDS response. Without commitment from government, parallel service delivery systems – usually dependent on large international NGOs – dominate a country's response. This model puts host nations at the mercy of continued funding, and continued management, by outsiders – the antithesis of sustainability.

Strengthening the institutional capacity of host governments and national systems is thus a fundamental strategy of the Emergency Plan. As a result, more than 20 percent of Emergency Plan partners in fiscal year 2005 were host government entities, including ministries of health (MOHs) 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 countries, U.S. personnel are located in, or detailed to, MOHs. In others, PEPFAR has supported MOH personnel retention schemes or contractual staffing arrangements, bolstering the number of health professionals working in the public sector and in rural areas. This supports national health system development in the face of the dramatic human resource crises these countries are facing. In Namibia, for example, the USG partners with Potentia, a private sector Namibian personnel agency, to support doctors, nurses and pharmacists for public hospitals, at the same salaries as government workers, thus supporting needed staff positions in an equitable fashion. The Kenyan Medical Research Institute uses PEPFAR funds to actively train and support 260 healthcare workers who provide such services as: technical assistance; personnel support to improve laboratory capacity; support for adherence to counseling; and assistance with monitoring and reporting on the progress of antiretroviral treatment (ART) regimens.

Local civil society organizations

Local community- and faith-based organizations also play critical roles as first responders to community needs, and often have access to hard-to-reach or underserved populations, such as orphans and people living with HIV/AIDS (PLWHA) in urban slums or remote rural areas. When trained in program management and HIV/AIDS best practices, these groups often design the most culturally appropriate and responsive interventions. They often have the legitimacy and authority to imple-

The HIV/AIDS Twinning Center

To assist nations' efforts to develop local capacity for sustainability, the Emergency Plan has supported establishment of the HIV/AIDS Twinning Center by HHS/HRSA. The Center is helping to strengthen human and organizational capacity by using health care volunteers and twinning relationships between similar organizations. These relationships facilitate skills transfer and can rapidly expand the pool of trained providers, managers, and allied health staff delivering quality HIV/AIDS services.

Twinning partnerships are typically formed between a U.S. partner and a country partner, but eligible participants may be U.S.-based, regional or local. Eligible entities include government agencies; schools of medicine, nursing, public health, management, and public administration; health sciences centers; community- and faith-based organizations; and third party country governments or organizations with cultural or linguistic ties to host nations.

The Twinning Center also oversees the new Volunteer Health-Care Corps, a network of health care volunteers, HIV/AIDS professionals, and support personnel who will be placed within the twinning partnerships. They will assist partners with clinical, educational, and capacity-building services without interrupting ongoing efforts.

ment successful programs that deal with sensitive subjects. In many focus countries, more than 80 percent of citizens participate in religious institutions, and upwards of 50 percent of health services are provided through faith-based institutions, making them crucial delivery points for HIV/AIDS information and services. The Emergency Plan thus recognizes the value faith-based organizations can add to HIV/AIDS efforts. In fiscal year 2005, approximately 25 percent of all Emergency Plan focus nation partners were faith-based.

In addition, local civil society organizations play a key role in organizing citizens to work in effective partnership with their governments. Organizations of people living with HIV/AIDS are among the key community-based groups that have been integrated into the Emergency Plan. PEPFAR has also launched pilot programs in multiple countries that allow 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. One example of PEPFAR's impact comes from Côte d'Ivoire, where despite a fragile political environment, the Emergency Plan has worked with community leaders to create a local organization which has now become a PEPFAR partner, while also making grants to smaller community-based entities.

The private sector

The nations where the Emergency Plan is at work have private sectors in a wide variety of stages of development. In many of the nations of sub-Saharan Africa, the private sector remains small, while in such nations as India, China, and South Africa, it is large and growing. Every nation does have a business community on some scale, however, and in every nation businesses have special contributions to make to the national HIV/AIDS response. PEPFAR considers expanding its support for public-private partnerships a priority area for fiscal year 2006. Key strengths businesses can bring to the fight include:

- Leveraging products, expertise and core competencies
- Educating employees and surrounding communities on HIV/AIDS prevention
- Making voluntary, confidential HIV counseling and testing available
- Supporting lifesaving ART
- Combating stigma and advocating for people living with HIV/AIDS
- Adopting company-wide polices to protect against HIV/AIDS discrimination
- Forming strategic partnerships with governments and civil society to address the needs of the broader community

Best Practices
The African Palliative Care Association: Improving quality of life for people living with HIV/AIDS across Africa

Supporting indigenous organizations in building their capacity is a key element of PEPFAR's focus on sustainability. Three months after its 2004 inaugural meeting in Arusha, Tanzania, the African Palliative Care Association (APCA) received $250,000 in Emergency Plan funding to support the expansion of palliative care for PLWHA in African focus countries. At that time, APCA was a nascent, indigenous pan-African association in the formative stages of organizational development. APCA aims to support the expansion of affordable and culturally-appropriate palliative care, helping to realize the Emergency Plan vision of a holistic approach to relieve physical, emotional and practical suffering of people living with HIV/AIDS (PLWHA). With PEPFAR support, APCA established headquarters in Kampala, Uganda and supported scale-up of local and national palliative care associations and programs across Africa. APCA mobilized its Advisory Committees to provide technical assistance and training in various countries.

The Emergency Plan supported APCA in providing institutional development to national palliative care associations in Zambia, Tanzania and Kenya. The Palliative Care Association of Zambia (PCAZ), for example, entered into a twinning partnership with APCA through PEPFAR's HIV/AIDS Twinning Center. Through the partnership's work, PCAZ established its office and work plan, and put plans in motion to hold a national stakeholders meeting and train-the-trainer program to advance Zambian palliative care goals.

For over three years the Government of Botswana sought training from palliative care experts in other African countries to integrate palliative approaches (such as pain and symptom management, holistic care, antiretroviral treatment (ART) support, and bereavement care) into their national community home-based care training program. With Emergency Plan support, APCA developed the training program in partnership with the government, and almost 200 health professionals and community home-based care coordinators were trained in palliative care in 2005. The Honorable Minister of Health, Professor Sheila Dinotshue Tlou, launched the training event.

In April 2005, APCA brought together African stakeholders and health providers from 10 of the 12 African focus countries to develop a strategy that would build donor relations and develop key palliative care policies across Africa. The workshop emphasized priorities set forth by the World Health Organization to advance palliative care, including expanded palliative care drug access, policy development, and training and education. With this support, African stakeholders and providers are now able to more effectively leverage other support and address key policy gaps in their countries. This includes appropriate symptom management for PLWHA who are on ART and pain management for PLWHA during the end-of-life stage of the disease.

Finally, as a direct result of the initial Emergency Fund support to build APCA's indigenous infrastructure, APCA has successfully leveraged $1.2 million in funding from other international partners, helping to ensure the sustainability of its valuable work.

The New Partners Initiative

On World AIDS Day, December 1, 2005, President Bush announced that the Emergency Plan will provide $200 million for grants to new partners to provide HIV/AIDS prevention and care services – the New Partners Initiative (NPI).

The need for new partners

Today, many organizations have the capability to reach people who need HIV/AIDS services, but lack experience in working with the USG and its processes. Community and faith-based organizations, in particular, represent vital but underutilized resources. Many such organizations are well-established within communities and well-placed to reach out to those infected and affected by HIV/AIDS.

Building the capacity of organizations at the community level also helps to build local ownership of HIV/AIDS responses for the long term. In some countries, such organizations provide as much as 40-50 percent of all care for people living with HIV/AIDS – with little support from the USG. In some cases, existing U.S.-based organizations can serve as a "bridge" due to their relationships with these entities in host countries.

NPI goals

The Emergency Plan will reach out to organizations through NPI, working to enable them to become new partners. The goals of the initiative are to:

Increase the Emergency Plan's ability to **reach** people with needed services:

- Identify potential new Emergency Plan partner organizations
- Increase their capacity to provide prevention and care services
- Increase the total number of Emergency Plan partners

Build **capacity** in host nations:

- Develop indigenous capacity to address HIV/AIDS to promote the sustainability of host nations' efforts

How the NPI will work

Competitive grants: NPI will include a competitive process for $200 million through fiscal year 2008 in grants to provide HIV/AIDS prevention and care services. Eligible entities are nongovernmental organizations, working in any of the fifteen Emergency Plan focus countries, with little or no experience working with the USG – defined as no more than $5 million in USG funding during the preceding five years, excluding disaster or emergency assistance or funding as a subcontractor.

Leadership: NPI will be led by the U.S. Global AIDS Coordinator, assisted by an interagency USG Executive Committee with representation from Emergency Plan in-country teams. The Coordinator will set and approve policies and direction for NPI and will appoint a New Partnerships Director, who will manage the program.

Partner outreach: Initial inventories of potential participants already working in affected countries will be conducted in order to shape outreach strategies. Regional bidders' conferences, held in the U.S. and abroad, will be offered. The first U.S. conferences will take place from January through April of 2006 in Philadelphia, Atlanta, Denver, and Los Angeles.

Pre-competition assistance: NPI will offer technical and capacity-building assistance to participants to help them compete now and in the future – both within the NPI grant process and in other competitions. Technical assistance will focus on topics such as: initial needs assessment; proposal writing; pre-award audits; personnel recruitment; competition processes; and monitoring and evaluation planning.

Post-award capacity-building assistance: NPI will offer assistance to successful applicants, focusing on: successful program implementation; needs analysis; and organizational growth and strengthening.

Best Practices
Côte d'Ivoire: A company reaches out to its employees – and its community

In late 2004, the Ivoirian Ministry of Health received an urgent call from Bardot, one of West Africa's largest slums and an international melting pot, in the port city of San Pedro. SOGB, a rubber company, was losing too many of its workers and their family members to AIDS, and company officials were looking for help. The Ministry's National HIV Care Program (PNPEC) conducted a site visit in April 2005 to assess the situation, setting in motion a PEPFAR-supported public-private partnership that now provides free HIV prevention, care, and treatment services for SOGB employees as well as the underserved surrounding community.

Company and local health authorities in the region developed a global action plan, and PEPFAR funded training of a physician and a laboratory technician at SOGB's medical facility. The company-owned health center is now open to the community and provides services free of charge. Further demonstrating its willingness to establish a strong and collaborative public-private partnership, SOGB provides laboratory services such as free hematological exams to all patients, including those coming from the public sector. The Emergency Plan also supports equipment for biochemistry and CD-4 counts for clients at the company's health center.

The 30-year-old physician at the company health center has a deep understanding of the family approach to HIV care and is committed to providing a comprehensive package of services to HIV-infected clients and their families. He participates regularly in weekly antiretroviral treatment (ART) prescription meetings. In accordance with national policy, the drugs are provided free to patients employed by the company. In August and September 2005, 44 patients started ART at the company health center, making up about 20% of all patients on ART in the region. During a supervisory visit, the physician reported that company officials are so enthusiastic about the program that they want to add a prevention of mother-to-child transmission program.

Through its leadership, SOGB has generated interest in extending the program among other major private companies, including San Pedro's sea port, which employs more than 3,000 people.

The Emergency Plan is working in partnership with a growing number of local businesses, helping them to grow their capacity to meet the needs of their employees and their families, as well as the larger communities of which they are a part. In South Africa, for example, the large mining company Anglo American is a PEPFAR partner, reaching out to the community with effective programs and building the nation's capacity to address HIV/AIDS.

Building Human Resources and Capacity

Quality and sustainability in HIV/AIDS prevention, treatment, and care begin with people – but under-resourced nations typically lack the trained health workforces to meet their desperate needs. 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.

Ministries of health throughout Africa are recognizing the importance of building their capacity in human resources management and human capacity development. The Emergency Plan, along with other international partners such as the Global Fund and the World Bank, is working with host governments to support these institutions, many of which suffer from severe shortages of staff. In Rwanda, the MOH requested that the USG fund and mentor a human resources for health (HRH)

specialist within the MOH. She has offered strong leadership and has made a significant difference on several important HRH initiatives, such as:

- Advising on recruitment criteria and contributing to plans for a staff appraisal system
- Preparation and presentation of a draft HRH policy for an interagency HRH technical working group
- Development of human resources strategic plan
- Identifying the need for and guiding the development of an HRH information database
- Arranging 32 postgraduate scholarships for Rwandan health professionals

This model of supporting the human resource planning and management functions within the MOH is currently being considered for other countries.

Training networks

Many nations have policies that mandate that only health professionals can provide health services – creating access constraints in under-resourced settings. The Emergency Plan supports efforts to train individuals to provide services at the hospital, clinic, community, and home levels, helping expand the reach of a limited pool of trained professionals such as doctors and nurses. Collaboration with the International Training and Education Center on HIV (I-TECH), active in Africa, East Asia, India, and the Caribbean, is a key part of efforts to develop highly trained HIV/AIDS educators, providers, and managers. PEPFAR and I-TECH collaborate on a Nursing Initiative, for example, which includes training of nurse trainers, development of curricula, and leadership and advocacy training. The Emergency Plan also supports training of home health aides to perform routine follow-up and patient counseling for adherence to drug regimens.

PEPFAR has developed a prevention of mother-to-child transmission (PMTCT) Generic Training Package in collaboration with the World Health Organization (WHO), building provider capacity and collaborative partnerships within countries. The Emergency Plan has sought to anchor the training in advanced centers to ensure quality, while also developing tools to assess the quality of the training. One example of a training assessment tool is the Instructional Design and Materials Evaluation Form. This research and evaluation tool evaluates and scores curricula in terms of instructional design elements, content review, and evaluation methodology. USG training efforts are directed not only at expanding clinical capacity, but at developing the pool of trained managerial personnel. These non-clinical staff are a key element of effective health networks, which foster quality programs. The Emergency Plan has made on-the-job HIV/AIDS training for health care workers a priority, in order to avoid the disruption to care that can occur with off-site training.

To reach prevention, treatment, and care goals, and to provide services equitably, networks must reach to the community level, often in rural areas that are not appealing places to live for many health care professionals. The Emergency Plan now supported a successful government project in Namibia to provide incentives to health professionals to locate to underserved rural areas. In Zambia, the Emergency Plan is supporting placement of 35 physicians in rural areas to help scale up treatment into these areas.

PEPFAR capacity-building activities integrate groups of PLWHA, training members to provide patient education, adherence counseling, and patient follow-up. This frees clinical staff to serve more specialized needs while helping to combat HIV/AIDS-related stigma.

Access to health professionals and "brain drain"

Shortages of physicians and other health professionals in the developing world remain a major challenge not only for HIV/AIDS efforts, but for all health care delivery. Root causes of limited human capacity include the toll of HIV/AIDS on providers, shortfalls in pre-service academic training, both in availability of professional education and accessibility of HIV/AIDS curricula within professional schools. The Emergency Plan supports the development and implementation of curricula in pre-

Best Practices
Namibia: Counselors from the community help meet the needs of the community

Namibia is one of few countries in Africa utilizing community or lay counselors for counseling and performance of rapid testing in public health facilities. The Ministry of Health and Social Services, in collaboration with the Emergency Plan, introduced the community counselors program in May 2005 to increase capacity to provide counseling and testing services and enhance the effectiveness of prevention of mother-to-child transmission (PMTCT) and antiretroviral treatment (ART) services.

Taimi Monica Nyangele (right), a community counselor in a Namibian Ministry of Health facility, receives training in rapid testing from Helena Hidenywa, a nurse.

Quality counseling and testing is a cornerstone for the success of PMTCT, ART and other services. Yet due to a lack of human resources capacity, quality services had been limited in Namibian public health facilities, with healthcare workers unable to cope with the high demand. Community counselors, selected from the community by health workers, fill this crucial gap in human resources by assisting over-burdened health workers with counseling and testing and a wide range of other activities.

The program grew from 24 counselors in May to 112 counselors, providing services in 45 public health facilities, in September 2005. The counselors are recruited and trained rigorously for twelve weeks before deployment to public health care facilities, and they work under close supervision from health care providers in charge of clinics. In just these initial few months, the initial counselors provided pre-test counseling to 11,474 clients and post-test counseling to 9,540, reflecting the important gap in the clinical setting that these counselors are filling.

In July 2005, the Ministry officially launched rapid HIV testing in public health facilities. Community counselors have been trained in rapid diagnostic test techniques by laboratory scientists at the Namibia Institute of Pathology (NIP). More than 95 % of deployed counselors have passed the rapid HIV testing examination and have been certified to perform the tests. This is a major accomplishment, considering that rapid testing is typically conducted by NIP laboratory scientists and the average community counselor has only a junior or senior secondary level of schooling. Community counselors provide an affordable ($200 per month) and effective resource appropriate to the needs of Namibian communities.

service settings and pre-service training for key health care professionals. Because HIV infection and stigma also contribute to limiting the number of clinical providers, prevention activities and leadership to combat stigma play important – but often overlooked – roles in addressing human capacity shortfalls.

The "brain drain" of trained health professionals from their home countries to wealthier nations continues to inflict a devastating toll on health systems in many countries with major HIV/AIDS burdens. Brain drain within countries, particularly from ministries of health to large international NGOs, is also a major issue. It should be noted, however, that recent discussions and data have questioned the impact of brain drain on systems in resource-poor settings. In Kenya, data suggest that limited nursing staff might be due primarily to nurses dying, presumably in large part from HIV/AIDS, rather than brain drain.

The Emergency Plan supports innovative programs in this area. Kenya, like many sub-Saharan countries, faces a human resources crisis due to lack of health care providers able to deliver treatment and care in high need areas. With PEPFAR support, the USAID-implemented Capacity Project is working with health sector leaders to refine and operationalize an emergency hiring plan that takes advantage of the country's surplus of unemployed nurses, physicians and other providers. The plan creates a non-governmental outsourcing mechanism to quickly hire, train and deploy 800 providers in public-sector health centers within a year's time. This plan has been approved and endorsed by the MOH. To keep physicians from leaving Zambia, the Emergency Plan is supporting hardship and housing allowances as an incentive to keep doctors in the country and in rural areas. Efforts to strengthen health care systems, discussed below, also play a key role in helping to keep qualified health professionals from leaving for other countries.

Strengthening Essential Health Care Systems

In most of the resource-poor countries served by the Emergency Plan, achieving the Plan's vision of a high-quality, sustainable HIV/AIDS response requires implementing and strengthening essential systems, including clinical quality assurance systems; health care networks, including infrastructure; and commodity procurement, distribution, and management systems. One critical area of PEPFAR work with host nations is development of surveillance and monitoring and evaluation capacity, including training of host government staff to carry out surveillance activities, analyze data, and report results to key stakeholders. These activities are discussed in the chapter on Improving Accountability and Programming.

Clinical quality assurance

The President's Emergency Plan reflects a belief that people in the developing world deserve HIV/AIDS prevention, treatment, and care services that are of high quality. In all of its clinical capacity-building work, PEPFAR seeks to support host nations as they expand their capacity to ensure quality.

Quality assurance capacity-building activities include support for monitoring and evaluating programmatic indicators, on-site supervision systems, and district, national, and international reviews. The Emergency Plan supports programs to adapt quality improvement approaches to the needs of developing countries. For example, the Quality Assurance and Workforce Development Project implemented by USAID uses a collaborative approach in which teams of providers have documented improvements in the quality of prevention, care and treatment services. These teams may bring counselors, clinicians, laboratorians, and pharmacists together to discuss difficult cases and recommend courses of action, such as helping to oversee changes to costly second line therapies. The providers work in tandem with community volunteers who help people living with HIV/AIDS to access appropriate services and develop self care skills.

Innovative means for information dissemination to improve clinical management also receive PEPFAR support. The Emergency Plan is supporting the updating and dissemination of HIV clinical care data management software (CAREWare), originally developed by HHS/HRSA for use in the U.S. The software promotes quality care by providing a clear, customizable, user-friendly, and confidential platform for entering, collecting, and reporting demographic, service, and extensive clinical information. An international version has been developed and implemented with PEPFAR support in Uganda, Zambia, Kenya, Tanzania, and Nigeria, with plans for adoption in Vietnam and Thailand. Clinical guides that have been made available both in hard copy and on CD-ROM include:

- A Guide to the Clinical Care of Women with HIV
- A Clinical Guide to Supportive and Palliative Care for People with HIV/AIDS
- A Guide to Primary Care of People with HIV/AIDS

The HIVQUAL software program is another tool currently in use in some PEPFAR host nations, such as in Rwanda's ART quality program. To facilitate quality improvement, HIVQUAL helps participants measure key indicators and use these measurements to benchmark

and make progress in working toward objectives. The software currently measures the following indicators: HIV staging, ART management, opportunistic infections prophylaxis, gynecologic care, tuberculosis and substance use screening, treatment adherence, specialty referrals, patient education, and access to expert HIV care. For further information, see the chapter on Treatment.

Health care network and infrastructure development

The HIV/AIDS epidemic has placed a huge burden on the health care systems of many high-prevalence countries. Major disparities often exist between urban and rural health services, with a concentration of health professionals and institutions in the major cities. The Emergency Plan is supporting host nations in meeting the demand for services by rapidly expanding existing indigenous health networks. This includes supporting linkages and coordination between central health facilities and outlying health clinics, including those in rural areas, to deliver quality HIV/AIDS services.

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. Pfizer's Global Health Fellows program, for example loans personnel worldwide to governmental and nongovernmental organizations. Historically, Pfizer loaned medical personnel; now, complementing the Emergency Plan, Pfizer also loans financial and organizational management experts that support partner NGOs and MOHs to strengthen health systems. As a result of Pfizer loaning a fellow with an expertise in financial management to the Mothers to Mothers-to-Be Program (M2M2B) in Cape Town, South Africa, the program has been able to start new sites and plan for even more, expanding HIV-positive mothers' access to services.

Common infrastructure obstacles to national responses 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. Flexible computer-based data systems can help host nations to classify, store, and analyze scientific information, allowing them to set national priorities, make important decisions on resource allocation, and monitor program activities.

In support of national strategies and Emergency Plan goals, PEPFAR is addressing these barriers by supporting such activities as renovation of existing health facilities; procurement of equipment, supplies, furniture, and vehi-

Best Practices
Developing a training package for HIV rapid tests

To meet the growing demand for a well-trained and competent workforce to perform rapid HIV tests, the USG worked with the World Health Organization to develop the HIV Rapid Testing Training Package. The package includes a training video/DVD, presentations slides, a trainer's guide, and a manual for participants. All training package materials are available in English and plans are under way to make them available in Spanish, French and Portuguese. The training package also provides flexibility for meeting specific country requirements.

Lab technicians work with HIV rapid tests.

Best Practices
Ethiopia: Talkline – A lifeline for people concerned about HIV/AIDS

In countries where health care infrastructure is scarce, creative steps for addressing HIV/AIDS can be critical. With support from PEPFAR, in March 2005, Ethiopia's first national, toll-free number, the Wegen HIV/AIDS Talkline, was officially activated to support the united HIV/AIDS response. The service reported that 363,970 callers from all over Ethiopia utilized it within its first nine months, of whom 11 percent sought and received counseling, 84 percent information, and 5 percent referral to clinical, psychological, financial and social support services.

Talkline provides a confidential and accessible avenue for up-to-date and accurate information and services to reach the general population, including those infected with and affected by HIV. Callers now have access to information on HIV/AIDS prevention, treatment and care, sexually transmitted infections, and tuberculosis. In many cases, this is their only reliable means for information or discussing sensitive, personal issues in a confidential manner.

A 27 year-old HIV-positive male in a rural location far from Addis Ababa has called Talkline regularly. It has been three years since the client discovered his HIV-positive status, but he has struggled to come to terms with it. He had declined to access other HIV services because he feared people would stigmatize him. Over the course of numerous calls to Talkline, the client developed a trusting relationship with a counselor, who provided clear and practical information on living with HIV/AIDS and eventually referred him to HIV services in the medical system. The client continues to rely on his counselor for psychosocial support and is preparing to initiate antiretroviral treatment – something that would likely not have happened if Talkline had not been there for him.

cles; improvement of information systems; and financing as needed for expanded HIV/AIDS service delivery under the Emergency Plan.

Laboratory support

A good laboratory network is a cornerstone of a strong response to HIV/AIDS. Without laboratory support, it is very difficult to diagnose HIV infection and provide quality care and treatment for PLWHA. In most Emergency Plan 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 to strengthen the capacity of all focus countries to diagnose HIV and related infections. This is allowing growing numbers of people to learn their HIV infection status, and allowing physicians to reliably determine which patients will benefit from HIV treatment and to monitor the success of that therapy.

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, as described in the Care chapter. Rapid HIV tests are especially important in peripheral testing sites, far from fully equipped laboratories. Emergency Plan personnel have prepared a training package on Rapid HIV Testing. They have participated in training of trainers and other staff to ensure that trained manpower will be available for conducting such testing at PMTCT and other counseling and testing sites. Similar training packages for hematology, chemistry and CD-4 testing are being prepared that can be used by national personnel for future training.

Emergency Plan staff have been involved in supporting countries and collaborating agencies in the important task of evaluating rapid HIV test algorithms for use in-country. This ensures that counseling and testing programs use the proper tests to identify people living with HIV/AIDS. The Emergency Plan is devoting consider-

able resources to building capacity in a National Reference Laboratory (NRL) in each country. As the apex of a laboratory network, NRLs have an important responsibility to supervise and train personnel in other laboratory sites within a country. The NRL is also responsible for quality assurance for laboratory testing.

Incidence testing provides countries with the best data on where recent transmission has occurred. This information is essential for planning effective prevention programs and for measuring the success of programs in achieving the PEPFAR prevention goal. Emergency Plan teams have provided in-country/regional training on incidence testing in Ethiopia, Rwanda, South Africa and Vietnam. Training in China and an Asia regional workshop are planned.

As discussed in the chapters on Children and Treatment, diagnosis of HIV infection in newborns is technically complicated and costly. Laboratories providing such testing are usually not located near PMTCT sites. In an effort to expand access to vital infant testing, Emergency Plan staff have trained local staff in the use of dried blood spots (DBS). This allows for the ready transport of specimens to central or provincial laboratories where testing is available.

CD-4 testing is necessary for determining the level of immunosuppression in HIV infection. It is an important adjunct for determining when to initiate treatment and for monitoring response to treatment. Emergency Plan staff have been involved in the evaluation of lower cost and simpler assays for measuring CD-4 cells. Training has been provided in conjunction with partners in Ethiopia, Tanzania, Côte d'Ivoire, Tanzania, and Malawi.

As more individuals are treated the issue of resistance to ARVs will become more prominent. PEPFAR country teams are working with host nations to develop national or regional programs to conduct population-based resistance testing for monitoring resistance within a country. These will also use DBS for specimen collection and transport to laboratories.

Laboratory quality assurance is critical in assuring accurate diagnosis of HIV infection, determining when to start treatment, and for monitoring while on treatment. The Emergency Plan has supported extensive training of in-county staff on building and sustaining quality laboratory systems and is helping to establish proficiency testing programs for laboratory testing in such areas as hematology, chemistry, CD-4 testing, and infant diagnosis. This will build confidence in the ability of the laboratories to support the HIV programs, as well as sexually transmitted infection (STI) and TB programs. The USG will also assist in the development of laboratory certification programs in each country.

Commodity procurement: the Partnership for Supply Chain Management

Comprehensive HIV/AIDS programs that are sustained for the long term require a continuous inflow of high-quality medicines and supplies. In concert with in-country partners, the U.S. Government is supporting host nations to build the necessary infrastructure to fight the global pandemic of HIV/AIDS. The Partnership for Supply Chain Management (the Partnership), established in fiscal year 2005, will strengthen systems to deliver an uninterrupted supply of high-quality, low-cost products that will flow through a transparent, accountable system.

Participation in the Partnership is voluntary and services can be selectively utilized depending on the needs of the country and program. In those countries where existing supply chains are working well, the Partnership will be available as an option to "fill in the gaps" and monitor key steps in the supply chain process. Among the menu of services the Partnership will make available are commodity quantification, procurement, and shipping and delivery to points of service. The Partnership consortium will help deliver essential lifesaving medicines to the front lines of Emergency Plan joint efforts with host nations. The Partnership will ensure a healthy, robust lifeline of continuous drugs and supplies that are safe, secure, reliable and sustainable, and will offer the possibility of cost efficiencies. It will also allow reliable forecasting of need to ensure adequate production.

Its activities will include supporting the purchase of life-saving antiretroviral drugs (including low-cost generic ARVs approved or tentatively approved by HHS/FDA); drugs for opportunistic infections such as tuberculosis; quality laboratory materials such as rapid test kits; and supplies like gowns, gloves, injection equipment, cleaning and sterilization items.

Based on the winning proposal, the contract funds up to $77 million in system operating expenses and technical assistance over the first three years. The drugs and supplies handled by the system could total $500 million or more over that same period. The contract will be responsive to requests from countries and programs in the field and will be adjusted accordingly.

Under the President's Emergency Plan, the Partnership will not build parallel systems; it will be additive and complementary to existing supply chain efforts in the field. It is intended to "fill in the gaps" where supply chain services are needed the most. It will:

- Develop and maintain a competitive and transparent procurement system, including forecasting future need and leveraging volume purchasing to achieve significant reductions in the current costs of commodities
- Establish a quality assurance plan to manage documentation and ensure quality of commodities
- Provide freight forwarding and warehousing services to facilitate consolidation and shipping from manufacturers worldwide
- Establish in-country support teams to provide the highly complex technical assistance needed to improve existing programs
- Develop Management Information Systems (MIS) to track the commodities provided through this agreement by estimating needs by recipient programs, financial accounts by country and funding source, production and warehouse stock levels, and the status of all shipments in-transit

The Partnership will support the purchase of non-ARV drugs that are needed for HIV/AIDS patients, including opportunistic infection, STI, tuberculosis, and some anti-malarial drugs. In addition, drugs needed for home and palliative care of HIV/AIDS patients will be purchased.

The Partnership is a non-profit organization established by leaders in international supply chain management, including four African organizations. The partners are:

- Affordable Medicines for Africa - Johannesburg, South Africa
- AMFA Foundation - St. Charles, Ill.
- Booz Allen Hamilton - McLean, Va.
- Crown Agents Consultancy, Inc. - Washington, DC
- Fuel Logistics Group (Pty) Ltd. - Sandton, South Africa
- International Dispensary Association - Amsterdam, Netherlands
- JSI Research and Training Institute, Inc. - Boston, Mass.
- Management Sciences for Health, Inc. - Boston, Mass.
- The Manoff Group, Inc. - Washington, DC
- MAP International - Brunswick, Ga.
- Net1 UEPS Technologies, Inc. - Rosebank, South Africa
- The North-West University - Potchefstroom, South Africa
- Northrop Grumman Information Technology - McLean, Va.
- Program for Appropriate Technology in Health - Seattle, Wash.
- UPS Supply Chain SolutionsSM - Atlanta, Ga.
- Voxiva, Inc. - Washington, DC
- 3i Information, Inc. - Edison, N.J.

Each partner offers unique capabilities that will ensure that high-quality ARVs, HIV tests, and other supplies for treating HIV/AIDS are available to the people – patients, clinicians, laboratory technicians, and others who need them.

Members of Sneha Samaj in Nepal encourage female leadership and the participation of HIV-positive women in the fight against HIV/AIDS.

"HIV/AIDS is a global health crisis – it is also a daily burden for many of our families and neighbors and friends. Across Africa, this pandemic threatens the stability and the future of whole societies. In Asia, HIV/AIDS is a challenge that grows daily and must be confronted directly."

President George W. Bush
World AIDS Day
December 1, 2005

Chapter 7

Strengthening Bilateral Programs Worldwide

The President's Emergency Plan for AIDS Relief is the single umbrella program for all existing and new U.S. Government (USG) international HIV/AIDS activities, including:

- Existing HIV/AIDS programs of all USG agencies and departments in 123 countries
- Enhanced bilateral programs of all USG agencies and departments in the 15 nations designated as focus countries
- USG-funded international HIV/AIDS research activities
- USG policies and oversight pertaining to the Global Fund to Fight AIDS, Tuberculosis, and Malaria ("Global Fund")
- USG relationships with all other multilateral HIV/AIDS organizations
- USG bilateral relationships with HIV/AIDS international partner governments
- All other USG international HIV/AIDS activities and partnerships, including regional platforms

The Emergency Plan targets $10 billion over five years to dramatically ramp up HIV/AIDS services in 15 focus countries that account for approximately one-half of the world's HIV infections. The Emergency Plan also targets $5 billion over five years to support HIV/AIDS programs in an additional 108 countries, international research, international partnerships (including the Global Fund), and other activities. In fiscal year 2005, PEPFAR directed $293 million to HIV/AIDS program activities in these 108 nations.

Beyond financial resources, the Emergency Plan represents an important change in how USG HIV/AIDS international assistance is planned, managed, and implemented. Priorities include coordinating all of the USG agencies working in HIV/AIDS to create one unified USG

Antiretroviral treatment supported by PEPFAR has enabled Ruth to continue to work and care for her family.

One Woman's Story
Malawi: Supporting a mother with life-saving treatment

Ruth Nkuya's small hands show signs of worry at the hem of her dress as she softly tells her story: when her husband wanted to have a second child, Ruth insisted on being tested for HIV first. Ruth, who lives in Malawi, discovered that she was HIV-positive when her only daughter was five years old in 1996. Her husband was two weeks from starting antiretroviral treatment (ART) when he died in 1993. Now a secretary for the National Association for People Living with AIDS, Ruth looks out at the flame trees in Lilongwe's City Centre and her face breaks into a smile as she thinks of the ART she receives through Lighthouse Trust, an organization supported by the U.S. Government. "Since I started antiretroviral treatment, my CD4 count has gone from 308 to 900. I am able to work now and take care of my daughter," she says.

response at the headquarters and country levels; a focus on accountability and achievement of results; and the strengthening of indigenous responses, organizations and systems to combat the pandemic and ensure sustainability.

In its first year, fiscal year 2004, PEPFAR established a Five-Year Global AIDS Strategy for achieving the President's goals; since then, programs, systems, and structures have operationalized the strategy in the focus countries. Fiscal year 2005 was a key year of transition, in which similar communication, coordinated strategic planning, resource allocation and evaluation mechanisms began to be extended in a formal way to bilateral HIV/AIDS programs in the other 108 countries.

This process will help to ensure that PEPFAR programs worldwide are in keeping with, and contributing to, the goals identified in the Five-Year Global Strategy. The Emergency Plan is working 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.

Even as PEPFAR works to ensure areas of consistency among programs in all 123 nations with bilateral USG programs, it recognizes that every host nation faces a unique HIV/AIDS epidemic. In all nations, the Emergency Plan works with national strategies to support interventions tailored to local circumstances.

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

After an interagency development process during fiscal year 2005, the Emergency Plan issued "General Policy Guidance for All Bilateral Programs" in October 2005. Seeking to ensure consistency of all bilateral programs with PEPFAR principles, the guidance sets forth the basic requirements for programs in all 123 nations receiving bilateral USG resources. The responsibilities set forth in the document follow.

Adherence to Emergency Plan policy

All HIV/AIDS programs, regardless of program size or funding account source, must follow PEPFAR policies as outlined in the Global Strategy and associated policy documents, such as the ABC guidance described in the chapter on Prevention, though the determination of how certain elements of the Emergency Plan structure and priorities are implemented varies based on the in-country context.

Collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria

All USG bilateral programs are to coordinate with and facilitate implementation of Global Fund resources, which are generally significantly larger than bilateral resources in countries outside of the focus countries. The USG is the largest donor to the Global Fund, providing approximately one-third of Global Fund resources. Investments in the Global Fund are essential elements of the Emergency Plan strategy, and PEPFAR implementation to date has demonstrated the interdependence of these two approaches on the ground.

Given the magnitude of the USG investment in the Global Fund and the commitment of the USG to the principles of the "Three Ones" described below, all bilateral programs are to invest resources and focus activities to support Global Fund grantees to leverage Global Fund resources and help bring successful programs to scale. Examples of support include strengthening the capacity of Country Coordination Mechanisms, placing time-limited logistics advisors in Ministries of Health to strengthen logistics systems and create unified procurement approaches, and other specialized technical assistance (including management training). Such investments are to be time-limited, as opposed to long-term recurring costs, and oriented to specific outcomes that will allow Global Fund money to flow more quickly and efficiently to implement high quality programs.

Coordinated programming across USG agencies

Coordination and collaborative programming of HIV/AIDS activities across USG agencies is an Emergency Plan essential standard of practice. In countries with small programs and few USG agencies, this practice may translate, for example, into coordination meetings several times a year, to include the Embassy, USG agencies and implementing partners. In larger country programs, programming is to assume the model of the focus countries, in which interagency teams working under Chiefs of Mission meet regularly, coordinate annual programming and reporting, and have single USG representation for communication with the Office of the U.S. Global AIDS Coordinator (OGAC) and host country government counterparts.

Best Practices

India: Counseling center reaches out to HIV-positive people and their families

India's first Family Counseling Center (FCC), based at the Government Hospital of Thoracic Medicine in the State of Tamil Nadu, receives Emergency Plan support. The Center has expanded counseling, care and support for HIV-infected people by reaching out to their family members. The support of the family is crucial for an HIV-infected person, but the stigma and misconceptions surrounding HIV can hinder such support. Secrecy within families has also led to transmission of the infection between spouses.

The FCC was set up to provide counseling for HIV-positive people as well as their spouses, family, friends and caretakers, and to link clients to a supportive community network. The FCC is managed by the Indian Network of Positive People, which also provides counselors and support to the program. The services include pre- and post-test counseling that addresses HIV transmission, disease progression, treatment options, health management, nutrition, and risk management. The Center also links clients to community resources through district-level networks of HIV-positive people.

The FCC's wide acceptance has led to positive results. It held 1,280 family counseling sessions (including sessions with 420 discordant couples) and nearly 19,000 individual sessions in fiscal year 2005. The model is now being scaled up with resources from an HIV/AIDS Round 4 grant of the Global Fund, with six new centers being initiated in Tamil Nadu and one in the state of Andhra Pradesh.

Relationship to host country HIV/AIDS strategies

The USG is committed to implementing the principles of the "Three Ones" (one agreed-upon action framework; one national HIV/AIDS coordinating authority; one agreed-upon country-level monitoring and evaluation system) across all of its international HIV/AIDS activi-

ties. All USG bilateral HIV/AIDS programs are thus developed and implemented within the context of multisectoral national HIV/AIDS strategies under the national authority. Programming is designed to reflect the comparative advantage of the USG within the national strategy, and leverage other resources, including both other international partner and private sector resources. As noted, given the USG investment in the Global Fund, coordination with and support to the Global Fund is of paramount importance in all countries.

Best Practices
China: Helping nurses become leaders on HIV/AIDS

The Emergency Plan supports the China Nursing Leadership Initiative for HIV/AIDS Risk Reduction Program. This program is dedicated to improving the capacity of community-level nurses who play a critical role in HIV/AIDS prevention, care, and treatment. Nurses who provide services addressing the needs of those most at risk and those infected with HIV were provided with intensive training not often available in rural communities. To date, nurses have received training and materials in areas such as antiretroviral treatment, palliative care, prevention, communication, counseling, and patient support.

Comprehensive HIV/AIDS technical interventions

PEPFAR programs are tailored to address the epidemic as it is manifested within the country context, address gaps in the existing response, and be consistent with the comparative advantage of the USG agencies working in country. Not all countries are required to support all key elements of the Emergency Plan Five-Year Global Strategy (i.e. prevention, treatment, and care including people living with HIV/AIDS and orphans and vulnerable children). However, USG programs in all countries are expected to adhere to the general goals of the Global Strategy, including strengthening leadership in the fight against the epidemic; capacity building for indigenous organizations; and the diversification of in-country partners, including faith- and community-based organizations.

Programs receiving greater than $10 million in USG funding are expected to reflect a comprehensive approach to the epidemic in order to ensure that all key technical areas are addressed, if not directly by the USG then by other partners who may or may not receive support from the USG. For example, a country may be supporting AIDS treatment using Global Fund resources. It would not then be expected that USG bilateral resources would be used in this area, although the USG team may choose to provide technical assistance to Global Fund grantees to promote the success of treatment efforts.

Accountability and focus on results

Regardless of levels of funding, all Emergency Plan programs are results-oriented, with clearly established targets. Budget reporting and program reporting against standard indicators in the relevant programming areas will be required.

Reporting and documentation

In fiscal year 2005, among the 108 programs receiving bilateral HIV/AIDS resources outside of the 15 focus countries, five received more than $10 million, 13 received between $5 and $10 million, 20 received between $1 million and $5 million, and the remainder received less than $1 million. A list of PEPFAR countries that received $1 million or more is provided at the end of this chapter. Requirements for reporting and documentation are dependent upon fiscal year 2005 HIV/AIDS funding levels, as follows.

Countries with funding under $1 million

- Programs will be expected to report to implementing agencies according to existing reporting requirements.
- No additional documents (e.g. Country Operational Plan or strategy) are required.

Countries with funding between $1 million and $5 million

- Programs will be expected to report annually on the relevant programming areas against a minimal set of indicators standardized across the Emergency Plan. Emergency Plan reporting will occur concurrently with existing reporting requirements for home agencies, and will be directed toward USG home implementing agencies, which will report the information to OGAC.
- No additional documents (e.g. Country Operational Plan or strategy) are required.

Countries with funding between $5 million and $10 million

- U.S. missions in these countries are required to submit a Five Year Country Strategy, prepared according to "Country-Specific HIV/AIDS Five-Year Strategy Guidance for Other Bilateral Country Programs," issued in October 2005. These country strategies will be reviewed by an interagency team and the appropriate USG home agency leadership, and approved by the U.S. Global AIDS Coordinator. Timing for submission of strategies will be phased.
- As with the previous group of countries, programs in these nations will be expected to report on the relevant programming areas against a set of indicators standardized across the Emergency Plan.

Countries with funding over $10 million

- The significant programming levels in these countries have generated a need for greater accountability in terms of programming and results. While these country programs are not expected to support programs across the full range of HIV/AIDS activities, it is anticipated that they will reflect a comprehensive mix of prevention, treatment and care interventions.
- As noted above, if resources for a central component of a comprehensive strategy are being supported by another partner, in particular the Global Fund, then USG resources can be directed to facilitate those programs. Even in countries receiving over $10 million in bilateral USG resources, it is likely that the greatest investment of USG resources will be through the Global Fund. It is unlikely that sufficient bilateral resources will be available to bring successful USG supported pilots to scale. Rather there is an expectation that the USG will collaborate closely to ensure that information from successful pilots and other best practices is widely available and

Best Practices

Democratic Republic of the Congo: Counseling by cell phone

Cell-phone customers in the Democratic Republic of Congo (DRC) now have access to trained volunteer counselors who can answer their questions about HIV/AIDS issues, including HIV transmission, risky behavior, HIV counseling and testing, HIV care and treatment and sexually transmitted infections. The HIV/AIDS telephone hotline, 800-SIDA, officially opened in May 2005 with the support of the U.S. Government, DRC's three largest cell-phone companies, the National Multi-Sector AIDS Commission, and the Ministry of Health. The 800-SIDA office received more than 1,440 phone calls in its first three days of operation, and more than 12 percent of callers were referred to HIV counseling and testing centers, health clinics and support groups.

Dr. Kebela, Acting Ministry of Health Secretary General, places the first official call to 800-SIDA.

expanded through other resource avenues such as the Global Fund.

- To allow the USG to aggregate data across the largest Emergency Plan country programs to assure that PEPFAR is addressing its mandate and meeting its goals, required documents will include:
  - Five Year Country Strategy, as described above.
  - Modified Annual Country Operational Plan (COP): The COP is a single interagency USG operational plan which outlines key activities, targets, funding requests and implementation partners for each technical area addressed by the program in each country. Although certain directives will need to be met, these bilateral plans do not need to address all of the technical areas addressed by the focus countries. The COP will be reviewed by an interagency team and the appropriate home agency leadership and approved by the Coordinator.
  - Reporting will be required annually on the relevant programming areas against a minimal set of indicators standardized across the Emergency Plan. As with the focus countries, Emergency Plan reporting will be submitted directly to OGAC within the database.

Communication and support strategy

OGAC and implementing agencies are working to ensure that U.S. missions are fully informed of their roles relative to the Emergency Plan, including the associated requirements for planning, reporting, and coordination. Particular support is offered to enable countries to complete the documentation requirements, especially for those countries that will be completing COPs. Key efforts include:

- Ensuring the accessibility of all relevant documents providing information on the Global Strategy and its key policies through the internet, along with guidance thereon.
- Using multi-country meetings as venues to disseminate information.
- Engaging OGAC regional coordinators and host-agency country backstops, including State Department regional bureaus and country desk officers to serve as key communication channels.
- Identifying partners from agencies and OGAC regional coordinators to provide technical assistance and support in the development of documents.
- Engaging in interagency field visits to further disseminate information and expectations on the ground.
- Organizing phone-based, distance-based, and regional COP development training.

Results

Prevention

Emergency Plan bilateral programs support prevention activities and build prevention capacity in host countries. Depending on the needs of the particular country, activities include: ABC activities to address sexual transmis-

Best Practices
Honduras: Communicating changes for life

In February 2005, the USG in Honduras awarded its first set of grants through USAID to ten local non-governmental organizations (NGOs) working with 43 Honduran communities most affected by HIV/AIDS. In their first seven months of implementation, the organizations reached over 27,000 at-risk individuals with behavior change modules. As part of their HIV prevention efforts, the groups began offering HIV counseling and testing. The counseling and testing programs were the first in Honduras to be offered by NGOs trained in accordance with Ministry of Health standards as part of the larger national HIV/AIDS prevention effort. The collaboration between the indigenous groups and the Ministry of Health set the standard for expanding access to testing in Honduras through the civil society sector.

sion of HIV; preventing mother-to-child transmission; safe medical injection and blood safety activities; and efforts to help injecting drug users. Stigma and discrimination remain challenges worldwide, greatly impacting the quality of life of those infected and affected by HIV/AIDS. PEPFAR efforts reflect the reality that 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.

Treatment

In addition to the 15 focus nations, 17 other nations have launched USG-financed treatment programs since

Best Practices
Nepal: Sneha Samaj provides support for HIV-positive women

Women living with HIV/AIDS in Nepal have new hope and opportunities as a result of Sneha Samaj and the Emergency Plan. Sneha Samaj was created in 2004 as a support group for women living with HIV/AIDS in Kathmandu and as a way of providing assistance to HIV-positive women throughout Nepal. A grant awarded to Sneha Samaj through the Emergency Plan will enable the newly established organization to provide care and support for HIV-positive women in Nepal, and to build their capacity and management systems.

Sneha Samaj is constructing a care and support center for women living with HIV/AIDS. The center will focus specifically on assisting women in dire need of short-term aid to recover from serious illness. Women will be able to receive health check-ups and screening and treatment for tuberculosis and other opportunistic infections. The clinic will provide counseling and psychological support as well as nutritional education and training to promote long-term health.

In addition to the care center, Sneha Samaj is using a portion of its funding to hire and train patient advocates (PAs) to provide a multitude of services for people living with HIV/AIDS. PAs receive training in patient advocacy, patient rights, provider responsibilities, stigma reduction, counseling, and home–based and palliative care. With their training, PAs will provide assistance at local Kathmandu hospitals and serve as outreach educators and providing help at the care and support center.

Best Practices
Senegal: Soldiers help to bring treatment to their nation

The Senegalese Armed Forces (SAF) have been at the forefront of prevention and treatment of HIV since early identification of the virus. Senegal was one of the first countries in Africa to provide free anti-retroviral treatment (ART) to its citizens. Since the government initiated the free ART program, military physicians and other healthcare providers have been working within the national program, providing treatment to military and civilian patients alike. The SAF SIDA-Armée program was commenced with support from the U.S. Government in 2001 and has been gaining momentum ever since. The SAF operates two hospitals and 16 Garrison Medical Centers, staffed by personnel trained with PEPFAR funds. Members of the military receive treatment at the hospitals, keeping them healthy so they can continue to serve their nation.

With U.S. Government support, the Senegalese Armed Forces lead HIV/AIDS treatment efforts.

Best Practices
Cambodia: Buddhist Monks provide home care along with resources for children

Faith-based programs play an essential role in implementing the Emergency Plan by providing home based-care to people living with HIV/AIDS (PLWHA) while confronting stigma and discrimination. In Cambodia, discrimination towards those living with HIV/AIDS creates difficult circumstances for health care and support systems. Funding from the Emergency Plan has assisted the organizations Buddhism for Development and the Kien Kes Health Education Network in providing home-based care to PLWHA while confronting stigma and discrimination.

In Battambang Province, Buddhism for Development runs home-based palliative care and psychosocial support projects for PLWHA in three communities. In addition, it has created the six week "Peace Development School" to educate monks about health care and HIV/AIDS along with community involvement, vocation-building efforts and agricultural extension methods. Of the more than 1,100 Buddhist monks who have completed the training, many have established HIV/ AIDS programs in their home villages, incorporating counseling and education on HIV/AIDS into their work. Graduates of the program have also initiated youth projects targeted at children affected by HIV/AIDS. Today, 320 children are attending primary, junior and senior high schools with scholarships from Buddhism for Development.

Kien Kes has also played a valuable role in HIV/AIDS care in Cambodia. The program, based at the Kien Kes Buddhist Temple, 30 km from Battambang Provinicial Town, serves 70 villages. Its home-based care programs are supported by 26 volunteers, who assist health center and temple staff during home visits. The program aided 75 PLWHA households this year and has provided shelter and foster family placement for more than 900 orphans. In 2006 it plans to assist all PLWHA in target areas and to help up to 2,000 orphans and vulnerable children.

Incorporating religious leaders like Buddhist monks into HIV/AIDS work has been crucial for creating community acceptance of those with the disease. Using existing structures to create strong ties among indigenous temples, community groups, and other faith-based organizations has fostered a positive response to the HIV/AIDS epidemic in Cambodian society.

A Buddhist monk works with women and children in Battambang Province, Cambodia.

the beginning of the Emergency Plan, and PEPFAR has provided support for treatment for 70,000 people in these nations.

Care

Care for orphans and vulnerable children (OVCs) received USG support in many nations beyond the focus countries in fiscal year 2005, strengthening the capacity of families and communities to care for children in their midst. The Emergency Plan also supports programs to care for people living with HIV/AIDS and to provide HIV counseling and testing in a growing number of countries.

Best Practices
Swaziland: A nation cares for its women and children

The Emergency Plan provides technical and financial assistance to the Swazi Ministry of Health and Social Welfare to scale up prevention of mother-to-child transmission (PMTCT) services countrywide.

Nurse counselor Thembi Masuku draws a dose of nevirapine suspension for a client to take home.

The King Sobhuza (KSII) Public Health Unit, the busiest maternal and child health primary health facility in Swaziland, has scaled up PMTCT services in order to accord HIV-exposed infants the opportunity to receive antiretroviral (ARV) prophylaxis within 72 hours after birth. Between November 2004 and September 2005, KSII registered 3,269 antenatal clinic first–visit women, counseled 3,606 (including referrals and revisits) for HIV, and tested and gave results to 3,570 clients. Of the 3,570 women who were tested for HIV, 1,602 tested HIV positive and 12% of these women were given packed nevirapine suspension for use to prevent mother-to-child transmission of HIV in the event of an unavoidable home delivery. The provision of nevirapine suspension for home use is essential to PMTCT efforts because approximately 26 percent of women in Swaziland deliver their babies at home.

KSII staff used triple layers of aluminum foil paper to protect the potency of the nevirapine suspension, allowing pregnant women at 36 weeks of gestation to take the medication home and keep it until delivery. To support the provision of take-home nevirapine suspension, counselors gave information about the drug to pregnant women during pre- and post-test counseling sessions, encouraged women to deliver in health facilities, demonstrated administration of nevirapine in case of unavoidable home delivery, and advised clients on appropriate storage of the medication.

A number of mothers who received the take-home doses expressed their appreciation for the program. Additionally, the nevirapine suspension program at KSII, implemented through PEPFAR partner the Elizabeth Glaser Pediatric AIDS Foundation, contributed to increasing the number of HIV–exposed infants receiving ARV prophylaxis at a neighboring maternity unit by over 40 percent and influenced the ongoing review of the Swaziland national PMTCT Guidelines.

The success of counseling and testing for women at KSII is owed to dedicated nurse counselors, trained with support from PEPFAR, who provide PMTCT services in labor wards and in antenatal clinics. Lushaba Mathanda and Sibongile Malaza, two nurses providing PMTCT services at the Mankayane Hospital, felt strongly that the PMTCT training changed their attitudes towards their work. They agreed that mothers developed trust in them because of the one-on-one counseling and the friendliness they extend to the women. Lushaba and Sibongile said that some mothers go back to them after discharge from the hospital to ask them questions about subjects that worry the mothers. With support from PEPFAR, nurses like Lushaba and Sibongile are helping to ensure that children born to HIV-positive mothers remain HIV-free.

Best Practices
Russia: Meeting the needs of HIV-positive children

In 2005, the U.S. Government's Assistance to Russian Orphans (ARO) Program awarded a grant to support care for HIV-positive children in long-term state care at the Federal Pediatric AIDS Hospital in St. Petersburg. Despite the growing numbers of HIV infections in the general population and the skyrocketing cohort of children living with HIV, the hospital is among the very few institutions in the Russian Federation that offer long-term care for such children, many of whom are orphaned or abandoned. Inpatient pediatric facilities in Russia are not mandated to care for a child's social and psychological well-being and do not have staff for such services.

In addition to improving clinical care, the ARO Program thus provides physicians and nurses with special training on psychological, developmental, and sociological aspects of working with HIV-positive children. These skills enable the staff to help children to develop and prepare to be integrated into society. Over time, the hospital will become a training facility to disseminate such services to other facilities across Russia.

Capacity Building

The Emergency Plan works with national strategies to improve HIV/AIDS responses worldwide. The USG supports policy development and system strengthening (including laboratories and surveillance and information systems), capitalizing on USG expertise in technical assistance and capacity-building for quality improvement and sustainability of programs. PEPFAR also provides technical assistance to public and private sector institutions for policy development, including policies aimed at reducing stigma and discrimination, and other institutional capacity-building activities.

The USG continues to support host nations' efforts to build human capacity, training people to prevent the medical transmission of HIV, provide prevention of mother-to-child transmission (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, PEPFAR supports programs to train country staff in monitoring and evaluation, surveillance, and health management information systems, as well as policy, capacity-building, and stigma and discrimination reduction programs.

Increased Financial Commitments

Augmenting its efforts in the focus nations, which are home to approximately half of the world's HIV-infected people, the Emergency Plan has increased resources for other nations facing urgent epidemics.

USG HIV/AIDS support for India was over $26 million in fiscal year 2005, up from approximately $17 million in 2003 – the largest Emergency Plan program outside the focus nations. In Russia, PEPFAR funding in fiscal year 2005 was almost $14 million – approximately a 100% increase since 2003. Emergency Plan coordination with China continues to grow, as the Chinese government has continued to seek active partnerships with the Emergency Plan to improve the national health care infrastructure and human capacity.

As discussed further in the chapter on Strengthening Multilateral Action, the USG remains the largest contributor to the Global Fund, having provided approximately one-third of its funding through fiscal year 2005. Thus, about 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.

Fiscal year 2005 country funding levels (aggregate totals):

A. Countries receiving over $10 million:

- Cambodia
- India
- Malawi
- Russia
- Zimbabwe

B. Countries receiving between $5 and $10 million:

Africa

- Angola
- Democratic Republic of the Congo
- Ghana
- Lesotho
- Senegal
- Swaziland

Asia

- China
- Indonesia
- Nepal
- Thailand

Europe/Eurasia

- Ukraine

Latin America/Caribbean

- Dominican Republic
- Honduras

C. Countries receiving over $1 million, but less than $5 million:

Africa

- Benin
- Egypt
- Eritrea
- Guinea
- Liberia
- Madagascar
- Mali
- Sudan

Asia

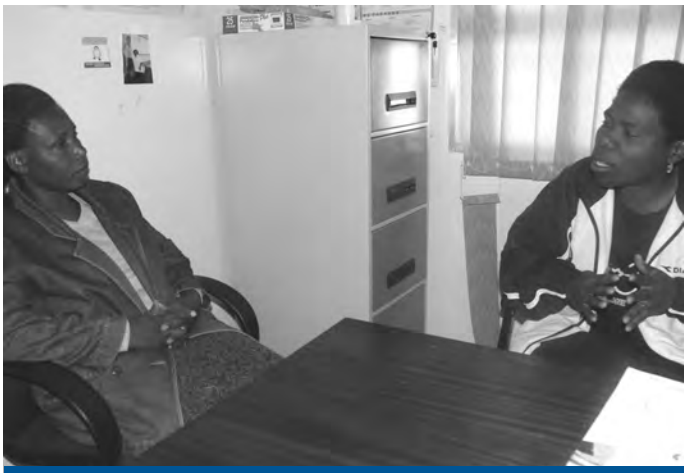
- Bangladesh
- Burma
- Laos
- Papua New Guinea
- Philippines

Europe/Eurasia

- Kazakhstan
- Tajikistan
- Uzbekistan

Latin America/Caribbean

- Guatemala
- Jamaica
- Mexico
- Nicaragua



Sharing best practices is an essential part of the Emergency Plan. In Botswana, the Mothers' Programme was based on the model of Mothers to Mothers-to-Be in South Africa. Here, Kutlwano Molalapata (right) works with a client in Selebi Phikwe, Botswana.

"New resources are not enough. We need new thinking by all nations. Our greatest challenge is to get beyond empty symbolism and discredited policies, and match our good intentions with good results."

President George W. Bush
June 30, 2005

Chapter 8
Strengthening Multilateral Action

The fight against HIV/AIDS must be sustained, and ultimately won, at the community and national levels. At this stage of the fight, the support of international partners is of vital importance in many places, and they must ensure that their support helps communities develop their own capacity to create and sustain their leadership in the fight.

The "stovepiping" that often occurs when international partners make contributions poses risks of duplication and waste while failing to help develop indigenous capacity. The onus rests on us: in addition to implementing high-quality, sustainable programs that deliver results, we must work together to ensure coordinated action in support of host countries' national strategies.

PEPFAR is increasingly seen by others involved in the fight against HIV/AIDS as a leader – not only at the aggregate level of total resources, but at the country level for its commitment to local capacity-building. PEPFAR is working to ensure that effectiveness and sustainability are core values upheld by all partners in the fight.

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 advantages 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 Multilateral Action at the Country Level

The Global Fund to Fight AIDS, Tuberculosis, and Malaria

The United States, as a founding member of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and its first and largest donor, continues to play a leadership role in ensuring the success of this essential international effort. The Global Fund is based on a unique model that encourages and relies on partnerships among governments; civil society, including community- and faith-based organizations; international organizations; bilateral and multilateral donors; the private sector; and affected communities in the fight against HIV/AIDS, tuberculosis (TB), and malaria.

U.S. financial support

Founded in January 2002, the Global Fund operates as a financing instrument — not as an implementing entity — to attract and disburse additional resources to prevent and treat these three deadly diseases. As a partnership among governments, civil society, the private sector and affected communities, the Global Fund acts as a coordinated, multilateral financing mechanism, which enables a variety of international partners — especially those which may not have bilateral programs but still wish to contribute to the fight against HIV/AIDS — to pool their resources and finance essential programs in resource-limited settings.

The U.S. contribution to the Fund is particularly impressive because it is in addition to massive bilateral efforts. In contrast to some nations, for which the Global Fund may be the most viable mechanism for matching HIV/AIDS resources to needs in the developing world, the U.S. contribution to the Global Fund is just one part of a diverse portfolio of United States investments in HIV/AIDS. The five-year, $15 billion commitment of the President's Emergency Plan for AIDS Relief includes bilateral and regional funding to 123 countries, international HIV/AIDS research, and contributions to multilateral efforts like the Global Fund.

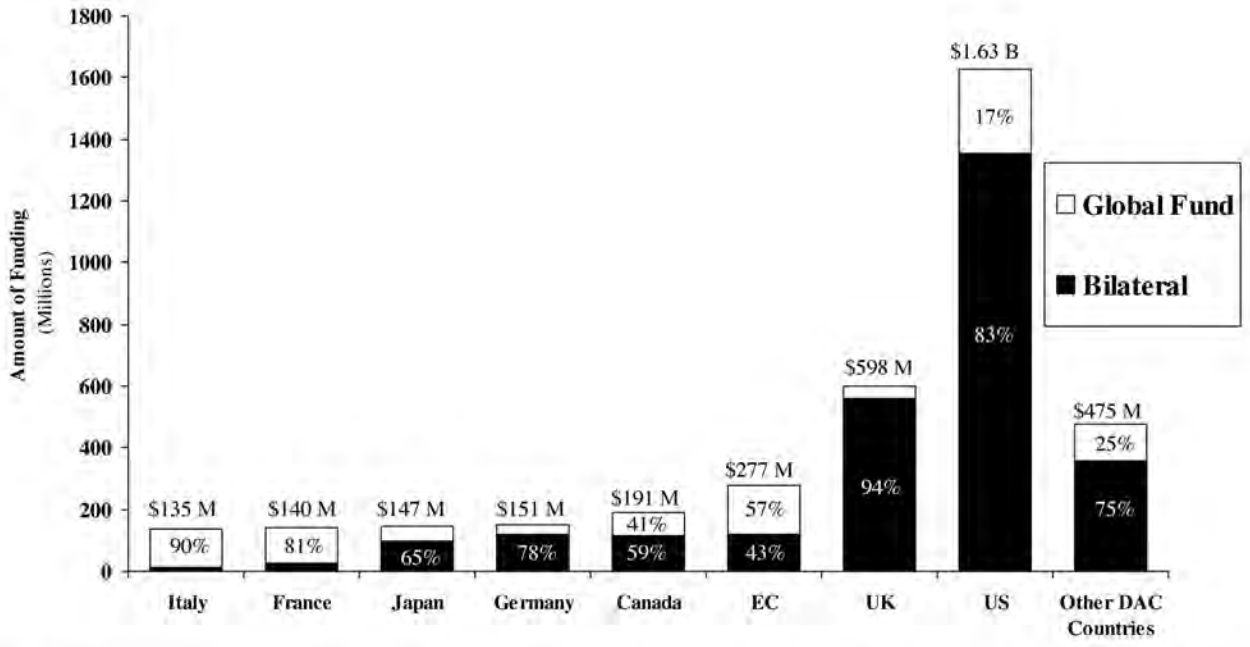
As the world's largest donor to combating HIV/AIDS, TB, and malaria internationally, the United States views its contribution to the Global Fund as both an invitation and a challenge to the rest of the international community to join in its commitment to fighting these diseases. While many countries have become generous contributors to the Global Fund and the resources mobilized to date have been impressive, there have been few new donors recently. For the long-term viability of the Global Fund, the Board of the Fund must seek and engage new public and private sector donors and turn them into sustained and committed contributors.

As mandated by Congress, the United States' contribution to the Global Fund cannot exceed 33 percent of all contributions to the Fund. The United States has clarified for the Global Fund Secretariat, Board and others that the cap on U.S. contributions is a maximum limit, not an annual obligation. At the same time, given that the Global Fund must raise sufficient funds to access the full United States contribution, the 33 percent limit provides other donors with added incentive to contribute to the Fund.

The United States has already contributed nearly 50 percent more to the Global Fund in just three years than President Bush's pledge of $1 billion over five years, made in 2003. The United States pledged an additional $600 million for 2006 and 2007 at the First Voluntary Replenishment conference in September 2005, bringing the total U.S. pledge to the Global Fund to more than double the President's $1 billion commitment.

Because of the terrible and immediate effects of HIV/AIDS – 14,000 new infections and 8,000 deaths every day – each country must assess how it can respond most urgently and effectively. Although it is important that the U.S. Government (USG) continue resources for the Global Fund, for the USG the most effective use of resources in the near term is through bilateral programs. Each nation must make its own decision about how to allocate its contributions between its bilateral programs (for nations that have them) and multilateral initiatives such as the Global Fund. As shown in Figure 8.1 for 2004, some other countries with significant bilateral programs have a higher bilateral ratio, as a share of all global

Figure 8.1 - Multilateral: G7/EC Funding Channels for Global HIV/AIDS Commitments, by Donor, 2004
Adjusted to Represent Estimated Share of Global HIV/AIDS Contributions



Notes: Includes bilateral assistance and Global Fund contributions. *Global Fund contributions adjusted to represent an HIV/AIDS share (60%). Funding for HIV/AIDS research not included. 2004 data for the UK and France are preliminary. Data for Japan, Australia, Belgium, Denmark, Greece, Luxembourg, Netherlands, New Zealand, Norway, Portugal and Spain estimated based on 2003 data.
Other DAC includes members of the Development Assistance Committee who are not part of the G7.
Sources: UNAIDS & Kaiser Family Foundation Analysis, June 2005; The Global Fund to Fight AIDS, Tuberculosis and Malaria

HIV/AIDS funding, than the U.S., and many other nations have ratios comparable to that of the U.S.

The Emergency Plan consistently encourages other developed countries to increase their own financial commitments to the global HIV/AIDS fight. Particularly for nations without strong bilateral programs, the Global Fund provides a vital mechanism to increase their financial commitment.

U.S. country-level support for grant management and coordination

It is in the interest of the United States, as well as in the interest of all people who are affected by HIV/AIDS, TB and malaria, to ensure the Global Fund is an effective, efficient and successful partner on the ground. The USG thus contributes significantly to enhancing the performance of Global Fund grants on the ground, while also working to coordinate its bilateral programs with those of the Fund.

With bilateral programs in 123 countries worldwide, established partners and two decades of experience combating HIV/AIDS internationally, the United States is uniquely positioned to assist Global Fund grantees to help ensure grant impact. In the focus countries, where the USG has committed resources intended to bring prevention, care and treatment programs up to national scale, collaboration based on comparative advantages contributes to consistent and comprehensive service provision. Outside the focus countries, U.S. bilateral support and technical assistance leverages Global Fund financing and helps to bring prevention, care and treatment programs up to full national scale.

In many nations outside the 15 focus countries, Global Fund financing will play a leading role in bringing national programs of prevention, treatment, and care to full national scale. In such countries, U.S. funding aims to improve the effectiveness of Global Fund dollars. Through coordination and the provision of technical assistance, U.S. bilateral support is working to ensure

that Global Fund dollars are used to maximum advantage.

Recognizing the importance of U.S. technical assistance to the success of the Global Fund, Congress authorized the U.S. Global AIDS Coordinator to employ up to 5 percent of the U.S. contribution for fiscal year 2005 for technical assistance to Global Fund grantees through U.S. bilateral mechanisms. Approximately $14 million is being directed to partners in the field worldwide to provide technical assistance to Fund grantees, including approximately $12 million in fiscal year 2005 funds. These funds will fill a critical need expressed by many Fund grantees, and will allow them to expand access to services and support the success of their grants.

This technical assistance is being used as a catalyst, focused on alleviating bottlenecks and resolving the major issues which can cause these grants to falter. It seeks to address a range of issues, including:

- improving institutional and program management
- strengthening governance and transparency
- upgrading financial management systems
- strengthening procurement and supply management
- improving monitoring and evaluation systems
- fostering multisectoral implementation
- building technical capacity

These funds will enable timely responses to requests from the field for technical assistance. Requests may come from grantees, the Global Fund's newly-developed Early Alert and Response System (EARS), or other in-country international partners such as UNAIDS and the World Health Organization (WHO).

U.S. Global Fund financial support, bilateral programs, and technical assistance all provide important opportunities to help Fund grants succeed. Also crucial are the unparalleled relationships the United States has in these host nations, thanks to the dedicated USG teams in country. U.S. field personnel represent the United States on local Country Coordinating Mechanism (CCMs), contributing to the decisions of these critical bodies in the development and selection of proposals to recommend for Global Fund Secretariat and Board approval, and playing a role in the oversight of program implementation. During the second Round of grant proposal submission (January 2003), U.S. Government representatives had seats on more than 26 percent of the Global Fund CCMs around the world. By the third Round (October, 2003), USG membership in CCMs had risen to 42 percent, and by the fourth Round (June 2004) to 47 percent.

To promote coordination, the U.S. has entered into Memoranda of Understanding (MOUs) in a number of countries. These documents bring together Ministries of Health, PEPFAR, and the Global Fund to clarify collaboration and partnership activities. Such MOUs have been entered into in Tanzania and Ethiopia, and will help to ensure a coordinated approach in such areas as antiretroviral treatment (ART) provision.

To strengthen coordination, PEPFAR held bilateral meetings with WHO, the Global Fund, and UNAIDS to better understand management practices and priorities at the individual country level. These discussions in Washington in February and March 2005 strengthened understanding and collaboration among international partners in the field. This work has led, for example, to joint visits to resolve antiretroviral drug (ARV) procurement issues in Haiti, Guyana and Malawi, and to the launch of a collaborative effort with WHO to strengthen TB/HIV programs in three countries.

U.S. policy and strategy support

The United States was privileged to be the leading participant in launching the Global Fund, and remains committed to supporting the Global Fund to overcome the inevitable hurdles it faces as it continues to grow and develop. Through membership on the Global Fund's Board of Directors and its Committees, and through both formal representations and informal discussions with the Fund's Executive Director and Secretariat staff, the United States is working to ensure that the Global Fund:

- Achieves maximum effectiveness

Best Practices
Rwanda: Coordination paves road to treatment success

Over the last year the number of HIV-infected Rwandans receiving antiretroviral drugs (ARVs) increased from around 4,000 people to nearly 16,000 people. The Rwandan Government and its international and implementing partners have pioneered an effective and accountable system to jointly procure ARVs for Rwanda. International partners include the U.S. Government (USG), the Global Fund, the World Bank, and others.

Thanks to coordinated procurement of ARVs, this patient and others in Rwanda are receiving treatment in a cost-effective manner, allowing resources to go farther.

In October 2004, the Rwandan Ministry of Health issued a Ministerial Order requiring that all ARVs be procured through CAMERWA, the national pharmaceutical procurement agency, in order to maximize purchasing power. The Ministerial Order requires providers to prescribe ARVs according to World Health Organization (WHO) guidelines, use generic drugs as first line treatment, and limit the use of brand-name ARVs to patients requiring second-line ARVs due to complications with the first line treatment.

In December 2004, the first coordinated procurement took place, with international partners purchasing portions of Rwanda's overall ARV needs according to their individual procurement parameters. Emergency Plan funds were used to buy HHS/FDA-approved ARVs for second-line treatment, while the Global Fund, World Bank and others purchased other WHO-prequalified drugs for first-line treatment. As a result of this new system, CAMERWA now distributes ARVs to pharmacies according to their patients' needs, regardless of which partner supports the site. Now, as more generic drugs gain HHS/FDA approval and tentative approval, the Emergency Plan is also supporting procurement of some generic drugs used in first-line treatment.

There are several benefits associated with the combined procurement. Rwanda is getting a better price for the ARVs due to the larger quantities being ordered, and money is also saved through lower management costs and reduced transportation costs. The coordination also has a clinical benefit: different drugs can be packaged differently with different shapes, quantities and inscriptions, leading to confusion and potential non-adherence, but coordinated procurement reduces the risk of confusion. In light of Rwanda's success, other African countries may well adopt similar approaches.

The system is also helping to build a strong system for monitoring, tracking, reporting and auditing ARV consumption and supply. CAMERWA maintains statistics on the number of patients receiving ARVs, the current stock of each pharmacy, and the consumption rate, making projections for future procurements more accurate.

The spirit of cooperation among the Government of Rwanda, implementing partners, and international partners such as PEPFAR, the Global Fund, and the World Bank, is making an essential contribution on the ground in Rwanda – and lives are being saved as a result.

- Operates with appropriate transparency and accountability
- Maintains its performance-based funding approach and unique financing role in the global response to AIDS, TB and malaria
- Supports country-driven processes and participation from civil society, private, and government sectors

The U.S. Global AIDS Coordinator, Ambassador Randall Tobias, has succeeded former Secretary of Health and Human Services Tommy G. Thompson as the United States representative on the Board. In June 2005, the new Board Chair and Vice Chair confirmed Ambassador Tobias to lead the newly formed Policy and Strategy Committee (PSC). The PSC is leading the development of a five-year strategy for the Fund, scheduled for adoption by the Board in mid-2006. With the assistance of U.S. field staff and an interagency headquarters core team, the United States actively contributes to discussions on Global Fund policies and procedures in Geneva.

The United States continues to work with the Global Fund Secretariat and its Board of Directors to establish a set of performance measures for all grants to maintain the consistent application of the Global Fund's principle of "performance-based" funding. The United States has also shared with the Global Fund Secretariat the performance measures used to evaluate the performance of all U.S. contributions to the Fund, and has encouraged the Fund to use this list or a similar list of indicators within the Secretariat to evaluate grant effectiveness.

An area of special concern is the Fund's current inability to track the results of specific prevention, care and treatment spending within each grant. However, the Office of the U.S. Global AIDS Coordinator has worked closely with the Global Fund Secretariat and other international donors over the past year to help develop a standardized set of progress indicators for each disease. The Global Fund Secretariat is currently retro-fitting these indicators into each of its existing grants, so that it will be able to compile this data in the future. The Global Fund will be reporting in mid-2006 on the impact of Global Fund grants on health systems in recipient countries. Other impact analyses will be done later as the portfolio of grants matures.

The Global Fund has been fully operational since January 2002, and in four years the institution has made remarkable progress. As the organization develops, the United States will pay special attention to helping the Fund coordinate with PEPFAR and bilateral and multilateral organizations. The USG will remain alert to the common need to monitor absorptive capacity in developing countries, and to provide fiduciary oversight and accountability.

The USG remains deeply committed to ensuring that the Global Fund succeeds in its mission to help in the global fight to combat HIV/AIDS, TB and malaria. Through its seat on the Board of Directors and its Chairmanship of the critical PSC; through formal and informal discussions with Global Fund Secretariat staff, CCMs and local fund agents; and through active engagement with both private- and public-sector stakeholders in affected countries, the USG will stay fully engaged with the Global Fund to ensure its ultimate success.

UNAIDS, the "Three Ones" and the Global Task Team

In 2004, the United States co-sponsored the "Three Ones" agreement under the auspices of UNAIDS. The Three Ones represent a commitment on the part of the major international HIV/AIDS partners, including the USG, to support one national HIV/AIDS framework, one national coordinating authority, and one country-level monitoring and evaluation system in each nation.

PEPFAR has assumed a leadership role in making the Three Ones a reality on the ground, reaching out to host governments and international partners to further the coordination sought by the Three Ones. In both the focus countries and other countries with USG bilateral programs, the central operating principle of PEPFAR assistance is the Three Ones.

The Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors (GTT) was created after a March 2005 UNAIDS

conference aimed at identifying strategies to implement the Three Ones. The GTT has made recommendations for further coordination, particularly within the multilateral system, to resolve areas of duplication and gaps in the global response to AIDS. The recommendations include options for how the multilateral system can streamline, simplify and harmonize AIDS procedures and practices.

As a leader in both the adoption of the Three Ones and the development of the GTT recommendations, the U.S. commends the GTT recommendations for identifying specific strategies for furthering international collaboration and coordination in the fight against HIV/AIDS. However, the U.S. emphasizes that implementation of the GTT recommendations must be within the framework of national laws and policies, as well as regulations and policies of the governing bodies of multilateral organizations and international institutions.

The GTT recommendations provide a means for partners to work together to ensure that programs reflect the values of accountability and program effectiveness, as well as the realities and priorities of governments and civil society in recipient countries.

PEPFAR's strategic information team has worked intensively with UNAIDS and other international partners to implement the GTT's recommendations in the monitoring and evaluation area, and one result has been the development of a Global Fund assessment tool, discussed further in the chapter on Improving Accountability and Programming. This tool will allow improved accountability for the effectiveness of Fund grants.

World Health Organization

The United States works closely with the WHO to support the implementation of evidence-based policies and sound management. WHO provides technical leadership as well as 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.

PEPFAR and WHO have worked to clear barriers to scale-up of ART programs (discussed further in the chapter on Treatment). In order to ensure that such medicines are available for purchase by Emergency Plan implementing partners in-country, HHS/FDA and the WHO Secretariat have signed a confidentiality agreement to share information on their reviews and inspections. As a result, HHS/FDA fully and tentatively approved ARVs have begun to be added to the WHO prequalification list. The USG also participated in the WHO/UNICEF high-level meeting to enhance and accelerate prevention of mother-to-child HIV transmission and provided funding to WHO for HIV/TB and safe blood programs.

Best Practices

Lesotho and Swaziland: Collaboration to ensure successful Global Fund grants

The Governments of Lesotho and Swaziland (including the National AIDS Commissions and the Ministries of Health and Social Welfare (MOHSW)), requested Emergency Plan support to review systems and structures for managing Global Fund grants and MOHSW mechanisms for coordinating and managing HIV/AIDS programs. PEPFAR, through the USAID Regional HIV/AIDS Program (RHAP), engaged an external organizational development consultant, supported by USG staff. The team visited the countries in August and September 2005 and submitted a report articulating numerous technical assistance opportunities. The team then returned in November to collaborate with the two governments on identifying priorities from among the proposed issues and has developed detailed scopes of work to help address them.

Collaborations on building capacity in the area of strategic information, discussed further in the chapter on Improving Accountability and Programming, have been particularly successful, making considerable progress in achieving standard definitions and reporting on HIV/AIDS-related activities. Working to ensure data quality, PEPFAR has worked with WHO and others to issue standards for data storage and reporting. PEPFAR has provided support for the WHO's Service Availability Mapping (SAM) project, and has worked with WHO to organize regional strategic information training meetings in Africa. PEPFAR funds also supported the development of a USG/WHO/UNAIDS standard for ART patient tracking at the clinic level, currently being scaled up in several countries.

Key Challenges and Future Directions

PEPFAR will continue to make coordination of international partner responses an intensive focus going forward. The Emergency Plan will continue to be a leader in working with international organizations and other partners to put accessibility, quality and sustainability at the center of all HIV/AIDS work. These cannot be achieved without accountability, and PEPFAR is working to disseminate best practices for accountability as bilateral programs scale up.

Given the importance of the Global Fund to the overall PEPFAR initiative, the U.S. will continue to work with the Fund, as well as the World Bank, to address grant management and implementation issues, coordination challenges on the ground, and larger issues around financing, policy and strategy.

President George W. Bush, Bono, Laura Bush and Bob Geldof hold a working meeting on Africa at the G8 Summit in Gleneagles, Scotland, Wednesday, July 6, 2005.

"Our concern about HIV/AIDS does not stop at our borders. Other nations face greater challenges, yet they are moving forward with courage and determination that inspires our respect, and deserves our support. Nations like Uganda and Kenya have demonstrated that leadership amd honesty can overcome stigma and reduce rates of infection. Nations like Botswana and Namibia have shown that antiretroviral treatments can be widely delivered and highly successful. These countries, and many others, are fighting for the lives of their citizens – and America is now their strongest partner in that fight, and we're proud to be so."

President George W. Bush
June 30, 2005

Chapter 9
Engendering Bold Leadership

HIV/AIDS is an emergency that is global – yet it is also local, impacting families and communities one by one.

The leadership needed to defeat the disease must come from every nation and from every sector of society within nations. PEPFAR has thus focused on fostering host country leadership on HIV/AIDS in the governmental and non-governmental sectors. Such leadership is especially critical in combating the stigma that continues to inhibit the fight against HIV/AIDS.

Public affairs outreach in the U.S. and public diplomacy abroad contribute importantly to the accountability and leadership goals of the Emergency Plan. At the global level, the U.S. continues to play the leadership role it assumed in the world's fight against HIV/AIDS with President Bush's launch of the Emergency Plan, seeking to mobilize bold leadership and additional resources from other countries, entities and individuals. Through diplomacy with other current and potential international partner governments and multilateral organizations, the Emergency Plan works to deepen other developed nations' commitment to the fight against global AIDS.

Promoting Leadership by Government and Community Leaders

When governments take on leadership responsibilities – including by providing resources to the extent possible – national HIV/AIDS responses are greatly strengthened. At the same time, ordinary people – often organized in community- or faith-based organizations – also have unique strengths that are needed for the fight. Such organizations – including organizations of people living with HIV/AIDS (PLWHA) – can effectively combat stigma, denial, and discrimination, paving the way for successful prevention, treatment, and care efforts. They can also confront negative cultural patterns, including gender inequity, that contribute to the spread of HIV/AIDS.

Emergency Plan personnel – particularly U.S. Government (USG) personnel in the field – work closely

with these organizations, as well as with governments and the private sector, in host nations. Working in a spirit of partnership, these personnel take advantage of their extensive contacts with local leaders to foster leadership on HIV/AIDS.

Senior USG leaders also visit host nations, making it a priority to meet with leaders to discuss ways to deepen and broaden national responses. First Lady Laura Bush, accompanied by Ambassador Randall L. Tobias, the U.S. Global AIDS Coordinator, visited Africa in July 2005. Visiting South Africa, Rwanda, and Tanzania, and touring several Emergency Plan projects, Mrs. Bush sent a powerful message to host nations on the importance of addressing HIV/AIDS, with a particular emphasis on women. Mrs. Bush reiterated this message, as did Ambassador Tobias, in addressing African First Ladies gathered in New York for a meeting of the United Nations General Assembly.

Such efforts to encourage greater leadership are promoted worldwide. Ambassador Tobias joined UNAIDS Executive Director Peter Piot in a visit to China, visiting a range of prevention, treatment, and care facilities, and meeting with governmental and civil society leaders in several cities. For one event, Ambassador Tobias was joined by Pu Cunxin, an extremely popular actor and the nation's goodwill ambassador on HIV/AIDS. Their statements in favor of counseling and testing – and being publicly tested themselves — generated substantial Chinese press coverage, building awareness of the disease at the grassroots level. At a meeting of the China State Council Leading Group on HIV/AIDS, Ambassador Tobias met with leaders from all sectors of Chinese government—from education to transportation—to learn about and discuss ways in which each sector can contribute to the fight against HIV/AIDS. USG personnel in China work to engage diverse community leaders, including religious leaders, PLWHA, popular culture leaders, business executives, and sports icons to raise awareness of HIV/AIDS.

In Swaziland and Lesotho, Ambassador Tobias met with key government leaders, including Ministers of Health, to support and encourage national leaders in their commitment to fight HIV/AIDS. In Swaziland, Ambassador Tobias and the Permanent Secretary of the Ministry of Health were tested together on Swazi TV, the first event of its kind in that nation. News coverage of the event raised HIV awareness and highlighted the importance of testing in one of the most impacted countries in the world.

Gatherings attended by host nation government leaders also afford key opportunities to encourage action against the pandemic. Highlighting the need for continued leadership and attention to combating HIV/AIDS in Latin America, Ambassador Tobias addressed the Annual Directing Council of the Pan American Health Organization, emphasizing growing Emergency Plan efforts in the Western Hemisphere and noting significant opportunities to leverage important partnerships for a strengthened response.

At the Africa Growth and Opportunity Act Forum, held in Dakar, Senegal, Ambassador Tobias and Honorable Sam Kutesa, Minister of Foreign Affairs for the Government of Uganda, chaired a session highlighting links between health and economic growth and development, demonstrating successful new models of partnership among government, civil society, and the private sector. Distinguished panelists represented each of these sectors, offering examples of contributions to amplified, sustainable responses to HIV/AIDS. Dr. Agnes Binagwaho, Executive Secretary of Rwanda's National Commission to Fight AIDS, stressed the importance of government leadership of coordination efforts. Dr. Peter Mugyenyi, Director of the Joint Clinical Research Center in Uganda, related his experience as a leader in the civil society sector, bringing complicated treatment to resource-poor settings through local innovation, with the support of international partners to enhance the efforts of local groups. Dr. Brian Brink, Senior Vice President of Health at Anglo American in South Africa, illustrated the potential of the private sector to build sustainable partnerships, describing Anglo American's groundbreaking efforts to provide HIV/AIDS prevention, care and treatment services.

To increase PEPFAR's ability to reach host nations and share lessons learned, key leaders were invited to

PEPFAR's Second Annual Field Meeting in Addis Ababa, Ethiopia (discussed in the chapter on Implementation and Management). This forum provided an opportunity for Emergency Plan personnel not only to encourage the host nation partners present, but also to exchange lessons learned and best practices against HIV/AIDS.

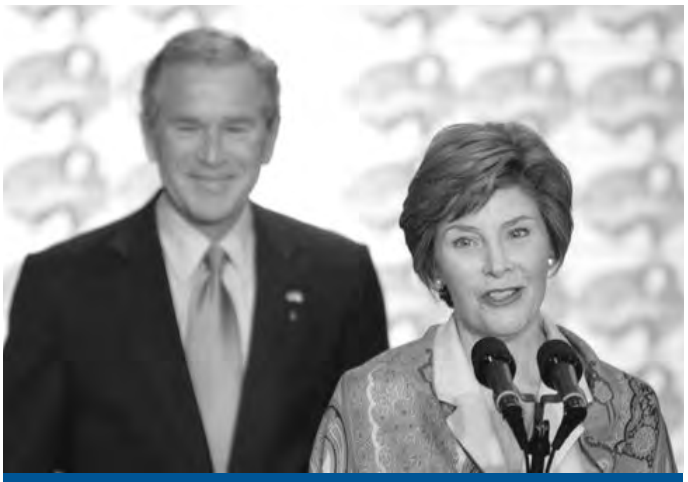
A key element of Emergency Plan efforts to encourage host nation leadership is ensuring that USG personnel themselves have the information they need to communicate effectively on HIV/AIDS. To help U.S. Ambassadors, who are critical to public diplomacy efforts abroad, in their efforts against the pandemic, Ambassador Tobias addressed conferences of U.S. Chiefs of Mission for the African and Caribbean regions. He also addressed meetings of Peace Corps and HHS/CDC Global AIDS Program personnel, boosting understanding of PEPFAR and encouraging staff to make use of opportunities to promote leadership in host nations.

Bolstering the Emergency Plan's diplomatic efforts to support leadership, Ambassador Jimmy Kolker was named as Assistant U.S. Global AIDS Coordinator. Ambassador Kolker served most recently as U.S. Ambassador to Uganda, where he led the initial phase of PEPFAR implementation.

Promoting Leadership Through Public Diplomacy and Communications

The USG employs a wide range of communications and outreach strategies to engage domestic and international audiences, building awareness of the global HIV/AIDS emergency and encouraging leadership.

President Bush observed World AIDS Day 2005 with an historic event at the White House. The President provided the nation and the world with a report on the status of the Emergency Plan while recognizing and celebrating the leadership of host nations in working to defeat the disease. He was joined at the address by the Darby family from South Africa, a mother and two young children



President George W. Bush stands by as he listens to remarks by Mrs. Bush on World AIDS Day before being introduced to the audience at the Dwight D. Eisenhower Executive Office Building, Thursday, Dec. 1, 2005.

living with HIV/AIDS who are receiving antiretroviral treatment with PEPFAR support. Also on hand was Dr. Peter Mugyenyi of Uganda's Joint Clinical Research Center, which has expanded from one treatment site to 35 in just two years with USG support, and is now providing treatment to approximately 35,000 people. The President's address drew international attention to the growing basis for hope in the fight against HIV/AIDS. Reflecting the interagency nature of PEPFAR, the Secretaries of State, Defense, Health and Human Services, Labor, and Commerce, the Administrator of USAID, and the Director of the Peace Corps, along with Members of Congress, joined the President to mark World AIDS Day.

Other PEPFAR World AIDS Day events included a briefing to foreign press at the Department of State, digital video conferences for overseas media, editorials placed in numerous newspapers worldwide by U.S. missions, and interviews with foreign and domestic media. Ambassador Tobias also marked International Women's Day 2005 with remarks on Capitol Hill, highlighting the importance of leadership against HIV/AIDS by and on behalf of women.

In addition to communicating with the general public on the Emergency Plan, efforts were made to engage particular subgroups with interest in the issue of global AIDS. At the annual meeting of the National Association of

People with AIDS, Ambassador Tobias spoke to the group about the leadership PLWHA are bringing to PEPFAR implementation in the field, and was awarded the organization's "Positive Ally Award."

Reaching out to the scientific community, Ambassador Tobias addressed the Institute for Human Virology, discussing the mechanisms through which scientific input influences Emergency Plan programming. Dr. Mark Dybul, Deputy U.S. Global AIDS Coordinator and Chief Medical Officer, made a presentation to the international development community in Washington, explaining issues around attribution of results to HIV/AIDS programs. To build linkages to organizations working to deliver the food aid which is so vital to PLWHA in the developing world, Ambassador Tobias addressed USAID's Export Food Aid conference in Kansas City, introducing many in this key audience to PEPFAR and opening doors to intensified cooperation.

In America as in other nations, the engagement of faith communities in the fight against global AIDS is important for the Emergency Plan to succeed. Ambassador Tobias has addressed a number of faith-based audiences,

Best Practices

Côte d'Ivoire: The U.S. Embassy and a mosque – partners against HIV/AIDS

Beneath the minaret walls of Yamoussoukro's Grand Mosque, the faithful flowed from the evening's last prayer into a temporary outdoor theatre which had been erected in the mosque's courtyard. They took their places for the first-ever formal discussion on HIV/AIDS at the largest mosque in Côte d'Ivoire's capital.

The Imam of the grand mosque in the Ivoirian capital of Yamoussoukro was joined by over 400 faithful for the first-ever presentation or discussion of AIDS at the mosque.

With the endorsement of the nation's top Muslim leadership and the mosque's Imam, the U.S. Embassy's HIV/AIDS Video Road Show was welcomed for a presentation and discussion on a topic shrouded in misunderstanding and stigma. Over 400 people – old and young, male and female — gathered for an event that opened the doors of Ivoirian mosques to discussions about HIV/AIDS and risky traditional practices, such as polygamy. The initiative was warmly received by those who attended, though some questioned whether such a topic should be raised inside a mosque. In his opening remarks the Imam addressed this issue directly. He said that HIV/AIDS is a serious problem for Ivoirian Muslims, and must be addressed openly and directly, adding that nothing in the Quran or in Islam forbids discussing the issue. He said he had brought the show to the mosque as a resource for its members and encouraged his congregants to listen, learn, and ask questions.

The event brought open discussion of an increasingly dangerous disease for Muslims into the heart of their community. On his departure, the Imam profusely thanked the U.S. personnel and expressed interest in further events — reflecting the growing relationship between the Embassy and the Islamic community in Côte d'Ivoire. The Imam showed leadership and courage in breaking a barrier that has prevented Muslims from understanding the risks of HIV/AIDS and the prevention, treatment, and care resources available to their community – and thanks to the initiative of the Embassy staff, the Emergency Plan was there to support that leadership.

including Esperanza USA, a network of Latino churches and ministries, and a pastors' conference at Saddleback Church organized by Rick Warren, author of *The Purpose-Driven Life*, highlighting opportunities for partnership in the fight.

PEPFAR continues to work for intensified leadership from the U.S. business community, as it does with the private sector in host nations. Secretary of State Condoleezza Rice addressed the Global Business Coalition on HIV/AIDS to discuss opportunities for joint efforts, and the Emergency Plan will increase its focus on public-private partnerships in 2006. Other outreach events in communities around the U.S. have helped to increase the sense of investment in the Emergency Plan among those on whose generosity it ultimately depends on the American people.

Best Practices

Vietnam: A business makes its workplace more welcoming to people living with HIV/AIDS

Vietnam's workforce is threatened by HIV/AIDS. The country's epidemic is growing rapidly, particularly among younger people. As in every country, businesses must be a part of a true multisectoral response. Colgate-Palmolive has a history of award-winning wellness programs for employees, and had established HIV/AIDS policies in its sub-Saharan Africa offices, but had done little in its significant Asian holdings. As was noted in an annual report, "With over 5.5 million reported AIDS cases in India, China, Thailand and Vietnam, it is clear that the Company's efforts must expand into Asia as well."

The Emergency Plan-supported SMARTWork (Strategically Managing AIDS Responses Together in the Workplace) project has supported the company in meeting the challenge in Vietnam. SMARTWork worked with Colgate-Palmolive to quickly establish a workplace policy on HIV/AIDS that protected HIV-positive employees and eliminated mandatory testing while making anonymous voluntary testing available. Care and support services for employees, as well as ongoing education activities, were also added. The company worked with SMARTWork to train more than 2,300 factory, field sales and management personnel.

Colgate-Palmolive operates in other nations such as China, Thailand, India, and Nepal, and an official noted that after its success in Vietnam, "We will take the lead in Asia and introduce SMARTWork to our other country affiliates in Asia."

Promoting Leadership for Increased International Partner Resources and Commitment

At this point in the global response to HIV/AIDS, it remains imperative that the global community provide additional resources. Currently, the USG provides more than one-half of all resources from international partner governments for global HIV/AIDS – a situation which is neither appropriate nor sustainable. The USG renews its call for other donor nations to meet this humanitarian crisis with human compassion.

The U.S. leads the G-8 industrialized nations in meeting the financing needs for HIV/AIDS. At the July 2005 G-8 Summit in Gleneagles, Scotland, President Bush and other heads of state endorsed language that promotes leadership from every nation affected by HIV/AIDS. The G-8 committed to:

> "Investing in improved health systems in partnership with African governments, by helping Africa train and retain doctors, nurses and community health workers. We will ensure our actions strengthen health systems at national and local level and across all sectors since this is vital for long-term improvements in overall health, and we will encourage donors to help build health capacity.
>
> "With the aim of an AIDS-free generation in Africa, significantly reducing HIV infections and working with WHO, UNAIDS and other international bodies to develop and implement a package for

HIV prevention, treatment and care, with the aim of as close as possible to universal access to treatment for all those who need it by 2010. Limited health systems capacity is a major constraint to achieving this and we will work with our partners in Africa to address this, including supporting the establishment of reliable and accountable supply chain manage ment and reporting systems. We will also work with them to ensure that all children left orphaned or vulnerable by AIDS or other pandemics are given proper support. We will work to meet the financing needs for HIV/AIDS, including through the replenishment this year of the Global Fund to fight AIDS, TB and Malaria; and actively working with local stakeholders to implement the '3 Ones' principles in all countries."

The U.S. leads the G-8 in contributing to the expansion of prevention, treatment, and care access. The G-8 commitment on HIV/AIDS embodies the commitment of the U.S. and other governments, working with multilateral organizations such as World Health Organization (WHO) and UNAIDS, to further increase access.

PEPFAR has emphasized setting achievable goals and insisting on results. It is only through accountability for real successes that sustainable progress in the fight against HIV/AIDS will be achieved.

As discussed in the chapter on Strengthening Multilateral Action, the USG continues to strengthen its relationships with multilateral institutions and international organizations to amplify global action against HIV/AIDS, encouraging coordination, filling gaps in current activities and ensuring the efficient and effective use of funds under the Three Ones principles for coordination among international partners at the country level.

The Gleneagles communique also reiterated the G-8 commitment to the Global HIV/AIDS Vaccine Enterprise endorsed by the group in 2004. The U.S. is increasing direct investment and promoting market

Vietnamese medical practitioners and Buddhist monks are leading the way in a unique partnership with the Emergency Plan. Doctors provide training and education, with respect for local traditions and cultures, to monks who work with youth.

incentives as a complement to basic research and pursuing mechanisms such as public-private partnerships.

The USG also continues to use its leadership roles (discussed in the chapter on Strengthening Multilateral Action) on the Board of the Global Fund (where Ambassador Tobias serves as Chair of the Policy and Strategy Committee) and the UNAIDS Programme Coordinating Board to advocate for increased international commitment of resources to global HIV/AIDS.

Bold leadership from political and social leaders in each country severely affected by HIV/AIDS remains an indispensable element of a truly successful response. This leadership must include a commitment to use indigenous as well as international resources to educate and empower individuals to prevent transmission of HIV/AIDS; to provide access to quality antiretroviral treatment and care for those infected and affected; and to reduce the stigma associated with HIV/AIDS in order to mitigate its impact on economies, societies, communities, families, and individuals.

In most resource-constrained countries, medical personnel, like this woman in Vietnam, are responsible for tracking patient and medical records, a crucial component of the success of the Emergency Plan.

"Overcoming extreme poverty will require humanitarian aid that focuses on results, not merely on inputs and other flawed measures of compassion. True compassion is measured by real improvements in the lives of men, women and children. And that is the goal and that is the focus of American policy."

President George W. Bush
June 30, 2005

Chapter 10

Improving Accountability and Programming

In order to ensure quality and sustainability of its programs, the Emergency Plan is committed to a continuous cycle of program improvement. With each year of implementation, PEPFAR's knowledge base of best practices and lessons learned grows. These drive funding decisions and adjustments to ongoing programs.

The collection and analysis of high-quality data in under-resourced settings is thus a critical challenge. Given the range of challenges faced by health care personnel, it is difficult for them to focus on patient tracking and records management. The weakness of health management information system (HMIS) infrastructures compounds the challenge.

In order to support host nations in addressing these issues, U.S. Government (USG) in-country teams, in coordination with host governments and partners, determine strategic information (SI) activities and priorities for the upcoming fiscal year as the part of the Country Operational Plan (COP) process.

PEPFAR-supported activities at the country level focus on both the availability and the quality of data – both must be assured. Efforts to meet these challenges include:

- Host country HIV-related strategic information capacity-building
- HIV surveillance and surveys
- Data quality assessments
- Information management systems for patient tracking and program monitoring
- Best practice evaluations and targeted evaluations across countries
- Coordination across USG agencies and international partner organizations

International Coordination

In the context of Emergency Plan support for host nations, coordination with other international partners is central to PEPFAR's strategic information efforts. One of the Three Ones principles for international coordination at the country level (discussed in the chapter on Strengthening Mulilateral Initiatives) is to support one national monitoring and evaluation (M&E) system. International partners are deeply involved in the responses of many nations hard-hit by HIV/AIDS, and uncoordinated efforts have the potential to handicap national responses.

In the surveillance arena, the USG participated in and supported regional UNAIDS surveillance trainings on estimating HIV prevalence and incidence. With the World Health Organization (WHO), UNAIDS, and others, PEPFAR has supported development of new

Best Practices

Côte d'Ivoire: Data diplomacy – Conducting an AIDS indicator survey in a country in crisis

Côte d'Ivoire's HIV prevalence rate continues to be reported as the highest in the West African region, at an estimated 7% among adults. To date, information on the epidemic has been limited to data collected on pregnant women and high-risk groups. Since September 2002, Côte d'Ivoire has experienced a profound political-military and economic crisis with an uncertain but anticipated exacerbating impact on HIV transmission. In order to better understand the current epidemiology of HIV/AIDS in this crisis environment, the Ivorian national authorities prioritized the implementation of a nationwide population-based AIDS Indicator Survey (AIS). As a result of Emergency Plan financial support and technical assistance, the data-collection phase of the nationwide AIS was successfully completed, despite the difficult conditions that prevailed in 2005.

Sporadic military hostilities gave way to a tense, unpredictable standoff when the AIS was launched in September 2004. Implementation of the survey required overcoming serious obstacles presented by the political-military crisis, which had divided the country into three zones, only one of which was fully controlled by government forces. The challenge of coordinating the implementation of a nationally representative high quality survey in such an environment was assured by an AIS Steering Committee, comprised of host country entities and international partners, with technical leadership provided by a PEPFAR implementing partner. Mapping for sampling and training in data and blood sample collection were completed in the first quarter of 2005, despite large-scale political demonstrations and violence. PEPFAR provided support for in all technical aspects of the survey, including preparation of questionnaires and manuals, training, data processing, and tabulation and analysis plans, even in the northern region where security agents had to be deployed with the technical experts to ensure safe passage.

Data and dry blood spot collection were successfully carried out nationwide between August 4 and October 20, 2005. Analysis of data from the field implementation of the survey is continuing. Despite ongoing tensions and the lack of unified leadership in the country, the response rate of the population in all three zones (government-controlled, rebel-controlled and buffer) was very high. All data were compiled and entered in the database in Abidjan, completing part of the AIS, for which the crisis conditions increased both the price tag and payoff in experience and knowledge gained.

Little is known about the dynamics of HIV/AIDS in crisis conditions, and yet such conditions are fairly common among those countries and populations most affected. The Côte d'Ivoire AIS, which could not have been implemented without Emergency Plan support, will provide high-quality information from such a setting. These data will be invaluable, informing USG HIV/AIDS programming and ensuring cost-effective use of Emergency Plan funding to mitigate the impact of the disease on highly vulnerable populations.

surveillance methods, monitoring of antiretroviral drug (ARV) resistance, and improved laboratory quality testing for HIV.

The USG has come together with WHO, UNAIDS, the UK Department for International Development (DfID), the World Bank, and the Global Fund to Fight AIDS, Tuberculosis and Malaria for a series of meetings on data harmonization. Among the results of these productive consultations were the first-ever joint analysis and release of data on treatment results in January 2005, improved estimates of treatment results by international partners (including PEPFAR), and initial steps toward improving estimates of prevention and care results. The organizations have also collaborated to produce coordinated guidance for reporting of future results.

USG strategic information staff have come together with staff from international organizations for joint training in such areas as monitoring and evaluation and management information systems. PEPFAR, along with UNAIDS, WHO, World Bank and Global Fund staff, offered two regional strategic information training meetings in Africa in fiscal year 2005, with the option of further meetings as needed. During these meetings, coordinated country monitoring and evaluation plans were discussed and outlined.

Working to ensure data quality, PEPFAR has worked with WHO and others to issue standards for the transfer of data among systems and data storage and reporting, and has worked with the Global Fund and the Health Metrics Network to develop a data quality diagnostic tool. Standardized data abstraction, storage, and access procedures will enable stakeholders in USG agencies and partner organizations to participate in antiretroviral treatment (ART) program evaluation and improvement. Consultations were held by international agencies and donors, including the USG, on use of HL7 standards in data transmission and common data storage and confidentiality procedures. These data collection standards will allow programs to efficiently transfer and better monitor progress and identify problems in order to refine and adapt implementation strategies. Analyses of these data will inform clinical decision-making, encourage improvement of ART program implementation, and assess impact of the USG's investment in treatment programs on individuals, families, and communities.

Ensuring accountability is predicated on obtaining high quality information on program results. In recognition of this joint objective, PEPFAR has partnered with the Global Fund and the Health Metrics Network to develop a framework for data quality. Three tools are linked together within this framework that target different stakeholders involved in data collection and results reporting: host country governments, grantees and prime partners, auditors, and USG or Global Fund managers. Initial pilots of the data quality harmonization framework and toolkit in 2005 have received favorable reviews from host country partners and grantees, which benefit greatly from standardized and coordinated approaches to results reporting and strategic information systems development.

Development of common indicators, to the extent possible, is another priority area for Emergency Plan strategic information efforts. PEPFAR is working with other international donors to create or improve indicator guides in such areas as treatment, counseling and testing, stigma, most at-risk populations, and orphans and vulnerable children (a joint effort with UNICEF).

The Emergency Plan and other key partners have collaborated within countries to share common data on program results and surveillance. At the international level, international partners have worked with host nations and each other to compare sub-recipients to help eliminate unnecessary duplication. With the Global Fund and UNAIDS, PEPFAR has established a Joint Monitoring and Evaluation Technical Assistance Facility. This facility, housed at UNAIDS, links countries requesting technical assistance with consultants who can assist them in the areas of need. The Global Fund and the Emergency Plan are also jointly supporting work by the U.S. Census Bureau to estimate infections averted in the 15 focus countries and other key countries

The Emergency Plan has also provided support for the WHO in laboratory surveillance, development of ART patient monitoring and reporting guidance, management

information systems standards, and monitoring and evaluation. For example, PEPFAR has supported WHO's Service Availability Mapping project – a census of health facilities that identifies which facility offers which HIV/AIDS services, critical information for international partner coordination.

Joint U.S. Government Planning

USG SI planning is accomplished in partnership between country strategic information teams and headquarters technical staff. Interagency teams in-country must create one SI plan as part of their annual COP submission. Headquarters SI personnel are also members of country core teams, supporting country teams through technical assistance, training, and work with international partners to assure common surveillance, MIS, and monitoring and evaluation guidelines and definitions.

USG and UNAIDS SI field officers and their national counterparts met in Tanzania to coordinate country monitoring and evaluation activities contributing to the goal of one national monitoring and evaluation system in each host nation.

In fiscal year 2005, the USG agencies implementing the Emergency Plan made further advances in integrating their surveillance, HMIS, targeted evaluation, and M&E activities. Building on success in 2005, both headquarters and country USG offices developed updated annual activity plans and joint budgets for strategic information for fiscal year 2006.

An important activity in fiscal year 2005 was the development of a number of SI technical working groups focused on developing standards and supporting country programs. Working groups address the following technical areas:

- Management information systems
- Surveillance
- Indicator development and reporting
- Monitoring and evaluation capacity-building

The Scientific Steering Committee, through its subcommittee on targeted evaluations, also guides headquarters participation in targeted evaluations. Twenty-five targeted evaluations, including some that had previously been initiated, were conducted in fiscal year 2005, and the number is expected to grow in the coming year.

In addition, fiscal year 2005 saw headquarters SI advisors help country teams to address challenges in Emergency Plan implementation, including target setting, COP submission, and results reporting. SI country liaisons helped to ensure submission of high quality data from the field.

In fiscal year 2005, the Country Operational Plan and Reporting System (COPRS) became fully operational. This web-based information system allows for the annual entry and updating of Emergency Plan COPs, annual and semiannual program results, and budget information by the focus country teams. Information can now be rapidly searched and reported by key factors and areas of interest to the program, including partner and partner type, program area, geographic coverage, gender issues, indicator targets and results, and budget.

The reporting burden task force formed in fiscal year 2005, which is discussed in the chapter on Implementation and Management, addressed and resolved many of the SI reporting issues raised by country teams.

As noted in the chapter on Prevention, PEPFAR created a Scientific Advisory Board to review data on the possible protective effect of male circumcision and to provide evidence-based guidance to Emergency Plan programs.

Table 10.1 - Strategic Information: FY05 Capacity-Building Results

Country	Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)
Botswana	100
Cote d'Ivoire	400
Ethiopia	2,700
Guyana	63
Haiti	600
Kenya	1,000
Mozambique	82
Namibia	100
Nigeria	1,900
Rwanda	500
South Africa	2,000
Tanzania	3,300
Uganda	3,700
Vietnam	300
Zambia	1,200
Total	**17,900**

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.

Surveillance Information to Track HIV Incidence, Prevalence, and Mortality

Surveillance information on HIV is important not only for countries to understand the dimensions of their national epidemics, but for assessing the impact of their interventions in response. PEPFAR supports such country efforts as behavioral surveillance surveys, demographic and health surveys (which have an HIV/AIDS module), AIDS indicator surveys, antenatal clinic surveillance, and most-at-risk population surveys.

In Kenya, the USG's investments in surveillance systems and surveys have been critical in producing data to monitor trends in HIV prevalence. Sentinel surveillance in pregnant women has been conducted annually since 1990, and the past year's analysis of the 2004 surveillance data demonstrated a continued drop in HIV prevalence among pregnant women from a high of 13.5 percent in 2000 to a national estimate of 7.4 percent in 2004. Additional USG support was provided in 2005 for the Kenya Demographic and Health Survey, the first national survey of HIV prevalence. Analysis of this survey's data provided further evidence of a decline in HIV prevalence in Kenya from 10 percent to 7 percent among adults 15 – 49 years of age from 1998 to 2003. Sentinel surveillance data were collected again in 2005, and will provide important measures of the potential impact of the USG's contributions to the prevention of HIV transmission in Kenya.

Behavioral surveillance is becoming more closely linked to HIV testing, with those surveyed offered testing, yielding additional data points on HIV prevalence. PEPFAR is also planning sentinel site surveillance to monitor treatment outcomes, as well as HIV-related morbidity and mortality. During 2005, the Emergency Plan drafted a protocol for ARV resistance surveys.

SAVVY (Sample Vital Registration with Verbal Autopsy) is an established best practice to collect sample vital registration information on national populations. In places where vital records systems are weak, SAVVY can improve the ability to estimate the levels and causes of morbidity and mortality through "verbal autopsies" conducted by interviewing surviving household members.

PEPFAR supports development of comprehensive curriculum and training materials to improve tuberculosis (TB)/HIV surveillance in TB clinics. This complements the successful electronic TB registers the Emergency Plan supports, which aid in tracking people living with HIV/AIDS (PLWHA) receiving TB care and treatment.

The USG supported testing of the BED-capture enzyme immunoassay (VED-CIA) to assess overall incidence trends in HIV epidemics. Testing efforts included working to make the assays available, training laboratory staff, and developing protocols to bring the assays to surveillance sites.

In recognition of the need to adapt surveillance strategies to the realities of particular countries, PEPFAR, in conjunction with international agencies, has developed tools and plans for surveillance in countries with concentrated epidemics.

Results of PEPFAR-supported surveillance efforts to date include improvements in HIV baseline estimates, methods for estimating and projecting incidence and prevalence, definition for AIDS case reporting, and methods for ART resistance surveillance.

Program Reporting and Monitoring Mechanisms

PEPFAR's central program monitoring process includes five-year strategic plans and annual COPs that set objectives, and annual and semi-annual reports on documentation of program results. Fiscal year 2005 saw the Emergency Plan's first full cycle of semi-annual program results reporting from the focus countries, and the quality and efficiency of reporting is improving with each new report. Results from the two fiscal year 2005 reports influenced program and budget decisions for fiscal year 2006.

PEPFAR's move to electronic reporting via the COPRS database is streamlining the process significantly, as country teams directly upload information that headquarters personnel can then download and review. The Emergency Plan conducted training and workshops on monitoring and evaluation for strategic information personnel in the focus countries – each of which now has an

Best Practices
Mozambique: Putting strategic information to work

The Emergency Plan recognizes the importance of strategic information, not only for accountability to the American people on what has been achieved against established targets, but also for program planning, advocacy, resource allocation decisions, and effective implementation. Reaching national consensus on where the HIV/AIDS epidemic is and where it is going is essential for planning, resource allocation, and evaluating results – yet such consensus is often lacking in the countries most affected by HIV/AIDS.

The Mozambique Multisectoral Technical Group (MTG) was formed in 1999 to advise the government on interpreting sentinel surveillance data on HIV prevalence and on improving data collection. The MTG includes broad representation from government agencies and others, and analyzes sentinel surveys, recommends changes to the surveillance system, and produces HIV/AIDS impact projections with internationally-recognized techniques. The U.S. Government (USG) has provided the technical and financial support that has been the driving force behind the MTG since its inception.

The strategic information generated by the MTG is discussed and approved in national consensus forums, involving national and international partners. MTG reports and analyses have been used as the most reliable sources of information about HIV prevalence and demographic impact. National advocacy groups and policy programs use MTG information for advocacy, resource mobilization, monitoring and evaluation, and for programmatic purposes such as estimating the number of people to be covered by specific interventions.

At the national level, the data generated by the MTG is used to draw a picture of the national HIV/AIDS situation, and has been used to inform key policies and programs to address the challenges of HIV/AIDS. This partnership – Emergency Plan funding, U.S. technical support, and strong leadership of Mozambican experts – has created a mechanism for the analysis and dissemination of HIV prevalence data and demographic impact. USG support for the work of the MTG has helped to provide the Mozambican government and civil society with a reliable and accurate source of data generation and analysis. In order to sustain and build capacity for analyzing and using improved data at more local levels, the national MTG has begun setting up provincial technical working groups that will help replicate the process throughout the country, broadening the availability and use of high quality strategic information in Mozambique.

SI team. PEPFAR is also working to integrate monitoring into staff training curricula on an ongoing basis. In fiscal year 2005, common indicator guidance was developed for USG agencies to use in their results reporting.

All USG partners provide semi-annual program results reports to USG activity managers on progress and challenges. PEPFAR staff also conduct regular site visits to review partner activities and assess the quality of data reported by partners. In South Africa, many new local partners were engaged to rapidly scale up HIV/AIDS programming in 2005. The USG SI team prioritized strengthening the M&E capacity of these partners as an essential component of effective program implementation. Implementing partners all attended one or more M&E capacity building workshops in 2005 and benefited from individualized site visits from M&E experts. As a long term strategy, the South Africa team is leveraging other USG investments in the University of Pretoria, which implements an M&E track in the Masters of Public Health program. Through an innovative internship program, recent graduates of the Masters program are matched with PEPFAR partners that are in particular need of M&E support.

PEPFAR invested in the development of a data quality diagnostic tool as a practical guide for program managers to improve the quality of data collected according to Emergency Plan guidance. Initial piloting of the tool has proven its effectiveness in aiding program managers to generate and manage data for advocacy and program improvement decisions. The USG has leveraged WHO and Global Fund in support of the development of a broad set of data quality tools, with the intent of training host country partners in their use in fiscal year 2006.

The Emergency Plan M&E capacity-building technical working group has being working collaboratively with UNAIDS, the Global Fund, and WHO on the development of guidelines for the evaluation of M&E capacity-building in recipient countries. Application of these guidelines is planned for fiscal year 2006, with the identification of best practices for wide dissemination.

Health Management Information Systems

Emergency Plan HMIS support pursues four key objectives:

- Assisting in the reporting of core indicator data
- Improving country capacity to collect client-level and clinical service/medical records information to assist in daily management of individual patient care
- Improving capacity to collect facility-, district-, and country-level information to assist with clinic and program management
- Supporting development of international guidance and standards for systems that store and transfer HIV-related information

HMIS developments in fiscal year 2005 include the application of USG and other health reporting technologies in developing country reporting and patient medical records monitoring systems. Technologies being piloted include smart cards, cellular phone reporting systems, and integrated patient management and prescription electronic records. Software tools for laboratory information systems have been inventoried, and PEPFAR has increased its use of geographical information systems. PEPFAR support for strategic information tools to help host nations improve clinical care management is described in the chapter on Building Capacity for Sustainability.

Examples of Emergency Plan-supported HMIS enhancements in 2005 include the following:

- In Botswana, the USG is piloting UNAIDS-developed software for national-level program reporting, and is investing in South African-designed patient medical records and reporting software.
- South Africa's Emergency Plan team has invested in biometrics and smart card technologies for ART, medical records and reporting, the Training Information Monitoring System, and a Strategic Information Data Warehouse.

Best Practices
Rwanda : TRACnet enhances monitoring of ART scale-up

When Rwanda's antiretroviral scale-up became fully operational in early 2004, the government needed a system for collecting current site-level data on the status of antiretroviral treatment (ART). With Emergency Plan support, Rwanda implemented TRACnet, a web-based system that provides monthly ART program indicators reporting, weekly reporting on drug shortages and stock outs, and case-by-case reporting of CD-4 test results.

Unlike many reporting systems, TRACnet accepts both phone and internet-based data entry. In Rwanda, internet access is limited, and an internet-only system would limit the reporting capabilities of specific centers. The fact that 85% of users input data via phone illustrates the importance of phone-based reporting capabilities. TRACnet has been deployed in 50 out of 53 health facilities offering ART in Rwanda, accounting for 95% of all ART patients.

The benefits of working with TRACnet to date include: allowing national decision-makers to quickly analyze and respond to time-sensitive information; enabling improved planning and response to critical needs down to the facility level; and tracking key program indicators to identify trends and view program impact over time.

In the future, TRACnet will be expanded to include prevention of mother-to-child transmission and counseling and testing modules, and will offer laboratory features to more sites. TRACnet will be interfaced with clinical information systems and will potentially be integrated with the National Health Information System.

- Uganda's USG team has invested in CAREWare for maintaining medical records, and the host government has also invested in a second patient monitoring and ART tracking system, the Anti-Retroviral Information Management System.
- In Zambia, the USG has supported the development of a national ART information system as part of the national HMIS, which is being used in all public health facilities providing ART services in the country. Nearly 300 health workers have been trained in its use. Local capacity to sustain the system's functioning has been strengthened by integrating ART data collection procedures into pre-service health worker curricular ART modules in nursing schools. An electronic version of the HMIS/ART information system was also developed and deployed in "level 2 and 3" hospitals in 2005.

Internal Reviews

During fiscal year 2005, programs of the Emergency Plan were audited by the Inspector General (IG) of the Department of State, as well as the Inspectors General of other USG implementing agencies such as USAID, the Peace Corps and HHS. For example, the Department of State's IG inspected posts in Botswana, Malawi, Zambia and Zimbabwe. USAID completed audits of Emergency Plan programs in Ethiopia, Rwanda, Kenya, Zambia, Haiti, and Uganda, and the Peace Corps completed audits in Uganda, Kenya, Namibia, Mozambique and Zambia.

In addition to its data and financial auditing efforts, the Office of the U.S. Global AIDS Coordinator (OGAC) has engaged an independent contractor to conduct a special Program Audit to assess implementation of ABC prevention activities by Emergency Plan grantees and subgrantees.

The Emergency Plan has also funded the MEASURE Evaluation Project to provide:

- Data quality audit guidance for program-level indicators
- Best practices for program-level reporting
- Implementation of data standards guidance in select countries

These products will help PEPFAR develop systems and processes that contribute to long-term, sustainable, high-

quality HIV/AIDS monitoring and evaluation capacity in host nations.

External Reviews

The Emergency Plan is also the subject of several reviews by external entities, and PEPFAR is working with these reviewers to ensure successful evaluation and use of their findings for program improvement.

The Government Accountability Office (GAO) is reviewing HIV/AIDS prevention under PEPFAR. This review is being done at the request of the U.S. House of Representatives' Committees on International Relations and Government Reform. The review addresses PEPFAR's strategy for HIV/AIDS prevention, its interpretation and implementation; obligation, expenditure, and allocation of prevention funding; and the award process for implementing partners. During fiscal year 2005, GAO representatives traveled to four focus countries and regularly discussed prevention efforts with senior staff members of OGAC.

Congress has also mandated the U.S. Institute of Medicine (IOM), a non-governmental entity, to evaluate Emergency Plan implementation. The task of the IOM Committee for the Evaluation of PEPFAR Implementation is to examine a variety of measures of program success, in order to provide constructive information to the U.S. Congress. Evaluation measures are being derived from a variety of sources, including baseline information and information on activity design at the point of funding decisions, at the point of implementation, and at intervals thereafter. During fiscal year 2006, members of the Committee will conduct site visits to focus countries. In fiscal year 2005, the IOM Committee produced a report, entitled *Healers Abroad*, that provided recommendations relating to potential involvement of American volunteers in PEPFAR activities.

Identifying Best Practices

PEPFAR has established an SI Technical Working Group to guide improvements in this area. Under discussion for fiscal year 2006 is a shared USG staff website that will allow implementing agency personnel across all countries to collaborate with one another and share best practices.

Because of the Emergency Plan's focus on producing results through sustainable programs of high quality, identifying evidence-based best practices is a core principle. Determining key evaluation questions, monitoring methods and results, and evaluating programs and activities on the ground are critical elements in bringing about continuous program improvement.

Many promising proposals for targeted evaluations have been considered by the subcommittee on targeted evaluations of the PEPFAR Scientific Steering Subcommittee. This body of USG program implementers, evaluators, and research scientists conducted technical review of proposed targeted evaluations for fiscal year 2006, and its input was reflected in funding decisions.

As noted above, PEPFAR is also considering the possibility of joining with other donors to establish a centralized mechanism for technical assistance to countries implementing monitoring and evaluation.

The Second Annual Field Meeting on the Emergency Plan in Addis Ababa, Ethiopia, included many presentations on information collection and serialization by country teams, affording another important opportunity for dissemination of best practices to in-country teams as well as to host governments and other partners represented at the meeting.

Key Challenges and Future Directions

Many of the countries where PEPFAR is at work have historically suffered from weak health information systems, and thus have few personnel trained in the area. The SI challenges of these under-resourced nations remain immense.

Disruptions to national health systems include major setbacks to developing nations' efforts to monitor and evaluate programs, as these activities are often the first things to be abandoned during emergencies. During fiscal year

2005, Haiti and Côte d'Ivoire experienced difficult challenges due to natural disasters and civil unrest, complicating the reporting task of in-country teams.

Attribution of results of upstream Emergency Plan program support (as described at the end of the Prevention, Treatment, and Care chapters) for national programs is an ongoing challenge. There is typically a lack of USG presence at the sites where the upstream support is being put to use, making PEPFAR dependent on host government reports. In addition, the fact that Emergency Plan support for national efforts is provided in close collaboration with other donors makes attribution of results especially difficult. PEPFAR is working with host governments to refine attribution of results in these contexts.

Another key challenge is posed by the new joint USG/WHO ARV guidelines, which provide medical records standards. The Emergency Plan is working to ensure technical assistance and training in medical records systems as this change takes place.

As noted above, ensuring the data quality in resource-constrained settings remains difficult, and PEPFAR is addressing this issue by providing training for country teams and partners on data quality tools.

PEPFAR has continued to work to build systems in-country for partner accountability and reporting. Some host nations have embraced database approaches analogous to PEPFAR's COPRS, and the USG is working with additional countries to facilitate their adoption of similar tools.

Another challenge in fiscal year 2006 will be the implementation of results reporting by a greatly expanded group of country teams – those in nations beyond the focus countries that receive more than $1 million in PEPFAR support.

At the Annual Field Meeting in Addis Ababa, Ethiopia, Ambassador Tobias honors the Emergency Plan team from Zambia with the Spirit of PEPFAR Award: "In recognition of effectiveness in moving toward Emergency Plan goals, supporting sustainable and innovative programs, cooperating across agencies, engaging new partners, coordinating the efforts of all stakeholders, and communicating about these efforts to the public."

"We're making good progress, and none of it would be possible without the devotion and professionalism of our partners on the ground: courageous leaders of African nations who care about their people and who tell the truth; doctors and pharmacists who work without rest in overcrowded wards; health workers, often with HIV themselves, who visit homes and make sure people are taking their medicine; people who run youth groups and clubs that encourage abstinence and help children with HIV face the challenges of life."

President George W. Bush
World AIDS Day
December 1, 2005

Chapter 11
Implementation and Management

Implementation and Management

Goal

Efficient, effective, and accountable use of resources

Achievements in Fiscal Year 2005

- Obligated approximately $2.9 billion
- Expanded PEPFAR strategic vision to all bilateral HIV/AIDS programs and transferred key country team best practices beyond the focus countries
- Developed new tools to strengthen and improve performance-based budgeting
- Established a task force to streamline reporting burdens on field personnel and implementing partners and streamlined the semi-annual results reporting process
- Established a technical working group on commodities procurement
- Established a consortium of partners for supply chain management
- Held second annual field meeting to facilitate flow of lessons learned and best practices among Emergency Plan personnel and with key implementing partners

At the inception of the Emergency Plan, the imperative to embrace a "new way of doing business" created numerous implementation and management challenges. New organizations were created within the U.S. Government (USG), and existing organizations began to work together in new ways, in order to implement the unified PEPFAR approach to global HIV/AIDS.

At the end of the second year of PEPFAR implementation, structures and practices are continuing to evolve. Yet in light of the early results achieved by the Emergency Plan, there is a broad recognition – widely shared within and beyond the USG – that the interagency PEPFAR model is working and should be maintained. Credit for this belongs to the people of the Emergency Plan's primary implementing agencies – the Departments of State, Defense, Health and Human Services, Commerce, and Labor; the U.S. Agency for International Development; and the Peace Corps. Both in the field and in Washington, they have demonstrated the power of a unified USG response.

The character of the implementation and management challenges facing the Emergency Plan has changed. Increasingly, the issues are no longer the organizational "startup" issues of a new venture, but the challenges of a highly successful venture that must manage rapid growth. With leadership from the Office of the U.S. Global AIDS Coordinator (OGAC) and the commitment of the implementing agencies, the Emergency Plan is focused on these operations challenges.

Operations initiatives

Key policy structures established during fiscal year 2004 were maintained and strengthened. The U.S. Global AIDS Coordinator continues to chair a weekly policy meeting of principals from the lead implementing agencies, while OGAC senior staff chair a weekly meeting of deputy principals focused on program management issues. A Scientific Steering Committee also meets regularly to ensure the highest quality technical approaches and leadership. Decision-making processes have been formalized and overall communication has been strengthened.

Technical and operations working groups, co-chaired by OGAC and agency personnel with headquarters and field representation, formulate technical guidance and support implementation in the field. An interagency Core Team also continues to serve as a channel for information to flow between the field and headquarters, as well as a source of technical assistance. Weekly News to the Field email messages also serve as a vehicle for dissemination of guidance and other information to the field.

Policy guidance for program implementation in the field was issued or is in the final stages of development in the following areas: Prevention of Sexual Transmission of HIV using the Abstinence, Be Faithful, and correct and consistent use of Condoms (ABC) approach; Palliative Care; Orphans and Vulnerable Children (OVC); Preventive Care Packages for Adults and Children; Injecting Drug Use; Procurement of Commodities; and Food and Nutrition.

The Coordinator decided not to pursue appointment of a Chief Operating Officer, as was contemplated at the time of last year's Annual Report to Congress. Instead, an operations division was established within OGAC to troubleshoot issues and devise systematic solutions.

In the focus countries where the interagency country team approach has been pioneered, it has sharpened the focus of programming, helping to ensure that decisions are made in a strategic fashion. This model has also helped to promote a unified strategy and voice for interactions with host governments and other partners. The expansion of this successful approach to a growing number of countries will be a PEPFAR priority in fiscal year 2006 and beyond. In the field, PEPFAR is working to disseminate best practices developed in the focus countries to the larger group of nations in which the Emergency Plan operates. One of these best practices is the country team leadership model. While this model is expected to be in place in all USG bilateral programs, in eleven additional countries in fiscal year 2005, additional steps were taken to consolidate a strategic interagency approach.

The heart of this approach is Ambassadorial leadership of a unified interagency team, which produces a five-year country USG strategy and an annual Country Operating Plan (COP) outlining the allocation of budget and activities to describe how the strategy is made operational. In keeping with the principles of the Three Ones, these are developed in close consultation with implementing partners in country, in particular the host country government, to 1) reflect unique challenges and opportunities for each country; 2) ensure support of host-country HIV/AIDS strategies; 3) effectively build on the comparative advantage of USG expertise; and 4) complement other international partners' programs. Eleven additional countries outside of the 15 focus countries submitted five-year country strategies and five of these countries also submitted modified COPs for fiscal year 2006 planning.

The COP, submitted by U.S. Ambassadors in their capacities as leaders of PEPFAR country teams, is a statement of annual targets for the coming year, along with detailed program and budget plans to achieve them. Because they offer a detailed description of what the USG expects of each implementing partner for the year, the COPs

have proven to be a key tool for tracking partner performance in-country.

Fiscal year 2006 is the third year for which COPs have been required in the focus countries, and both the COPs themselves and the process for their review continue to improve with each year of experience. After submission of the COPs to OGAC, an interagency technical team assessed the technical quality of proposed activities and management as well as consistency with Emergency Plan strategies. Programmatic teams then reviewed entire COPs from a more strategic perspective, incorporating the technical findings. The findings were then discussed in detail with country teams. Program review teams submitted recommendations and comments to an interagency principals committee chaired by the Coordinator, who made final funding decisions.

Ambassador Tobias views drugs in storage at a medical facility in Namibia. The Partnership for Supply Chain Management will help to ensure quality and efficient procurement of drugs and other commodities.

The results reporting system is critical to Emergency Plan accountability and is another key element of this country team approach. It is being expanded in stages to the bilateral programs outside of the focus countries. In fiscal year 2006, all bilateral programs that receive $1 million or more in USG HIV/AIDS funding will report against a set of indicators standardized across the Emergency Plan. Specific reporting requirements by country are determined by funding level and are detailed in the general policy guidance document for all bilateral programs that is explained in the chapter on Strengthening Bilateral Programs Worldwide.

In order to facilitate transparent communication with the general public as well as PEPFAR personnel and partners, OGAC significantly upgraded its website in fiscal year 2005, making a growing amount of information on program activities available. Further website improvements are planned for fiscal year 2006. OGAC is also developing an Information Technology Strategic Plan. This will promote use and dissemination of relevant PEPFAR information to the public and to personnel and partners in the field, as well as addressing the operational needs and data management issues of PEPFAR.

In order to evaluate the staffing required to implement and manage PEPFAR, OGAC is examining current staffing requirements at headquarters and in the field, with the goal of developing a long-term USG staffing plan for implementation of HIV/AIDS programs.

Performance-based budgeting

From its inception, the Emergency Plan has insisted on tying funding to results, a practice not always characteristic of international development initiatives. Funding and continuation of partnerships with individual partners depends on their performance against the targets set by country teams and partners and finalized in the COPs.

In the field, country teams conducted annual reviews of partner performance prior to submitting COPs for the succeeding year. In particular countries, these reviews have included:

- Pipeline analysis to assess partner efficiency in putting funds to work
- Assessment of cost-effectiveness of partner activities
- Performance of partners against targets established in the COPs

The Emergency Plan has developed significant new tools to strengthen this performance-based budgeting approach. Based on analysis conducted during fiscal year 2005, select high-performing countries received additional resources for fiscal year 2006, while others that performed below expectations were maintained at their base levels. In fiscal year 2006, PEPFAR will continue to apply and refine its tools for performance-based budgeting to

ensure optimal use of prevention, treatment, and care resources.

As of September 30, 2005, the Emergency Plan had obligated approximately $2.9 billion during fiscal year 2005.

Annual field meeting

"Building on Success: Supporting National Strategies," the Second Annual Field Meeting of the Emergency Plan, was held in Addis Ababa, Ethiopia in May 2005, providing an opportunity for an exchange of information in many directions.

Ambassador Tobias presents the "Against All Odds" award to the Haiti Country Team at the Annual Field Meeting. The award was given to PEPFAR teams in Haiti and Cote d'Ivoire, who continued to lead Emergency Plan implementation despite serious challenges within their countries.

The Field Meeting, which had been limited to USG personnel in 2004, was opened to representatives from selected PEPFAR partners, including those from host governments and indigenous community- and faith-based organizations. In addition to extensive programmatic presentations and papers, representatives of the Emergency Plan teams in each focus country – led by their Ambassadors – reported on their implementation challenges, successes, and lessons learned. This sharing of information generated invaluable dialogue among the teams.

Streamlining reporting requirements

The Field Meeting included significant opportunities for conversation between field teams and OGAC headquarters personnel. One recurring theme expressed by personnel in the field was concern about the burdens they face in reporting information to OGAC, host governments, their home USG agencies, and other entities that conduct reviews of PEPFAR operations. Many personnel described these reporting obligations as limiting their efforts to manage other activities.

In response, OGAC organized a Reporting Burden Task Force, which conducted field visits and discussions with personnel in the implementing agencies and with partners to investigate the reporting requirements – both from the Emergency Plan and from other sources – facing PEPFAR personnel.

This Task Force has already completed an initial assessment in four countries and is working on several recommendations to the Coordinator on opportunities for streamlining reporting requirements while ensuring continued collection of information needed for such purposes as accountability and quality assurance. Already, the reporting requirements for the March semi-annual report have been significantly streamlined.

Commodities procurement

PEPFAR efforts to build capacity for the delivery of services in the focus countries have succeeded to such a degree that capacity in many countries now exceeds USG funds to provide services. This situation makes it essential to ensure that available funds are being used with maximum efficiency. With the rapid growth in the availability of treatment services under PEPFAR, management issues around the procurement of commodities – including antiretroviral drugs (ARVs) – are important. Interruptions in the supply of ARVs are potentially disastrous for people who are receiving life-saving treatment services and the Emergency Plan is committed to supporting a supply system that avoids this situation.

To address any issues as they arise while also planning for the future, the Emergency Plan established an interagency commodity procurement technical working group in fiscal year 2005. This working group is actively engaged and has worked closely in countries such as

Haiti, Zambia, Vietnam and South Africa to prevent any interruption in ARV supply. In addition, the working group has identified as a best practice the need to have one member of the USG in-country team designated as the point person for commodity procurement across USG agencies. In fiscal year 2006 the group will work with the Partnership for Supply Chain Management to help establish standard commodity projection and procurement plans for countries, as well as guiding implementation of the new partnership, described in the chapter on Building Capacity for Sustainability, as it improves commodities procurement.

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 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), Food and Drug Administration (FDA), and Substance Abuse and Mental Health Services Administration (SAMHSA), 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 (USG) programs.

Examples of HHS programs and activities follow:

- The CDC Global AIDS Program (GAP) has highly trained physicians, epidemiologists, public health advisors, behavioral scientists, and laboratory scien-

tists working in offices in 24 countries (including the 15 focus countries) as part of USG teams implementing the Emergency Plan. Additionally, GAP Headquarters supports 25 countries through its regional offices in Asia, the Caribbean, Central America, and Southern Africa and provides technical and financial support to six additional countries through GAP offices in neighboring countries. With technical assistance from regional and headquarters offices, CDC's Global AIDS Program assists with surveillance, laboratory capacity building, training, monitoring, evaluation, and implementation of HIV/AIDS prevention, treatment, and care programs through partnerships with host governments, ministries of health, non-governmental organizations, international organizations, U.S.-based universities, and the private sector to help implement the Emergency Plan, including supporting the Global Fund to Fight AIDS, Tuberculosis and Malaria. GAP is uniquely positioned to coordinate with CDC's other global health programs, such as global disease detection, public health training, and prevention and control of other infectious diseases such as malaria and tuberculosis, as well as with CDC's domestic HIV/AIDS prevention programs in the United States.

- 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 20 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 manages an expedited review process to ensure that OGAC 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.

- SAMHSA works domestically through domestic State and community programs to treat addiction and dependence, to prevent substance abuse, and to provide mental health services, including support of an educational and training center network that disseminates state-of-the-art information and best practices. This technical expertise and program experience is being applied to the program areas of drug and alcohol abuse in the Emergency Plan.

- 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 Coordinator.

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 countries and through seven regional programs in the remaining countries. 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's staff of foreign service officers, trained physicians, epidemiologists, and public health advisors works with governments, nongovernmental organizations and the private sector to provide training, technical assistance, and

commodities, including pharmaceuticals, to prevent and 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 USG 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 (DHAPP) 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.

Members of the Defense Forces in thirteen Emergency Plan focus countries have been the recipients of DoD military-specific HIV/AIDS prevention, care and treatment programs designed to address their unique risk factors. In these thirteen countries alone, military programs have the potential to impact over 1.2 million active duty troops. With PEPFAR support and in collaboration with the USG, ministries of defense in Emergency Plan countries have developed culturally-appropriate peer education, drama, video, and interactive "edutainment" methods of sharing comprehensive prevention messages with their troops. Military members have been trained to promote HIV prevention on an individual level, and country military programs have supported targeted condom service outlets, with some countries even developing a military-specific theme for packaging and distribution to appeal to soldiers. In 13 of the focus countries, ministries of defense and DHAPP have jointly supported counseling and testing centers. Integrating HIV testing into routine care is also being supported through successful peer-based prevention and education efforts and large-scale efforts to reduce stigma and discrimination in military communities.

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 discrimina-

tion 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 is heavily involved in the fight against HIV/AIDS, having programs in over 90% of its 71 posts, serving 77 countries throughout the world. The Peace Corps implements Emergency Plan programs in 9 of the 15 Emergency Plan focus countries-Botswana, Zambia, Namibia, South Africa, Mozambique, Kenya, Tanzania, Uganda, 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. The Peace Corps' involvement in the Emergency Plan acts as a catalyst as Peace Corps volunteers provide long-term capacity development support to non-governmental, 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)

	FY 2004	FY 2005
EXISTING BILATERAL PROGRAMS	**Enacted**	**Enacted**
USAID Bilateral Programs:	**641**	**477**
Child Survival *HIV/AIDS*	513	347
Child Survival TB	75	79
TB	*75*	*79*
(Malaria)[1]	*80*	*89*
Other Accounts HIV/AIDS, TB	52	50
HIV/AIDS	*42*	*37*
TB	*10*	*13*
(Malaria)	*0*	*2*
HHS Bilateral Programs:	**453**	**472**
CDC HIV/AIDS	134	138
CDC Global AIDS Program	*125*	*124*
CDC International HIV Research	*9*	*14*
CDC TB	2	2
TB	*2*	*2*
(Malaria)	*9*	*9*
NIH HIV/AIDS Research	317	332
State/Foreign Military Finance	**1**	**2**
DOL Bilateral Programs	**10**	**2**
DOD Bilateral Programs	**4**	**7**
Sub-total:	**1,109**	**960**
U.S. Global AIDS Coordinator's Office	**488**	**1,374**
UNAIDS (non-add)	0	*27*
Other Bilateral Programs (non-add)	*16*	*35*
Mother and Child HIV/AIDS Prevention Initiative:	**149**	**0**
USAID Child Survival	*0*	*0*
HHS/CDC	*149*	*0*
Global Trust Fund:	**547**	**347**
USAID Child Survival	*398*	*248*
HHS/NIH	*149*	*99*
Sub-total:	**1,184**	**1,721**
TOTAL, GLOBAL HIV/AIDS & TB	**2,293**	**2,681**
(Total Global HIV/AIDS, TB and Base Malaria) [1]	2,382	2,781

[1] USG spending on Malaria, newly categorized (beginning in FY 2006) as the President's Malaria Initiative (PMI), is now displayed in a separate table and is no longer included in the overall Emergency Plan total. However, because HIV/AIDS, TB and Malaria have historically been grouped together, non-additive line-items for malaria are included in this chart and a separate Emergency Plan total that includes Malaria spending has been provided for comparability purposes.

THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF USES OF FUNDING

(dollars in millions)

PROGRAMS	FY 2004 ENACTED	FY 2005 ENACTED
FOCUS COUNTRIES[1]	845	1,371
GLOBAL FUND	547	347
OTHER BILATERAL PROGRAMS	426	453
IAVI,UNAIDS,MICROBICIDES	71	83
HIV/AIDS RESEARCH	317	332
TB	87	94
[Malaria][2]	[89]	[100]
TOTAL EMERGENCY PLAN	2,293	2,681
TOTAL EMERGENCY PLAN, With Malaria	2,382	2,781

[1] Includes funding for country budgets, central programs, and strategic information and evaluation activities, and technical oversight and management costs.

[2] USG spending on Malaria, newly categorized (beginning in FY 2006) as the President's Malaria Initiative (PMI), is now displayed in a separate table and is no longer included in the overall Emergency Plan total. However, because HIV/AIDS, TB and Malaria have historically been grouped together, a separate total that includes Malaria spending has been provided in this chart for comparability purposes.

Allocation of Funding to Focus Countries

(dollars)

Country	FY 04 Actual Country Managed	FY 04 Actual Central Programs	FY 04 Total	FY 05 Planned Country Managed	FY 05 Planned Central Programs	FY 05 Total
Botswana	$17,870,871	$6,472,447	$24,343,318	$43,329,129	$8,508,989	$51,838,118
Cote d'Ivoire	$13,035,496	$11,323,967	$24,359,463	$30,764,505	$13,611,261	$44,375,766
Ethiopia	$40,990,732	$7,099,750	$48,090,482	$75,744,213	$7,987,207	$83,731,420
Guyana	$9,326,543	$2,740,714	$12,067,257	$15,753,000	$3,639,318	$19,392,318
Haiti	$20,326,735	$7,712,683	$28,039,418	$45,094,931	$6,690,090	$51,785,021
Kenya	$71,359,718	$21,114,672	$92,474,390	$124,615,281	$18,321,872	$142,937,153
Mozambique	$25,528,206	$11,940,854	$37,469,060	$50,771,038	$9,446,052	$60,217,090
Namibia	$21,185,762	$3,311,478	$24,497,240	$38,961,474	$3,557,034	$42,518,508
Nigeria	$55,491,358	$15,441,817	$70,933,175	$88,983,642	$21,266,455	$110,250,097
Rwanda	$27,973,778	$11,267,207	$39,240,985	$46,234,725	$10,674,762	$56,909,487
South Africa	$65,424,371	$23,848,617	$89,272,988	$123,860,630	$24,326,797	$148,187,427
Tanzania	$45,791,174	$24,954,400	$70,745,574	$85,683,827	$23,094,268	$108,778,095
Uganda	$80,579,298	$10,194,797	$90,774,095	$132,280,223	$16,155,104	$148,435,327
Vietnam	$17,354,885	0	$17,354,885	$27,575,000	0	$27,575,000
Zambia	$57,933,801	$23,728,609	$81,662,410	$102,745,140	$27,343,465	$130,088,605
Total	**$570,172,728**	**$181,152,012**	**$751,324,740**	**$1,032,396,758**	**$194,622,674**	**$1,227,019,432**

THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF TECHNICAL WORKING GROUPS (NOVEMBER 2005)

Prevention Steering Committee

- Prevention of Sexual Transmission in the General Population (including youth) Working Group
- Prevention of Sexual Transmission in High Risk Populations Working Group
- Medical Transmission Working Group

Care and Treatment Steering Committee

- Adult Treatment Working Group
- Prevention of Mother-to-Child Transmission and Pediatric AIDS Working Group
- Tuberculosis/HIV Working Group
- Palliative Care Working Group
- Counseling and Testing Working Group

Human Capacity Development Working Group

Orphans and Vulnerable Children Working Group

Faith-Based Organizations Working Group

Gender Working Group

Food, Nutrition and HIV/AIDS Working Group

Commodity Procurement Working Group

Procurement and Assistance Working Group

Strategic Information Steering Committee

- Monitoring & Evaluation Capacity Building Working Group
- Indicator & Reporting Working Group
- Surveillance and Survey Working Group
- Management Information Systems Working Group

Scientific Steering Committee

- Scientific Advisory Board
- Targeted Evaluations Subcommittee

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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UNITED STATES PRESIDENT'S
EMERGENCY PLAN FOR AIDS RELIEF