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.

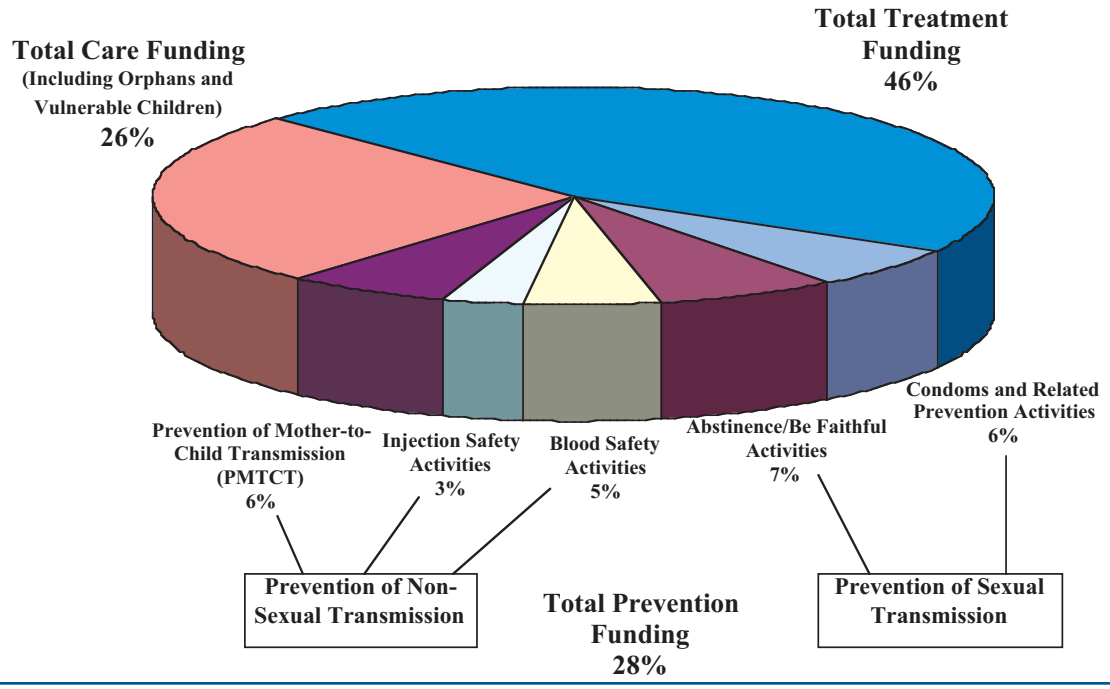
This chapter describes the efforts of the Emergency Plan in the focus nations, where PEPFAR is working within national strategies to identify and scale up interventions that meet the challenges of quality and sustainability. In our second year, we are pleased to note significant progress.

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**

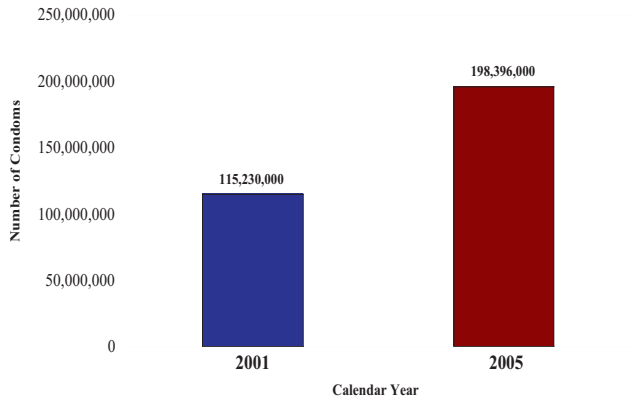
Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.
Footnotes:
[1] AB programs promote as their primary behavioral objectives that: (1) unmarried individuals abstain from sexual activity as the best and only certain way 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 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.

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

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	**724,200**	**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:

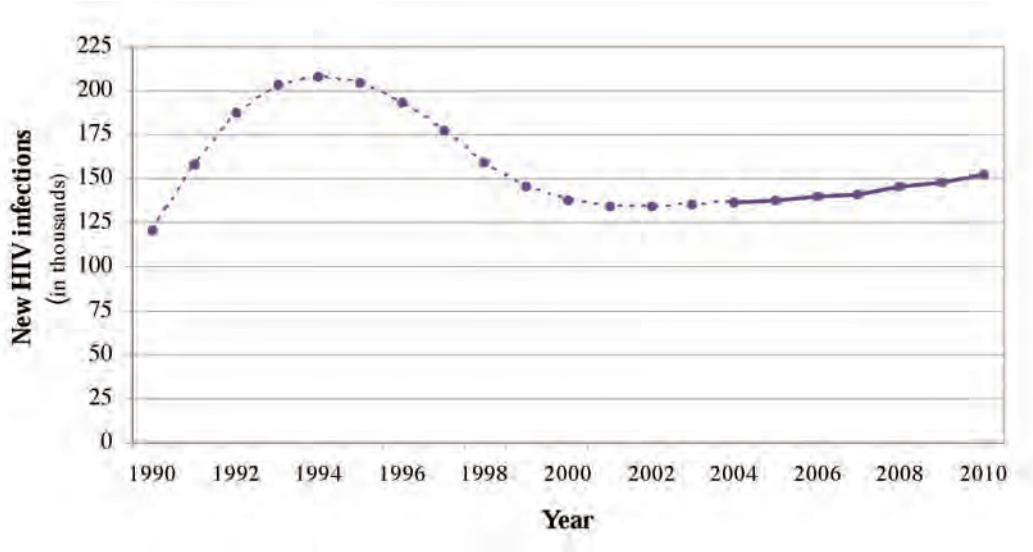
- Data quality audit guidance for program-level indicators
- Best practices for program-level reporting
- Implementation of data standards guidance in select countries

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.