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

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

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

Chapter 3
Critical Intervention in the Focus Countries: Care

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

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

Care Summary

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

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

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

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

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

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

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

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

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

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

- Support basic needs of orphans and vulnerable children

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

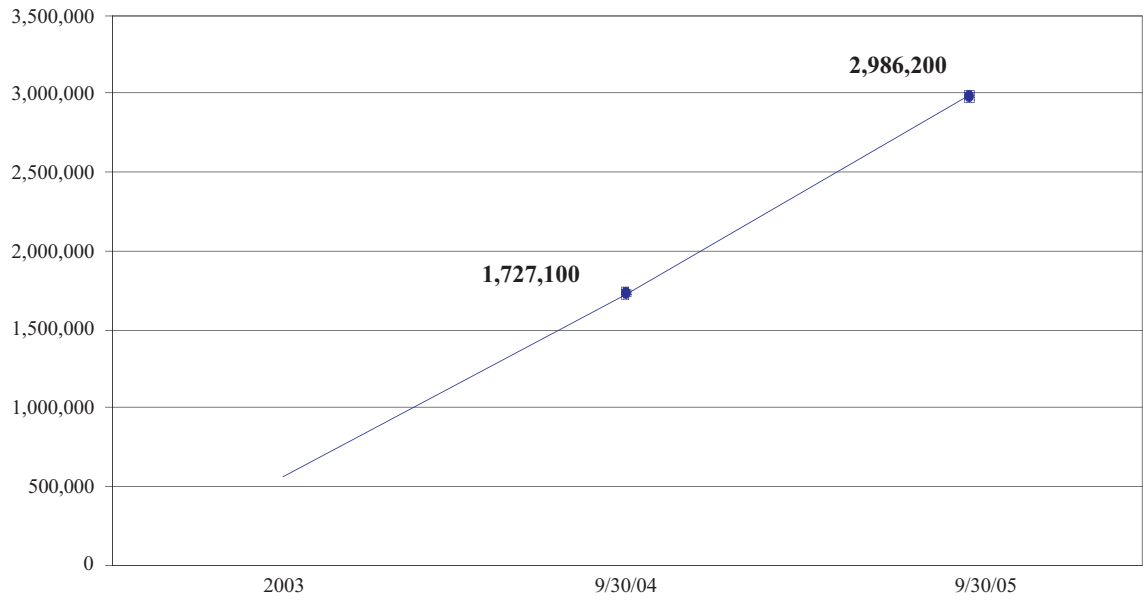

Table 3.1 - Care[1]: FY05 Progress Toward Emergency Plan Target of 10 Million Individuals Receiving Care (including OVC and Palliative Care activities)			
Country	**Emergency Plan 5 Year Target**	**Total number receiving care services[2]**	**Percentage of Year 5 Target Met**
Botswana	165,000	69,800	42%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

Note: Numbers may be adjusted as attribution criteria and reporting systems are refined. Numbers above 100 are rounded to nearest 100.
Footnotes:
[1] Care includes the areas of Palliative Care Basic Health Care & Support and TB/HIV and Orphans and Vulnerable Children.
[2] Total includes the number of individuals reached through contributions to national, regional and local activities such as training, laboratory support, monitoring and evaluation, logistics and distribution systems, protocol and curriculum development and those receiving services at U.S. Government-supported service delivery sites.

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

Orphans and Vulnerable Children

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

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

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

Results: Rapid Scale-Up

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

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

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

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

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

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

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

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

Sustainability: Building Capacity

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

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

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

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

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

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

Key Challenges and Future Directions

Scaling up support to families and communities

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

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

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

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

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

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

Quality of programs for orphans and vulnerable children

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

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

Addressing the special vulnerability of girls

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

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

Education and HIV/AIDS

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

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

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

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

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

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

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

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

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

Working with other sectors and partners for a multisectoral approach

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

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

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

Leveraging partners and resources

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

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

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

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

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

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

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

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

Best Practices

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

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

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

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

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

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

Basic Palliative Care Services Provided Through the Emergency Plan

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

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

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

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

Results: Rapid Scale-Up

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

Emergency Plan support is provided for a variety of interventions at different levels within the network model (including home-based care programs, as well as health care sites that deliver services). In addition, support is provided to fill specific gaps in national training, laboratory systems, and strategic information systems (e.g. monitoring and evaluation, logistics, and distribution systems) essential to the effective roll-out of quality care.

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

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

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

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

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

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

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

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

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

Sustainability: Building Capacity

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

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

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

Footnotes:

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

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

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

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

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

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

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

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

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

Key Challenges and Future Directions

Human capacity

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

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

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

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

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

Footnotes:

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

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

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

Addressing key policies that limit care

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

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

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

Addressing burden on women and girls

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

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

Food and nutrition

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

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

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

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

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

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

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

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

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

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

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

Secure and reliable supply chain for drugs and commodities

As with antiretroviral drugs, a consistent and secure supply chain for commodities and medications is necessary for quality palliative care. The Partnership for Supply Chain Management established in fiscal year 2005 and described at length in the chapter on Building Capacity for Sustainability will help to ensure the quality of these items.

HIV Counseling and Testing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Results: Rapid Scale-Up

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

Of the over 6.6 million counseled and tested in fiscal year 2005, over 3.7 million received these services with downstream PEPFAR support at USG-supported sites, while the remainder were supported through upstream PEPFAR support for countries' capacity to provide services (including assistance for national and regional policies, communications, protocols to ensure quality services, laboratory support, and purchase of test kits). Definitions for upstream and downstream support are provided in the Accountability section at the end of this chapter.

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

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

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

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

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

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

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

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

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

Sustainability: Building Capacity

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

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

Key Challenges and Future Directions

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

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

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

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

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

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

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

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

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

Ensuring quality in counseling and testing

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

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

Accountability: Reporting on the Components of Care

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

Downstream support

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

Upstream support

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

Attribution challenges due to country-level coordination

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

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

Care reporting conventions

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

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

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

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

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

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