USAID's Expanded Response to HIV/AIDS

U.S. Agency for International Development

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Cover photos: (top) Harriett Destler/USAID,
(center) Rich Marchewka/USAID, and (bottom) Waak/PAHO

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I am pleased to present you with this report on the U.S. Agency for International Development's Expanded Response to HIV/AIDS. This report describes our HIV/AIDS program, and details how, with our increased HIV/AIDS budget, we began scaling up our response to the pandemic.

We are now stepping up our war on AIDS even further. We have launched a plan that will accelerate the implementation of our Expanded Response strategy and maximize its impact. We are working in more than 50 countries around the world. We are focusing resources in 23 priority countries. The additional countries concentrate their efforts through in-country and regional programs. Our new plan gets more money to the field to scale up prevention, care and treatment programs and to support children affected by AIDS. We will increase staff levels in the field by reassigning technical staff and hiring additional personnel. Finally, we are establishing a comprehensive monitoring and reporting system that will allow USAID to track progress in our priority countries and to document the impact of our programs.

USAID Administrator Andrew Natsios has named the fight against HIV/AIDS as one of the agency's top priorities. We are in a race against time with still-increasing rates, expanding disease and devastation—an ongoing disaster situation. We have to redouble our efforts, speed up our processes, and constantly seek to refine our approach. We do now have success stories to inspire hope and to model future programs on, but there are still many others that must be written. The war on AIDS will be a long and arduous one, but it is a war that we can, and ultimately, must win.

E. Anne Peterson, MD, MPH
Assistant Administrator for Global Health
U.S. Agency for International Development

I. THE HIV/AIDS PANDEMIC

In the 20 years since acquired immune deficiency syndrome (AIDS) was first identified, it has killed more than 22 million people around the world. Today, more than 40 million people live with AIDS or human immunodeficiency virus (HIV), the virus that causes AIDS. Despite a few successes in slowing transmission, the pandemic is still spreading worldwide. In the year 2000 alone, 3 million people, including 500,000 children, died of AIDS; and another 5.3 million people, including 600,000 children, were newly infected with HIV. This means that 440,000 people are newly infected every month—one person every six seconds.

HIV/AIDS IN THE DEVELOPING WORLD

The vast majority of those affected—95 percent—live in the developing world. Africa alone accounts for two-thirds of current HIV/AIDS cases. In seven African countries, HIV prevalence in adults is 20 percent or higher; in nine additional countries, it exceeds 10 percent (see Table 1).

The number of HIV/AIDS cases in Asia remains relatively smaller. However, because the region contains more than 60 percent of the world's population, large numbers of people are at great risk. Even small increases in prevalence could create epidemics. The Caribbean region has a small population but the second highest prevalence after sub-Saharan Africa. In Eastern Europe and Eurasia, until recently considered to be less impacted than other parts of the world, HIV is growing faster than anywhere else in the world. According to UNAIDS, an estimated 250,000 new HIV infections occurred in that region in 2001, raising to 1 million the total number of people infected. Although overall prevalence is still low, this rapid increase in infections indicates that a major epidemic may be imminent in Eastern Europe and Eurasia.

HIV/AIDS SLOWS DEVELOPMENT PROGRESS

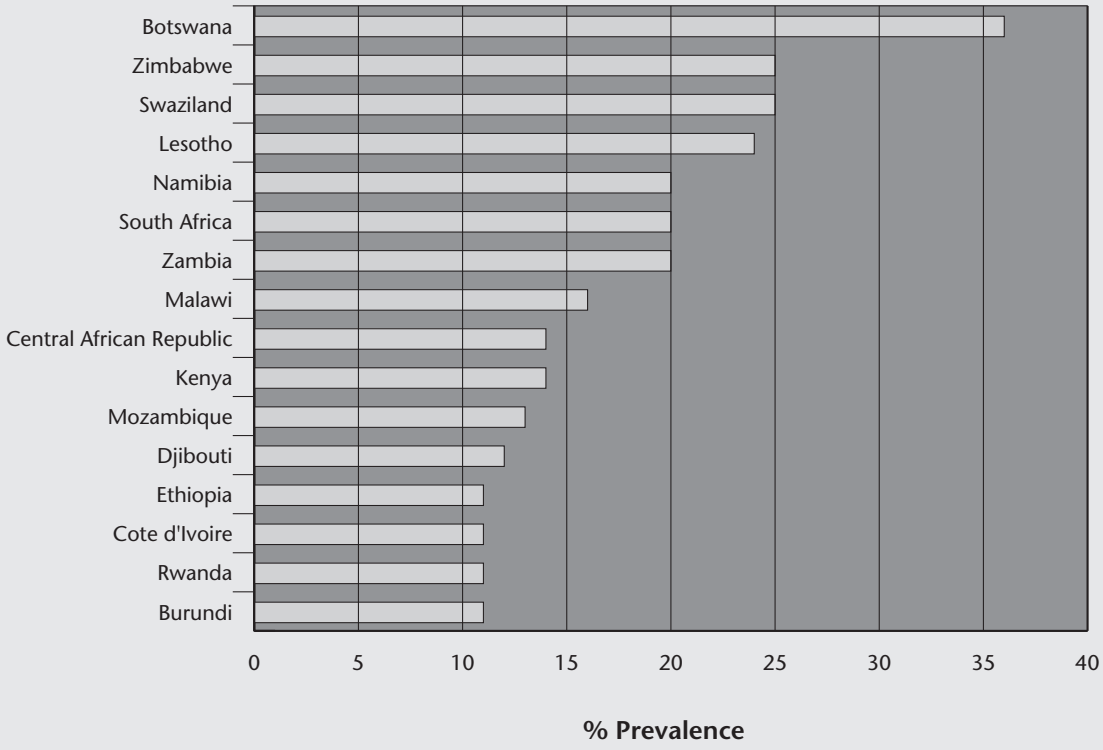
HIV/AIDS is now the fourth leading cause of death worldwide and a significant health crisis in many parts of the world. But, it is also a development crisis, which threatens to stop—and even reverse—the health advances and other gains made over the last several decades. Unlike most other diseases, it strikes men and women in their most productive years. Particularly in the poorest countries, HIV/AIDS has had and continues to have catastrophic economic and social ramifications. Family and community well-being are being compromised, as well as development progress and national stability. In addition to the enormous loss of life caused by the HIV/AIDS pandemic, other serious effects include:

Photo by: Harriett Destler/USAID

Financial and Other Losses for Families and Communities

The illness, progressive disability, and death of one or more family members from HIV/AIDS affect not just the individual but the entire household in multiple ways. The most immediate impact is financial—loss of income and increased medical expenditures, particularly when the ill family member is the principal breadwinner. If other family members, usually daughters and wives, have to leave school or work to take care of the ill family member, household income and long-term prospects decline even more. Children, some very young, are forced to care for their parents, and in many cases, to head up households. Any family savings are needed to cover medical and funeral expenses. There is little money for food or shelter and none for school fees and uniforms. Grain stocks are used up and livestock sold to cover expenses. This loss of income,

Table 1: African Countries with Greater Than 10% Prevalence



Data Source: UNAIDS/U.S. Bureau of the Census

savings, and productive assets jeopardizes the family's survival. The average cost of treatment, funeral, and mourning expenses was found in a study in Ethiopia to be several times the average household income.

But the effect on the household is not just economic. When adults in the family die, the very structure of the household changes. Grandparents, aunts, uncles, and even children take on new responsibilities. With fewer household resources and less available time, children receive less attention and less health care, and become more vulnerable to malnutrition.

When large numbers of families experience such losses, the communities in which they live are affected as well. They may have large numbers of orphans and significantly fewer productive adults. In many places, there may be few if any formal social service or government agencies. But throughout the developing world, communities are proving remarkably resilient, providing support to children and families affected by HIV/AIDS because there is no one else to do it. They are creating volunteer organizations, identifying vulnerable children, mobilizing local resources, establishing day care centers, and becoming advocates for needed changes.

Increased Demands on the Health Care System

In countries hardest hit by HIV/AIDS and related diseases, such as tuberculosis, demand for service is overwhelming health care systems. As a result, few patients receive even the most rudimentary palliative care and

most suffer and die in pain. In many hospitals, AIDS patients occupy more than half of the hospital beds. In some countries, AIDS is projected to take up more than half the health ministry's budget within the next couple of years. Because resources are limited, the hardest-hit—and poorest—countries are facing terrible trade-offs: between treating AIDS and preventing HIV transmission, between treating AIDS and other diseases, and between spending for health and spending for other objectives.

Declines in Life Expectancy and Population Growth

More than four decades of continuous progress in improving health and life expectancy are now threatened in many countries. In southern Africa, where life expectancy at birth increased from 44 years in the 1950s to 59 years in the 1990s and was expected to reach 70 years by 2010, life expectancy is falling dramatically. By the end of the decade, average life expectancy in the countries hardest hit by HIV/AIDS could be as low as 30 years—comparable to life expectancies prevalent at the beginning of the 20th century.

Because of the high HIV/AIDS death rate among young adults, population growth is expected to decline in more than 12 countries by 2003. In many sub-Saharan African countries, up to one-third of adults in their prime will die of HIV/AIDS. Six sub-Saharan African countries have life expectancies below 40 years; life expectancy would have been 50 years or longer without AIDS. By 2010, many countries in southern Africa will see life expectancies fall to near 30 years of age: Botswana (29), Namibia (33), Swaziland (30) and Zimbabwe (33). These high mortality levels are changing population structures. The combined effect of fewer births (because HIV-infected women die before their childbearing years are over), fewer surviving children (up to one-third of children born to HIV-infected mothers die of AIDS), and the large number of adult deaths creates dramatic shifts in dependency ratios, with a small number of young adults caring for society's dependents—the young and the old. If these young adults are sick themselves, they will need to receive care from their children or elderly parents rather than provide it.

Costs for the Business Sector

In the hardest-hit areas, AIDS-related illness and death have had a significant effect on the business sector both by increasing expenditures and by decreasing revenues. Firms experience increased expenditures for a number of reasons, including higher health care costs, costs associated with recruiting and training replacement workers, and payment of burial fees for employees or their family members. Revenues are affected by time employees spend away from work either sick or attending funerals, time spent on training, the inexperience of replacement staff, time spent on training new staff, and reduced productivity of staff who may be ill but are still trying to work. Some companies have estimated that AIDS-related costs could reduce productivity by 5 percent annually, and profits by 6 to 8 percent.

The transport and mining sectors, with large numbers of personnel routinely away from their families for long periods of time, are particularly vulnerable. High rates of infection in these sectors threaten the viability of these crucial industries and could be important factors in the further spread of HIV, making workplace education an important part of HIV prevention measures.

Declines in Agricultural Production and Food Security

In most African countries, agriculture is the largest sector, contributing to both food security and income. The loss of even a few workers can make a significant difference in the size of the harvest. In families that are dependent on subsistence-level farming, surviving children and family members sometimes go hungry after the farm worker in the family dies. As the number of people available to plant and harvest food declines, the production of both food crops and cash crops declines as well. There are places in Malawi, Uganda, Zambia, and Zimbabwe where HIV/AIDS has taken such a toll on farmers and farm workers that we are seeing alarming rates of malnutrition, even near famine-like conditions where food supply should be abundant and the people healthy.

Declines in Education

In many countries, high HIV prevalence is undermining education, as the disease takes a toll among teachers, and the number of students in school declines. The death of HIV-infected women in their childbearing years leads to fewer births and thus fewer children. And even healthy children may leave school temporarily or permanently to care for sick family members, work in the field, seek income-earning employment, or simply because their families can no longer afford the school fees. Education, which equips people to make better choices, is an important component in the fight against HIV/AIDS. Teenagers are particularly susceptible to acquiring HIV, and education systems face the special challenge of educating them about AIDS and helping them to protect themselves. In KwaZuluNatal, South Africa, first grade enrollment declined by 12 percent between 1998 and 1999, largely due to the impact of HIV/AIDS. A 2000 study reported that in Malawi, teacher absenteeism was estimated at 20 percent due to HIV/AIDS. The same study found absenteeism among pupils who care for sick relatives at 30 percent.

Reduced Economic Growth

Although it is difficult to estimate the effect of HIV/AIDS on a country's macroeconomy, there is growing evidence that high HIV prevalence will have a substantially negative effect on economic growth. Studies in Cameroon, Kenya, Swaziland, Tanzania, Zambia, and other sub-Saharan countries have found that the rate of growth in gross domestic product could be reduced by as much as 25 percent over a 20-year period.

Some countries with high HIV prevalence are already experiencing declining economic growth. One study suggests that HIV/AIDS reduced the growth of per capita gross domestic product in African countries in the 1990s by 0.7 percent per year. For countries with HIV/AIDS prevalence higher than 20 percent, the study estimates that growth in gross domestic product will be 2.6 percent less per year than otherwise. In 20 years, gross domestic product in those countries will be two-thirds less than it would have been without HIV/AIDS. At the same time, health spending is rising, and the need for social services spending will increase as well.

Increased Political Instability and Violence

In many of the countries hardest hit by HIV/AIDS, worsening economic, social, and political trends contribute to instability across all sectors and increase the potential for violent conflict, ethnic unrest, and migration. Where the AIDS crisis is most severe, governing institutions and civil society are weakened, and key personnel—such as civil service technicians, teachers, health workers, and military professionals—are dying. Some African militaries have significantly higher infection rates than the general population. This has clear national security and peacekeeping consequences.

A particularly dangerous consequence of the AIDS pandemic is the large cohort of youth left to struggle to survive without family support, education, or employment opportunity. They often live on the street, join gangs, use drugs, are forced to steal to eat, and can become victims of sexual predators. Poor, uneducated, and with little hope for the future, these young people are vulnerable to recruitment by corrupt armies, militias, or criminal organizations, and thus pose a threat to both domestic and international security.

II. THE USAID RESPONSE

USAID'S STRATEGY: STEPPING UP THE WAR AGAINST AIDS

The U.S. Agency for International Development's administrator, Andrew Natsios, has named the fight against HIV/AIDS as one of the agency's top priorities. The global community is in a race against time with still increasing rates, expanding disease and devastation—an ongoing disaster situation.

To fight the AIDS pandemic, USAID is redoubling its efforts, speeding up processes, and refining approaches. There are now success stories to inspire hope and to model future programs on, but there are still many others that must be written. The war on AIDS will be a long and arduous one, but it is a war that can, and ultimately, must be won.

In fiscal year 2001, with increased resources from Congress, USAID developed an "Expanded Response" to the HIV/AIDS pandemic. This strategy was designed to enhance the ability of countries to prevent new HIV/AIDS infections and provide services to those who are either infected or otherwise affected by the epidemic, especially children orphaned by AIDS.

USAID is now stepping up the war on AIDS even further, by launching a plan that will accelerate the implementation of the Expanded Response strategy and maximize its impact. USAID is working in more than 50 countries around the world, and in 2002, increased the number of high priority countries from 17 to 23. The new resource allocation plan puts more money—and thus more decision-making—in the field, to scale up prevention, care and treatment programs and support children affected by AIDS. This plan will increase staff levels in both country and regional field offices by reassigning technical staff. This scale up of technical and programmatic capacity must be commensurate with the increased funding to assure that the programs are strategically planned and implemented, incorporating the latest research results and technologies.

USAID is also expanding a comprehensive monitoring and reporting system that will allow USAID to track progress in priority countries and to document the impact of programs.

In 2002, USAID was reorganized and a new Bureau for Global Health was established. Within that, an Office of HIV/AIDS was developed to ensure that field programs get the best available technical and program support, that assistance is closely coordinated with that of other U.S. agencies and donors, and that practical field-based and biomedical research is directed at the most critical challenges.

Photo by: Harriett Destler/USAID

FOCUS ON PRIORITY COUNTRIES

USAID is collaborating closely with host country governments, citizen groups, and other donors to work toward the following goals by 2007:

- Reduce HIV prevalence by 50 percent among 15-to-24-year-olds in high prevalence countries;
- Maintain HIV prevalence below 1 percent among 15-to-49-year-olds in low prevalence countries;

- Ensure that at least 25 percent of HIV-infected mothers in high prevalence countries have access to interventions to reduce HIV transmission to their infants;
- Ensure that high prevalence countries can provide basic care and psychosocial support to at least 25 percent of HIV-infected persons; and
- Ensure that high prevalence countries can provide community support services to at least 25 percent of children affected by AIDS (including children in households with sick or dying parents and orphaned children).

Toward these ends, USAID is increasing its financial and technical support to selected countries. These countries are grouped into three categories, and the amount, level, and type of assistance they receive are based on criteria such as:

- Severity and magnitude of the epidemic;
- impact of HIV/AIDS on economic and social sectors;
- Risk of a rapid increase in prevalence;
- Availability of other sources of funding;
- U.S. national interests; and
- Strength of host country partnerships.

The three categories are:

High Priority - Rapid Scale-Up Countries. Four high prevalence countries (Cambodia*, Kenya, Uganda, and Zambia) received significant increases in resources in fiscal years 2001 and 2002 in order to achieve measurable progress. These countries are considered potential models for other countries, and USAID is working to see that significant increases in program coverage and intensity occur rapidly in the targeted population.

High Priority - Intensive Focus Countries. Nineteen "Intensive Focus" countries are receiving increased assistance. Of these, nine have a high prevalence of HIV/AIDS, and 10 are considered low prevalence countries. The goal is to reduce HIV prevalence (or keep prevalence low in low prevalence countries), to reduce HIV transmission from mother to infant, and to increase support services for people either living with or affected by HIV/AIDS. In the high prevalence Intensive Focus countries, USAID is working with other donors to ensure that at least 80 percent of the targeted population has a comprehensive package of services within three to five years. In the low prevalence Intensive Focus countries, USAID is working with other donors to ensure that at least 80 percent of the targeted high-risk population has a comprehensive package of prevention activities within three to five years.

Basic Countries. In 31 countries, USAID resources help track the epidemic, maintain technical assistance, training, and commodity support, as well as leverage additional sources of funding and support. In Basic countries, USAID recommends that missions support surveillance systems and targeted interventions toward the populations that are most vulnerable.

Table 2: USAID Budget for HIV/AIDS

Fiscal Year	Budget (in millions)
2002	510.0†
2001	433.0†
2000	200.0
1999	139.1
1998	125.4
1997	118.9
1996	137.5
1995	151.9
1994	112.8
1993	124.5
1992	95.7

†*includes funding for the Global Fund to Fight AIDS, Tuberculosis and Malaria*

*Assistance for the government of Cambodia was provided under the authority of section 522 of the Foreign Operations Appropriations Act, which permits HIV/AIDS assistance, notwithstanding provisions of law.

Table 3: Stages of the HIV/AIDS Epidemic

In partnership with USAID, UNAIDS and the World Health Organization released a report in 2000 defining three stages of the HIV/AIDS epidemic.

Low-level epidemics occur in areas where HIV has not yet spread widely, even among groups whose behaviors put them at risk. In high-risk groups, HIV/AIDS does not consistently exceed 5 percent.

Concentrated epidemics occur when HIV prevalence consistently exceeds 5 percent in one or more groups with high-risk behavior, but is less than 1 percent in pregnant women in urban areas.

In *generalized epidemics*, HIV is firmly established in the population, and HIV prevalence is consistently more than 1 percent in pregnant women. Although high-risk groups continue to contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain the epidemic independent of the behavior of high-risk groups.

Within a generalized epidemic, USAID defines epidemics in which more than 5 percent of the adult population (aged 15 to 49) is HIV-infected as ***high prevalence countries***. ***Low prevalence countries*** have a less than 5 percent infection rate but have risk factors such as trend data and levels of risk behaviors that suggest their infection rate could accelerate in the absence of effective interventions.

INCREASING FOCUS ON EMERGING EPIDEMICS

Over the past 15 years, our understanding of the dynamics of the global AIDS pandemic has vastly improved. We now recognize that there are a number of biological, viral and social factors that determine transmission and vulnerability. Table 4 describes three stages of an AIDS pandemic.

Of the 5.3 million new HIV infections that will occur this year, nearly 60 percent take place in high prevalence countries, demonstrating that these countries must continue to be a major part of USAID's focus. In these high prevalence countries, there is the greatest need for more comprehensive programs, which include not only prevention efforts, but also care and support for those already infected and families and survivors.

Generalized adult epidemics often occur after moving sequentially through the first two stages, but this progression is not inevitable in all countries. While every country in the world has identified the presence of HIV infection, it is critical to identify those countries at most risk of emerging epidemics and prevent these from occurring. In order to assess this risk, it has become increasingly important to integrate biologic and behavioral surveillance data with detailed information about the social and economic patterns that lead to increased risk behaviors in order to understand the likelihood of an explosion of infections.

Over the past two years, USAID has undertaken an extensive analysis of all countries it works in, as well as neighboring countries that may affect the dynamics of a national epidemic. This analysis includes examining the historical trends of HIV infection in sub-populations; levels of co-infection with other sexually transmitted diseases; estimated numbers of persons engaging in risk behaviors, for example, clients of prostitutes; age of sexual debut; median age at first marriage; and the number of males who are circumcised. In addition, USAID examined a range of socio-cultural factors, including the extent of migration within the country and across borders.

Of USAID's 23 priority countries, 12 have generalized epidemics and USAID is working with partners to stem the tide of the epidemic. USAID's remaining 11 priority countries, and 29 of 31 "basic" countries have low HIV prevalence. In these countries, USAID is working to prevent the epidemic from spreading to the general population.

Table 4: Stage of HIV/AIDS Epidemic in USAID Priority Countries

Countries	Generalized High Prevalence	Generalized Low Prevalence	Concentrated	Low Level
Brazil			X	
Cambodia		X		
Dominican Republic		X		
Ethiopia	X			
Ghana		X		
Haiti	X			
Honduras		X		
India		*	X	
Indonesia			X	
Kenya	X			
Malawi	X			
Mozambique	X			
Nepal			X	
Nigeria	X			
Russia			X	
Rwanda	X			
Senegal		X		
South Africa	X			
Tanzania	X			
Uganda	X			
Ukraine			X	
Zambia	X			
Zimbabwe	X			
Albania				X
Angola		X		
Armenia				X
Bangladesh				X
Benin		X		
Bolivia				X
Croatia				X
Democratic Republic of Congo	X			
Egypt				X
El Salvador				X
Eritrea		X		
Georgia				X
Guatemala		X		
Guinea		X		
Guyana		X		
Jamaica			X	
Jordan				X
Kazakhstan				X
Kosovo				X
Kyrgyzstan				X
Madagascar				X
Mali		X		
Mexico			X	
Namibia	X			
Nicaragua			X	
Peru				X
Philippines				X
Romania			X	
Tajikistan				X
Turkmenistan				X
Uzbekistan				X

** Generalized low prevalence in some states.*

In addition, USAID is working in a number of countries outside this list, such as Cameroon, Lithuania, Swaziland, Uzbekistan and Vietnam, that are covered by regional programs. Many of these are also either low level, concentrated or generalized low prevalence countries.

The stage and nature of the epidemic determines what types of assistance are most needed and effective. In high prevalence countries, USAID is continuing to focus on prevention, both among the high-risk and the general population, at the same time strengthening care and support systems for those who are already infected or affected by the epidemic. The greatest challenge faced in high prevalence countries is how to rapidly scale-up proven interventions to reach significantly affected populations.

While generalized epidemics need a comprehensive, multi-pronged approach, low-level or concentrated epidemics need a more focused approach. A joint USAID – UNAIDS publication, "Effective Prevention Strategies in Low HIV Prevalence Settings" gives program guidance on the most strategic approaches in these settings, where USAID is working to contain or stop the epidemic. Of primary importance are basic surveillance systems, which make it possible to track the epidemic and provide an early warning of increasing infection.

Behavior change communication is the essential program element in low prevalence settings. Working with governments and civil society, USAID's behavior change programs use focused intensive interpersonal communication activities targeted specifically to reach vulnerable sub-populations. To be effective, this must be done in the context of broader mass media efforts that raise the general level of awareness about HIV infection and AIDS. In addition, programs need to address risk, stigma and discrimination.

This focus and early intervention can avert massive increases in HIV infection and keep countries from experiencing the devastation that is now being witnessed in countries in sub-Saharan Africa.

EXPANDED RESPONSE STRATEGY

The Expanded Response strategy is multi-faceted and includes eight interrelated approaches.

1. Prevent New Infections

Preventing new infections continues to be the most urgent priority in the fight against HIV/AIDS in both high prevalence and low prevalence countries, with about 70 percent of USAID's HIV/AIDS budget committed to this goal. Prevention activities are designed to slow—and ultimately reverse—rising HIV infection rates, so that fewer people will suffer the dire consequences of AIDS.

Table 5: How is HIV Transmitted?
(percent of global total)

Sexual Intercourse	80%
Mother-to-Child Transmission	10%
Injecting Drug Use	5%
Blood Transfusion	5%
Health Care	.01%

Source: USAID

On a global basis, 90 percent of new infections result from either sexual transmission (80 percent) or mother-to-child transmission (10 percent). HIV infection also results from blood transfusion and use of contaminated needles by injection drug users. USAID's approach to prevention is to reduce the risk factors that contribute to HIV transmission by:

- Developing interventions to change high-risk sexual behavior;
- Treating other sexually transmitted infections;
- Increasing demand for and access to condoms and other essential commodities;
- Preventing mother-to-child transmission of HIV; and
- Promoting voluntary HIV counseling and testing.

HIV prevention efforts, particularly those combining multiple approaches, have had considerable success. Some examples:

Risk Behaviors of Youth Help Determine HIV Prevalence. Approximately one-third of those currently living with HIV/AIDS are aged 15 to 24, and, in many places, the majority of new infections occur in this age group. Girls and young women are especially vulnerable to the transmission of HIV because of social and biological factors. Experience shows that reducing generalized HIV infection among the young is essential to keeping HIV prevalence low. In Uganda and Zambia, an array of USAID-supported interventions helped to significantly reduce HIV prevalence among the targeted populations. Uganda reduced national HIV prevalence by 50 percent between 1992 and 1999, and among young women by one-third. Zambia reduced HIV prevalence among 15- to 19-year-olds by more than 40 percent. In both cases, a key element in reducing HIV prevalence was a delay of almost two years in the onset of sexual activity by young people. Between 1989 and 1995, the proportion of teenagers who had had sex by age 15 in Uganda declined from 50 to 30 percent; the proportion who had had sex by age 18 declined from 90 to 60 percent.

In the Russian Federation and other parts of the former Soviet Union, the vast majority of HIV infections are related to injection drug use among sexually active youth; approximately 1 percent of the population in these countries inject drugs. Although, currently overall HIV prevalence is low, among high-risk groups in Central Asia, Russia, and Ukraine, prevalence exceeds 5 percent. The high odds of transmitting HIV through needle sharing, combined with high levels of sexually transmitted infection in the wider population, makes prevention efforts in these countries, targeted at youth, an urgent priority.

Condoms Reduce the Spread of HIV. The social marketing of condoms is a powerful tool that combines private sector advertising and commercial distribution with messages to promote behavior change. Where it has been used, it has significantly increased condom sales and use. USAID has been a leader in social marketing, which emphasizes voluntary behavior change, such as using condoms, based on benefits to the user of the item or concept. USAID distributed more than 360 million condoms in 2000 alone and developed effective messages emphasizing the benefits.

Distribution of 300 million condoms is estimated to prevent half a million new HIV infections per year. In Eastern Europe, a condom brand developed for young people was sold in outlets they frequent at a price they could afford. This condom brand was marketed with messages about responsible sexual and reproductive health practices. Combined with peer education programs in schools, such social marketing has led to dramatic increases in condom sales.

Combined with other approaches—strong political leadership, mass media campaigns promoting delayed onset of sexual activity, policies requiring 100 percent condom use in brothels—increased condom use has been a significant element in reducing HIV infection in key populations in a range of countries.

y, increased condom sales; the mili-
y purchased 12 million condoms for

Preventing Mother-to-Child Transmission (MTCT). Recent studies have shown that short, affordable courses of antiretroviral therapy for HIV-infected pregnant women can reduce HIV transmission to newborn babies by 20 to 50 percent. USAID currently funds programs using antiretroviral drugs to reduce mother-to-child transmission in four countries, and expects to add additional programs in the coming year.

- In Zambia, USAID supports an innovative community-based program in Ndola District that provides education on HIV and infant feeding choices and offers referral to the district health center for testing and counseling. This program is adding antiretroviral prophylaxis. This innovative model will be expanded to Malawi this year.
- In South Africa, USAID is providing management support to the MTCT program at Chris Hani Baragwanath Hospital in Soweto. This hospital, which performs 16,000 deliveries per year, provides MTCT services to women delivering in the hospital and has established MTCT services in more than 10 outreach centers.
- In Uganda, USAID is supporting MTCT services in Mulago Hospital (in Kampala) along with the Elizabeth Glaser Pediatric AIDS Foundation. USAID funds the testing and counseling components, while the hospital is providing the antiretroviral drugs and antenatal care.
- In Kenya, USAID currently supports MTCT prevention projects in three sites. This is a collaborative effort with the government of Kenya, UNICEF, UNAIDS, the World Health Organization, and African researchers. An important part of this effort is a comprehensive operations research study, so that USAID can learn from the experience and share the knowledge gained.

Voluntary Counseling and Testing (VCT) is an Important Tool. USAID-funded research shows that when voluntary counseling and testing services are accessible, affordable, and secure, the number of people who take steps to learn their HIV/AIDS status increases dramatically. Studies in many countries show that knowing HIV status, and how to prevent infection, promotes more responsible behavior among both infected and uninfected individuals. It also opens the door to additional care and support services and helps to overcome the stigma associated with HIV/AIDS. Those who test positive can benefit from early medical care and interventions to treat or prevent associated illnesses; they can also receive counseling and ongoing emotional support. Pregnant women who learn they are HIV-infected can take steps to prevent transmission of the virus to their infants.

Photo by: Armando Waak/PAHO

It is estimated that 90 to 95 percent of people globally do not know their HIV status, although most would like to. USAID has been the international leader in moving voluntary counseling and testing to the forefront of HIV/AIDS programming. More than 20 USAID programs in Asia and Africa have adopted voluntary counseling and testing as a prevention intervention. New technologies such as rapid tests allowing same-day results are making it easier to get tested by reducing the burden of having to travel back to a clinic for the results and counseling. Studies in Kenya and Uganda are exploring how to expand testing among young people after earlier studies demonstrated that effective counseling helps to reduce HIV risk behavior. Another study showed that the number of people who come in to be tested increased significantly when rapid

tests (providing results in just a few minutes) are available. Efforts to promote voluntary counseling and testing in Malawi in 1999 and early 2000 more than tripled the number of clients tested. In Zimbabwe, USAID is supporting nine voluntary counseling and testing sites that have shown a remarkable increase in the number of people tested since the sites were opened in 1999.

2. Provide Care and Treatment to Individuals and Communities

Experience shows that individuals will seek to learn their HIV status where care and treatment are available. Today the fight against HIV/AIDS includes providing care and treatment; both for humanitarian reasons and because prevention efforts work best when these efforts include working with those who are already ill. Care and treatment interventions help to stabilize or improve the physical or mental health of individuals infected or affected by HIV/AIDS and reduce the burden on their families. They provide hope to those who have or fear they may have HIV/AIDS, destigmatize HIV/AIDS, prevent secondary epidemics of tuberculosis, and stabilize communities.

USAID's care and treatment interventions include:

- *Treating tuberculosis and other opportunistic infections.* HIV and tuberculosis are the two biggest infectious disease killers, and almost one-third of people with HIV infection have tuberculosis, making it the number one killer of people with AIDS. Preventing and treating active tuberculosis is one of the most important interventions for increasing the length and quality of life of HIV-infected individuals, and benefiting families and communities affected by HIV/AIDS.
- *Providing psychosocial and palliative care for persons with HIV-related symptoms such as pain, fever, or diarrhea.* For the vast majority without access to drug treatment, psychosocial care and palliative care can greatly improve quality of life.
- *Providing adequate nutrition.* A USAID study, "HIV/AIDS: A Guide for Nutrition, Care and Support" found that, compared with an average adult, a person with HIV requires 10 to 15 percent more energy a day, and 50 to 100 percent more protein a day. USAID is now incorporating food security activities into care and support efforts.
- *Working with faith- and community-based organizations to develop care and support systems.* USAID introduced a new initiative, the Communities Organized in Response to the HIV/AIDS Epidemic (CORE), as a way to get resources and technical assistance to faith-based and community-based organizations, which are often best suited to provide care and support.
- *Exploring the potential of antiretroviral drugs in the context of limited health resources.* The urgent need for prevention and tenuous health infrastructures make it difficult to bring the advantages of antiretroviral drugs to developing countries. However, USAID continues to explore ways to make these drugs, which are helping HIV-infected individuals in developed countries, more available in developing countries.

3. Address the Needs of Children Affected by HIV/AIDS

More than 13 million children under age 15 have lost their mother or both parents due to AIDS. By 2010, an estimated 44 million children in 34 countries will have lost one or both parents primarily due to AIDS. The impact of such large numbers of orphans and other vulnerable children is substantial for the children themselves, their families, and the communities in which they live. Orphaned children lose the security of their families, often have to give up school, have less access to health care, and become vulnerable to malnutrition, homelessness, abuse, and are at-risk themselves to HIV and AIDS. In sub-Saharan Africa, where the majority of AIDS orphans reside, gains in child health achieved over recent decades are unraveling.

Many have suggested that building more orphanages or other group residential facilities is an effective way to care for the increasing numbers of orphans in AIDS-

affected countries. USAID does not recommend employing this as a frontline response to the AIDS crisis as it affects children. Care provided in institutional settings often fails to meet the developmental and long-term needs of children, and orphanages are much more expensive to maintain than providing direct assistance to families and communities to care for orphaned children themselves. In addition, in Africa, it is part of the culture for a community to take care of a child who has lost his or her parents. Community-based care is also more cost-effective, enabling assistance to far more children than orphanages could ever reach.

Nongovernmental organizations are implementing a variety of innovative programs in support of children infected with or affected by HIV/AIDS. USAID has provided support to such initiatives since 1999—in some cases, providing direct support to community organizations; in others, helping to build the capacity of local groups to provide improved services to a larger group of beneficiaries than they could otherwise reach. In addition, since 2000, USAID has provided $10 million a year in food aid to children affected by AIDS and their families, to help reduce the impact of AIDS on households.

Examples USAID's programs for children affected by AIDS include:

- In Uganda, parents and children learn to plan for the impending death of a family member.
- In Rwanda, several programs work together to provide food to 22,000 AIDS-affected children.
- In Zambia, interactive radio and local volunteers help out-of-school and vulnerable children continue to learn.
- In Cambodia, local and national nongovernmental groups integrate orphans and children affected by HIV/AIDS into ongoing prevention activities.
- In Romania, a pediatric AIDS center provides care, support, and counseling to HIV-infected children and their families.

4. Increase National and International Surveillance

From the earliest days of the pandemic, USAID recognized the importance of collecting surveillance data to track the expanding HIV/AIDS pandemic and to measure the effect of prevention interventions. With USAID support, the U.S. Census Bureau has created the HIV/AIDS Surveillance Database, which collects widely scattered information from small-scale surveys and studies presented in the medical and scientific literature, at international conferences, and in the press. Today, the U.S. Census Bureau is the globally recognized leader in tracking HIV patterns and trends.

In collaboration with the Centers for Disease Control and Prevention, USAID also provides technical assistance and training to help countries improve their surveillance programs to better capture the diverse and changing pandemic. In Russia, for example, such collaboration with local officials and the Ministry of Health improved the ability of Moscow officials to conduct extensive behavioral and epidemiological research. In Cambodia, a strengthened surveillance system has helped Cambodian officials and donors target key populations and geographic areas for prevention as well as care and support interventions.

USAID is also collaborating with the World Health Organization, UNAIDS, and other partners to implement "second generation" surveillance systems. These new systems concentrate surveillance among the most at-risk sub-populations. The systems are flexible, and can adjust to the needs and state of the epidemic. By using both behavioral and biological surveillance data, they provide a better understanding of trends over time and of the behaviors driving the HIV/AIDS epidemic. Second-generation surveillance systems help ensure that money and expertise are used as efficiently as possible and improve a country's ability to provide prevention and care where it is most needed.

5. Increase the Capacity of Developing Country Health Systems

Already overstretched health systems in poor countries have difficulty responding to the many issues raised by

the emergence of a deadly new epidemic. These issues include how to allocate resources between prevention and care; how to determine overall resource needs and negotiate appropriate budget levels; how to develop protocols for HIV/AIDS and other health services; how to ensure that drugs, staff, and other resources are available; and how to secure appropriate and sufficient health care personnel.

In order to address these issues and make their health systems better able to respond to the HIV/AIDS pandemic, countries need to develop guidelines about the kinds of care their system can provide and organize support for those guidelines among health care providers. They also need to develop management systems that support prevention and care and to regulate private sector care.

Photo by: Harriett Destler/USAID

USAID is the preeminent world leader in health systems research and development. It has adapted approaches first used in the United States to accommodate circumstances in developing countries, and now has an array of tools that can help developing countries address the challenges posed by HIV/AIDS.

In order to respond to HIV/AIDS while balancing other health care needs, policymakers need information about who pays for health care and how much it costs. National health accounts provide a way of analyzing where health care system resources come from and how they are used. A USAID-supported study in Rwanda adapted the national health accounts framework to generate disease-specific information and found that HIV has a severe financial impact on households with infected family members and that these households bear almost all the treatment costs. The study was useful both for the specific information it generated about Rwanda and for what it taught about the need to use actual health care cost data, both public and private expenditures, in designing and implementing policy.

6. Work in Partnership

Collaboration with partners is a distinctive feature of USAID's HIV/AIDS program. USAID has worked extensively with other international donors, national governments, and a range of host country and U.S.-based institutions and community organizations to build sustainable systems, use participatory approaches, and incorporate lessons learned. In the Expanded Response, USAID works with this network of partners to achieve maximum impact, avoid duplication, ensure broad coverage, monitor and evaluate the cumulative effect of interventions, and identify and share tools, innovations, and successes.

Nongovernmental organizations are among the most effective means of reaching individuals at high risk of infection, as well as those most in need of care and support. USAID missions in more than 50 countries work directly with these groups at both local and international levels to provide technical assistance, training, technology exchange, and institutional support. More than 70 percent of USAID's HIV/AIDS support over the years has been allocated to nearly a thousand nongovernmental organizations worldwide.

In many developing countries, faith-based and community organizations administer a significant portion of health and social services, making them key partners in any response to the HIV/AIDS crisis. USAID has long worked with faith-based organizations in implementing agriculture, education, disaster relief, and microenterprise initiatives, and is now working to help faith-based groups scale up their HIV/AIDS programs.

Collaborating with other bilateral and multilateral donors is essential to ensuring that all HIV/AIDS efforts

complement and reinforce each other without duplication. USAID works with bilateral donors at both the policy and the field levels, and is an active partner with UNAIDS and other international donors. As the world's lead HIV/AIDS donor, USAID promotes ongoing collaboration in the fight against the pandemic, particularly on the part of multilateral organizations such as UNAIDS, the World Health Organization, and the World Bank.

As the pandemic has escalated, leaders throughout the developing world have increased their resolve to address HIV/AIDS and the issues it raises. USAID collaborates with developing world partners who take the lead in mobilizing political will, identifying at-risk populations, and promoting behavior change, among other roles, to maximize the benefits of USAID support. The countries that have been most successful in slowing the spread of HIV had bold, decisive leadership at an early stage. In Uganda, for example, HIV infection fell by half between 1992 and 1999, after President Yoweri Museveni introduced and promoted a mix of interventions consisting of voluntary HIV testing, condom distribution, education, and counseling and support services.

USAID partners with a range of U.S.-based organizations, including other government agencies, corporations, and private foundations in its worldwide HIV/AIDS programs. Collaborative efforts with the Centers for Disease Control and Prevention, the Department of Defense, and the Peace Corps allow each of those agencies to bring their unique experiences and perspectives to the international fight against HIV/AIDS. In one example of collaboration with the private sector, the pharmaceutical company Pfizer, Inc., has agreed to donate an antibiotic for use in a USAID-supported study to evaluate the effect of periodic treatment of sexually transmitted infections as part of a comprehensive approach to HIV/sexually transmitted infection prevention. And USAID has had considerable support in leveraging foundation support for HIV/AIDS initiatives in the developing world.

Between 1996 and 2001, USAID provided more than $97 million to UNAIDS. The United States is the largest donor to UNAIDS, with USAID providing approximately 25 percent of its annual budget. UNAIDS provided leadership to create the International Partnership Against AIDS in Africa (IPAA) in 1999. IPAA was put in place to help coordinate the efforts of African governments, donors, the private sector (including multinational corporations, pharmaceutical firms, foundations, and trade unions), and the community sector (including international, national, and community organizations; academic and research institutions, and others).

The U.S. has been a leader in the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria. President Bush made the first pledge by a government to the Fund, and to date the U.S. has pledged $500 million. In addition, USAID contributed substantially to the development of the Fund by providing $1 million in start-up funds, and detailing a USAID foreign service officer as the team leader of the Technical Support Secretariat.

7. Provide Technical Leadership through Research

A hallmark of USAID's HIV/AIDS program is ongoing biomedical and behavioral research to develop and evaluate new tools for preventing HIV transmission and for providing improved services for those living with HIV/AIDS.

In order to replicate or scale up a successful project to a national level program, it is important to first determine accurately the factors contributing to its success. USAID, through its Horizons project, collaborates with its partners to conduct research on how and why HIV/AIDS programs and policies work (or do not work, because much can also be learned from less-than-successful efforts). Horizons currently conducts more than 60 operations research activities in key areas. Through this research, USAID continually improves the quality and effectiveness of its programs.

USAID currently supports applied research in 21 countries, including research to develop and improve interventions that reach youth with effective prevention messages; to improve programs to prevent mother-to-child transmission; and to reduce the stigma of HIV/AIDS.

In addition, USAID funds groundbreaking research on vaginal microbicides, and the International AIDS Vaccine Initiative to accelerate development of a workable vaccine.

USAID's leadership and commitment to research has produced many interventions widely used in HIV/AIDS prevention and care today. Examples of USAID-supported research initiatives include:

Lesedi: From Pilot Project to Self-Sustaining Intervention. A USAID-supported intervention aimed at 407 high-risk women in a South African mining town succeeded in reducing HIV prevalence not only among the women but in the community as a whole. Called *Lesedi* (meaning "We have seen the light"), the project is being replicated in other mining communities and other areas with similar transmission dynamics. It is an excellent example of how USAID analyzes a program to find the essential elements of success and replicate it in other areas.

Monitoring the AIDS Pandemic (MAP) Network. The MAP Network, created in 1996, brings together more than 100 epidemiologists, modelers, economists, and social, behavior, public health, and international development specialists from 40 countries to assess HIV/AIDS status and trends. The MAP Network provides objective, high-quality, and timely analyses of the most current available data on HIV/AIDS. These analyses in turn are used to inform countries and expand their national capacities to respond to the pandemic.

8. Create an Environment that Supports HIV/AIDS Prevention and Care

HIV/AIDS prevention and care programs do not operate in a vacuum. To be effective, the larger context in which they operate must be supportive. For this reason, USAID addresses a number of issues that increase communities' vulnerability to HIV/AIDS, including stigma and discrimination, gender inequality, food insecurity, lack of infrastructure, and capacity within the country for political and legislative advocacy.

Overcoming the stigma attached to HIV/AIDS and the resulting discrimination is essential to combating the epidemic. Protecting the human rights of persons living with HIV/AIDS and their caregivers is an important concern for USAID programs. The issues that need attention include discrimination in the workplace, the legal rights of persons living with HIV/AIDS, attitudes of the media and of medical personnel, and the human and legal rights of caregivers. A pilot project in Zambia that taught important lessons about how to incorporate these issues into HIV prevention and care programs is being expanded to include additional countries.

When stigma and discrimination are overcome, it is much easier to involve people who are living with HIV/AIDS in community and country programs. Creating an environment in which persons living with HIV/AIDS are comfortable coming forward as educators and community mobilizers is an important focus for USAID. USAID projects and studies have shown that prevention messages delivered by persons living with HIV/AIDS are a powerful tool to effect change, and that care and support provided by someone who has the infection is particularly comforting to the recipient. USAID's work in this area had immediate impact on the participating community organizations in Burkina Faso.

Until the mid-1990s, the role of women in the AIDS crisis was little recognized. But women now comprise nearly half of all infections (in Africa, more than half), and among younger women, the infection rate is particularly high. In addition, women bear much of the burden of caring for HIV-infected family members and risk passing HIV on to their infants. Because USAID's HIV/AIDS programs recognize the difficulties women and girls face, the programs:

- Work through maternal, child, and other health services that women use;
- Help women develop action plans to reduce their risk of HIV infection and to increase their access to services:
- Address economic and social issues that put women at a disadvantage;

- Develop microfinance initiatives through which women can mitigate the effect of HIV/AIDS on their families;
- Educate widows about inheritance rights;
- Pay special attention to the needs and participation of girls; and
- Involve men as well as women in supporting the health and welfare of women and girls.

In Senegal, a program that recruited traditional women's associations to promote condom use helped to significantly increase condom use in the neighborhoods in which they were active. In Ukraine, efforts to prevent HIV transmission from mother-to-child and to health care workers provide useful lessons for other countries trying to address this issue.

Finally, a broad-based, sustained approach to HIV/AIDS requires a supportive policy environment in which human rights are respected, stigma and discrimination are eliminated, national guidelines and plans bring consistency to programs, and financial and human resources are mobilized. The USAID-funded Policy Project develops activities and programs to improve the ability of public and private sector institutions to participate in the policy process, including those that might not otherwise be involved in policymaking, such as nongovernmental organizations, women's groups, universities, professional associations, research institutions, pharmacies, and other health service providers.

MONITORING AND EVALUATION

An important component of USAID's Expanded Response is creating a better system for managing programs and resources, and measuring program progress. The increased level of resources, the scaling up of projects, and the development of new program areas make measuring progress and effectively targeting USAID effort and resources more urgent than ever. USAID has established an expanded system for gathering, analyzing and sharing data on the state of the pandemic and program results and effectiveness.

USAID has established a comprehensive system to collect, analyze and share key information on HIV/AIDS. This system has three elements:

- The annual and periodic collection of key national and program-level data;
- The use of standard indicators; and
- The reporting of data to central repositories for additional analysis and dissemination.

Data Collection

The key national and program-level data are:

- HIV seroprevalence rates (from annual sentinel surveillance systems);
- Changes in risk reduction behavior (from national surveys repeated every three to five years); and
- Progress on USAID program implementation and coverage of target populations (from USAID program reporting systems/reported annually).

USAID/Washington, in collaboration with missions, the Centers for Disease Control and Prevention, UNAIDS, the World Health Organization, and others, will work to improve and expand national sentinel surveillance systems to track the rate of HIV transmission to monitor national impact. The Centers for Disease Control and Prevention will take the lead in strengthening sentinel systems. By 2007, USAID-assisted countries should have sentinel surveillance systems that provide annual data on HIV seroprevalence rates. The standard indicator will be HIV seroprevalence rates for 15- to 24-year-olds and the disaggregated rates for 15- to 19-year-olds and 20- to 24-year-olds.

Standardized Indicators

Under USAID leadership, a new set of standard international indicators allows program managers to track results over time in ways that enable managers to look at parallel results in different countries. Some of these indicators were first identified and published in March 2000 in the *USAID Handbook of Indicators for*

HIV/AIDS/STI Programs. USAID subsequently funded, along with UNAIDS, an international consultative process with other national governments, multilateral donors, and nongovernmental organizations to reach agreement on a standard set of indicators and monitoring and evaluation instruments. That process resulted in the UNAIDS handbook, *National AIDS Programs: A Guide to Monitoring and Evaluation* in July 2000. The indicators and data collection instruments in both handbooks have become world standards. USAID/Washington, missions, and regional bureaus now use these standard indicators to report on program results and to set objectives and targets for newly designed programs. Additional indicators are being refined and tested to track new program areas.

In addition, USAID has developed indicators to measure progress in achieving the global targets in new areas covered by the Expanded Response, such as reducing mother-to-child HIV transmission, supporting orphans and other children affected by HIV/AIDS, and providing basic care and support to HIV-infected individuals, families, and communities. These new indicators were developed by several technical working groups late in 2001, and will be shared with USAID field offices this year. USAID collaborated with the Centers for Disease Control and Prevention and UNAIDS in planning two workshops to train technical experts in African countries in the use of standardized indicators and monitoring and evaluation.

Improved Reporting

In 2001, USAID developed an improved and simplified reporting system for monitoring and evaluating programs in priority countries (Rapid Scale-Up and Intensive Focus). This new system collects and analyzes three kinds of data:

HIV Prevalence to Measure National Level Impact. USAID's most important objective is to reduce the rate of HIV transmission. In collaboration with various partners, USAID will improve and expand national surveillance systems to track HIV prevalence records.

Changes in Sexual Behavior. Monitoring changes in sexual behavior provides data both to measure the success of national (including USAID) HIV/AIDS programs and to improve the efficiency and coverage of those programs. USAID, with other donors, will support standardized national sexual behavior surveys every three to five years that will collect data on the number of sexual partners in the last year, condom use with last non-regular partner, and age of first sex.

Program Progress and Coverage. USAID missions in priority countries are required to report annually on progress toward implementing their HIV/AIDS programs and increasing the proportion of their target populations reached. Much of this information is already collected at the project level. Under the Expanded Response, USAID missions will aggregate the information and report on overall progress. The following indicators for field programs are under serious consideration:

- Percent of target population requesting HIV testing and receiving counseling;
- Percent of orphans and vulnerable children with access to community services;
- Percent of target population with access to mother-to-child transmission programs;
- Percent of HIV-infected persons with access to basic care and psychosocial support; and
- Total number of condoms sold.

The improved system for monitoring and evaluating USAID HIV/AIDS programs will make both tracking trends within countries and comparing them across countries easier, more reliable, and more consistent. All Rapid Scale-Up and Intensive Focus countries under the Expanded Response are expected to implement this comprehensive monitoring and evaluation reporting system and to work closely with USAID/Washington to issue periodic reports on progress at the country level.

The monitoring and evaluation program will be implemented in fiscal year 2002, and the first comprehensive annual report on results will be issued in 2003.

III. THE CHALLENGE AHEAD

Twenty years after it was first identified, HIV/AIDS has become far more devastating and widespread than anticipated in even the most pessimistic predictions, affecting men, women, and children in all parts of the world, with the impact greatest among the poorest peoples and countries. To date, more than 60 million people have been infected; there is no cure, and vaccines are only in development.

The pace and level of international attention to the pandemic has continued to accelerate, and the prospects for stemming the spread of infection, and ultimately reducing HIV prevalence, are much better at the beginning of 2002 than they were a year or two ago. Much has happened, both within USAID and internationally, to increase the chances of successfully attacking the spread of HIV. The challenge now is to build on the current momentum and continue with a full-scale, coordinated international effort.

With the Expanded Response, USAID began a significant scaling up of successful interventions developed over the last 15 years to reach more individuals, combined with concentrating its efforts in key selected countries. Focusing more resources to reach more people in a selected number of countries will have a major impact in those particular countries and allow them to serve as models for what can be done. The improved system for measuring and reporting on progress developed as part of the Expanded Response will help USAID, host countries, and other donors determine effectiveness and respond to key challenges in a timely manner.

Internationally, the political will and financial commitment to address HIV/AIDS has never been stronger. Leaders around the world expressed support for responses to the pandemic with bold action by participating at the United Nations General Assembly Special Session on AIDS in June 2001, the first Special Session ever held on a public health issue. The Declaration of Commitment signed at the session pledged financial and political support for efforts to stem the spread of HIV/AIDS. It outlined a comprehensive international strategy involving national governments, multilateral and bilateral donors, nongovernmental organizations, pharmaceutical and other companies, and a host of other interests and associations. The Declaration expressed strong support for internationally agreed-upon targets in HIV prevention, care, and treatment; called for strong national and international leadership; and committed to providing substantial and increased resources for addressing HIV/AIDS. More than 180 countries were signatories to this groundbreaking document.

The Global Fund to Fight AIDS, Tuberculosis and Malaria was an important new development in 2001. The Fund is an innovative public-private partnership to extend prevention, care and treatment interventions, and services to larger numbers of people. The launching of the Global Fund represents a major new additional source of funds that can be quickly disbursed in an effective, targeted manner. To date, government and private pledges to the Fund amount to more than $1.9 billion, with the U.S. pledging $500 million.

The challenge for USAID and others during 2002 will be to continue to build on past successes while simultaneously developing and incorporating new and promising strategies in prevention, care, treatment, support, and research. Africa continues have the largest number of HIV/AIDS cases and the highest prevalence. However, UNAIDS has identified Eastern European and Eurasian countries as an important focus region because of the rapid increases in HIV infection rates now emerging.

In 2002, USAID launched a new plan to build on past successes, accelerate its Expanded Response strategy, and establish benchmarks to measure program impact and refine approaches. In stepping up its war on AIDS, USAID is directing more funding to the field and expanding the number of priority countries from 17 to 23. Funding for sub-Saharan Africa is being increased significantly.

Even as USAID continues to focus on key areas proven to be important in the fight against HIV/AIDS, it is expanding investment in promising new areas. These include:

- ***Microbicides***. Development of an effective microbicide to reduce sexual transmission of HIV and other infections could significantly help in the fight against HIV/AIDS. For this reason, USAID has invested in the development of microbicides for more than 10 years, at a level of approximately $2 million annually. That amount increased to $12 million in fiscal year 2001 and is $15 million in 2002. In order to ensure that a successful microbicide can be brought to market, USAID supports development and testing of products by numerous agencies.

- ***The Female Condom***. First introduced in 1992, the female condom is a highly effective method of preventing pregnancy and sexually transmitted infections, including HIV. USAID has worked through public and private partnerships to market, distribute, and encourage use of the female condom. Such research helps to refine marketing approaches, which in turn increase use and acceptability.

- ***Vaccines***. Over the long term, one of the best approaches to preventing HIV transmission will be a vaccine. For this reason, USAID provides support to the International AIDS Vaccine Initiative, a coalition of scientists, development agencies, and government and industry leaders working to create vaccines that will address the needs and conditions of developing countries. USAID provided $6 million to IAVI in fiscal year 2001, and $10 million in 2002.

- ***Programs to Reduce HIV/AIDS Among Youth***. YouthNet is a new USAID program designed to meet the unique, complex, and often wide-ranging reproductive health and HIV prevention needs of young people as well as those of their parents and other adults who work with youth and influence their well-being.

- ***Programs to Expand Community-Based Care and Support***. With the launch of the Communities Organized in Response to the HIV/AIDS Epidemic initiative in November 2001, USAID seeks to focus HIV/AIDS activity and behavior change at the community level. Through this initiative, USAID is providing small empowerment grants to grassroots organizations; support demonstration projects in which religious, secular, or nondenominational groups deliver HIV/AIDS care and address stigma and discrimination issues; provide technical assistance and strategic planning support to community and faith-based groups; expand voluntary counseling and testing services; involve persons living with HIV/AIDS at all levels of program planning and implementation; and create mechanisms for community groups to share best practices.

  USAID also established the Community Reach program as a way to facilitate the efficient flow of grant funds to organizations playing valuable roles in the fight against HIV/AIDS, including regional and local nongovernmental organizations, universities, and faith-based organizations. Grants will typically range from $100,000 to $500,000, and will be made in three broad categories: primary prevention and education, voluntary counseling and testing, and care for those living with HIV/AIDS.

Increasing programs to the needed scale and continuing to develop new interventions is an enormous task. The competition for resources and political attention will be intense. But the ground has been laid for a strong, committed international response, and the emergence of new priorities must not threaten that resolve. HIV/AIDS is not an isolated disease treatable through health measures alone. Its course and spread are integrally related to the social and economic conditions that exist in the world's poorest countries. These are the same conditions that breed political instability and violence; they must be addressed for health, humanitarian, and national security reasons.

The challenge now is to build on lessons learned, international commitment, and heightened political will to maintain the momentum.

HIV/AIDS FUNDING FISCAL YEARS 1999-2002 (all numbers in thousands)

AFRICA	FY 1999	FY 2000	FY 2001	FY 2002
Angola	–	1,500	1,485	1,500
Benin	1,200	1,025	2,005	2,005
Democratic Republic of the Congo	1,914	1,500	3,464	3,500
Eritrea	217	500	1,497	1,750
Ethiopia	5,540	7,600	8,182	11,250
Ghana	4,000	4,000	4,454	5,500
Guinea	1,200	1,725	2,202	2,200
Kenya	4,450	9,200	10,407	17,200
Madagascar	500	800	1,485	1,250
Malawi	2,685	6,000	7,186	8,500
Mali	2,220	2,500	3,167	3,167
Mozambique	2,820	5,600	6,635	7,500
Namibia	–	1,000	1,485	1,500
Nigeria	2,815	6,675	12,830	14,500
Rwanda	3,000	4,150	5,151	6,500
Senegal	2,775	4,200	4,502	5,000
South Africa	2,950	6,450	10,900	15,000
Tanzania	4,000	6,273	7,427	8,500
Uganda	7,010	9,300	13,378	20,000
Zambia	4,250	9,100	12,882	18,500
Zimbabwe	1,850	5,000	6,438	7,450
REDSO/ESA*	302	1,200	2,680	4,800
Southern Africa Regional	–	1,500	3,959	4,000
West Africa Regional	3,605	8,301	8,193	8,778
PL 480 Title II Food Aid	–	10,000	10,000	10,000
Office of Sustainable Development	3,749	3,800	3,959	3,400
Africa Total	**63,052**	**118,899**	**155,953**	**193,250**

*REDSO/ESA: Regional Economic Development Service for East and Southern Africa

ASIA & NEAR EAST	FY 1999	FY 2000	FY 2001	FY 2002
Bangladesh	2,000	3,007	3,000	3,200
Burma	154	–	–	–
Cambodia	3,000	2,050	8,247	12,000
East Timor	–	–	997	1,000
Egypt	340	–	1,196	1,200
India	6,450	8,500	8,993	12,200
Indonesia	–	4,460	4,000	8,300
Jordan	–	–	299	300
Nepal	1,700	2,000	4,000	6,700
Philippines	2,500	1,500	1,500	1,500
Asia & Near East Regional	4,996	–	6,902	10,600
Asia & Near East Total	**21,140**	**21,517**	**39,134**	**57,000**

Countries in bold face type are USAID's HIV/AIDS priority countries.

EUROPE & EURASIA	FY 1999	FY 2000	FY 2001	FY 2002
Albania	–	–	–	350
Armenia	–	–	161	500
Croatia	–	–	–	100
Georgia	–	–	400	1,100
Kazakhstan	81	231	1,587	838
Kosovo	–	–	–	750
Kyrgyzstan	35	90	876	580
Romania	–	–	747	945
Russia	1,710	1,650	4,243	3,607
Tajikistan	–	–	107	761
Turkmenistan	–	–	123	185
Ukraine	150	500	1,470	1,311
Uzbekistan	55	32	1,248	4,000
Central Asian Republics Regional	18	24	667	880
Central and Eastern Europe Regional	135	502	1,120	963
Eurasia Regional	175	425	1,063	1,091
Europe and Eurasia Total	**2,359**	**3,454**	**13,812**	**16,861**

LATIN AMERICA & CARIBBEAN	FY 1999	FY 2000	FY 2001	FY 2002
Bolivia	800	800	649	650
Brazil	2,000	2,000	4,390	5,000
Dominican Repubic	2,300	2,313	3,342	4,000
El Salvador	300	250	499	500
Guatemala	–	–	499	500
Guyana	–	200	798	1,000
Haiti	1,350	1,489	4,350	4,000
Honduras	1,400	1,400	2,566	3,500
Jamaica	1,700	1,825	1,297	1,300
Mexico	1,050	1,200	1,996	1,500
Nicaragua	390	500	499	500
Peru	300	500	748	750
Central America Regional	2,700	3,150	3,692	4,000
Caribbean Regional	–	–	1,497	5,550
Office of Sustainable Development	6	200	1,297	500
Latin America & Caribbean Total	**14,350**	**15,827**	**28,119**	**33,250**

USAID/WASHINGTON	FY 1999	FY 2000	FY 2001	FY 2002
Bureau for Global Health	21,500	23,250	56,521	62,000
Other bureaus	1,200	1,600	8,138	1,000
Global Fund	-	-	100,000	75,000
UNAIDS	15,200	15,200	17,050	18,000
IAVI	-	-	6,000	10,000
Microbicides	300	300	8,000	15,000
funded from POP	*[2,000]*	*[2,000]*	*[4,000]*	-
Commodity Promotion Fund	-	-	-	25,000
Economic Support Fund (TBD)	-	-	-	3,639
Sub-total	**15,500**	**15,500**	**131,050**	**123,639**
USAID/Washington Total	**38,200**	**40,350**	**195,709**	**186,639**
TOTAL	**139,541**	**200,047**	**432,727**	**510,000**

Countries in bold face type are USAID's HIV/AIDS priority countries.

BUREAU FOR GLOBAL HEALTH'S HIV/AIDS PROGRAM

USAID's Bureau for Global Health's HIV/AIDS program draws upon the expertise and resources of other U.S. government agencies, universities, voluntary organizations and industry to strengthen national HIV/AIDS prevention, care, treatment and support programs worldwide. The major components of the central program include:

Global leadership and coordination among donors, national governments and community groups. Examples: TAACS, JHPIEGO and personnel.

Regional and country level technical assistance and program support which makes U.S. expertise, commodities and other assistance available at country level to those fighting HIV/AIDS and caring for those affected including children and families. Examples: IMPACT, AIDSMARK, and Peace Corps.

Research and system support to improve approaches, systems and tools available to prevent the spread of HIV/AIDS. Examples: World Health Organization, Horizons, and Voice of America.

Monitoring and evaluating programs to determine program priorities and impact and to ensure the best use of limited resources. Examples: Synergy, Centers for Disease Control and Prevention and Bureau of Census.

The Bureau for Global Health HIV/AIDS fiscal year 2002 funding is shown in the following table:

Table 6: FY 02 Global Health Central HIV/AIDS Funding

Global Leadership and Coordination	$ 6,000,000
Regional and Country Level Technical Assistance and Support	$26,000,000
Research and System Support	$18,000,000
Monitoring and Technical Assistance Support	$12,000,000
Total	**$62,000,000**

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