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 antiretroviral 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 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