Two new motorcycles were presented to the Tanzania Red Cross Society to aid health care workers administering home-based care.

"The Emergency Plan is the single largest international initiative by any country for any disease, and we're making progress each step along the way; one more orphan, one more patient is taken care of or treated, and one more person can live with the disease."

Secretary of State Condoleezza Rice
Remarks at the Swearing-in of the
U.S. Global AIDS Coordinator
October 10, 2006

Chapter 3

Critical Intervention in the Focus Countries: Care

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 by September 30, 2006

- Care for more than two million orphans and vulnerable children.
- Care for more than 2.4 million people living with HIV/AIDS, including over 301,000 who received treatment and care for tuberculosis.
- Supported over 18.6 million counseling and testing sessions to date, including over 9.2 million in fiscal year 2006, through prevention of mother-to-child transmission and other counseling and testing activities.
- Supported training or retraining of approximately 143,000 individuals to care for orphans and vulnerable children in fiscal year 2006.
- Supported training or retraining of nearly 94,000 individuals to care for people living with HIV/AIDS at 8,019 service sites.
- Supported training or retraining of over 66,000 individuals to provide counseling and testing at over 11,300 service sites through prevention of mother-to-child transmission and other counseling and testing activities.

Allocation of Resources in Fiscal Year 2006

Approximately $541 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 (including approximately $63 million for pediatric AIDS). This comprises approximately 31 percent of total focus country resources for prevention, treatment, and care when funding for pediatric AIDS is included, and approximately 27 percent excluding pediatric AIDS funding.

The President's Emergency Plan for AIDS Relief (Emergency Plan/PEPFAR) is committed to supporting societies in developing comprehensive responses that address the many impacts 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 for care is especially great. Approximately half of the more than 39 million people currently living with HIV/AIDS worldwide live in the 15 focus countries of PEPFAR. Of the more than 15 million children orphaned by HIV/AIDS, at least eight million are estimated to live in the focus countries, and many more children are made vulnerable due to the reduced care-taking abilities of their HIV-positive parents. In most of the focus nations, the limited availability of care for those infected or affected by the virus is placing additional stresses on social bonds that already may be severely frayed. Solutions that are of high quality and can be sustained for the long term may be all that protect these societies from unraveling altogether.

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 18 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 caregiver.

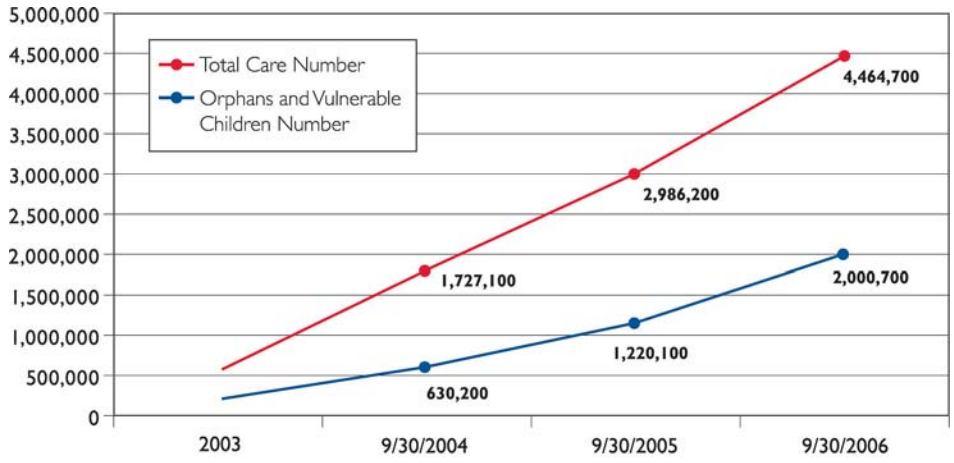
Many communities have traditional, family-based care approaches for children, such as care by grandparents, but even extended family and social structures are being stretched beyond their capacity, overwhelmed by the sheer number of children who are in need of care. Orphans and other vulnerable children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

Also straining these societies are the large numbers of people living with HIV/AIDS (PLWHA) who are in need of care. Both those not yet in need of antiretroviral treatment (ART) and those 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 for the task.

In many cases, caring for family, friends, and children infected or 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 even nations, to respond.

A related challenge is increasing the number of people who know their HIV status. In some surveys, only 10 percent of people know their HIV status, yet when asked, most people say that they would like to know. Confidential counseling and testing provide an entry point to treatment and care,

Figure 3.1: Care: Number of Individuals Receiving Care in the 15 Focus Countries (Orphans and Vulnerable Children + Care for People Living with HIV/AIDS)



Note: 2003 OVC estimate includes all OVCs in focus countries whether or not affected by AIDS.

as well as a crucial opportunity for prevention education – for those who are infected and their partners, and also for those who are not infected. Unfortunately, counseling and testing remain stigmatized and thus are 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 OVCs.
- Support care for PLWHA (also known as palliative care).

Table 3.1: Care[1]: FY2006 Progress Toward Emergency Plan Target of 10 Million Individuals Receiving Care (including OVC and care for people living with HIV/AIDS activities)

Country	Emergency Plan 5-year target	Total number receiving care services[2]	Percentage of 5-year target met
Botswana[3]	165,000	149,300	90%
Côte d'Ivoire	385,000	65,200	17%
Ethiopia	1,050,000	484,100	46%
Guyana	9,000	3,800	42%
Haiti	125,000	77,200	62%
Kenya	1,250,000	546,000	44%
Mozambique	550,000	323,400	59%
Namibia	115,000	142,700	124%
Nigeria	1,750,000	234,600	13%
Rwanda	250,000	100,800	40%
South Africa	2,500,000	763,200	31%
Tanzania	750,000	568,800	76%
Uganda	300,000	511,800	171%
Vietnam	110,000	26,200	24%
Zambia	600,000	467,700	78%
Total	**10,000,000**	**4,464,700**	**45%**

Notes:

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

Upstream and downstream numbers above 100 are rounded to the nearest 100 and then added to get totals.

Footnotes:

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

[2] Total number receiving care includes individuals reached through upstream 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 downstream services at U.S. Government-funded service delivery sites.

[3] Botswana results are attributed to the National HIV Program. Beginning FY2006, USG downstream contributions in Botswana are embedded in the upstream numbers, following a consensus reached between the USG and the Government of Botswana to report single upstream figures for each relevant indicator.

- Support HIV counseling and testing, especially in settings with people at high risk for having HIV (e.g., tuberculosis clinics).

Orphans and Vulnerable Children

Because HIV/AIDS predominantly affects people of childbearing age, its impact on children, extended families, and communities is devastating. If a parent dies of AIDS, the child is three times more likely to die, even though he or she is HIV-negative. Besides increased risk of death, children whose parents have died of AIDS also face stigmatization and rejection, and often suffer from emotional distress, malnutrition, a lack of health care, poor or no access to education, and a lack of love and care. They are also at high risk for labor exploitation, sex trafficking, homelessness, and exposure to HIV. Extended families and communities in highly affected areas often are hard-pressed to care for all the children.

In communities hard-hit by both HIV/AIDS and poverty, there are many children who are not orphans, but who have been made more vulnerable by HIV/AIDS. For example, children whose parents are infected with HIV might not receive the care and support they require, and may instead become their parents' caregivers, dropping out of school and assuming the responsibilities of the head of the household. Research indicates that these children, caring for sick and dying parents, are among the most vulnerable.

The most fundamental way to meet the needs of vulnerable children is to keep their parents alive and well, thus preventing these children from becoming caretakers or orphans. Treatment and care for PLWHA, supported by the Emergency Plan, often enable parents to resume their role as caregivers, allow children to reclaim their childhood, and protect families. Nonetheless, even with treatment and a reduction in HIV prevalence, the number of orphans will continue to rise in many countries. By 2010, the number of children orphaned by AIDS is projected to exceed 20 million, and the number of other children made vulnerable because of HIV/AIDS is estimated by some to be more than double that number.

The Emergency Plan recognizes the urgency of addressing the growing needs of children orphaned or made vulnerable by HIV/AIDS. PEPFAR is committed to the development of evidence-based policy and the implementation of sound practices in the care and support of orphans and

PEPFAR-Supported Services Provided to Orphans and Vulnerable Children

- Strengthening the capacity of families to 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 identify, locate, and protect OVCs and provide both immediate and long-term therapeutic and socioeconomic assistance to vulnerable households.
- Ensuring OVC access to core services including education, vocational training, prevention, treatment, care, psychosocial support, targeted food and nutrition, protection, birth registration, legal services, and other resources.
- Supporting efforts by governments to 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 OVCs and reduce stigma and discrimination.
- Helping OVCs acquire the skills and knowledge to protect themselves from HIV infection.

other children made vulnerable by HIV/AIDS. Our goal is to support these children's and adolescents' growth and development, so they become healthy, stable, and productive members of society.

The Emergency Plan supports varied interventions to enable communities to mobilize their own resources 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 who are faced with both the normal challenges of growing up and heavy economic, psychosocial, and stigma burdens.

OVC services include caregiver training, access to education, economic support, targeted food and nutritional support, protection and legal aid, medical care, psychological and emotional care, and other social and material support. Please see accompanying text box and the chapter on Children.

OVCs themselves face elevated risk of HIV infection, and PEPFAR supports efforts to expand prevention and 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 also can serve as a way to build relationships with their caregivers, who may themselves be in need of services.

Promoting Comprehensive, High-Quality Care: Reporting as a Tool for Better Care

PEPFAR supports comprehensive, high-quality care for OVCs so that these children may live happy, healthy lives with opportunities for a positive future. The important information gained through PEPFAR's reporting requirements serves to further this goal. Reporting requirements also increase transparency and accountability. Therefore, in 2006, PEPFAR changed its OVC reporting structure, to be implemented for reporting in fiscal year 2007.

Direct OVC Support: Direct recipients of support are OVCs who are regularly monitored in the six core areas (food/nutrition, shelter and care, protection, health care, psychosocial support, and education) and whose individual needs are addressed accordingly. Economic strengthening should be evaluated according to its benefit to the six core areas.

- *Primary Direct Support:* OVCs in this category are periodically monitored in all six core areas and receive PEPFAR-funded or -leveraged support during the relevant reporting period, in three or more areas that are appropriate for that child's needs and context.
- *Supplemental Direct Support:* OVCs in this category are periodically monitored in all six core areas and receive PEPFAR-funded or -leveraged support during the relevant reporting period, in one or two areas that are appropriate for that child's needs and context.

The total number of OVCs receiving direct support in a country is the sum of those receiving primary and supplemental support.

Indirect OVC Support: Indirect recipients of support are OVCs who are not individually monitored but who collectively benefit from national- or district-level system-strengthening or other interventions. For example:

- OVCs benefiting from a policy change or improved system (e.g., birth registration, inheritance laws, educational system).
- OVCs benefiting from the training of, or support for, caregivers.

Table 3.2: Care: FY2006 Orphans and Vulnerable Children[1] Results			
Country	**Number of OVCs receiving upstream systems-strengthening support[2]**	**Number of OVCs receiving downstream site-specific support[3]**	**Total**
Botswana[4]	58,800	0	58,800
Côte d'Ivoire	0	22,600	22,600
Ethiopia	0	173,300	173,300
Guyana[5]	0	800	800
Haiti	0	20,000	20,000
Kenya	0	239,600	239,600
Mozambique	0	147,500	147,500
Namibia	51,000	37,700	88,700
Nigeria	1,100	21,200	22,300
Rwanda	14,700	28,700	43,400
South Africa	141,900	107,000	248,900
Tanzania	250,000	145,300	395,300
Uganda	83,100	138,800	221,900
Vietnam	0	2,000	2,000
Zambia	53,800	261,800	315,600
Total	**654,400**	**1,346,300**	**2,000,700**

Notes:

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

Upstream and downstream numbers above 100 are rounded to the nearest 100 and then added to get totals.

Footnotes:

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

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

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

[4] Botswana results are attributed to the National HIV Program. Beginning FY2006, USG downstream contributions in Botswana are embedded in the upstream numbers, following a consensus reached between the USG and the Government of Botswana to report single upstream figures for each relevant indicator.

[5] In Guyana, there was a decrease in the reported number of OVC served in FY2006 as compared to FY2005 due to increased reporting compliance with final OVC Guidance and the OGAC SI indicator definitions; implementing agencies adhere more strictly now to reporting only the number of OVC who received services over a period of time (as opposed and OVC who received services on only one occasion). Additionally, the reporting system utilized by implementing agencies providing OVC services was standardized in FY2006, leading to an increase in data quality and ability to verify numbers reported.

Results: Rapid Scale-Up

In fiscal year 2006, Emergency Plan funding for treatment and care services for OVCs totaled more than $213 million in the focus countries (including approximately $63 million for pediatric AIDS) – approximately 12 percent of prevention, treatment, and care resources (approximately nine percent when funding for pediatric AIDS is excluded). PEPFAR-supported activities reached more than two million OVCs during fiscal year 2006. This figure is in addition to OVCs receiving antiretroviral treatment (ART) through USG programs. More than 1,346,00 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 development. Of those receiving downstream support that partners reported by gender, 51 percent were girls and 49 percent were boys.

PEPFAR seeks to support evidence-based, high-quality OVC programs that result in making a measurable difference in the lives of children affected by HIV/AIDS, so that these children can enjoy their childhoods and grow into healthy, productive members of society. In 2006, to increase the effectiveness and expand the reach of PEPFAR-supported OVC programs, PEPFAR's OVC Technical Working Group (including field staff) developed guidance for OVC programs. The guidance includes principles for program implementation and examples of core services that can be funded by PEPFAR. The guidance emphasizes developmentally based and gender-sensitive programs, along with clear definitions of an OVC and distinctions between OVCs receiving primary and supplemental direct services and those receiving indirect support (please see accompanying text box).

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 must also include those provided by a range of other sources (including other USG programs).

Among the most important potential sources of long-term 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 more than 143,000

Table 3.3: Care: FY2006 Orphans and Vulnerable Children[1] Capacity-Building Results	
Country	**Total number of individuals trained or retrained to provide OVC care**
Botswana[2]	1,600
Côte d'Ivoire	400
Ethiopia	12,600
Guyana	15
Haiti	4,400
Kenya	13,600
Mozambique	24,800
Namibia	4,600
Nigeria	2,200
Rwanda	4,900
South Africa	16,100
Tanzania	21,000
Uganda	25,000
Vietnam	400
Zambia	11,700
Total	**143,300**

Notes:

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

Numbers above 100 are rounded to nearest 100.

Footnotes:

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

[2] Botswana results are attributed to the National HIV Program. Beginning FY2006, USG downstream contributions in Botswana are embedded in the upstream numbers, following a consensus reached between the USG and the Government of Botswana to report single upstream figures for each relevant indicator.

Haiti: Integrating OVC and Other Services

In Fond des Nègres, Haiti, the Bethel Clinic supports a wide range of interventions in children's health and protection, including comprehensive services for orphans and vulnerable children (OVCs). With support from PEPFAR, Bethel Clinic staff and a PEPFAR partner organization have established a successful community-based model for HIV/AIDS treatment and care. The project integrates OVC support services with an antiretroviral treatment program.

In addition to treatment services, OVCs enrolled at the clinic benefit from a wide variety of support activities. Services include support for professional and vocational training fees, and training in subjects such as HIV/AIDS prevention and care, living positively with HIV/AIDS, civic education, health, and hygiene and nutrition.

The Emergency Plan has linked these activities to USAID Food for Peace/Title II support, which provides clients with food rations. At the same time, the program staff works to develop sustainable food sources by actively supporting OVC efforts to develop community gardens. These gardens serve as both a food source and a source of income. Bethel Clinic's integrated program is serving as a model for future projects in Haiti and beyond.

community or family caregivers in the focus nations during fiscal year 2006, enabling them to access time- and labor-saving technologies and income-generating activities, and connecting children and families to health and social services, where available.

Key Challenges and Future Directions

Scaling Up Support to Families and Communities

Isablita Orlando and her daughter Evancia Raimundo, age 10, benefit from HIV treatment and care services, supported by the Emergency Plan in Mozambique.

The ideal for orphaned children is usually 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, HIV/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 concentrates its efforts on strengthening families and communities, working with community- and faith-based organizations (CBOs and FBOs) to identify promising models and bring them to scale. For example, in Fond des Nègres, Haiti, Bethel Clinic supports a wide range of interventions in health and child protection, including comprehensive services for OVCs (see accompanying story).

Quality of Programs for Orphans and Vulnerable Children

Providing high-quality services that make a measurable difference in the lives of the children is essential in programming for OVCs. One way of supporting quality is by requesting programs to monitor the well-being of a child in

six key areas of his or her life and to provide comprehensive services to address the areas of need. In order to facilitate this monitoring and service provision, new service tracking requirements were established in 2006 that will be implemented for reporting in fiscal year 2007. Coordinating activities with government and civil society partners to determine standards of care for delivering effective and efficient services to OVCs also serves to improve quality in line with national plans of action for OVCs. Harmonized care practices paired with continuous quality improvement will enable programs to achieve measurable results in the lives of children.

Addressing the Special Vulnerability of Girls

As noted in the chapters on Prevention and Gender, adolescent 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. They often bear the burdens of care for families impacted by the disease and become primary care providers. Girls are typically the first to lose access to school, as resources are diverted to provide care for persons in households infected with HIV. Such girls are at high risk of abuse and exploitation, violence, and transactional and cross-generational sex – all pathways to HIV/AIDS infection.

Because of this special vulnerability, the Emergency Plan focuses special attention on female OVCs and their distinctive issues. In Mozambique, a PEPFAR partner developed a plan to boost the income of 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 with a local market. When the local school introduced a school uniforms requirement for the new academic year, the existing income-generating activity was incorporated into the on-site manufacture of the school uniforms, with additional skills training provided with USG support.

Working with Other Sectors and Partners for a Multi-Sectoral 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:

- Care & shelter
- Food
- Education
- Vocational training
- Protection
- Health care
- Emotional support
- Substance abuse prevention and treatment

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, therefore, is 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. OVC programs and the OVC technical working group work closely with the United Nations Children's Fund (UNICEF) in particular, on both the

PEPFAR programs target orphans and vulnerable children with support services. These children from Côte d'Ivoire benefit from educational support through integrated care services.

Education and HIV/AIDS

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 the 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 they are able to attend school. Many teachers have been infected with HIV, and their illnesses and deaths have forced schools to close and class sizes to explode.

Yet schooling remains an essential element to 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.

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 the USG's African Education Initiative (AEI), implemented through USAID. The goal of AEI is to improve educational opportunities for Africa's children, so they may lead happier, healthier lives, and become productive members of society.

In June of 2005, President Bush recognized the importance of the AEI by doubling the funding for the initiative. Over the next four years, the United States will provide $400 million for the 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.

An example of effective prevention education in the schools is the Community Health and Nutrition, Gender and Education Support Project (CHANGES-2). Supported by the Emergency Plan and AEI, the CHANGES-2 scholarship program helps to keep nearly 3,500 AIDS-affected orphans and vulnerable children in secondary school and encourages them to play an active role in HIV/AIDS prevention activities.

Ruth, a grade 12 student at Mumbwa High School in Kabwe, Zambia, is one beneficiary of the CHANGES-2 program. When she was younger, Ruth lacked proper care and support at home from her mother, a poor subsistence farmer. Ruth dropped out of school and sought love and comfort in her boyfriend, from whom she contracted HIV.

When she found out that she was HIV-positive, she started antiretroviral treatment. With the life-saving drugs, Ruth regained her health and the willpower to live positively with HIV/AIDS.

Ruth was offered a scholarship from CHANGES-2, which pays for her tuition, books and school uniform. She said, "I want to complete school, become a teacher, and contribute to the nation's development."

country and international levels, to coordinate programs, strategize, and leverage funding.

In many cases, successful programs are those 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.

Food insecurity is a critical challenge for children in many countries, and PEPFAR works with other international and USG partners to leverage food and nutrition resources for OVCs. USG high priority target groups for food and nutritional support include OVCs, especially children under the age of two born to HIV-positive mothers. Support to these groups can include nutritional assessment and counseling, therapeutic and supplementary feeding, replacement feeding and support under acceptable, feasible, affordable, sustainable, and safe conditions, and, where indicated, micronutrient supplementation. For the wider group of OVCs, leveraging nutritional support from other sources is a central focus of PEPFAR efforts. PEPFAR provided guidance to the field on food and nutritional support in May 2006 (*Use of Emergency Plan Funds to Address Food and Nutrition Needs of People Infected and Affected by HIV/AIDS*), and reported to Congress on its activities in this area (Report to Congress: *Food and Nutrition for People Living with HIV/AIDS*). Both documents can be found at *http://www.PEPFAR.gov/progress.*

Tanzania: A Local Leader in the Fight Against HIV/AIDS

Aisha Ally enjoys her work as a community home-based care supervisor. She has nine clients, whom she visits one to three times per week, depending on their condition. Through her work, Aisha has gained respect and prominence in her community. "People love me because I am saving them," she said.

With support from PEPFAR, the Tutunzane program reaches clients who are unable physically or financially to travel to health facilities. It also serves to ease the burden that HIV/AIDS has placed on the traditional medical infrastructure.

Communities ultimately must take ownership of community home-based care activities for them to be sustainable. Aisha found a way to promote community ownership through her job in the local government. She uses her influence in this position to allocate money to help care for PLWHA. If her clients are too sick or otherwise unable to feed themselves, she makes sure they receive assistance from the local government.

Aisha Ally is a leader in her Tanzanian community in the fight against HIV/AIDS.

Local people like Aisha are leading the fight against HIV/AIDS in their own nations and communities, buoyed by the generosity and goodwill of the American people.

Care for People Living with HIV/AIDS

For HIV-positive people, the need for care extends throughout the continuum from diagnosis of 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 (HHS) and the World Health Organization (WHO). In the United States, palliative care sometimes is 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 nearly 40 million HIV-positive people living worldwide at present, it is estimated that about 6.8 million currently need ART. Therefore it is critical to establish programs and services for HIV-positive people that address the needs of those not yet on ART. A key aspect of caring for PLWHA who are not yet on ART is ensuring that they receive ART soon after they are eligible. Studies and program reports show that patients who start ART late, often when their immune systems are already severely compromised and they have serious opportunistic illnesses, do not fare as well as those who start on ART soon after being eligible. In fact, Emergency Plan programs are working hard to enroll PLWHA in care programs that include regular evaluations for ART eligibility – programs that do this have experienced fewer early illnesses and death than other programs.

While the basic health care needs of HIV-positive people and people who are HIV-negative are similar, HIV-positive individuals often require additional care for HIV related symptoms. These care services can include pain and symptom management, treatment and prevention of opportunistic infections (OIs) and other diseases, social, spiritual and emotional support, and compassionate end-of-life care.

In fact, some countries are beginning to standardize their approach and are working with implementing partners to ensure that all HIV-positive people who receive care, even if they are not eligible for ART, receive a "basic preventive care package" that provides a number of these lifesaving interventions (see accompanying text box). These interventions benefit all HIV-positive individuals at every stage of the disease. Moreover, when people receive ART without other needed care, they fail to reap the full clinical benefit of ART. Establishing a basic standard of care allows health

Adult and Pediatric Basic Preventive Care Packages

As part of a comprehensive approach to Care, the Emergency Plan has supported the development of preventive care packages for HIV-positive adults and children. For adults, preventive services include, but are not necessarily limited to: cotrimoxazole, a broad spectrum antibiotic that reduces the risk of opportunistic infections and mortality; insecticide-treated bed nets to reduce the risk of malaria; commodities needed for point-of-use chlorination to improve water safety and reduce the risk of diarrhea; condoms; prevention counseling for people living with HIV/AIDS; counseling and testing for family members; and screening and treatment for tuberculosis (TB).

Although many of the recommendations for preventive care for adults hold true for children, the clinical, immunologic, and virologic manifestations of HIV/AIDS in children differ from those in adults. Moreover, children are growing, have different metabolisms, and are dependent upon adults. As a result, infants and adolescents have very specific and age-dependent needs. Preventive care for children supported by the Emergency Plan includes early diagnosis, prevention, screening and management of opportunistic infections and water-borne illnesses, and nutritional assessment and support.

The prevention of HIV infection in children and the treatment and care of HIV-infected children are important priorities of the Emergency Plan. Since other health programs support basic health care and basic social services for children, in many cases, the Emergency Plan links delivery of HIV/AIDS care interventions with existing community and health facilities that provide such care, supported by other mechanisms. Emergency Plan programs link, where possible, with other Emergency Plan programs, such as those to prevent mother-to-child HIV transmission, those to serve orphans and vulnerable children, and those to provide home-based care. In addition, USG teams in countries that also are part of the President's Malaria Initiative (PMI) and/or are recipients of grants for the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) work closely to integrate Emergency Plan work with activities funded by these programs.

Emergency Plan teams in countries such as Kenya, Nigeria, Uganda, and Zambia are working with host governments and partners to ensure that PLWHAs have access to a minimum package of care services. In Uganda, for example, the Emergency Plan supports district-wide, community-based counseling and testing for families and a package of preventive services. HIV-positive persons obtain replacement commodities from village health workers in their parish. By September 2006, 80,000 kits with the full package of services had been distributed, making substantial progress toward their goal of providing these services to all HIV-positive Ugandans.

Contents of the Emergency Plan's adult and pediatric preventive care packages may be found at *http://www.PEPFAR.gov.*

Care Activities for People Living with HIV/AIDS (PLWHA) Supported by the Emergency Plan

- Evaluation of PLWHA eligibility for antiretroviral treatment (ART) is an important component of providing quality care services. Starting ART as soon as a person is eligible is critical in reducing deaths and morbidity from HIV/AIDS. Many Emergency Plan programs enroll or register PLWHA and have regular clinical and laboratory follow-up to be sure that they receive ART when they become eligible; this sort of follow-up also ensures that they can be offered other key care services.
- Clinical services include preventive care for opportunistic infections (OIs) with antibiotic prophylaxis (e.g., cotrimoxazole), insecticide treated bed nets, and interventions to improve the quality of drinking water and hygienic practices; screening for active tuberculosis (TB), treatment and care services related to the treatment of OIs (including TB); pain alleviation and symptom management; nutritional counseling, assessment and rehabilitation for malnourishment; routine clinical monitoring, including evaluating the need for ART; support for ART adherence; and end-of-life care. PEPFAR support includes advocacy for appropriate policies related to antibiotic prophylaxis and pain control.
- Social care supports community mobilization, leadership development for people living with HIV/AIDS, legal services, linkages to food support and income-generating programs, and other activities to strengthen the health and well-being of affected households and communities.
- Psychological services include mental health counseling, family care and support groups, memory books, cultural and age-specific approaches for psychological care, identification and treatment of HIV-related psychiatric illnesses, and bereavement preparedness.
- Spiritual care includes assessment, counseling, facilitating forgiveness, and life completion tasks.

Exciting Developments in Care for People Living with HIV/AIDS

Among the accomplishments in fiscal year 2006, the Emergency Plan team has worked with the Zambian government for full recognition of the Palliative Care Association of Zambia as a nationally recognized palliative care professional association. Through its leadership, palliative care has evolved from a solely hospice-focused program to a wide-ranging set of preventive, clinical, and supportive care services for PLWHA.

In Ethiopia, the Emergency Plan supports the delivery of elements of the preventive care package for adults, including long-lasting insecticide-treated nets (LLITNs) to prevent malaria in endemic areas, cotrimoxazole prophylaxis, screening for tuberculosis (TB) infection, prevention for positives counseling, condoms, referral of household contacts for confidential counseling and testing, safe water and hygiene support, nutrition counseling, and multivitamin supplementation.

In Rwanda, the Emergency Plan supports palliative care clinical services such as the provision of cotrimoxazole for eligible adults and exposed infants according to national guidelines, referral for CD4 testing, diagnosis and treatment of opportunistic infections (OIs), adherence counseling, clinical monitoring and related laboratory services, nutritional assessment and support, and referrals for community-based care and support services.

In fiscal year 2007, the Emergency Plan will support Rwanda's efforts to implement a preventive care package for children that will include: prevention of serious illnesses like pneumocystis pneumonia, TB and malaria; prevention and treatment of diarrhea; nutrition and micronutrient supplementation; and linkage to national childhood immunization programs.

In Tanzania, with USG support, the National AIDS Control Programme (NACP) has developed national guidelines for palliative care services, a training course and trainer's guide, standardized referral forms, and a simple provider reference guide. The guidelines set out the minimum package for high-quality, facility- and home-based palliative care, including physical care (health care; OI treatment; nursing care; ART monitoring for side effects and adherence; pain/symptom management; nutritional counseling and support; and hygiene), emotional, social, spiritual, legal/economic support; and stigma and discrimination reduction. The guidelines also emphasize prevention; care for caretakers; and effective referral, record-keeping, and reporting systems. In addition, NACP has established a Home-Based Care (HBC) Working Group to ensure that implementing organizations are coordinated and adhere to quality and service standards. Priorities for the future are to support the development of a national palliative care strategy, promote a minimum package of comprehensive high-quality services, strengthen links between health care facilities and home-based care programs, and implement a newly developed accreditation system.

The Emergency Plan in South Africa will work to support the integration of the preventive care package and family-centered services across all treatment and care programs for adults and children living with HIV; and improving integrated supply chain management systems for an uninterrupted stock of essential medications for OI management and pain and symptom control, and HBC kit supplies. The USG's minimum standard of HIV-related services will be adopted and implemented at facility- and community-based sites for HIV-infected adults and children. Many facility-based services are integrated into comprehensive ART programs, providing wellness care for HIV-infected people prior to their eligibility for ART.

care providers to benchmark the quality of services and strive to improve, so that all PLWHA receive high-quality care interventions.

The Emergency Plan focuses on integrating care for PLWHA with treatment and prevention. Prevention is a crucial component of PEPFAR and is important regardless of one's sero-status. Linkages between care for PLWHA and "prevention with positives" programs, further discussed in the chapter on Prevention, support positive living.

For successful implementation of care programs, reliable procurement and distribution of essential commodities are required. In addition to medications for pain and symptom relief and OI management, providers of care need access to items necessary for managing clinical conditions (e.g., drug-dispensing equipment, gloves, wound-care and mouth-care supplies, and HIV-testing kits). The Emergency Plan works closely with governments and their procurement systems to strengthen timely acquisition and usage of these types of commodities and to increase the effectiveness of care.

Furthermore, there is a need to train health providers and peer educators in the prevention of HIV transmission, the prevention and management of OIs, and the use of program data and reporting to inform and improve the delivery of interventions. Experience in Uganda and elsewhere also supports the development and monitoring of program indicators to benchmark and improve program quality and ensure that PLWHA receive the highest possible standard of care. The Emergency Plan provides support for an inter-

disciplinary, holistic range of palliative care services, listed in the accompanying text box.

Results: Rapid Scale-Up

In fiscal year 2006, the Emergency Plan committed $198 million for care for PLWHA (consisting of funding for palliative care, including basic health care and support and TB/HIV services; funding for OVCs; and counseling and testing as discussed elsewhere in this chapter) in the focus countries. These resources supported care for nearly 4.5 million people. Approximately 11.3 percent of resources for prevention, treatment, and care activities in the focus countries were devoted to care for PLWHA.

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) that are essential to the effective roll-out and sustained delivery of quality care.

Tuberculosis and HIV/AIDS

More than 40 percent of HIV-infected people in many areas of the focus nations are co-infected with *Mycobacterium tuberculosis* – a leading cause of illness and death in PLWHA. Of those co-infected, approximately 10 percent 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 supports activities to serve people living with HIV-TB co-infection.

Cohort analyses of patients on highly active antiretroviral therapy (HAART) reveal high rates of prevalent and incident TB (15-30 percent). TB incidence is especially high during the first six months of HAART and is associated with high mortality in HIV-infected patients. Screening for TB as part of the preventive care package for HIV-infected persons is taking place in many places, and the Emergency Plan is working closely with host country partners to expand these efforts.

Given the serious implications of TB/HIV for PLWHA, the Emergency Plan supports governments and non-governmental organizations, including community- and faith-based organizations, which work at the facility level, including hospital wards, to ensure that health care providers screen HIV-infected patients for TB at each encounter. With USG support, host country programs have developed simple symptom-screening tools and recording-and-reporting forms to document screening for TB. When appropriate, health facilities are responsible for ensuring the proper diagnosis and management of TB according to WHO-recommended Directly Observed Therapy, Short Course (DOTS) strategy and national TB program guidelines. Because TB is so common among PLWHA, the Emergency

A TB/HIV Partnership with Kenya

The Emergency Plan, through its support for the Ministry of Health and other partners, has played an important role in efforts to address Kenya's serious TB/HIV problem. Kenya launched Guidelines for HIV counseling and testing in clinical settings in October 2004. In November 2004, the national TB/HIV steering committee was launched to coordinate implementation of TB/HIV collaborative activities. TB/HIV guidelines were adopted in the country in September 2005, followed by the development of TB/HIV training curricula and revision of data collection tools. In addition, tools to facilitate referrals between TB and HIV services were developed, pre-tested, and printed. The training materials, data collection tools and referral forms were widely disseminated to all sites where TB and HIV patients access treatment and care. Steering committees have been formed at all levels - national, provincial, and district-level committees are involved in implementation of TB/HIV activities.

HIV counseling and testing in TB patients began in Kenya in the second quarter of 2005 in the context of Diagnostic Testing and Counseling (DTC). Within nine months almost all government health units providing tuberculosis treatment offered HIV testing, and 42 percent (28,227) of all newly recruited TB patients in the country had been tested for HIV. Of these, 56 percent (15,877) turned out to have HIV infection. For these patients, lifesaving antibiotic treatment with cotrimoxazole, recommended by the World Health Organization (WHO) for HIV-associated tuberculosis, was made available. In addition, 30 percent of tuberculosis patients with HIV have started on ART, making a considerable contribution toward access for HIV diagnosis and treatment.

In early 2005, the Emergency Plan and WHO renewed their commitment to work together to confront the HIV/AIDS pandemic. During discussions, TB/HIV was highlighted as an important potential area for focused activities. The Emergency Plan is working with WHO to complement the ongoing country-level TB/HIV activities in 15 districts that do not have international support for TB/HIV activities. The primary objectives of this proposal are to: 1) scale up district TB control for TB patients and provide care and support for HIV infected TB patients; and 2) enhance TB case finding among PLWHAs and access to TB services as needed.

PEPFAR will work with WHO, the Government of Kenya, and civil society to promote DTC for all TB patients and TB screening for PLWHA, thus expanding access to HIV care and prevention.

Plan also supports screening of HIV-infected persons in settings outside of health care facilities, such as in their homes through home-based care programs.

The Emergency Plan is working with host governments and technical partners such as WHO to increase TB patients' access to HIV testing and other HIV/AIDS services. At present, TB patients in many places are referred to voluntary counseling and testing centers that are physically separate from their TB clinics, while elsewhere HIV testing is available in the TB clinic. The percentage of TB patients who undergo HIV testing varies accordingly. For example, in An Giang province in Vietnam 100 percent of TB patients undergo HIV testing, while in Western province of Zambia only about 50 percent of TB patients undergo HIV testing.

In many countries, including Botswana, Ethiopia, Kenya, Rwanda, and Tanzania, the Emergency Plan is thus working with partners to support expansion of provider-initiated HIV counseling and testing among TB patients. The results are impressive. Recent data from Botswana's National TB program suggest that 68 percent of registered

Malaria and HIV/AIDS

In sub-Saharan Africa, malaria and HIV co-infection is common. Even modest interactions between malaria and HIV infections can have substantial public health impact. HIV may increase the risk of clinical malaria for both adults and children; it may increase the likelihood of severe disease, particularly in areas of unstable malaria transmission; and it increases the risk of adverse outcomes of malaria in pregnancy. There is also some evidence regarding the impact of malaria on the risk of HIV transmission.

Clinical malaria can be prevented by reducing exposure to infected mosquitoes with indoor residual spraying, insecticide-treated nets, or intermittent preventive treatment with two doses of sulfadoxine-pyramethamine (SP) during pregnancy. Cotrimoxazole, which is a commonly prescribed medication for people with HIV, also serves as a malaria prophylaxis, and is especially valuable for this purpose in areas where resistance to sulfa drugs is common. Pregnant women with HIV require additional doses of intermittent preventive therapy to achieve the same health benefits seen in women without HIV. Whether cotrimoxazole prevents the morbidity associated with placental malaria is unknown, but WHO does not recommend SP-based therapy for HIV-infected women who are receiving cotrimoxazole prophylaxis for opportunistic infections.

WHO recommends that all countries adopt artemisinin-based combination therapy (ACT) for first-line treatment of malaria. ACT rapidly reduces parasite density in the blood and controls fever, and the drugs have essentially no serious or life-threatening adverse drug reactions (even mild side effects are uncommon). In addition, these drugs offer the potential of reducing the rate of transmission, as they are active against the stages of the malaria parasite, which are transmitted to mosquitoes.

Patients with HIV infection are more likely to have symptomatic malaria infections, and co-infection with HIV and malaria increases both the severity of illness and the risk of anemia. Treatment of malaria in people with HIV may be complicated by drug resistance, particularly if malaria occurs despite cotrimoxizole, and there is some evidence that advanced HIV is a risk factor for malaria treatment failure. For these reasons, accurate diagnosis and prompt therapy with a highly-effective antimalarial drug regimen, preferably ACT, is recommended.

Because of high prevalence and substantial geographic overlap of both diseases, there is a compelling need for HIV/AIDS and malaria programs to interface in the field. Coordination is needed in order to: avoid duplication of efforts; capitalize on opportunities to reach populations at risk of both diseases with essential interventions; and ensure that there is efficient use of resources, commodities, and personnel.

The Presidential Malaria Initiative (PMI) and PEPFAR are both five-year programs that focus on expanded efforts to reduce the burden of malaria and HIV/AIDS, respectively. PMI is a $1.2 billion program that aims to achieve a 50 percent reduction in malaria-related mortality in its focus countries. It seeks to do so by rapidly scaling up insecticide-treated net coverage among pregnant women and children under five to 85 percent; ensuring prompt access to effective treatment, especially ACT; increasing the use of indoor residual spraying; and increasing the coverage of pregnant women with intermittent preventive treatment to 85 percent. Over the next three years, PMI will add eight additional countries to its current focus countries (Angola, Benin, Ethiopia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Rwanda, Senegal, Tanzania, Uganda, and Zambia), and it will seek to serve 175 million people.

PMI target groups include those who bear the major burden of malaria in sub-Saharan Africa - children under five (a priority group), pregnant women, and to a lesser extent people living with HIV/AIDS (PLWHA). PEPFAR targets a broad cross-section of people, as the goals of the program are to not only provide treatment and care for PLWHA, but also to prevent new infections and provide care to orphans and vulnerable children. Recent data suggests that a combination of interventions, including the provision of nets, cotrimoxazole and ART, contributes to a greater reduction in the risk of malaria among PLWHA than each of the individual interventions alone.

PMI and PEPFAR will continue to work together to support host countries in their efforts to confront HIV and malaria.

Collaboration to Address TB/HIV in Rwanda

In early 2005, the Emergency Plan and WHO renewed their commitment to work together to confront the HIV/AIDS pandemic, and TB/HIV was highlighted as a potential area for focused activities. As part of ongoing USG and WHO collaboration with the Government of Rwanda (GoR), the Emergency Plan is working with WHO to complement the ongoing country-level TB/HIV activities supported by the USG and the Global Fund.

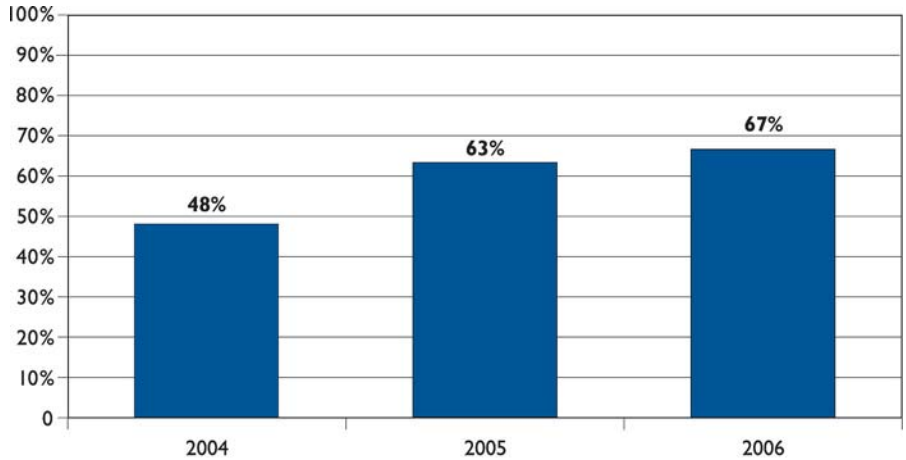
The collaborative project will build on significant successes integrating TB and HIV care in Rwanda. For example, the GoR has led efforts to identify and address the extent of TB/HIV co-infection, and innovative approaches to the identification of HIV infections in TB patients and the adoption of feasible methods to screen for TB in HIV-infected patients has led to a 50 percent increase in HIV testing of TB patients and successful initiation of appropriate HIV care. According to a GoR epidemiological report, 48 percent of the 6,167 total registered TB patients in 2004 were tested for HIV, and, of those, 1429 (48 percent) were found to be HIV-positive. Records for Quarters 1 and 2 in 2005 and 2006 show an increase in HIV testing among registered TB patients, to 63 and 67 percent, respectively, as illustrated in figure 3.2. Additionally, preliminary reports suggest that in Quarter 3 of 2006, 81 percent of all patients were tested for HIV. As part of a comprehensive treatment and care approach, 49 percent received cotrimoxazole and 34 percent received ART.

Over the two-year project period, the new WHO-USG TB/HIV collaboration will contribute to achieving the following measurable goals by September 2007:

- 100 percent of Centres Diagnostic and Treatment (CDT) and ART clinics per district staff will be trained on provider-initiated HIV testing (PIT), cotrimoxazole preventive therapy (CPT) and TB screening.
- 75 percent of registered TB cases in each district each quarter will be tested for HIV.
- 80 percent of HIV-infected TB patients registered in each district each quarter will receive CPT.
- 40 percent of HIV-infected TB patients registered in each district each quarter will be referred to ART clinics and receive ART.
- 80 percent of PLWHA will be screened for TB.

WHO will leverage its comparative advantage in catalyzing change, supporting and mobilizing health ministries and authorities, and convening and coordinating national and local partnerships. This will support all partners in achieving the goal of testing all TB patients for HIV, ensuring their access to HIV care and prevention, and identifying and ensuring TB treatment for PLWHA found to have TB. As part of this collaborative project, WHO's country-based technical staff will continue to work closely with the USG country team, technical advisors and the GoR to prepare and implement a work plan focused on achieving measurable results.

Figure 3.2: Care: Percentage of TB patients tested for HIV in Rwanda



Note: 2004 represents data from the completed treatment cohort; 2005 and 2006 represent half-year results.

Shadrack and his family discovered the promise of partnerships in fighting HIV/AIDS.

South Africa: Good Shepherd Hospice Gives Hope to a Young Family

Shadrack Lelani is a 31-year-old husband and father of a three-year-old daughter. Shadrack and his family live in a small, rural community in South Africa's Eastern Cape province. In 2004, Shadrack contracted tuberculosis and learned that he was HIV-positive. "I did not even feel sick at the time," he recalled.

Thankfully, the PEPFAR-supported Good Shepherd Hospice was able to provide Shadrack with tuberculosis medication. His cough improved, but soon he fell ill and began to lose weight.

In May 2006, Shadrack returned to the Hospice for life-saving antiretroviral treatment. Today he reports: "I have picked up some weight. It has really helped me." Like many people living with HIV/AIDS in the community, Shadrack is visited regularly by Hospice staff and his home-based caregiver, Sylvia. Sylvia lives a couple of streets away and visits Shadrack every week. Shadrack considers the Good Shepherd Hospice staff very supportive: "They are good to me and have helped me a lot."

The hospice also provides Shadrack's family with a food parcel every two weeks and hospice staff members helped him access a disability grant from the South African government. The antiretroviral medication and care packages – and the community's love and support – have given Shadrack and his family hope for a brighter future.

TB patients undergo HIV testing. In districts with provider-initiated HIV counseling and testing in Tanzania, more than 80 percent of TB patients accept testing and learn their HIV status. Other Emergency Plan countries are also moving toward provider-initiated HIV counseling and testing. Emergency Plan support for efforts to increase HIV testing among TB patients translates into increasing numbers of HIV-infected TB patients being linked to prevention programs and HIV treatment and care.

For TB/HIV co-infected patients, there is a critical need to ensure adequate treatment and care for both diseases. Linking suspected TB patients who have been identified through screening to TB diagnosis and treatment, and maintaining HIV-infected TB patients on both TB treatment and HIV treatment and care, are major challenges. Some countries, including Kenya and Mozambique, are exploring ways to provide DOTS TB treatment in HIV clinics or cotrimoxazole at TB sites, to facilitate simultaneous care for TB/HIV co-infected patients. Other countries, such as Tanzania, are initiating provision of ARVs in TB clinics; this requires a strong national TB program. Others, such as Côte d'Ivoire, whose ART programs are decentralizing, are trying to co-locate TB and HIV care in the same facilities. Regardless of the location of care, the Emergency Plan and its partners are increasing support for efforts to control TB infection in health care facilities.

The Emergency Plan supported TB treatment and care for approximately 301,000 co-infected people in focus countries during fiscal year 2006. Given the high prevalence of TB among PLWHA both before and after starting treatment, the priority is support for the diagnosis and treatment of active TB using DOTS principles, with support also provided for diagnosis and treatment of latent TB infection to prevent the development of active disease. Another important priority is ensuring that all TB patients receive confidential HIV counseling and testing and are provided access to HIV prevention and, if necessary, treatment and care. In most focus countries, the Emergency Plan also supports the development of a strong, tiered public health laboratory network for diagnosing and managing OIs such as TB. Laboratories will be especially important as countries increase their efforts to diagnose and manage drug-resistant TB, particularly extensively drug-resistant TB (XDR TB), which is resistant to many of the essential TB medicines. Of all adults and children who received TB treatment and care with PEPFAR support, 139,000 received it at USG-supported delivery sites, while the remainder received support through contributions to national, regional, and local programs.

Table 3.4: Care: FY2006 Palliative Care[1] Results

Country	Number of HIV-infected individuals who received palliative care/basic health care and support (including TB/HIV)			Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (subset of all palliative care)		
	Number receiving upstream systems-strengthening support[2]	Number receiving downstream site-specific support[3]	Total	Number receiving upstream systems-strengthening support[2]	Number receiving downstream site-specific support[3]	Total
Botswana[4]	90,500	0	90,500	5,900	0	5,900
Côte d'Ivoire	0	42,600	42,600	0	1,500	1,500
Ethiopia[5]	0	310,800	310,800	0	11,000	11,000
Guyana	0	2,900	2,900	0	300	300
Haiti	2,500	54,700	57,200	0	1,000	1,000
Kenya[6]	0	306,400	306,400	0	59,800	59,800
Mozambique[7]	67,600	108,300	175,900	0	1,700	1,700
Namibia[6]	7,700	46,300	54,000	0	3,000	3,000
Nigeria[6]	1,600	210,700	212,300	300	6,200	6,500
Rwanda	17,100	40,300	57,400	1,800	600	2,400
South Africa	62,400	451,900	514,300	148,000	28,800	176,800
Tanzania[8]	75,000	98,500	173,500	0	6,200	6,200
Uganda	37,800	252,100	289,900	6,600	14,600	21,200
Vietnam	0	24,200	24,200	0	1,600	1,600
Zambia[9]	0	152,100	152,100	0	2,700	2,700
Total	**362,200**	**2,101,800**	**2,464,000**	**162,600**	**139,000**	**301,600**

Notes:

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

Upstream and downstream numbers above 100 are rounded to the nearest 100 and then added to get totals.

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, and protocol and curriculum development.

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

[4] Botswana results are attributed to the National HIV Program. Beginning FY2006, USG downstream contributions in Botswana are embedded in the upstream numbers, following a consensus reached between the USG and the Government of Botswana to report single upstream figures for each relevant indicator. Botswana experienced expansion of services to the community through strengthening of civil society participation leading to increased coverage and linkages to the National TB program, resulting in significant increases over last year.

[5] In Ethiopia the reported number of HIV-infected clients receiving care/treatment for TB disease dropped by 67 percent compared to the previous year's report. This was primarily due to underreporting. Last year partners were able to collect information directly from the delivery sites. This year National numbers are reported directly by the MoH and the USG team reports that these numbers are greatly underestimated. The team is currently working with the MoH and other USG partners to collect the unreported information and improve the reporting mechanism.

[6] Introduction of data quality measures in 2006 resulted in reduced number of people reported as receiving TB treatment in 2006 compared to 2005.

[7] In Mozambique, persons receiving upstream HIV care are likely undercounted. Reasons for this include, 1) Home-based Care (HBC) data are incomplete or missing for months or for smaller non-USG HBC providers; 2) MoH lacks staff to collect and ensure data quality for HBC; 3) Clinical care data are generated from ARV reports from day clinics and this number does not include persons receiving HIV care outside of day clinics. The USG recognizes that some overcounting may occur due to duplicated counts for persons in clinical care that are also receiving home-based care. Despite this, we believe that the number of persons not counted in care services is greater than the number of persons included incorrectly.

[8] Tanzania noted significant increases in the number of HIV-infected clients receiving treatment for TB disease due to improvements in both referrals systems and monitoring tools.

[9] In Zambia, the number of HIV-infected clients receiving care/treatment for TB disease dropped by 88 percent compared to the previous year's report. The drop is due to a change in how this indicator is reported. The mission no longer counts home-based care clients receiving DOTS at the community level. Currently, only clients receiving TB treatment at the facility level are included due to reliability of data.

For example, the Emergency Plan has made a major commitment to support the Government of Rwanda's (GoR) national efforts to address TB/HIV. The Emergency Plan has provided technical and financial support, assistance with national implementation guidelines, and training of health care workers. In fiscal year 2006, the USG supported central-level coordination through a national TB/HIV technical advisor and program coordinators at the Programme National Intégré de lutte contre la Lèpre et la Tuberculose (PNILT) and the Treatment and Research AIDS Center (TRAC). The PNILT technical manual has been revised to include a chapter on TB/HIV, and the national TB register and treatment cards have been updated to include HIV-related information. A paper-based HIV register was developed that includes information on screening for active TB disease and will be distributed for use at all HIV treatment and care sites. In fiscal year 2007, the USG plans to support implementation of recently developed national guidelines to achieve the goal of testing all TB patients for HIV as part of routine care and providing referral and access to HIV treatment and care. Priority will be placed on regular evaluation of HIV-infected patients for TB, using a recently developed WHO TB screening tool to quickly identify and ensure appropriate and timely TB treatment. For more information on PEPFAR's TB/HIV efforts in Rwanda, see the accompanying text box.

Table 3.5: Care: FY2006 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]	718	4,200
Côte d'Ivoire	118	700
Ethiopia	455	6,300
Guyana	19	500
Haiti	39	800
Kenya	2,369	5,500
Mozambique	44	1,400
Namibia	333	4,200
Nigeria	94	3,700
Rwanda	190	5,700
South Africa	2,268	21,300
Tanzania	173	10,500
Uganda	561	16,400
Vietnam	163	2,600
Zambia	475	10,100
Total	**8,019**	**93,900**

Notes:

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

Among individuals trained, numbers above 100 are rounded to nearest 100. Number of sites is not rounded.

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] Botswana results are attributed to the National HIV Program. Beginning FY2006, USG downstream contributions in Botswana are embedded in the upstream numbers, following a consensus reached between the USG and the Government of Botswana to report single upstream figures for each relevant indicator.

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 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 and leadership is another key element of PEPFAR's work in this area. The involvement of these networks in palliative care helps build sustainable systems that respond fully to the challenges PLWHA face.

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

USG support was provided for training of close to 94,000 palliative care providers in the focus countries in fiscal year 2006, while 8,019 sites received support for personnel, infrastructure development, logistics, strategic information services, and other components of high-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 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 also has supported the African Palliative Care Association.

To ensure quality, the Emergency Plan supports efforts to strengthen supervision of lay workers by health professionals, where possible. Initiatives to provide incentives to volunteers, including remuneration, also receive support, which strengthens the 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 PLWHA. Given the centrality of nurses to provision of care in the developing world, it is essential 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.

Opioids, which may be one element of such care, and can be essential for pain relief, are often not registered by national governments for pain relief for AIDS patients. 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 the dissemination of "basic preventive care packages" developed by the Emergency Plan under National Strategies, offering services such as medications to prevent OIs, insecticide-treated nets to prevent malaria, and clean drinking water. The effort to establish a high standard of care for PLWHA includes support for the development of basic program monitoring indicators, supportive supervision to provide on-site guidance and mentoring, and monitoring and evaluation to measure the impact of the new care services.

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 of people who have 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. The Emergency Plan's interagency technical working group on food and nutrition includes OGAC, U.S. Agency for International Development (USAID), HHS, and the U.S. Department of Agriculture (USDA). As discussed above, this interagency group has developed guidance on food and nutrition for incorporation into the care activities of USG teams in the field. The guidance clarifies circumstances under which the Emergency Plan supports appropriate assessment, monitoring, and counseling regarding the nutritional needs of PLWHA.

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 efforts to provide for their own 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, which not only helps to address the human capacity shortfall in developing countries, but also ensures 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 implementa-

tion 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, such as men who have sex with men and injecting drug users. 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 support communities as they confront the challenge of providing care and support. As part of these efforts to engage the community, many countries have pioneered the provision of home-based care. In Uganda, a family-centered approach serves as the foundation for home-based HIV testing for entire families, with linkages to treatment and care services. More than 90 percent of all family members who participate in this program accept confidential testing in the privacy of their home.

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 high-quality palliative care. The Supply Chain Management System, described in the chapter on Building Capacity: Partnerships for Sustainability, is working 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. Knowledge of HIV status is increasingly recognized as essential for all persons living in high-prevalence countries, both for access to treatment and care and so that individuals and couples can make informed decisions and choices about HIV prevention strategies. Technological advances have led to rapid HIV tests that provide results within minutes. In spite of these advances, however, it is estimated that more than 80 percent of all people living in PEPFAR focus countries do not know their HIV status.

Knowing one's status provides a gateway for critical prevention, treatment, and care services. Millions of persons must be tested for PEPFAR to meet its ambitious treatment and care and goals in the focus countries. It is estimated that a minimum of 30 million people will need to be tested to meet PEPFAR's 2-7-10 goals – if countries appropriately target counseling and testing to populations at increased risk of HIV infection (such as TB patients and women seeking PMTCT services) and if health care providers offer counseling and testing in health care encounters. To the extent counseling and testing is not well-targeted, the number who must be tested for PEPFAR to meet its goals will be correspondingly higher.

Table 3.6 shows the steep increase in the number of people receiving counseling and testing services with Emergency Plan support. Although many others also receive these serv-

Uganda: Door-to-Door Counseling and Testing Restores Hope for HIV-Discordant Couple

"I used to be weak, with frequent fevers and skin rash, and I had lost a lot of weight," Mawanda Magezi said. A married, 42-year-old farmer with three children, Mawanda and his family learned that he is HIV-positive through an innovative door-to-door HIV counseling and testing program in Uganda's Bushenyi District.

With support from PEPFAR, a local non-governmental organization called Integrated Community Based Initiatives (ICOBI) brings HIV counseling and testing services to clients' homes. This home-based approach provides all family members the opportunity to learn about HIV and the benefits of knowing their status, and to share their concerns with trained community members in the comfort of their own homes.

The ICOBI team visited Mawanda's home equipped with educational materials and rapid HIV test kits. Mawanda and his wife were tested for HIV together as a couple. The results showed that they are HIV-discordant.

"Discovering that I was HIV-positive and my wife negative shocked us, and I felt that this was the end of the world. But with support from the counselors on HIV prevention and positive living, we learned how to continue," Mawanda explained.

Mawanda was immediately referred to the health unit for care, tuberculosis screening and treatment assessments. The family received a basic preventive care package consisting of a safe water system, insecticide-treated bed nets, condoms and information on positive prevention strategies. With regular follow-up visits from the ICOBI team, Mawanda's health greatly improved. Ongoing counseling facilitated the couple's decision to disclose their HIV status to their children and community.

The door-to-door approach to counseling and testing enables families and communities to build stronger support systems in the fight against HIV/AIDS.

Table 3.6: Care: FY2006 Counseling & Testing Services Results[1] (in settings other than PMTCT)			
Country	**Number of individuals receiving upstream system-strengthening support[2]**	**Number of individuals receiving downstream site-specific support[3]**	**Total number of individuals receiving counseling and testing**
Botswana[4]	189,300	0	189,300
Côte d'Ivoire	18,600	48,300	66,900
Ethiopia	0	516,800	516,800
Guyana	0	28,300	28,300
Haiti	0	193,600	193,600
Kenya	0	748,900	748,900
Mozambique[5]	52,500	156,300	208,800
Namibia	0	107,600	107,600
Nigeria	64,400	450,400	514,800
Rwanda	258,000	207,500	465,500
South Africa	1,135,200	342,700	1,477,900
Tanzania	287,200	393,400	680,600
Uganda	74,600	925,400	1,000,000
Vietnam	0	59,100	59,100
Zambia[6]	0	168,400	168,400
Total	**2,079,800**	**4,346,700**	**6,426,500**

Notes:

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

Upstream and downstream numbers above 100 are rounded to the nearest 100 and then added to get totals.

Footnotes:

[1] Counseling and testing includes only those individuals who received their test results.

[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, and protocol and curriculum development.

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

[4] Botswana results are attributed to the National HIV Program. Beginning FY2006, USG downstream contributions in Botswana are embedded in the upstream numbers, following a consensus reached between the USG and the Government of Botswana to report single upstream figures for each relevant indicator.

[5] In Mozambique, counseling and testing through PMTCT and other settings use the same reporting system. An analysis of the data show that some sites have incorrectly reported PMTCT. Data from these misclassified sites have been excluded from the FY2006 results.

[6] In Zambia, the total number of individuals receiving counseling and testing has dropped. This is because nationally-reported data on counseling and testing has not been updated since June 2005, therefore upstream results were not reported. The number of individuals reached through downstream support has doubled since the last reporting period.

Table 3.7: Care: Cumulative Counseling and Testing (C&T) Results, FY2004-FY2006				
	FY2004[1]	**FY2005**	**FY2006**	**Cumulative C&T to date**
Number of women receiving C&T through PMTCT	1,017,000	1,957,900	2,814,700	**5,789,600**
Number of individuals receiving C&T in other settings	1,791,900	4,653,200	6,426,500	**12,871,600**
Total	**2,809,900**	**6,611,100**	**9,241,200**	**18,661,200**
Women as a percentage of all individuals receiving C&T in PMTCT and other settings through downstream support				
	66%	**69%**	**71%**	**70%**

Notes:

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

Upstream and downstream numbers above 100 are rounded to the nearest 100 and then added to get totals.

Values include the number of individuals reached through upstream 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 downstream services at U.S. Government-funded service delivery sites.

The same individual may receive counseling and testing on multiple occasions.

Footnote:

[1] In FY2004 only, it was assumed that 80 percent of women receiving PMTCT services were counseled and tested.

Table 3.8: Care: Counseling and Testing: Percent of Counseling and Testing Targets Reached as of September 30, 2006			
	Cumulative Counseling and Testing results, FY2004-FY2006	Estimated Number of Counseling and Testing sessions required to meet treatment goal	% of goal reached (2006)
Total	18,661,200	30-40 million	47-62%

Notes:

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

The actual number of counseling and testing sessions required to meet the Emergency Plan treatment goal depends on the balance of counseling and testing in low-risk settings such as PMTCT and community outreach, versus settings where a higher percentage of persons tested are likely to be HIV infected, such as TB clinics and medical wards and high-risk settings such as TB clinics.

ices through the support of host governments, the Global Fund and others, the Emergency Plan is a leader in support for access to HIV testing. The figure also shows that the massive increase in testing is accompanied by a sharp increase in the number of PLWHA who are accessing ART. As expected, the numbers receiving ART are far below those receiving counseling and testing, since people can be tested for HIV more than once and most of those tested are not yet eligible for ART.

The Emergency Plan is moving with urgency and innovation, commensurate with this extraordinary challenge. A growing number of best practices have been identified to increase testing in health facilities and to increase access to testing services in rural and remote areas. In addition, the PEPFAR-supported scale-up of PMTCT programs has increased the number of women who have learned their HIV status during pregnancy.

A key barrier to the universal knowledge of serostatus is the lack of routine testing in medical settings, including TB and sexually transmitted infection (STI) clinics and hospitals. In many focus countries, studies have found that 50 to 80 percent of hospital and TB patients are infected with HIV; many of these patients are in urgent need of treatment. As noted in table 3.10, there is increasing international support for this model of "routine" or "opt-out" testing, where in selected health care settings, all patients are tested for HIV unless they refuse; this approach has successfully identified many patients in need of treatment and care. Several studies presented at the HIV/AIDS Implementers' Meeting in Durban demonstrated the impact this policy can have. A pilot project in Zimbabwe showed a 54 percent increase in testing rates at urban ANCs after the introduction of routine testing and a 76 percent increase in rural areas. Another study conducted in the maternity ward of a 200-bed hospital in rural Uganda found that moving to routine testing more than doubled the proportion of women discharged from the ward with a known HIV status, from 39 percent to 88 percent.

In all approaches, the person tested should give consent, be informed of his or her test results, be provided with information on how to prevent HIV transmission or acquisition, and if infected, be referred for treatment and care. Nigeria has made considerable progress in this area, with some partners having a tenfold increase in the number of

Table 3.9: Care: FY2006 Counseling and 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[1]	710	600
Côte d'Ivoire	81	500
Ethiopia	625	3,400
Guyana	27	52
Haiti	93	700
Kenya	947	2,200
Mozambique	90	300
Namibia	232	1,000
Nigeria	277	1,000
Rwanda	97	400
South Africa	1,519	15,500
Tanzania	206	900
Uganda	1,178	4,400
Vietnam	67	1,000
Zambia	317	1,500
Total	**6,466**	**33,500**

Notes:

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

Among individuals trained, numbers above 100 are rounded to nearest 100. Number of sites is not rounded.

Footnotes:

[1] Botswana results are attributed to the National HIV Program. Beginning FY2006, USG downstream contributions in Botswana are embedded in the upstream numbers, following a consensus reached between the USG and the Government of Botswana to report single upstream figures for each relevant indicator.

Table 3.10: Care: Key Policy Changes: Counseling and Testing		
Country	**Date of policy adoption on provider-initiated testing[1]**	**Date of policy adoption on use of rapid test kits[1]**
Botswana	2003	2006
Côte d'Ivoire	-	2001
Ethiopia	-	2006
Guyana	2006[2]	2004
Haiti[3]	-	-
Kenya	2004	2006
Mozambique	-	2006
Namibia	2004[4]	2005
Nigeria	-	2006[5]
Rwanda	2006	2006
South Africa	-	2006
Tanzania	2006	2006
Uganda	2005	2006
Vietnam	2006	-
Zambia	2005[6]	2005

Footnotes:

[1] Unless otherwise noted, information obtained through correspondence with country teams.

[2] Guyana's provider-initiated testing policy is for labor and delivery wards only.

[3] While Haiti has no official written policy on the use of rapid test kits, the use of rapid test kits is the *de facto* policy. Haiti's health system adopted rapid test kits early and use of rapid kits is considered routine practice.

[4] Namibia's provider-initiated testing policy is for PMTCT, ANC, and TB only and includes provision for non-laboratory personnel including community counselors to perform rapid HIV-testing.

[5] Nigeria adopted an interim testing policy to support the use of rapid tests in 2006 and will draft its final policy after the results of the PEPFAR-supported rapid test assessment.

[6] Zambia adopted a PMTCT-specific provider-initiated testing policy in 2004.

patients being tested at their clinical sites. Other countries that have made significant progress in the scale-up of HIV counseling and testing in medical settings in 2006 include Botswana, Kenya, Malawi, Rwanda, and Tanzania.

A major challenge associated with this best practice is linking patients who have been identified as seropositive with HIV care, including cotrimoxazole and ART. Other obstacles include the distance of patients from facilities and the inadequate numbers of health care workers and inconsistent test kit supplies at health care facilities.

In addition to HIV testing in medical settings, PEPFAR continues to support the expansion of testing in the community in many countries. Stand-alone centers in urban areas attract many young men and other groups who otherwise do not frequent medical facilities. Some of these centers, often known as voluntary counseling and testing (VCT) sites, also provide services to special groups such as the deaf, rape victims, injecting drug users, and people in prostitution. Couple counseling and testing, both for premarital and married couples, is provided in many sites supported by PEPFAR, including through faith-based organizations that encourage members to know their status. Couples who know they are HIV-discordant (couples in which one partner has HIV and the other does not) can successfully prevent transmission to the negative partner.

Emergency Plan Priorities for HIV Counseling and Testing

- Promote counseling and testing in clinical settings: With the availability of antiretroviral and opportunistic infection treatment, there is an urgent need to ensure that people who are ill with HIV-related symptoms are tested for HIV.
- Make diagnostic HIV counseling and testing routine for patients in tuberculosis (TB) clinics, antenatal clinics, and medical wards.
- Improve access to counseling and testing for the general population: Every person who wants to know his or her status should have access to testing, particularly in countries with high HIV prevalence.
- Support innovative approaches to extending the availability of confidential counseling and testing.
- Support couple counseling and testing to identify discordant couples: Once they learn they are HIV-discordant, couples can adopt preventive behaviors to reduce the chances of HIV transmission to the negative partner.
- Promote varied forms of HIV counseling and testing: Professional advertising campaigns have proved highly effective in increasing demand for counseling and testing services and reducing stigma associated with testing.
- Link counseling and testing to other HIV services: Functioning referral systems are essential to ensure that clients are linked to prevention, treatment, and care.
- Expand availability and acceptance of rapid test kit technology: Rapid testing is important for testing conducted outside of health facilities. Finger-prick (whole blood) and oral rapid testing do not require cold chain storage or additional equipment and supplies, allowing health care workers to test in a variety of settings. In some countries, policy barriers block the use of rapid testing.
- Support routine, opt-out HIV testing for pregnant women by using rapid tests with same-day results.

A ceremony in Côte d'Ivoire marking a counseling and testing center in San Pedro brought together support from national leaders, local partners and the Emergency Plan.

The experience of home-based counseling and testing in Uganda demonstrates the value of identifying family members who are at high risk of either having undiagnosed HIV infection or acquiring HIV. Identification of discordant couples through home-based HIV testing was identified as a best practice at the PEPFAR Implementers' Meeting in June 2006.

The Emergency Plan also supports laboratory quality improvement, a key element of effective testing programs, through training of laboratory workers, improving the physical infrastructure of labs, and ensuring consistent supplies of test kits.

Effective programs must overcome these obstacles, while ensuring that counseling and testing services are of high quality. Compounding all these challenges are the fear, stigma, and discrimination against those who are infected with HIV, which remain significant barriers in many nations.

Results: Rapid Scale-Up

To date, the Emergency Plan has provided support for more than 18.6 million confidential HIV counseling and testing sessions in the focus countries. More than 9.2 million of these occurred in fiscal year 2006: more than 2.8 million in PMTCT settings and more than 6.4 million through other counseling and testing activities.

Of the more than 9.2 million counseling and testing sessions in fiscal year 2006, approximately 6.4 million were performed at USG-supported sites, while the remainder were the result of PEPFAR support for countries' capacity to provide services (including assistance for national and regional policies, communications, protocols to ensure high-quality services, laboratory support, and purchase of test kits).

Reflecting the importance of counseling and testing in achieving the goals of the Emergency Plan, $130 million,

Vietnam: Counseling and Testing Program Reaches Out to At-Risk Populations

Vietnam's HIV/AIDS epidemic is concentrated primarily among injecting drug users, women in prostitution and men who have sex with men. Outreach workers regularly walk into neighborhoods in Hai Phong City with the hope of reaching these at-risk populations with information about HIV/AIDS and voluntary counseling and testing. The outreach workers encourage individuals to seek confidential HIV counseling and testing at the Community Health Counseling Center in Hai Phong City.

The Community Health Counseling Center is one of many HIV counseling and testing sites operated by the Vietnamese Ministry of Health with support from PEPFAR. Counseling and testing services in Vietnam have expanded rapidly, and are currently located in the 40 provinces with the highest HIV prevalence. These sites reach out to the country's most stigmatized individuals by offering flexible hours and confidential services free of charge.

The counseling and testing program is having a positive impact. "This intervention helps HIV-negative people maintain their negative status, assists HIV-infected people to avoid HIV transmission to others and to live healthy lives, and links infected people to care and treatment services," said Huynh Thi Nhan, a counselor at a Ministry of Health site in Can Tho City.

Launched at the end of May 2006, a new communications campaign will further expand the reach of the program. The campaign targets potential clients with information about confidential HIV counseling and testing and the locations of service sites. Billboards and posters encourage clients to talk with counselors to discuss feelings of fear and concern and to answer questions related to HIV/AIDS. The campaign also emphasizes the importance of testing as a crucial step in improving overall health and quality of life.

or approximately seven percent of fiscal year 2006 focus country resources for prevention, treatment, and care, were committed to counseling and testing activities. An additional $92 million, or five percent, were committed to PMTCT activities, which include counseling and testing of pregnant women along with other activities.

Approximately 71 percent of those who received downstream USG-supported counseling and testing services in fiscal year 2006 were female. This figure includes all women tested through PMTCT services. In other, non-PMTCT sites, including VCT centers, medical facilities, and mobile sites, 56 percent were women.

Sustainability: Building Capacity

Emergency Plan teams have worked with host governments and other partners to integrate counseling and testing into routine health care, as well as supporting local, indigenous, and faith-based organizations to provide confidential counseling and testing services to their communities.

In the focus countries in fiscal year 2006, the Emergency Plan provided support for training of approximately 66,100 individuals in counseling and testing (including approximately 32,600 as part of PMTCT training and approximately 33,500 others). PEPFAR also supported more than 11,000 service sites (including 4,800 PMTCT sites and 6,400 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 challenges involved in rolling out counseling and testing on a massive scale, it is critical to focus efforts upon people with a higher likelihood of HIV infection than the general population. 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 is bolstering its support for routine counseling and testing in clinics that treat TB or STIs, hospitals, and other health care settings.

Table 3.11: Care: FY2006 Total Counseling and Testing Capacity-Building Results

Country	Number of USG-supported sites in a PMTCT setting	Number of USG-supported sites other than PMTCT	Total	Number of health workers trained or retrained in PMTCT services	Total number of individuals trained or retrained in counseling and testing in settings other than PMTCT	Total
Botswana[1]	634	710	1,344	400	600	1,000
Côte d'Ivoire	69	81	150	400	500	900
Ethiopia	204	625	829	2,700	3,400	6,100
Guyana	45	27	72	50	52	102
Haiti	73	93	166	800	700	1,500
Kenya	1,674	947	2,621	4,800	2,200	7,000
Mozambique	81	90	171	1,500	300	1,800
Namibia	179	232	411	1,300	1,000	2,300
Nigeria	80	277	357	1,600	1,000	2,600
Rwanda	103	97	200	1,000	400	1,400
South Africa	570	1,519	2,089	11,100	15,500	26,600
Tanzania	488	206	694	2,000	900	2,900
Uganda	362	1,178	1,540	3,900	4,400	8,300
Vietnam	17	67	84	500	1,000	1,500
Zambia	284	317	601	500	1,500	2,000
Total	**4,863**	**6,466**	**11,329**	**32,600**	**33,500**	**66,100**

Notes:

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

Among individuals trained, numbers above 100 are rounded to nearest 100. Number of sites is not rounded.

Footnote:

[1] Botswana results are attributed to the National HIV Program. Beginning FY2006, USG downstream contributions in Botswana are embedded in the upstream numbers, following a consensus reached between the USG and the Government of Botswana to report single upstream figures for each relevant indicator.

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 treatment and care as needed. Many of the initiatives described have fostered the achievement of 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. The USG has collaborated with UNICEF, WHO, and others to produce a PMTCT counseling and testing tool that streamlines and standardizes high-quality counseling and increases the uptake of HIV testing.

At the same time, it is important to ensure access for the population at large, especially in countries with generalized epidemics. Community-based counseling and testing remains an important HIV prevention opportunity. PEPFAR works to ensure that all people who want to know their status have access to testing services, particularly in countries with high HIV prevalence, where all sexually active persons have some risk for HIV infection. This includes innovative methods to reach special or hard-to-reach populations, such as mobile services in remote areas; outreach services for persons engaging in high-risk behaviors, such as persons in prostitution or injecting drug users; or services targeting vulnerable groups, such as refugees, prisoners, and the disabled. Several countries, including Kenya and Nigeria, have piloted "moonlight VCT" programs, in which teams of counselors go out at night to provide outreach services to high-risk groups such as truck drivers, people in prostitution and their clients, and patrons at bars and clubs. Moonlight VCT was highlighted as a "best practice" at the 2006 HIV/AIDS Implementers' Meeting. Another innovation highlighted at the meeting was a mobile testing service for rural populations; some community groups use bicycles and even camels to reach nomadic populations.

One requisite for high-quality counseling and testing programming is that those who are tested actually receive their test results. Due to long delays in obtaining test results, however, many who are tested have not returned for their results. Finger-prick (whole blood) and oral rapid testing, which do not require cold chain storage or additional equipment or supplies, can be used in a variety of settings by a variety of health care workers, from nurses to lay counselors. Rapid testing is especially important when testing is conducted outside of health facilities. The increasing availability and quality of rapid tests is 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, and PEPFAR supports efforts to resolve regulatory and policy obstacles to the implementation of rapid tests.

Ensuring Quality in Counseling and Testing. Widely available, high-quality HIV testing requires large numbers of testing kits. The Emergency Plan-supported Supply Chain Management System, described in the chapter on Building Capacity: Partnerships for Sustainability, works with host nations to ensure uninterrupted supplies of high-quality test kits.

High quality in counseling is equally important. A number of countries have developed protocols and systems to assess and improve counseling services. Counseling for those who test negative is an area that has received insufficient attention in the past, wasting critical opportunities for prevention efforts. The Emergency Plan therefore is supporting efforts to expand and improve training of counselors to ensure that they are able to offer appropriate prevention information.

International Counseling and Testing Day. In her remarks to the United Nations General Assembly High Level Meeting on HIV/AIDS in June 2006, First Lady Laura Bush called

Due to capacity building assistance, staff at the Nyarami Voluntary Counseling and Testing Center in Migori, Kenya learned technical skills that enabled them to provide better HIV counseling and testing services to clients.

for the establishment of an International HIV Testing Day. PEPFAR subsequently developed a feasibility analysis for UNAIDS, outlining issues to be addressed for the establishment and success of an International HIV Testing Day. In December 2006, the General Assembly of the United Nations adopted the proposal. This initiative, implemented by each country beginning in 2007 according to its own capacity and needs, will be an important step toward expanding access to confidential HIV counseling and testing and de-stigmatizing learning one's status; in so doing, it will contribute to meeting PEPFAR's prevention, treatment, and care goals.

Accountability: Reporting on the Components of Care

As discussed earlier, PEPFAR works closely with countries to maximize both downstream and upstream support wherever partnership limitations or technical, material or financial constraints require it. The Emergency Plan, either alone or in concert with another partner, may support every aspect of the complete package of prevention, treatment, or care services at a specific public or private delivery site, in coordination with the host country's national strategies. The comprehensive and ongoing nature of providing HIV/AIDS care poses significant challenges for program monitoring and evaluation. The Emergency Plan recognizes this, as well as the importance of accurate program monitoring in establishing high-quality services. Understanding and recording the types of care services that are delivered is the foundation of ensuring that programs maximize scarce resources for as many PLWHA as possible. As part of Emergency Plan capacity-building, country teams are working closely with host governments and partners to build and improve upon information systems for monitoring and evaluating routine program indicators for care. For more information, please see the Improving Accountability and Programming chapter.

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

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, treatment, and care, 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; 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; psychological and spiritual support; 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 also funded an 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; and
- Implementation of data standards guidance in select countries.