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Folder Title:
Leadership and Investment in Fighting an Epidemic (LIFE) Initiative [Folder 2] [1]

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DRAFT FY 1998-2000 HIV/AIDS Funding (in $000)

Country Operating Unit	FY 1998 TOTAL	FY 1999 Core	FY 1999 AIDS Orphans Supp	FY 99 TOTAL	FY 2000 Core	FY 2000 LIFE Initiative	FY 2000 Sub-Total	DCOF * (CHS Account)	FY 2000 AIDS Children Supp.	FY 2000 TOTAL	Title II Food Aid (BHR)	FY 2001 Recommended SEE FOOTNOTE
ANGOLA	0	0		0	1,000		1,000	500		1,500		1,500
BENIN	1,500	1,200		1,200	1,025	0	1,025			1,025		2,054
CONGO	1,000	1,914		1,914	1,500	0	1,500			1,500		3,500
ERITREA	500	217		217	500	0	500			500		1,000
ETHIOPIA	5,125	5,540		5,540	5,000	1,700	6,700	400		7,100		7,500
GHANA	3,700	4,000		4,000	4,000	-	4,000			4,000		4,500
GUINEA	1,300	1,200		1,200	1,725	-	1,725			1,725		2,225
KENYA	3,200	3,300	1,150	4,450	3,200	2,500	5,700	500	600	6,800		7,500
LIBERIA	0	0		0	-							500
MADAGASCAR	500	500		500	800	0	800			800		1,500
MALAWI	2,600	2,600	85	2,685	2,200	2,800	5,000	500		5,500		6,000
MALI	2,400	2,220		2,220	2,500	-	2,500			2,500		3,000
MOZAMBIQUE	3,200	2,820		2,820	3,000	2,100	5,100			5,100		6,200
NAMIBIA	0	0		0	1,000		1,000			1,000		1,500
NIGERIA	1,900	2,000	815	2,815	3,300	3,450	6,750			6,750		11,897 → 8,750
RWANDA	500	2,000	1,000	3,000	1,500	2,000	3,500		1,000	4,500		4,700
SENEGAL	100	2,774		2,774	1,700	2,000	3,700			3,700		4,700
SIERRA LEONE								350		350		
SOMALIA	0	0		0	-	-	0					
SOUTH AFRICA	2,000	1,500	1,450	2,950	900	4,800	5,700	750	400	6,850		8,000 → 8,850
TANZANIA	3,800	4,000		4,000	3,500	2,500	6,000		800	6,800		7,000
UGANDA	4,900	6,010	1,000	7,010	4,400	2,500	6,900		2,200	9,100		10,762
ZAMBIA	2,700	3,250	1,000	4,250	3,500	3,500	7,000	- 1,000	500	6,500		10,000
ZIMBABWE	1,950	1,550	300	1,850	2,000	3,000	5,000		500	5,500		6,000
RCSA	0	0		0	-	-	0					
REDSO/E	360	250		250	200	1,000	1,200			1,200		1,700
REDSO/WCA	3,405	3,405	200	3,605	5,700	1,700	7,400			7,400		7,700
AFR/SD	2,500	3,000		3,000	1,850	1,450	3,300			3,300		3,800
Southern Africa	0	750		750	500	1,000	1,500			1,500		4,000
SAHEL	100	0		0	100	-	100			100		
UNAIDS	2,000	0		0								
TOTAL AFR	51,100	56,000	7,000	63,000	58,800	38,000	94,800	4,000	6,000	104,800	-	128,738
India (LIFE)						3,000						
G/PHN (LIFE)**						4,000						
GRAND TOTAL - LIFE						45,000					10,000	
GRAND TOTAL - DCOF AIDS Orphans								4,000				
GRAND TOTAL - AIDS Children Supplemental (Recoveries)									6,000			
USAID Global Bureau Attribution for Africa	15,950			18,000						19,375		
(USAID Africa TOTAL)***	(67,050)			(81,000)						(123,975)**	(10,000)	
USAID Agency HIV Total	[121000]			[135,000]						[200.000]	[10,000]	

FY 2000 → 8,750

8,850

Donl use

* = DCOF for AIDS orphans

** = About 50% of the G/PHN LIFE amount is attributable to Africa

*** = Total of AFR and G/PHN attribution for Africa (including $2 m of $4 m of G/PHN LIFE); $10 m in food aid not included in this total; Africa total for 2000 is thus $133,625,000)

Revised 05/08/00 Alex Ross, AFR/SD
CDC FY 2000: $35 million -- Africa

FY 2001 FOOTNOTE: DOES NOT INCLUDE ANY DCOF OR AIDS CHILDREN SUPPLEMENTAL, NOR GLOBAL BUREAU ATTRIBUTION
FY 2001 FIGURES ARE VERY MUCH DRAFT

LEADERSHIP AND INVESTMENT IN FIGHTING AN EPIDEMIC (*LIFE*)

Proposed Joint Operating Plan of the U.S. Agency for International Development, the U.S. Department of Health and Human Services, and the U.S. Department of Defense

November 23, 1999

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LEADERSHIP AND INVESTMENT IN FIGHTING AN EPIDEMIC (*LIFE*)

Proposed Joint USAID-USDHHS-USDOD Operating Plan

I. Introduction

On July 19, 1999, the Administration announced a new Initiative to address the global AIDS pandemic. This Initiative is supported by an amendment to the Fiscal Year 2000 budget proposal signed by the President and submitted to Congress for its consideration. A central feature of this *LIFE* Initiative is a $100 million increase in US support for sub-Saharan African countries and India, which are working to prevent the further spread of HIV and to care for those affected by this devastating disease. This additional funding is a critical step by the United States Government in recognizing the impact that AIDS continues to have on individuals, families, communities and nations responding to the imperative to do more. It is our hope that other nations and institutions will match this action.

This plan contains a framework of interventions, grounded in a series of goals and objectives consistent with those established for the international community in collaboration with the Joint United Nations Programme on AIDS (UNAIDS). Specific activities and outcomes will be delineated through dialogue with those African nations that partner with the United States, as well as with the multinational and community-based non-governmental organizations that support the front line fight against AIDS.

The Initiative builds on the existing investment by the US in HIV/AIDS programs in Africa and India and involves an unprecedented collaboration between the United States Agency for International Development (USAID), the Department of Health and Human Services (HHS), and the Department of Defense (DoD). USAID will have lead responsibility in the facilitation of coordinated action. The Initiative is a significant turning point in the United States Government fight against AIDS and will contribute over the next 3 to 5 years to broad global targets that seek to reduce the transmission of HIV by 25% and provide basic care and support services to at least 30% of infected persons.

LIFE INITIATIVE'S GUIDING PRINCIPLES

US agencies will apply the following principles to the design and implementation of *LIFE*:

- ✓ Country ownership of the activities is essential.
- ✓ Initiative funding must complement existing programs and activities conducted abroad, as well as work within the context of national HIV/AIDS strategic plans.
- ✓ Leverage of and coordination with other donors and organizations (including working with the International Partnership against AIDS in Africa) is critical.
- ✓ The number of collaborating USG agencies and other partners in the fight against AIDS must be increased.
- ✓ Support for indigenous expertise and institutions in implementing program elements must be emphasized.
- ✓ Information sharing must be two-way so as to enhance opportunities to learn about new models that will assist US-based HIV programs as well as to share US experiences abroad.

The Initiative focuses on sub-Saharan Africa and India, which will be complemented by regional activities in western and southern Africa. The countries targeted represent those with the most severe epidemic, the highest number of new infections, where the potential for impact is greatest, and where USG agencies are already active.

The Initiative will contribute to the achievement of the goal's articulated by UNAIDS and to the partnerships necessary to that achievement. Yet curtailing this epidemic will require a significantly enhanced response by the global community and cannot be viewed as just the responsibility of the US government. Therefore, US partners involved in the *LIFE* Initiative will collaborate with UNAIDS and other international and local agencies both to leverage additional resources from host countries, multilateral institutions, and the private sector and to maximize coordination.

Specific planning for activities and results under the LIFE initiative must be responsive to individual country needs, existing efforts underway, and opportunities for intervention. As a result, the actual scope of interventions will vary across countries and cannot be determined in advance.

WORLDWIDE HIV/AIDS GOALS

UNAIDS, in cooperation with its bilateral and multi-lateral partners, has laid out a series of international goals for the next five years as described below. These goals represent the result of the total worldwide contribution of resources and effort. The Administration seeks to further these goals through the *LIFE* Initiative efforts.

- ✓ The incidence of HIV infection will be reduced by 25% among 15-24 year olds by 2005. (Currently 2 million young adults are infected each year in sub-Saharan Africa.)
- ✓ At least 75% of HIV infected persons will have access to basic care and support services at the home and community levels, including drugs for common opportunistic infections (TB, pneumonia, and diarrhea). (Currently, less than 1% of HIV infected persons have such access.)
- ✓ Orphans will have access to education and food on an equal basis with their non-orphaned peers.
- ✓ By 2002, domestic and external resources available for HIV/AIDS efforts in Africa will have doubled to $300 million per year. (Currently, approximately $150 million per year is spent on HIV/AIDS prevention in sub-Saharan Africa.)
- ✓ By 2005, 50% of HIV infected pregnant women will have access to interventions to reduce mother-to-child HIV transmission. (Currently, less than 1% of HIV infected pregnant women have access to such services in sub-Saharan Africa.)

A. Geographic Focus

The initiative focuses on 15 target countries (14 in sub-Saharan Africa and India) as well as on regional activities in western and southern Africa. In each of these countries, there will be collaborative support from more than one federal agency. Countries were selected based on the magnitude of the epidemic, history of political commitment to fighting the epidemic, anticipated receptivity to US assistance, and presence of existing US implementation mechanisms. Additional criteria are presented below. DoD participation will be dependent on their availability of resources.

II. Program Elements

The initiative addresses four key program elements critical to fighting the AIDS pandemic: primary prevention, improving community and home based care and treatment, caring for children affected by AIDS, capacity and infrastructure development, and. Each of these elements must be coordinated and integrated within an overall comprehensive response. To facilitate this coordination, USAID missions will have the lead responsibility for facilitating inter-agency communication, ensuring adequate dialogue with host nation agencies and organizations, and establishing a joint country-specific implementation plan.

The design of the initiative will foster the expansion of current activities and provide support for evaluating and integrating more recently developed interventions (e.g. methods to reduce mother-to-child HIV transmission) that have not yet been incorporated into comprehensive programs. Although the Initiative will not support all elements in every country, its funding must be coordinated and integrated within an overall comprehensive response. Country programs will be tailored to their needs and existing efforts underway.

Program Element	Investment
A. Primary Prevention	
1) Program Delivery and Other Activities	USAID: $25M
2) Technical Assistance and Training	HHS:$13M
3) Prevention activities for African military and uniformed services	DoD:$10M
	Subtotal: $48M
B. Improving Community and Home Based Care and Treatment	
1) Program Delivery	USAID: $14M
2) Technical Assistance and Training	HHS: $9M
	Subtotal: $23M
C. Caring for Children Affected by AIDS	USAID: $10M
D. Capacity & Infrastructure Development	
1) Increasing political commitment and strengthening AIDS programs	USAID: $6M
2) Surveillance	HHS: $13M
	Subtotal:$19M

A. *Primary Prevention*

The Global AIDS initiative focuses primarily on prevention ($48 million of $100 million) to slow—and hopefully reverse—the trend of rising HIV infection rates in developing countries. The goal of primary prevention is to reduce the incidence of new HIV infections. Ninety percent of new infections in the developing world derive from either sexual transmission (80%) or mother to child transmission (10%), and another 5% from contaminated blood transfusions and infected needles.

Therefore, the primary prevention component of this initiative seeks to reduce these means of transmission through the following activities (differentiation is made between civilian and military prevention efforts, reflecting the mutually supportive yet distinct role of the Department of Defense within this initiative):

Primary Prevention - Civilian

The program element of primary prevention has been broken down into four distinct, mutually supportive activities.

Performance Measures for Primary Prevention

Within three years, monitoring systems will measure the combination of enhanced existing programs and the additional "new" activities that are supported through the initiative. The following performance measures and targets are expected:

- ✓ decrease in reported non-regular sex partners over the first year
- ✓ increase in reported barrier method use with non-regular/regular sex partners
- ✓ decrease in reported STD prevalence for men/women
- ✓ decrease in HIV incidence rate in 15-24 year olds
- ✓ decrease in perinatal infections

1) Voluntary Counseling and Testing

The purpose of voluntary counseling and testing is to identify persons already infected with HIV. In addition, the counseling sessions (both before and after the actual HIV test) offer an important opportunity for one-on-one prevention education.

Therefore, this initiative will allow USAID and HHS to assist to develop and implement locally appropriate voluntary counseling and HIV testing services (see Annex B for a potential list of countries that could make use of this assistance). DHHS will support this work by providing critical technical assistance to ensure the quality and accuracy of HIV testing, identifying methods to target high risk groups with VCT services, and assisting USAID with developing linkages between VCT and health and social services.

2) Social Marketing

The utilization of barrier methods (primarily male and female condoms) has proven to be an essential element of HIV and STD prevention. Providing accurate information on the importance of barrier method protection and reducing societal resistance to its use is an essential prevention activity.

Therefore, this initiative will allow USAID to increase their social marketing efforts to improve access to barrier methods (see Annex B for a potential list of countries that could make use of this assistance).

3) Behavior Change

In addition to broad community messages used to support the social marketing of barrier protection, more individualized interventions are needed to effect actual changes in behavior. Social marketing creates a more receptive attitude to the behavior change interventions, which build on that receptivity and promote individual acceptance and use of barrier protection. In addition, efforts to reduce the stigma of HIV will be employed (using faith communities and other organizations of influence) in order to reduce resistance to getting tested, informing partners and family if infected, and seeking help in obtaining HIV-related care services.

Therefore, this initiative will allow USAID, HHS and DOD to establish new or enhanced behavior change activities countries and one regional area (see Annex B for a potential list of countries that could make use of this assistance). The goal of each will be to expand behavior change interventions, with specific targeting of youth and adult males.

4) Mother-to-Child HIV transmission

At least ten percent of new HIV infections are a result of transmission of HIV from mother to child either during pregnancy or birth, or subsequently through breastfeeding. New treatments offer tremendous promise in greatly reducing the likelihood of mother-to-child transmission. However, significant barriers to their utilization remain, including low percentages of HIV-positive mothers who get tested before birth, lack of training of health care providers in the use of the treatments, and cultural acceptance of preventative medicine.

Therefore, this initiative will support USAID and HHS to assist in implementing programs to design and implement successful interventions to prevent mother-to-child transmission of HIV. At these sites, USAID will provide support for screening of pregnant women, and training of maternal health providers. DHHS will also support this activity by identifying barriers that exist for accessing these services and by monitoring the outcomes of these interventions on both infants and mothers. (see Annex B for a potential list of countries that could make use of this assistance).

5) STD Management

The successful prevention and treatment of sexually transmitted diseases (STDs) are important strategies for reducing the incidence of HIV infections. Because STDs result from many of the same behaviors that lead to HIV infection, efforts to prevent STDs are critical to stopping HIV infections as well. In addition, untreated STDs significantly increase the likelihood of infection by HIV upon exposure; therefore, identifying those with STDs and getting them into treatment is also effective in reducing HIV infection rates.

Therefore, this initiative will support USAID and CDC to implement new or expand existing STD prevention, diagnostic and treatment services (see Annex B for a potential list of countries that could make use of this assistance).

6) Blood Safety

HIV infection through the use of contaminated blood or blood products is a significant problem in many poorer countries. However, implementation of modest screening, testing, training, and quality control programs can dramatically reduce this risk.

Therefore, this initiative will support implementation of programs to improve blood collection from volunteer donors, increase the quality of HIV testing of blood and ensure more appropriate use of blood transfusions.

Primary Prevention - Military

With the availability of resources, the U.S. Department of Defense will support primary prevention activities targeted at military and uniformed services in a number of countries. The sub-Saharan region has been marred by decades of political strife that has resulted in numerous armed conflicts. Many nations in the region maintain large military forces, and frequently deploy them outside their own borders. Military personnel often become unwitting vectors of HIV from one part of Africa to another. Therefore, efforts to increase awareness of individual HIV status and implementation of effective HIV prevention and education programs among military personnel are essential.

The program element of primary prevention for military personnel has been broken down into three specific areas: assessment, education of indigenous military personnel, and education of UN peacekeeping forces stationed in the region.

1) Assessment

Experience with AIDS prevention in the U.S. military provides a model for effective intervention in African military populations. It has been demonstrated that assessment of knowledge, attitudes, and behaviors, coupled with serial prevalence or incidence measurements, can be done while maintaining confidentiality and with a high level of voluntary participation. The U.S. military population is exposed to multiple HIV subtypes while on deployment, in response rapid diagnosis of HIV subtypes have already been developed. There are a number of factors contributing to HIV risk. These include travel away from home base, alcohol use, and economic means to use commercial sex workers. Assessment of these components of HIV risk in African military populations will develop the regional profile to design and guide prevention activities.

2) Regional specific military-based education.

Based on findings of the assessments described above and through work with UNAIDS, regional scientists, and African militaries, military-based education will be directed to four specific African regions: East, South, West, and West-Central, respectively. The approach will proceed by stages:

- ✓ assessment of HIV prevalence and risk behaviors
- ✓ development of a regional prevention plan
- ✓ implementation through training and development of infrastructure
- ✓ evaluation of the effect of prevention
- ✓ refinement and incorporation into the military culture for enduring impact

DoD will tailor its unique tri-service military education programs developed to prevent alcohol abuse and STDs, as well as the region-specific HIV prevention work by NGOs and USAID, to African contexts. Anonymous serosurveys with risk behavior data collection will begin as soon as feasible. In addition, locally developed or adapted interventions identified by USAID or DHHS may also be utilized.

The initial round of serosurveys and risk behavior assessment will take a minimum of six months. Assessment of HIV-1 subtypes in African military populations, with opportunity for follow-up, will permit an evaluation of these factors in many different settings, ranging from a virtually single-subtype epidemic in Southern Africa to a highly complex mixture of subtypes and recombinants in West Central Africa. A "train the trainer" approach that has been very successful within the U.S. Air Force will be used. This training can occur simultaneously within the different regions and will be completed within three months. All of these programs will be coordinated with similar USAID activities (for example, education concerning condoms, counseling, and testing of general populations).

3) Enhanced military education of African UN Peace-Keeper forces

African military personnel deployed far from their home base for long periods in conjunction with UN peacekeeping activities may experience a different HIV risk profile than soldiers remaining at home. In conjunction with the ongoing UN peace-keeping project to combat HIV/AIDS, COL Peter Leenijes coordinated with the Ford Foundation, the Civil Military Alliance, and the U.S. Military HIV Research Program to develop a special intervention program targeted to the African military UN peace-keepers. The program was patterned on one currently being piloted through the South African Army field units. The current project involves five specific curriculum modules:

- ✓ Defining HIV and its impact in the military
- ✓ HIV Prevention
- ✓ Substance Abuse, HIV, STDs
- ✓ Risk Assessment and Prevention Strategies
- ✓ Course Summary

B. Improving Community and Home Based Care and Treatment

Performance Measures for Community and Home Based Care and Treatment

The following performance measures and targets are expected within three years:

- ✓ Increase in the percentage of local governments implementing care and support activities
- ✓ Increase in the number of primary health facilities providing quality prevention and treatment (i.e. according to national guidelines) for opportunistic infections
- ✓ Increase in the number of households caring for persons living with HIV/AIDS that receive help in delivering that care from an institution or group outside the family
- ✓ Increase in the percentage of dually infected (TB-HIV) persons who complete standard TB therapy within 12 months.

Currently in Sub-Saharan Africa and India, care and treatment for HIV infected persons and support to their families is minimal. Less than 5% of persons know their HIV status and health care

providers do not have ready access to diagnose and treat HIV and the associated opportunistic infections, let alone use of the latest "state of the art" antiviral treatment regimens. Ideally, there should be a continuum between in-patient and community outpatient treatment, combined with psychosocial support services utilizing a wide range of community workers, including traditional healers.

Even in the absence of antiretroviral drugs, there is much that can be done to improve the quality and duration of *LIFE* for persons living with HIV/AIDS and their families within the developing country setting. For instance, while the leading killer of AIDS patients in the developing world is TB, through use of directly observed therapy regimens (DOTS), TB can be cured in HIV infected persons, increasing the both the quality and duration of a person's *LIFE*.

1. Care and Treatment

The Initiative seeks to provide medical and social services to HIV infected individuals, including preventive therapy, and early diagnosis and effective treatment of AIDS-related diseases. Countries will be assisted to implement locally appropriate programs to link people living with HIV or AIDS to prevention, care and support services. These individuals will be identified through enhanced voluntary counseling and testing services (described above), to which they will be closely linked.

Pilot sites would be established to assess methods to improve TB and respiratory disease care in HIV infected persons and to evaluate the applicability of U.S.-based early intervention care and treatment models in a developing world setting (see Annex B for a potential list of countries that could make use of this assistance).

2. Home and Community Based Care and Support

Through this initiative, countries will receive assistance in instituting home and community based care model programs. In addition, indicators for accurately measuring the impact of care services will be developed. USAID will provide support for health provider training, establishing home and community care models, and increasing the involvement of traditional healers. DHHS will focus on developing treatment guidelines, creating training and curriculum materials, increasing the use of DOTS, and linking psychosocial support services with improved biomedical interventions (see Annex B for a potential list of countries that could make use of this assistance).

C. Caring for Children Affected by AIDS

Performance Measures for Caring for Children Affected by AIDS

Within three years, expected performance measures and targets include:

- ✓ Percent of households in high HIV prevalence communities with increased access to food.
- ✓ Percent of households in high prevalence communities receiving assistance from community based organizations.

Over eight million children under the age of 15 have lost their mother or both parents as a result of HIV/AIDS. By the year 2000, there will be close to 32 million children who will have lost one or both parents in the 19 of the African countries where HIV/AIDS is found in epidemic proportions. By the end of the next decade, this number will increase to 40 million. Despite the magnitude of this crisis,

services in developing countries for children orphaned by AIDS are extremely limited or non-existent.

Therefore, this initiative will support USAID to help countries take primary responsibility for activities to assist children affected by AIDS and for their families, primarily through the use of Title II, Food for Peace programs. In addition, child survival funds not part of this initiative will be used to enhance the scope of interventions directed at orphaned children in target countries.

Prior to this Initiative, USAID has supported a limited number of activities focusing on children affected by HIV/AIDS. With supplemental funds appropriated by Congress for FY1999, interventions are being developed and implemented in nine countries in Africa, three countries in Asia, and in Haiti. In addition, since 1991, USAID's Displaced Children and Orphans Fund (DCOF) has supported AIDS orphans activities in Africa and is currently supporting community-based programs in Zambia and Malawi. Through the use of Title II resources, USAID is currently supporting mother and child health programs, "food-for-work" interventions, and general relief programs.

The enormity of the problem makes it imperative that interventions are both effective and can be scaled-up to provide services to as many people as possible. A community-based approach will continue to be the focus of USAID activities. It is families and communities who are the front line of the response to the impact of HIV/AIDS. All over Africa extended families are still absorbing most orphans. However, in many places their capacity to do so is weakened by extreme poverty, lack of access to services and the growing number of children in need. The most effective response is to strengthen the capacities of families and communities in the geographic areas where HIV/AIDS has made them especially vulnerable (see Annex B for a potential list of countries that could make use of this assistance).

The needs of children affected by AIDS, similar to those of other children living in extreme poverty, include the need for food, clothing, shelter, schooling and health care. Childhood malnutrition is potentially one of the most severe and lasting consequences of an adult death in the household. Extended families caring for orphans – whether their family members are infected or not – struggle to provide enough nourishment to the increasing number of children for whom they have become responsible. Seeking to mitigate the impact of the AIDS epidemic on childhood nutrition is an important area of vulnerability that must be addressed in a manner that is effective and provides the most benefit to families and to communities. In addition, the impact of using Title II resources will be evaluated and the needs of very young children will be assessed.

D. *Capacity and Infrastructure Development*

Performance Measures for Capacity and Infrastructure Development

The following performance measures and targets are expected within three years:

- ✓ increased number of HIV/AIDS/STD/TB information and service delivery points which meet minimum quality standards
- ✓ surveillance plans and survey designs in all focus countries
- ✓ lab capacity for surveillance strengthened
- ✓ training of surveillance managers and key staff in country in at least 8 of the 12 countries
- ✓ increased national AIDS control program capacity to plan, manage and evaluate national AIDS programs,

Within the focus countries, it is critical that political commitment is increased and host country capacity to implement effective interventions is strengthened, focusing on government, private sector, NGOs and research institution capabilities. Key activities are to increase the use of accurate HIV surveillance data to inform decisions on targeting of HIV/AIDS prevention and care interventions, to measure the impact of these interventions, and to support new capabilities for the delivery of care and services.

1. Increasing Political Commitment

USAID will take the lead in countries and the regional program to implement activities to increase national political commitment towards HIV/AIDS efforts. There will be extensive use of surveillance data in this dialogue, derived from DHHS supported efforts.

2. Surveillance

In all countries and regional programs, DHHS will provide technical assistance and support to improve surveillance programs for HIV, TB and STDs. In addition, new surveillance tools will also be tested and adapted for local application. USAID will also provide funding for activities that will ensure close collaboration with key international partners, such as UNAIDS, WHO and other multilateral and bilateral donors.

3. AIDS Program Strengthening

The initiative will support expanded training and support for local NGOs and of government personnel for HIV/AIDS program and service delivery.

III. Managing and Monitoring the *LIFE* Initiative

To establish an active link between the initiative's partners (US Agencies, UNAIDS, World Bank, EU, donors, etc.), a joint management and monitoring *LIFE* Initiative Task Force will be established. This Task Force will be composed of designated focus point persons from each of the relevant Federal agencies. The Task Force will be convened under the auspices of ONAP, with secretariat support provided by USAID. Additional members will be included as necessary (e.g. UNAIDS representative). The Task Force will meet on a monthly basis over the next year, because of the wide range of issues that must be resolved in a timely way. After one year, meeting schedules can be reviewed.

It is essential that the activities funded through the *LIFE* initiative build on existing resources and programs in order to achieve the maximal coverage and impact. It should be recognized that it is difficult to measure performance, which is attributable to discrete funding sources. Instead, monitoring systems will measure the impact of consolidated programs that have been established in each country.

IV. Next Steps

A. Country Level

The ultimate success of this initiative will depend on the scale, scope and quality of services delivered in target countries, particularly at the community level. To achieve this, there must be extensive dialogue and collaboration at country level with government, private sector, non-governmental organizations, the faith community and community groups, especially including persons living with HIV/AIDS and their care-givers. Some of the focus countries already have established coordination mechanisms, which will be utilized wherever possible.

However, joint country planning teams will also be formed over the next three to six months, in order to work with USAID Missions, HHS and other USG agencies, Host Country Governments, etc, to finalize one to two year work plans, which will include more discrete performance measures. It is also necessary to further examine what other bilateral and multilateral donor are planning and to collaborate with local government, non-governmental organizations, persons living with HIV/AIDS, etc. to ensure that the program responds to priorities and existing gaps.

B Global/Regional Level

At global and regional level, multiple partners must be engaged in a collaborative effort to leverage new resources, identify areas for cooperative efforts and areas for complementary programs, and achieve consensus on measurements of performance. A series of "Partnership" meetings will occur over the next three to six months to assure the success of this initiative. Examples of these "Partnership Meetings" are presented below.

Examples of Partnership Mtgs.	Purpose
Washington-based African Diplomatic Corps	To initiate dialogue for individual countries, which would lead to, improved collaborative efforts and mobilization of increased host country resources and commitment.
U.S. AIDS Advocacy Groups	To increase awareness and garner support for the focus and activities of the Initiative.

U.S.-based Faith Groups	To identify U.S. and international faith networks that will ultimately create networks and support for prevention, counseling, psychosocial support and care interventions in sub-Saharan Africa.
U.S. NGOs and CBOs	To provide support and collaborate with other African NGOs
U.S. and International Communities of Persons Living with HIV/AIDS (NAPWA, GNP +, etc)	To ensure that PLWHA needs and priorities are met and to establish processes so that host country PLWHA input is utilized optimally.
U.S. Teaching/Academic Institutions	To identify technical resources within the United States in order to expand the technical assistance resource platform which will be initiated in sub-Saharan Africa.
UNAIDS (including its seven co-sponsors)	To link with the UNAIDS International Partnership for Africa.
Bilateral Donors	To identify gaps and areas for complementary programming in individual countries
Mulitlateral Donors (EU, World Bank)	To integrate country plans with overall prevention and care activities.
U.S. Diplomatic Corps	To coordinate with U.S. diplomatic AIDS initiatives

C. Milestones

1. Country notification and communication – November - January
   - In December, USAID is sending a formal cable to the USAID missions and embassies, as well as to HHS, informing them about the final status of the LIFE initiative, country list, and next steps. HHS will communicate with its field sites and with embassies regarding establishing NSDD-38 agreements. [Responsibility: USAID; HHS].
   - In the next month, ONAP will convene a meeting of all African ambassadors to the US to discuss USAID and other programs, with discussion of LIFE [Responsibility: ONAP]
   - In the next two months, USAID will commence communication with the country governments and respective stakeholders: government, multilateral and bilateral donors, NGOs, communities affected, etc to set the stage for the planning process for the LIFE initiative efforts.[Responsibility: USAID]

2. Joint planning assessments – November – March
   - In the next month, USAID with input from HHS and ONAP, will issue guidance to the field on the planning parameters for the LIFE initiative activities. [USAID, with HHS and ONAP] As part of this, the joint teams (USG, country) will review previously established country profiles (US and donor response information). In close negotiations with countries, USAID, HHS will determine gaps and response needs to be enhanced. [Responsibility: USAID, with HHS]
   - Within 6 months, all 13 countries and regional programs will have conducted a participatory needs assessment, identified current responses and gaps, and develop workplans. [Responsibility: USAID and HHS field staff will have primary responsibility, with USAID lead coordinating role. Additional backup TA from Washington/Atlanta will be available.]

3. Strategies for implementation – Developed November onwards
   - In the next 12 months, activities begin in all 13 countries, with phasing in of some countries for some activities. [Responsibility: All partners]

4. Funding and Mechanisms
   - ➢ USAID to accelerate its OYB process (e.g. allocations to missions) to allow access to funding by missions.
   - ➢ HHS will develop NSDD-38 agreements with appropriate embassies.
   - ➢ In the next two to six months, various mechanisms for implementation will be identified and used. These will vary by country. They include:
   - -- USAID contractors: bilateral and field support
   - -- USAID/HHS grants to multilateral institutions: WHO, WHO/AFRO, UNAIDS, UNICEF; possibility of others
   - -- USAID/HHS relationships with African institutions
   - -- HHS/USAID relationships with embassies
   - -- Use of USAID contractors by HHS (interagency agreement)
   - -- Possibility of detailing HHS personnel to USAID (to go the field)
   - -- HHS Cooperative agreements with US based organizations
   - -- Other

5. Workshops and partnership meetings on parallel track – November onwards
   - ➢ In the next 6-12 months, USAID will organize workshops to discuss technical issues (e.g., VCT, MTCT, care and support). These will include a broad mix of African, donor, and US specific participation. [Responsibility: USAID; HHS]
     - ➢ November 23: USAID convened a working group of HHS agencies (CDC and HRSA), NORA organizations and USAID to discuss care and support issues.
     - ➢ December 6-7, 1999: Private meeting of the UN Secretary General to discuss with key partners (donors, governments, NGOs, private sector) the International Partnership against AIDS in Africa).
     - ➢ December 5-8: Paris AIDS conference to focus on AIDS care and support issues.
     - ➢ January 2000: WHO/AFRO is convening a meeting of all international and national interested parties to discuss HIV/AIDS surveillance programs and issues.
     - ➢ February 2000: Meeting of the International Partnership Against AIDS in Africa.
     - ➢ July 2000: International AIDS conference in Durban.
   - ➢ In the next 6 months, USAID will organize a series of key stakeholder meetings to discuss the initiative (US based) [Responsibility: USAID]
   - ➢ In one year's time (approximately), USAID, with HHS and ONAP, will convene a meeting of all of the partners to assess progress of implementation and to discuss ways to improve. [Responsibility: USAID and HHS]

6. Coordination at the USG level: Ongoing
   - ➢ In the next month, ONAP will hold its first meeting of the working group of higher level agency representatives to discuss progress and issues. This group will meet periodically to ensure that the initiative is on track. [Responsibility: ONAP]
   - ➢ Throughout the next year, a coordination working group with USG agencies at the working level will meet (USAID-CDC have been meeting informally; need to meet soon with expanded group of other agencies.). [Responsibility: USAID to convene]
   - ➢ Over the next six months, four technical working groups around the four categories of the LIFE initiative will be convened to help inform ourselves about the set of issues and possible interventions. Actual planning to be conducted at the field level. These groups will be time limited. [Responsibility: USAID and HHS]

7. Indicators/milestones: Ongoing
   - Broad indicators and targets are already identified.
   - Based on the joint planning teams and process, each country will develop its own set of monitoring and evaluation indicators, baselines, and targets.

ANNEX A: CURRENT USG HIV/AIDS ASSISTANCE IN TARGET COUNTRIES AND REGIONS.

COUNTRY	Primary Prevention							Caring for Children Affected by AIDS*		Home and Community Based Care and Treatment*			Infrastructure and Capacity Development*				
	VCT	SM/ Procurement	BC/ SR	MTCT	Blood Suppl /nosocomial/ OE	STD	Tool Dev.	Support to Affected Children	Comm .Mobilization	OI/TB/ STD	Drug Supply	Home/ Comm.-Based Care	Policy/ advocacy	NGO support	Training and TA	Surveill.	Multi-sectoral
otswana							H			H	H				H	H	U
ote d'Ivoire		U	U				H	U	U	H				U	U;H	H	
thiopia	U	U	U			U	H			U	U	U	U	U	U;H	U	U
enya	U	U	U;H	U;H	U;H	U	H	U	U	U		U	U	U	U;H	U;H	U
alawi	U;H	U	U			U	H	U	U			U	U	U	U;H	U;H	U
ozambique	U	U	U			U								U	U	U	
igeria		U	U					U	U	U		U	U	U	U	U	U
wanda		U	U			U		U	U	U				U	U;H	U;H	
enegal			U				H	U	U				U	U	U;H	U	U
outh Africa	U	U	H	U		U;H	H	U	U	U;H			U	U	U;H	H	U;H
anzania	U	U	U		U;H	U	H					U	U;H	U	U;H	H	
ganda	U;H	U	U	U;H		U	H	U	U	U;H	H	U;H	U	U	H	H	
ambia	U;H	U	U			U	H	U	U	U	U	U	U;H	U	U;H	U;H	
imbabwe	U;H	U	U				H	U	U				U;H	U	U;H	H	U
ndia	U	U	U			U	H	U	U	H		U	U	U;H	U;H	U;H	U
EGIONAL																	
AFR/ AFR/EAFR	(U)	U	(U)					U					U	U	U	(U)(H)	
EAD UARTERS																	
ID/W			U	U				U		U	U	U			U		U

Notes: * = Indicates additional HHS agency involvement (e.g. HRSA, ACF, etc) that may not be reflected on the table
( ) = indicates additional linkage between USAID regional program and Botswana and Cote D'Ivoire HHS activities
VCT = voluntary counseling and testing; SM = social marketing; BC = behavior change; SR = stigma reduction; MTCT = mother-to-child transmission; STD= sexually transmitted disease; OI = opportunistic infections; TB= tuberculosis; NS = nosocomial infection control; OE = occupational exposure reduction
U = USAID H = HHS

ANNEX B: ACTIVITIES SUPPORTED BY THE *LIFE* INITIATIVE IN TARGET AFRICAN AND ASIAN COUNTRIES

COUNTRY	Primary Prevention						Caring for Children Affected by AIDS**		Home and Community Based Care and Treatment**			Infrastructure and Capacity Development**				
	VCT	SM/ Procurement	BC/ SR	MTCT	Blood Supp/ nosocomial / OE	STD	Support to Affected Children **	Comm. Mobilization**	OI/TB/ STD	Drug Supply	Home/ Comm.-Based Care**	Policy/ advocacy **	NGO support **	Training and TA**	Surveill. ***	Multi-sectoral
Botswana	H		H; D1	H		H			H		H				H	
Cote d'Ivoire	H		H	H	H(NS	H			H		H				H	
Ethiopia	U;H	U	U; D2			U	U*		U	U					U,H	
Kenya	U;H		U;H;D1	U;H	U;H	H	U*		U;H		H				U,H	U
Malawi	U;H		U; D2				U*	U			U		U	U	U;H	U
Mozambique	U		U			U	U*		U				U	U	U;H	U
Nigeria	U	U	D1	U		U			U		U	U			H; U	
Rwanda	U		U	U		U	U*				U		U	U	U;H	
Senegal			U; D1			U					U	U	U	U	U	U
South Africa	U;H		H; D1	U;H	H(NS	U;H			U;H		H		U	U	H	U
Tanzania	U	U	U		H						U	U;H	U	U	U;H	
Uganda	U;H		U;H;D2	U;H		U;H	U*		H		U;H				H	
Zambia	U;H		U	U		U	U*	U				U;H	U		H	
Zimbabwe	U;H	U	U; D2									U;H	U	U	H	U
India		U	U			U	U*	U	H		U	(H)	U	U	U;H	
REGIONAL																
WAFR/ SAFR/EAFR	(U)	U	(U)									U		U	(U)(H)	
HEAD-QUARTERS																
AID/W			U	U			U		U	U	U			U		U

Notes: * = Ongoing or potential Title II-"Food for Peace" countries.

** = Indicates additional HHS agency involvement (e.g., HRSA, ACF, etc) that may not be reflected on the table

*** = DOD will also implement specific surveillance activities in military populations in selected countries.

( ) = indicates additional linkage between USAID regional program and Botswana and Cote D'Ivoire HHS activities

VCT = voluntary counseling and testing; SM = social marketing; BC = behavior change; SR = stigma reduction; MTCT = mother-to-child transmission; STD= sexually transmitted disease; OI = opportunistic infections; TB= tuberculosis; NS = nosocomial infection control; OE = occupational exposure reduction

U = USAID H = HHS D = DOD

ISSUES LIFE IN

FY 2000 LIFE COUNTRY ACTIVITIES
PRIMARY PREVENTION

Ethiopia, India, Kenya, Rwanda, Tanzania, Zambia, Zimbabwe, FHA/WCA
(Reports received as of 5/18/00)

COUNTRY: Ethiopia
FY 2000

	FUNDING SOURCE ($ 000) NOA CSD *HIV/AIDS: Non-LIFE*	*HIV/AIDS: LIFE*	*DCOF*	**Recoveries**	**Food Aid[1]**
AFR/DP FY 2000 Control Levels	*5000*	*1700*	*400*		
CATEGORY					
I. Primary Prevention	4500	750			
II. Care and Support	150	350			
III. AIDS Affected Children/ Orphans	50	400	100[2]		
IV. Capacity Building	300	300			
TOTAL	5000	1700	100		

Narrative on Expanded and/or New Activities – FY 2000
MISSION: USAID/Ethiopia

Primary Prevention
Illustrative activities: These include some existing and some new activities. New interventions include the VCT and cross-border activities. Others are mainly expansion activities.

- IEC/BCC: Cross-border (Ethio-Djibouti) and Indigenous Military HIV/AIDS prevention: needs assessment and planning, training of peer educators, condoms procurement and project M&E.
- CSM and Procurement: This is targeted at mobile population groups including the cross-border population and the military.
- VCT: complement on-going training of counselors and development of guidelines. Procurement of testing kits (so far only for sentinel surveillance).
- STD case management: complement existing activities of providing STI drugs and supplies, and training on syndromic management. New activities in this area will be among the military.

Illustrative mechanisms:

- Pathfinder and its sub-grantees working on IEC/BCC and VCT.
- DKT and Ethio-Djibouti Port administration primarily for CSM activities.
- WHO grant for quality STD management.
- DoD and the Ethiopian MoD with DKT will work on the military program.

[1] FHA has food aid but money value could not be established now (will report later)
[2] Attributed out of 500 grant provided to PACT

COUNTRY: India
FY 2000

	FUNDING SOURCE ($ 000) NOA CSD			Recoveries	Food Aid
	HIV/AIDS: Non-LIFE	*HIV/AIDS: LIFE*	*DCOF*		
AFR/DP FY 2000 Control Levels	*?*	*3000*			
CATEGORY					
I. Primary Prevention		1650			
A. MTCT					
II. Care and Support	NA	250			
III. AIDS Affected Children/Orphans	600	600			
IV. Capacity Building	NA	500			
TOTAL		3000			

Narrative on Expanded and/or New Activities – FY 2000
MISSION: USAID/INDIA

Primary Prevention

Illustrative activities: Under primary prevention, the mission will undertake the following activities:

- **HIV Business Coalition** – The full engagement of Indian industry in HIV prevention will be institutionalized through a cooperative agreement with the Confederation of Indian Industry (CII). Captains of industry will be engaged to promote information and prevention in the workplace through innovative, workplace-based services such as IEC, counseling, STI diagnosis and treatment, condom promotion and HIV public relations events for workers, supervisors and families. Media events will be supported to highlight industry leadership and maintain fiscal and political momentum in both the private and public sector.

Illustrative Mechanism: OBY Transfer to FHI and direct grants to CII
LOP Funding: $800,000 over 3 years

- **Voluntary Testing & Counseling**: In conjunction with the strengthening of the surveillance system (under capacity building), USAID will support the development of testing and counseling centers (equipment, counselors, linkages to care and crisis centers) nationwide. This would entail developing programs for couples, antenatal, family and individual counseling. A program would be designed that would ensure that the system is culturally appropriate and relevant to the Indian context.

Illustrative Mechanism: OYB Transfer to FHI or CDC to NACO
LOP Funding: $250,000 over 1-2 years

- **Sensitization of the Media** – The communication of correct information is vital to any program, especially the understanding of HIV/AIDS in India because myths and

misconceptions plague the media channels. A core group of journalists will be sensitized to the issues surrounding the HIV/AIDS epidemic - professionals who can raise awareness, improve knowledge and understanding among the general population, influence decision makers and create a supportive environment for the implementation of HIV/AIDS programs nation-wide.

Illustrative Mechanism: OYB Transfer to FHI, USAID/PA(USIS) partnership
LOP Funding: $200,000 over 2 years

- **Male Involvement:** With the launch of the UNAIDS 2000 World AIDS Campaign: "Men and AIDS – gender approach" USAID will support interventions among men that would look at critical areas of how to effectively involve men, including adolescents and Men Having Sex with Men (MSM) in HIV/AIDS prevention and care programs. On average, men have more sexual partners than women. Moreover, HIV is more easily transmitted sexually from men to women. Men are less likely to seek health care than women, and are more likely to engaged in risk behaviors that put their health at risk. This coupled with the fact that women lack the power to determine where, when and whether sex takes place, it is imperative that male sexuality is understood and preventive programs be implemented that address these particular needs.

Illustrative Mechanism: OYB Transfer to FHI to NGOs
LOP Funding: $400,000 over 2 years

Subtotal Primary Prevention: $1,650,000

COUNTRY: Kenya
FY 2000

	FUNDING SOURCE ($ 000) NOA CSD			Recoveries	Food Aid
	HIV/AIDS: Non-LIFE	*HIV/AIDS: LIFE*	*DCOF*		
AFR/DP FY 2000 Control Levels	*3200*	*2500*	*500*	*600*	0
CATEGORY					
I. Primary Prevention	2523	1335		600	0
A. MTCT	0	0			
II. Care and Support	0	825			
III. AIDS Affected Children/Orphans	27	0	500		
IV. Capacity Building	650	340			
TOTAL	3200	2500	500	600	0

Narrative on Expanded and/or New Activities – FY 2000
MISSION: USAID/Kenya

Primary Prevention:
Illustrative Activities:
VCT – support for VCT at three levels: (1) Assist GOK to finalize, produce and disseminate national standards and guidelines on VCT. (2) Establish a center of excellence at Kenyatta National Hospital that will upgrade their ongoing services and create satellite services in the community. In time, this center can be built up to provide model HIV VCT services and to be a training center for counselors. (3) Establish HIV VCT services in Mombasa and in Western province. This entails identifying the most promising sites and strengthening their capacity to deliver high quality VCT.

Behavior change interventions – Motivate and enable individuals in targeted communities to reduce their sexual risk using peer education and outreach. Intensive behavior change programs target sex workers, employed adults (with a focus on men), adult women (accessed through neighborhood-based peer education), youth (accessed through schools and through popular outreach). Full-scale behavior change interventions with these target groups are being implemented in six sites in Western province, two sites in Rift Valley and in Mombasa.

STD case management – Upgrade diagnosis and treatment of STDs. Using national guidelines on syndromic management of STDs, train health providers from clinics in targeted communities in STD case management; implement a quality assurance and monitoring plan to ensure continuation of upgraded services.

Examples of primary prevention activities include:
- IEC: person-to-person and mass media
- Behavior change and communication indicators

- VCT
- STD case management
- Training of health and non-health personnel for prevention
- Stigma reduction

Illustrative Mechanism: Field support to FHI/IMPACT

COUNTRY: Rwanda
FY 2000

	FUNDING SOURCE ($ 000) NOA CSD *HIV/AIDS: Non-LIFE*	*HIV/AIDS: LIFE*	*DCOF*	**Recoveries**	**Food Aid**
AFR/DP FY 2000 Control Levels	*1500*	*2000*		*1000*	1500 ?
CATEGORY					
I. Primary Prevention					
A. MTCT					
II. Care and Support					
III. AIDS Affected Children/Orphans					
IV. Capacity Building					
TOTAL					

Narrative on Expanded and/or New Activities – FY 2000
MISSION: USAID/Rwanda

Primary Prevention
Illustrative Activities:
IEC - SO2 is planning with cooperating agencies (CAs) involved in AIDS behavior change to undertake a series of innovative IEC activities through traditional and non-traditional channels. A major focus will also be on donor and MOH coordination in the regions. The IMPACT Project (Family Health International) will continue to execute block grants to the 4 focus regions of Kigali, Kibungo, Gitarama, and Byumba in CY2000. IMPACT will execute sub-agreements with the target regional and district MOH medical teams to help them carry out their own local behavior change programs.

USAID has successfully engaged a number of protestant church networks in Rwanda in HIV prevention programs, and has helped to provide a series of HIV/AIDS messages and discussion guides to these churches through an American NGO. USAID has recently been approached by the Episcopal Archbishop's office to expand these activities, and provide high-level support within Rwanda's protestant religious community. This is a very encouraging development and USAID expects to broaden this dialogue to other church-related organizations during this year. Mission is sponsoring 10 people from a cross-section of Rwandan AIDS program partners, including church leaders, to the International AIDS Conference in Durbin in July 2000.

USAID has also jointly established a local Rwandan production center for IEC materials and services. In collaboration with the ministry of health (MOH), World Bank, and government of Luxemburg, USAID has created, equipped and ensured staff training of the Rwanda center for Health Communications. The Center will offer its services to the MOH and other paying clients and retain revenues to support its operating costs. The Center is now operational and has begun to negotiate with paying clients for IEC services.

STD management - IMPACT will continue to follow up on health workers trained in STD management in its focus regions and strengthen the technical supervision provided by regional and district MOH staff. They will coordinate closely with the Belgian Cooperation, which will probably renew its donations of STD drugs for certain areas. IMPACT will work with the National Reference Laboratory and other donors on promoting aggressive screening and treatment of STDs, particularly among high HIV risk groups. USAID, the Belgian Cooperation, UNICEF and other actors are working toward what I hope will be more effective information management in the district-region and central level drug supply system.

Voluntary testing and counseling (VCT) activities - IMPACT project will establish three or more new VCT center in Rwanda during Y2K using buy-in funds. They will also work to improve the quality of counseling and testing services at other VCT centers currently operational, most of which are in Kigali or Rwamagana. Specific support will be in training counselors and lab technicians, providing basic materials which may be missing at the site, and ensuring technical quality control supervision of both the lab testing and counseling services. (The National Retro-Viral Reference Lab will take the lead in regular lab supervision, in hopes that this will allay their fears of low quality should we introduce low-tech rapid testing in the periphery).

USAID has supported development/adaptation of simple protocols and standards for VCT activities in Rwanda, including standardized curriculum for counseling training. The Belgian Cooperation has assisted the MOH to develop (accept) a simple rapid test protocol, which it will now use to train technicians for this testing in new VCT sites. USAID will encourage CDC to support some training and set-up of additional VCT centers following these guidelines. IMPACT will be able to support other associated activities around sites in this zone. USAID has successfully recruited other donors to buy into this program with them and the MOH to rapidly expand the number of well-functioning VCT sites in Rwanda to around 10 between now and December 2000.

Mother to Child Transmission (MTCT) activities - USAID will collaborate with UNICEF and CDC in finalizing protocols and minimum standards for MTCT expansion to additional sites. USAID may not finance the intervention directly, as UNICEF already has resources in its pipeline for a small number of new centers. CDC is also very interested in MTCT expansion and appears willing to provide resources and TA to this directly. USAID may then provide accessory activities such as community level counseling and other IEC/awareness raising interventions through the IMPACT project, provided these centers fall within the IMPACT project zone.

The MOH and UNICEF have initiated a pilot activity for prevention of mother to child HIV transmission (MTCT) through AZT prophylaxis in Kigali. Technical monitoring is also provided by the U.S. Centers for Disease Control and Prevention (CDC). Given the high HIV prevalence rate among pregnant women, and subsequent ratio of HIV positive infants born to these women in Rwanda, USAID will assist the MOH and its other partners in extending this MTCT program to other centers in Rwanda, but will not supply drugs. The supply of AZT is currently provided by UNICEF, and other donors have promised a supply of Nivaripine, the next-line drug of choice, to extend the activity. USAID will collaborate with UNICEF and CDC in finalizing protocols and minimum standards for MTCT expansion to additional sites. CDC is also very interested in MTCT expansion and may provide resources and technical support to this program directly. Other elements of the USAID program will provide ancillary outreach and community support activities to create a more holistic program of prevention and support around these MTCT centers.

Examples of primary prevention activities include:

- IEC: person to person and mass media
- Behavior change and communication indicators
- (Male and female) Condom procurement and distribution
- Social marketing
- VCT
- MTCT
- STD case management
- Blood safety
- Breastfeeding advice and programs
- Training of health and non-health personnel for prevention
- Stigma reduction

Illustrative mechanisms:

The buy-in to the IEC Project, with Population Communication Services (PCS-Johns Hopkins and AED) is now finishing a detailed action plan for IEC support activities with the MOH for AIDS and other health areas. PCS will coordinate closely with IMPACT, CARE International (under its current Mission AIDS and Children grant), the MOH and other donors.

COUNTRY: Tanzania
FY 2000

	FUNDING SOURCE ($ 000)				
	NOA CSD			Recoveries	Food Aid
	HIV/AIDS: Non-LIFE	*HIV/AIDS: LIFE*	*DCOF*		
AFR/DP FY 2000 Control Levels	*3600*	*2500*		*800*	
CATEGORY					
I. Primary Prevention	2,970	1,400			
A. MTCT					
II. Care and Support	420	100			
III. AIDS Affected Children/Orphans	210				
IV. Capacity Building		1,000		800	
TOTAL	3,600	2,500		800	
	Total HIV/AIDS funding	6,900			

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Narrative on Expanded and/or New Activities – FY 2000
MISSION: USAID/Tanzania

Primary Prevention
Illustrative Activities:

Expansion of Voluntary Counseling and Testing (VCT) activities - Presently, access to VCT services is extremely limited in Tanzania. A recent USAID funded study on VCT accessibility (October 1999) shows that public sector hospital based VCT services, which have been primary access points for VCT, have met with significant challenges. Issues of confidentiality, cost and actually functioning of VCT programs in certain hospitals have shown low use of these services, while the DHS 1996 indicates high demand for testing (66%). A few NGO and private sites operate in all but five regions of Tanzania's 21 regions, however, only a small percentage are offering on site testing as part of their VCT services. USAID plans to strengthen and expand access to quality VCT services in the NGO sector as well as institutionalize training for VCT by through a grant to a local NGO partner. This grant will be funded in a partnership with JICA support for test kits and other related VCT materials. Examples of VCT activities include:

- Expansion of services under present VCT sites
- Development of new sites where access in unavailable
- Institutionalization of VCT training and quality control
- Piloting of latest testing techniques with reference lab support
- Capacity building for quality control through monitoring and supervision

Illustrative Mechanism:

- Grant support to local NGO ($1.0 million)
- Continuation of JICA Partnership for VCT related materials provision

National Communication Strategy for HIV/AIDS - Plans are underway to develop a much needed national communication strategy for HIV/AIDS. Various partners will be included from public, private and NGO sectors. The strategy will be a conduit for USAID and other donors to fund cohesive and well planned communication activities. Examples of communication activities include:

- Development of a National Communication Strategy
- Support for community level awareness building and stigma reduction (ie. Drama troupes, local NGO activities, community youth organizations)
- National radio programs
- Television programs focusing on youth

Illustrative Mechanism: Funding through bilateral agreement with the Ministry of Health to support local costs and TA through field support to Johns Hopkins, Center for Communication Programs ($700,000).

COUNTRY: Zambia
FY 2000

FUNDING SOURCE ($ 000)

	NOA CSD			Recoveries	Food Aid
	HIV/AIDS: Non-LIFE	*HIV/AIDS: LIFE*	*DCOF*		
AFR/DP FY 2000 Control Levels	*3500*	*3500*	*1000*	*500*	
CATEGORY					
I. Primary Prevention	1300	1800			
A. MTCT		650			
II. Care and Support	500	200			
III. AIDS Affected Children/Orphans			1000	500	
IV. Capacity Building	1700	850			
TOTAL	3500	3500	1000	500	

Narrative on Expanded and/or New Activities – FY 2000
MISSION: USAID/Zambia

Primary Prevention
Illustrative activities: USAID/Zambia has not yet submitted a narrative summary of proposed LIFE activities.

COUNTRY: Zimbabwe
FY 2000

	FUNDING SOURCE ($ 000)				
	NOA CSD			**Recoveries**	**Food Aid**
	HIV/AIDS: Non-LIFE	*HIV/AIDS: LIFE*	*DCOF*		
AFR/DP FY 2000 Control Levels	*2000*	*3000*		*500*	
CATEGORY					
I. Primary Prevention					
A. MTCT	1200	1800		300	
II. Care and Support	200	300		50	
III. AIDS Affected Children/Orphans	400	600		100	
IV. Capacity Building	200	300		50	
TOTAL	2000	3000		500	

Narrative on Expanded and/or New Activities – FY 2000
Mission: USAID/Zimbabwe

Primary Prevention
Illustrative activities:
Voluntary Counseling and Testing - Voluntary Counseling and Testing (VCT) was recently introduced to Zimbabwe. Five centers were opened in 1999 with USAID assistance through PSI, and four more are scheduled to open in 2000 through the current USAID/PSI agreement. The early results from the VCT work in Zimbabwe is promising, especially the user rates in Harare, where approximately 50 people per day are being counseled and tested.

Over the 5-year strategy period, the VCT activity will focus on increasing the number of users and on expanding high-quality follow-up services. Follow-up for those tested will be strengthened by offering services during more convenient times, by offering additional and longer-term post-test counseling and by providing support group services to those tested. The activity will also expand linkages to community groups to ensure support for tested clients when they return to the community.

The modest experience to date suggests that more densely populated areas are more conducive than less densely populated areas to a cost-effective response, i.e., high numbers of community users. Thus the new sites will be in urban areas, including up to four more sites in Harare and Chitungwiza and up to two more sites in Bulawayo and surrounding areas.

The strategy will include capacity building for the service providers from various sites, including the clinics, NGOs, church groups, as well as community based distribution programs. A "menu" will be developed for the providers so they can access training and technical assistance as appropriate. (Note: not all groups will provide all follow-up services. For example, community-based distributors will differ in what they offer from NGOs and VCT sites.)

VCT sites will be linked to NGOs/CBOs and church groups where an appropriate organization exists. These will be referral sites for clients and couples whose counseling and group support needs cannot be met by the VCT site, or to enhance the support offered by the site, and the youth component will be continued. The NGO/CBO or church group will provide counseling, post-counseling support services and information to those testing positive, positive couples, discordant couples, caregivers of clients, and caregivers of those deceased. They will also develop the capacity to advocate for and promote prevention of HIV transmission and will distribute or sell condoms, provide information about seeking care for STIs, and provide information on abstinence and safer sex.

Condom and contraceptive social marketing - USAID will continue to support both private and public sector condom and contraceptives distribution systems. On the private sector side, the condom social marketing program will continue throughout the five-year strategic period. The program will seek to increase acceptance of condoms among high-risk populations and to ensure increased availability of condoms in both rural and urban areas. Educational and entertaining promotional material on condom use and HIV prevention will be developed. The contraceptive social marketing activity, "Pro Fam", will be folded into the condom social marketing effort to enhance effectiveness. The module on STI prevention and treatment will be expanded. Private sector providers – physicians, nurses, and pharmacists—will be trained in family planning, STI prevention and HIV counseling.

Broadened Role of Community Based Distributors - The 600 Community Based Distributors of contraceptives in Zimbabwe are paid employees of the Ministry of Health who currently provide information on family planning and distribute both condoms and pills. Using LIFE funds, the role of CBDs will be expanded to include support for HIV counseling and testing (VCT clients) at the community. It is widely understood that these workers are already involved at the household level in care and support issues. Inevitably any community worker with established rapport in a community will become involved at the household level in the ramifications of AIDS. These same community workers also enjoy excellent access and rapport with local leaders and can play a strong role in advocacy for attention and resources to the AIDS epidemic. The VCT program will build on the strengths of CBD distribution networks and access to households. USAID assistance would likely be focused on training, supervision, technical assistance, and some operations research to ensure impact measurement.

Illustrative mechanism: The three activities – VCT services and community linkages, broadened role of community-based distributors, and condom and contraceptive social marketing – will be implemented through a cooperative agreement with an organization experienced in these activities in Zimbabwe.

COUNTRY: FHA/WCA
FY 2000

	FUNDING SOURCE ($ 000)				
	NOA CSD			Recoveries	Food Aid
	HIV/AIDS: Non-LIFE	*HIV/AIDS: LIFE*	*DCOF*		
AFR/DP FY 2000 Control Levels	*5700*	*1700*			
CATEGORY					
I. Primary Prevention	4,522,552	500			
A. MTCT	0	0			
II. Care and Support	0	700			
III. AIDS Affected Children/Orphans	0	0			
IV. Capacity Building	450,000	500			
TOTAL	4,972,552	1,700,000			

Narrative on Expanded and/or New Activities – FY 2000
MISSION: Family Health & AIDS—West and Central Africa

Primary Prevention
Illustrative activities:
Behavior Change Communication

- Regional message design workshop to develop accurate, consistent, effective second generation STI/HIV/AIDS messages—messages to focus on areas of risk assessment and reduction, condom negotiation, living positively with AIDS and supporting PLWHA—target variety of audiences including women and youth (SFPS/JHU/CCP)
- Wake Up!—a regional mass media campaign will be expanded in three new countries (SFPS/JHU/CCP)
- Revamp the current integrated counseling and clinical FP curriculum adding modules for risk assessment and reduction including condom use for dual protection (SFPS/JHU/CCP & SFPS/JHPIEGO)
- Develop a curriculum to train providers to offer "youth friendly" services (SFPS/JHU/CCP)
- Launch a regional multi-media behavior change communication campaign targeting young people aged 14-25—main objectives of the campaign will be to increase the adoption of low risk behavior, encourage discussion between partners regarding sex, stimulate the use of RH information and services including STI treatment—campaign will provide critical links to VCT, hotlines, youth friendly clinics and STI sites (SFPS/JHU/CCP/PSI/Tulane U)

STI Management

- As per above, revamp the current curriculum for STI (SFPS/JHPIEGO & IMPACT)
- Develop generic service delivery guidelines to encompass new HIV/AIDS/STI information and to provide a basis for assessing the quality of care being delivered in both private and public healthcare sectors. SDGs will serve as a basis for developing competency-based

training materials for in service and pre service training and tools for the provision of services at the clinic level (SFPS/JHPIEGO & IMPACT)

- Conduct regional training for providers in the syndromic management, diagnosis and treatment of STIs—expand the activity to more vulnerable populations in border towns/crossings (SFPS/JHPIEGO & IMPACT)
- Assess non-clinic settings such as pharmacies to determine their role in STI treatment and provide training to improve STI management and referral; also develop supervisory systems for the non-clinic based SDPs (SFPS/JHPIEGO/TULANE & IMPACT)

Work-Based Interventions

- Conduct a situation analysis of effective work-based programs in the region, identify companies that are interested in starting or expanding activities—particular focus will be on companies that employ migrant or seasonal laborers and those with cross-border interests (SFPS/JHU-CCP/JHPIEGO/Tulane U & IMPACT)
- Facilitate the development of work-based programs by offering tools and TA to companies ready to implement programs (SFPS/JHU-CCP/JHPIEGO & IMPACT)
- Develop a how-to manual on establishing work-based programs (SFPS/JHU-CCP & IMPACT)

Voluntary Testing And Counseling

- Conduct a situation analysis to determine where and how to target VCT in the region and to coordinate efforts with other donors such as French Cooperation and World Bank (SFPS/Tulane University & IMPACT)
- Conduct targeted operations research to examine specific programmatic issues and explore alternative models of VCT delivery to improve its quality and make VCT more cost effective (SFPS/Tulane University & IMPACT)
- Diagnostic research will be conducted to identify and assess factors likely to be associated with the acceptance and use of VCT services by targeted groups, youth in particular (Tulane University & IMPACT)
- Develop standardized HIV counseling training curriculum and guidelines on HIV counseling and testing (SFPS/JHPIEGO/JHU/CCP & IMPACT)

Condom Social Marketing

- Continue condom social marketing program in Cote d'Ivoire, Burkina Faso, Togo and Cameroon (SFPS/PSI)
- Expand the Prevention du SIDA sur les Axes Migratoires de l'Afrique de l'Ouest (PSAMAO) activity into Benin, Mali, Ghana and Senegal—maintain focus on mobile populations such as truck drivers, CSWs, seasonal workers, migrant laborers (SFPS/PSI)
- Develop PSAMAO messages that inform target populations about VCT and STI services (SFPS/PSI/JHU/CCP)
- Replicate and adapt the successful bus passenger IEC campaign initiated in Cote d'Ivoire (SFPS/PSI)
- Conduct a study in program countries to determine barriers to condom use--develop a multi-media campaign including documentary on social marketing, radio and TV spots, newspaper inserts aimed at opinion leaders, and promotional events to improve condom use (SFPS/PSI/TULANE)
- Test an alternative male condom through social marketing program (SFPS/PSI/Tulane U)
- Identify opportunities for possible development of a female condom social marketing program (SFPS/PSI)

Condom Supplies

- FHA-WCA to procure social marketing condoms for Togo and Cameroon FY00—looking to KfW, the World Bank and other donors for funding in FY01 and FY02 (FHA-WCA, Central Contraceptive Procurement)

Stigma Reduction

- Support the regional network of PLWHA for their effective involvement in activities to fight stigma and discrimination through policy and advocacy work (IMPACT)

MTCT

- No Activities Scheduled

DRAFT

US CAMPAIGN TO CLOSE THE GLOBAL AIDS RESOURCE GAP:

I. Strategic Purpose: To significantly reduce worldwide HIV transmission; improve basic care and treatment for those infected and affected; and, reduce the associated impacts. Taking aggressive and concerted action to realize these goals is in the strategic interest of the United States and the public interest of all Americans.

II. Resources Required:

Financial resources (FY2000):

Sub-Saharan Africa alone: $3 billion annually[1]

For Asia, Eastern Europe/NIS, and Latin America: $3 billion annually[2]

[1]Of this amount, 20% of annual public sector costs should be leveraged from HIPC governments, 40% from mid-income countries; Target region: all of sub-Saharan Africa. Figures exclude US-based research efforts.

[2]Target region includes clusters of countries as described in section V below.

Annual Amount Required for Africa for HIV/AIDS Prevention and Care and Current Spending in FY2000

	Amount needed	**World Spending[1]**	**Shortfall**	**USAID[2]**	**Other USG (CDC)**
Prevention	$1.5 billion	$425 million	$1.075 billion	$ 99 million	$ 34 million
Care	$1.5 billion	$ 75 million	$1.425 billion	$ 35 million	$ 0
Total	**$3.0 billion**	**$500 million[3]**	**$2.5 billion**	$134 million	$34 million

[1]Includes all donors, lending agencies and host country public sector. Does not include foundations or personal out-of-pocket expenditures.

[2]Included in World Spending total; USAID annual funding needs in section VIII. USAID worldwide HIV spending is $200 million in FY2000.

[3]Of this amount, approximately $415 million is funded through developed country grants and loans and $85 million derives from host country governments, primarily for inpatient care costs.

Annual Amount Required for other Developing Regions (LAC, Asia, EE/NIS) and Current Spending in FY2000[1]

	Amount needed	**World Spending[2]**	**Shortfall**	**USAID**	**Other USG**
Prevention	$2.0 billion	$1 billion	$1.0 billion	$ 60 million	$ 1 million
Care	$1.0 billion	$0.5 billion	$0.5 billion	$ 6 million	$ 0
Total	**$3.0 billion**	**$1.5 billion[3]**	**$1.5 billion**	$ 66 million	$1 million

[1]ExludesChina.

[2]Host country resources are more substantial in these regions. Thus the anticipated shortfalls are less and the need for developed country input is less.

[3]Of this amount, approximately $500 million is funded through developed country grants and loans and $1 billion derives from host country governments.

Human and institutional resources:

1. Additional US personnel devoted to HIV/AIDS internationally. Expansion of USG agencies involved. Increased utilization of US-based expertise (NGOs, universities)
2. Significant increase in African and other national human and institutional capacity devoted to HIV/AIDS.

III. Key Trends

- 4 million new infections in Africa; 6 million worldwide; 95% of infections in the developing world. 34 million total infected in Africa;
- In the past 20 years, 16.3 million deaths from HIV/AIDS (11.5m deaths in Africa). Death toll will double in 5 to 6 years, most of it occurring in sub-Saharan Africa;
- One-third of African countries (16) have adult (15-49) HIV prevalence rates above 10 percent. Of these, 7 countries have HIV prevalence rates above 20 percent;
- Negative population growth by 2010 in South Africa, Botswana, and Zimbabwe (–1.3, -1.3, and –0.9 respectively). Six more countries in sub-Saharan Africa will see their population growth rates approach zero because of HIV/AIDS. Mozambique's growth rate will slow to just 0.1% per year, a twenty-fold decline in population due to HIV/AIDS;
- By 2010, over 40 million children will have lost one or both parents to HIV/AIDS in Africa;
- Prevalence rates in African militaries can be as high as 40-60%, with highest rates in officer cadres; and,
- By 2000, cumulative worldwide direct and indirect costs of HIV/AIDS top $500 billion. HIV/AIDS will account for over 50% of health spending in many African countries.

IV. Result Targets:

- Reduce the expected new HIV infections over the next five years in Africa from 20 million to 10 million, and in other regions from 10 million to 7 million.
- At least 30% of HIV infected persons have access to basic care and support services.
- At least 30% of AIDS orphans will have access to basic community support services.

V. Strategic Approach:

Twenty years of experience with this pandemic has allowed for the development and small scale implementation of AIDS strategies with documented success. These approaches include: a combination of prevention, care and treatment, capacity building, as well as political will, multisectoral involvement, donor coordination, financing, and monitoring and evaluation.

The primary focus is on sub-Saharan Africa, which has generalized HIV infection throughout the adult population. This focus will recognize migration patterns and the mosaic of epidemics in different sub-regions. In Asia, Eastern Europe, the newly independent states of the former Soviet Union, and Latin America, the epidemics are concentrated in specific vulnerable populations. Our action is focused on these subpopulations and will target clusters of countries with significant cross border migration: India-Bangladesh-Nepal; Thailand-Vietnam-Cambodia-Laos; Russia-Ukraine-NIS countries-Poland-Romania; Caribbean-Guyana-Brazil. For these countries and non-focus countries, an expanded and rigorous sentinel surveillance system will monitor the epidemic and identify trends and outbreaks of transmission.

- **Primary prevention:** Essential to controlling and stopping this global scourge. Enhanced and new activities to focus on targeted vulnerable populations (e.g., youth, women, military), as well as highly used transport corridors, better access to voluntary

testing and counseling (VCT), massive investments in mother-to-child prevention; reductions in stigma and discrimination.

- **Care and support for those infected and their families**: Focus on three points of access to infected persons: VCT, antenatal clinic attenders, and inpatients, especially those with active TB. Each of these points of access will provide the optimum way to identify HIV infected persons and to initiate care and support interventions. Each of these also will dramatically enhance our primary prevention agenda. Provide training for health workers and health care system infrastructure improvements to deliver care and support community based care programs (including food distribution). Special focus on drug procurement and distribution systems will enhance the availability and accessibility of these medications.

- **Programs addressing orphans and vulnerable children**: Provide support to community based programs assisting children and families at risk. Includes medical care, education, food, and income generation activities.

- **Capacity building**: Support building national analytical, planning and management capabilities to combat HIV/AIDS in Africa and elsewhere. Strengthen HIV/AIDS surveillance efforts, as well as national monitoring and evaluation efforts. Health system infrastructure development to assure safe and effective delivery of HIV/AIDS drugs and prevention services, including: training, clinics, basic drugs for opportunistic infections, expanded NGOs, PWA empowerment, and bicycles for community health workers.

- **Enhanced multisectoral response.** Engage multiple sectors: education, agriculture, military, economic growth, microenterprise, democracy and governance, commerce, and others to launch HIV/AIDS advocacy, education, prevention and/or care programs. Specific funding is required.

VI. Managing the Global Battle:

- US-based: restructure ONAP to manage the Federal Agency response;
- Using the PEACS apparatus, engage OECD and affected countries at the highest political level;
- The US LIFE Initiative and International Partnership Against AIDS in Africa (IPAA) Initiative can work together to focus on the hardest hit countries in Africa; and,
- Periodic NSC/ONAP convened IWG, along with executive committee to monitor US and worldwide progress;

VII. Key USG Actors:

USAID is the designated lead USG agency for field based action. Other key implementation agencies include DHHS, DOD, DOL, State, Treasury, USTR, and the intelligence community. All other USG agencies have important roles to play, e.g., DOCommerce.

VIII. Major Challenges that now confront us:

- Closing the Resources Gap:
  - In FY2000, as part of the "LIFE Initiative" (Leadership and Investment in Fighting an Epidemic), the President proposed and the Congress appropriated a $100

million increase for the USG's global AIDS effort. For FY2001, the President has requested an additional $100 million increase. This initiative has not only enabled the USG to more than double its global HIV prevention and AIDS care programs but to expand participation in this effort to include HHS, DOL, DOD, and Ag in the funding, and a host of other strategic players in the overall implementation of the USG's program.

- The USG will redouble its global AIDS spending in the next two years and will develop a plan for the accelerated assistance needed to do its share to help close the global gap for the next five years;
- The USG will call on other countries to double their bilateral HIV/AIDS assistance over the next two years, and to develop a plan for the accelerated assistance needed to do its share to help close the global gap over the next five years.

- Limited Capacity:
  -In affected countries, governments, NGOs, communities, institutions, all need major capacity building efforts
  -USAID requires dedicated HIV/AIDS staff in each LIFE emphasis country to manage its programs and coordinate USG efforts.

- Lack of Critical Tools: (such as AIDS prevention vaccines and microbicides.) Requires an intensive focused effort (NIH, IAVI, GAVI) involving a coordinated, multi-pronged approach to simultaneously testing promising vaccine and drug candidates. Currently $1.9 billion is expended by the USG on AIDS research.

IX. Monitoring and Evaluation

The USG will use indicators firmly established under the LIFE Initiative and the International Partnership Against AIDS in Africa to monitor progress. A country profile database will be established providing country-based information on the epidemiology of the epidemic, scope of the country response, and indicators of progress. These profiles will be created through a collaborative effort led by the USG (USAID, CDC, Bureau of Census, NIA, DOD, etc) working with UNAIDS, WHO and selected other governments (e.g. U.K. and Sweden), and will use established indicators, and data aggregation and analysis systems. Profiles will be updated semi-annually and will facilitate regrouping/strategy revisions, etc. A semi-annual supplemental report will address data that relates to security issues.

X. Next Steps: (12 month plan)

- Discussion of HIV/AIDS at international fora: G-8, SADC, EU-US, UNAIDS PCB;
- Discussion of HIV/AIDS efforts and required assistance in upcoming President Mbeki visit and with other high level visits;
- UN special meeting of General Assembly; Millennium conference;
- Personal calls by POTUS/VP with specific leaders to galvanize worldwide attention and resource mobilization;
- Specific work with DOD, DOL, Treasury—US HIV/AIDS "strikeforce". Coordination with USAID to provide background HIV/AIDS technical assistance on the issues;
- Increased communication and collaboration with USG advocacy and expert groups (e.g. NGOs, universities, etc);

- Identification of necessary studies (e.g. economic, intelligence, military, HIV surveillance) to be undertaken; and,
- Increased USG participation in country level IPAA actions.

ANNEX 1: HIV/AIDS GLOBAL PANDEMIC FUTURE TRENDS

CONTINUED SPREAD OF HIV AROUND THE WORLD: Large increases in HIV infections are projected by the U.S. Bureau of the Census for sub-Saharan Africa. In South Africa, for example, adult prevalence is expected to increase from 22% to 38% within the decade. In the same time frame, Nigeria's adult prevalence will jump from 5.6% to 11% -- rise of nearly 50%.

One-third of African countries (16) have adult (15-49) HIV/AIDS prevalence rates above 10 percent. Of these, 7 countries have HIV prevalence rates above 20 percent. While HIV will continue to take a staggering toll on sub Saharan Africa, other regions particularly parts of Asia and the former Soviet Union will experience a rapid growth in HIV infections. The National Intelligence Council in its report on the global infectious disease threat, estimates that by 2010 Asia could surpass Africa in the number of persons living with HIV infection. Already, India with 3.7 million persons infected is second only to South Africa with 4.2 million.

MORTALITY: In the last twenty years, 16.3 million people died from HIV/AIDS. At current rates, this death toll will double in 5 to 6 years with most of the deaths occurring in sub Saharan Africa. For example, infant mortality in Zimbabwe is projected to triple from 22 to 66 deaths per 1,000 live births and child mortality will have risen five-fold from 29 to 153 deaths per 1,000 children under 5. By 2010, life expectancy in Zimbabwe will have fallen from 73 years to less than 33 years.

DECLINING POPULATION GROWTH: U.S. Bureau of Census projections show that by 2010, South Africa, Botswana, and Zimbabwe will experience negative population growth as a result of HIV/AIDS, with growth rates of –1.3, -1.3, and –0.9 respectively. Six more countries in sub-Saharan Africa will see their population growth rates approach zero because of HIV/AIDS. Mozambique's growth rate will slow to just 0.1% per year. Without the HIV/AIDS epidemic the 2010 growth rate would have been 2%. This represents a twenty-fold decline in population growth because of HIV/AIDS.

ORPHANS: In 34 of the most severely impacted developing countries over 40 million children will have lost their mother or both parents to HIV/AIDS within the next decade. Many of these children will be adolescents and young adults. Without adequate education and social integration, orphans will add significantly to crime rates, serve as child soldiers, and could threaten political stability.

IMPACTS ON ECONOMIES, POLITICAL AND SOCIAL STABILITY: Significant impacts of HIV/AIDS on multiple sectors are being seen. HIV prevalence rates in militaries of heavily affected countries can range from 10 to 60%, and is often double the civilian population rate. HIV/AIDS causes at least a 1% GDP rate decline in heavily affected countries, as well as large costs for firms. Millions of orphans translate into a significant pool of untrained adults further exacerbating social and political instability. In Zambia, 1300 teachers died (many from AIDS) last year, whereby only 700 were trained. Swaziland, using a national 30% HIV prevalence rate, estimates that it would require an 86% increase in the education budget (above current levels) just to maintain teacher levels of two years ago.

DRAFT

OPERATION "JOINING FORCE": LAUNCHING A GLOBAL CAMPAIGN TO CLOSE THE AIDS RESOURCE GAP

I. Overview

In 1998, the global community gathered in Geneva, Switzerland for the 12th International Conference on AIDS. At that summit, much "good news" about new drug therapies was announced and much was written about the beginning of the end of AIDS. While the news was certainly good, its impact on the overwhelming majority of people living with AIDS was dramatically exaggerated. Somewhere in the scramble to declare victory, the harsh reality that these treatments would likely remain far beyond the reach of the more than 90% of people with AIDS living in the developing world was missed. Also absent was a focus on expanding access to prevention programs that had proven effective in Africa, but were mostly unavailable to the millions living in the growing number of nations with double digit infection rates. Despite the fact that the theme of the conference was "Bridging the Gap", it was increasingly clear that far too little attention had been paid to a pandemic that was raging across Africa and other developing nations. In fact, we were losing the global battle against AIDS. Since that time, the USG has helped to increase both awareness and resources dedicated to fighting this fight. But much more remains to be done as the gap between what we know we can do and what is currently being done continues to grow.

In early July, the 13th International Conference on HIV/AIDS opens in Durban, South Africa. This is the first time that the conference has been held in the developing world. As the global community turns its attention to Durban, the USG has an unique opportunity to launch a campaign designed to .....

II. Key Trends

- To date, more than 50 million people have become infected with HIV, 34 million in Africa alone. By 2005, more than 100 million people will have been infected. In 1999, 6 million (16,000 per day) worldwide became infected, 4 million in Africa;
- In the past 20 years, 16.3 million people have died of AIDS, nearly 12 million in Africa. This death toll will double in 5- 6 years, mostly occurring in sub-Saharan Africa;
- By 2010, over 40 million children will have lost one or both parents to HIV/AIDS in Africa;
- By 2000, cumulative worldwide direct and indirect costs of HIV/AIDS top $500 billion. HIV/AIDS will account for over 50% of health spending in many African countries.
- The National Intelligence Council in its report on the global infectious disease threat, estimates that by 2010, Asia not Africa will be the AIDS epicenter.

III. Global AIDS Goals

Universal access to HIV prevention and treatment services continues to be a fundamental principle for guiding global action to end the HIV pandemic. However, given the magnitude of the global AIDS pandemic, the international community has identified a series of goal oriented benchmarks for framing the concerted action needed over the next five years. While

these targets are ambitious for the time frame envisioned, they are both realistic and achievable if the appropriate resources are identified, the essential political will is exercised, and the necessary infrastructure is developed to support interventions of the scope and scale needed. ***The USG has not developed these goals in isolation but in partnership with UNAIDS, WHO, the World Bank, UNDP, UNICEF, other donor nations and affected countries***. It is clear that the USG cannot and should not do this alone. Realization of these goals is dependent on a coordinated global mobilization that leverages leadership and resources from all sectors of all societies.

Prevention of new infection

- **GOAL: Reduce expected new HIV infections over the next five years in Africa from 20 million to 10 million, and in all other regions from 10 million to 7 million.**

    - **At least 50% of HIV infected pregnant women will have access to interventions that will reduce mother-to-infant HIV infection.**

        NOTE: 50% of HIV+ pregnant women is the number that currently sees a health care provider prior to, or at the time of, delivery. Currently, less than 1% of these women receive this intervention.

    - **Ensure that all transfused blood is safe.**

Context: In 1999, in sub- Saharan Africa, approximately 4 million persons were newly infected with HIV, of which 55% were women. In addition, 2 million persons became HIV infected in other parts of the world, with especially high rates in India and the Newly Independent States of the former Soviet Union. This is a *doubling of annual incidence* (number of new infections in any given year) from 1993. Extensive experience from prevention programs in Uganda, Thailand, Dominican Republic and Senegal support the achievability of a target to reduce new annual HIV infections by 50% within the next five years. According to the World Bank: "Studies have shown that specific interventions using voluntary testing and counseling (VCT), condom social marketing, peer education, and treatment for sexually transmitted infections (STI) can change behaviors and reduce the transmission of HIV. Modeling has shown that the synergistic effect of combining these interventions reduces the risk even further." This best practice package can be purchased for approximately $2.50 per capita per year. In addition, as one in ten new infections (600,000) are among infants and an equal number result from blood transfusion – specific interventions and sub-goals have been identified to reach these special populations.

Care and treatment for people living with HIV/AIDS

- **GOAL: At least 30% of HIV infected persons have access to basic care and support services.**

Context: As of the end of 1999, there were over 22 million people with HIV infected living in sub-Saharan Africa. Persons with end stage HIV related disease are often hospitalized for short periods of time. In fact, in the most severely affected countries in east and southern

Africa, up to 60% of hospital beds are devoted to HIV infected patients. However, the level of care available and access to even the most basic symptomatic treatments, let alone effective prophylactic treatments of opportunistic infections, is essentially non-existent. This is due to lack of infrastructure, training, and critical health commodities for the care of HIV related disease. Over the next five years, with significant investments in capacity development, a basic package of care can be made available. This would include prophylaxis for tuberculosis and treatment of an array of other opportunistic infections, such as common pneumonias and diarrheal disease. It is important to note that in the US, slightly more than one third of persons living with HIV actually have access to antiviral drugs. Considering the massive need to provide better access to HIV testing and the building up of healthcare systems in Africa, a goal of 30% within five years represents a dramatic increase. The package of care and support that would be provided could enhance survival and quality of life in Africa as significantly as that achieved in the U.S. through the use of combination antiviral therapies.

Support for children orphaned by AIDS

- **GOAL: At least 30% of AIDS orphans will have access to basic community support services.**

Context: There are now nearly 24 million children who have lost one or both parents in the 19 most severely affected countries in Africa. Interventions must be directed at maintaining these children within their community, either in extended kinship families or in supported child headed households. These services must initially be targeted at those families most at risk for orphanhood, such as children serving as caregivers to sick and dying parents. Community support services include health and non-health services: paying for school fees, providing food assistance, provision of health services, provision of vocational training, and protection from stigma related isolation or exploitation. Current assistance programs reach only several hundred thousand orphans and affected children. Significantly increased resources would support community and family based assistance programs to reach at least a third of the children at risk. Faith based organizations are particularly important. In addition, increasing access to AIDS care and treatment will allow parents to survive longer, thus delaying orphanhood.

IV. Financial Resources Required (FY2000):

UNAIDS, USAID, and other global partner have developed that following .....

Sub-Saharan Africa alone: $3 billion annually[1]
For Asia, Eastern Europe/NIS, and Latin America: $3 billion annually[2]

[1]Of this amount, 20% of annual public sector costs should be leveraged from HIPC governments, 40% from mid-income countries; Target region: all of sub-Saharan Africa. Figures exclude US-based research efforts.
[2]Target region includes clusters of countries as described in section V below.

Annual Amount Required for Africa for HIV/AIDS Prevention and Care and Current Spending in FY2000

	Amount needed	World Spending[1]	Shortfall	USAID[2]	Other USG (CDC)
Prevention	$1.5 billion	$425 million	$1.075 billion	$ 99 million	$ 34 million

Care	$1.5 billion	$ 75 million	$1.425 billion	$ 35 million	$ 0
Total	**$3.0 billion**	**$500 million**[3]	**$2.5 billion**	$134 million	$34 million

[1]Includes all donors, lending agencies and host country public sector. Does not include foundations or personal out-of-pocket expenditures.
[2]Included in World Spending total; USAID annual funding needs in section VIII. USAID worldwide HIV spending is $200 million in FY2000.
[3]Of this amount, approximately $415 million is funded through developed country grants and loans and $85 million derives from host country governments, primarily for inpatient care costs.

Annual Amount Required for other Developing Regions (LAC, Asia, EE/NIS) and Current Spending in FY2000[1]

	Amount needed	**World Spending**[2]	**Shortfall**	**USAID**	**Other USG**
Prevention	$2.0 billion	$1 billion	$1.0 billion	$ 60 million	$ 1 million
Care	$1.0 billion	$0.5 billion	$0.5 billion	$ 6 million	$ 0
Total	**$3.0 billion**	**$1.5 billion**[3]	**$1.5 billion**	$ 66 million	$1 million

[1]ExludesChina.
[2]Host country resources are more substantial in these regions. Thus the anticipated shortfalls are less and the need for developed country input is less.
[3]Of this amount, approximately $500 million is funded through developed country grants and loans and $1 billion derives from host country governments.

V. Strategic Approach:

Twenty years of experience with this pandemic has allowed for the development and small scale implementation of AIDS strategies with documented success. These approaches include: a combination of prevention, care and treatment, capacity building, as well as political will, multisectoral involvement, donor coordination, financing, and monitoring and evaluation.

The primary focus is on sub-Saharan Africa, which has generalized HIV infection throughout the adult population. This focus will recognize migration patterns and the mosaic of epidemics in different sub-regions. In Asia, Eastern Europe, the newly independent states of the former Soviet Union, and Latin America, the epidemics are concentrated in specific vulnerable populations. USG action is focused on these subpopulations and will target clusters of countries with significant cross border migration: India-Bangladesh-Nepal; Thailand- Vietnam-Cambodia-Laos; Russia-Ukraine-NIS countries-Poland-Romania; Caribbean-Guyana-Brazil. For these countries and non-focus countries, an expanded and rigorous sentinel surveillance system will monitor the epidemic and identify trends and outbreaks of transmission.

ISSUES - USG Initiative

GUIDING PRINCIPLES FOR U.S. GOVERNMENT AGENCIES INVOLVED WITH LIFE INITIATIVE HIV/AIDS ACTIVITIES IN DEVELOPING COUNTRIES

I. BACKGROUND

The HIV/AIDS epidemic has progressed far beyond original predictions. In its wake, thousands of once healthy individuals have died and many others will follow. Besides devastating individual loses, the mortality and morbidity resulting from HIV/AIDS, undercuts countries' capacity to manage, govern, grow and compete in a global economy. To prevent the further spread of HIV/AIDS, the White House and Congress have developed and funded the Leadership and Investment in Fighting an Epidemic (LIFE) initiative. Through a strong partnership between U.S. Government agencies, the LIFE initiative will provide additional USG resources to reduce the impact of the HIV/AIDS pandemic.

II. GUIDING PRINCIPLES

The LIFE initiative will bring together USG agencies to work toward a common goal. In order to produce a synergistic outcome, it is critical to regularize a coordination process between implementing agencies. At country level, USAID will continue to take the lead in coordinating the US response to the HIV/AIDS epidemic, building on established relationships with its host country partners. This will serve to facilitate the design and implementation of program activities and will ensure optimum coordination between USG agencies. In those countries where there is no USAID presence, but there is a CDC presence, CDC will take the lead in coordinating the US response to the HIV/AIDS epidemic. In countries where there is no USAID or CDC presence, alternative working relationships will be established.

The following guiding principles will direct the efforts of each implementing agency toward effective implementation:

- *Country Leadership and Ownership of the Activities;*
- *Complementarity of Existing HIV/AIDS Programs with New Initiative Activities;*
- *Leverage of and Coordination with Other Donors and Organizations;*
- *USAID led Coordination of and Advocacy for U.S. Government agencies in each Country;*
- *Priority Focus on the Promotion of Indigenous Expertise and Institutions in Implementing Program Elements;*
- *Two-Way Information Sharing to Enhance Opportunities to Learn about New Models that will Assist US-Based HIV Programs, while Sharing US Experiences Abroad;*
- *Active Involvement of People with HIV/AIDS and Full Recognition and Respect for Their Rights; and*
- *Teamwork, with all partners, is essential for success.*

III. PROGRAM DEVELOPMENT

Country ownership is central to the LIFE initiative; thus, a participatory design process is essential. Involvement of host country governments, donors, private sector, PVOs/NGOs, affected communities, persons living with HIV/AIDS, and other stakeholders in the design process and ongoing program activity will maximize the potential for success. Country plans should adhere to the national HIV/AIDS strategy and complement the Embassy's Mission Performance Plan (MPP) thus ensuring a strong US government response. From the onset, building capacity within each country is integral to establishing a sustainable program from the onset. Country ownership of LIFE activities is critical.

In conjunction with USG agencies, USAID will coordinate and facilitate country plan development. In each country, forming a joint USG team including USAID, CDC and other USG agencies will promote solid collaboration.

A. Assessment Visits

Previous to an assessment visit, communication with the USAID HPN Office is critical for successful program development. Communication should include the following elements:

a. Timing and length of visit (ETA and ETD);
b. Desired appointments and suggestions for appointments (indicate whether USAID will make appointments)
c. Timing/date for an initial meeting with USAID PHN staff;
d. Possibility of the participation of a USAID PHN staff person during the visit;
e. Timing/date for an end-of-visit briefing with USAID staff;
f. Approval process for the initial draft plan (e.g., who will review, when); and a full review process for the strategy/workplan.

USAID should provide teams with key documents, including:

a. USAID Country Strategy
b. National HIV/AIDS Country Strategy
c. USAID HIV/AIDS Strategy and Implementation Plans
d. Background documents that will assist the team in formulating a country plan.

The greater the communication between USAID,CDC and other USG agencies,the greater the chance for program success and avoiding/resolving conflicts. Initial and periodic communication by telephone may assist in developing needed rapport for successful program implementation.

B. Country Plan Review Process

The review process for the initial, as well as the final plan, should be outlined and clear to all USG agencies. Plans should include the scope of work, placement of new USG staff in-country, and a monitoring and evaluation framework. To insure optimum coordination, country plan review should follow these steps:

1. USAID: Before circulating to other stakeholders in-country, a draft plan should be discussed and shared with USAID for review, and comments provided to CDC.

2. National AIDS Program Officials: Once the draft plan is revised by CDC, the revised plan should be shared with USAID for circulation to appropriate national government officials (e.g., Ministry of Health, National AIDS Control Program, etc.) for review and approval.

3. Key Counterparts: Once approved by national government officials, key partners should review the plan.

4. USAID/Washington and CDC/Atlanta: Before plans are finalized, USAID/Washington and CDC/Atlanta (with other participating DHHS agencies)should review the plans, focusing on thematic areas (primary prevention, care and treatment, children affected by AIDS, infrastructure development) to insure consistency with the broader LIFE goals.

5. Finalized plans should be shared with USAID, government officials and key in-country partners.

Following these steps should reduce the potential for misunderstandings and set the program on the right footing. Although consensus building is time consuming, the end result is worth the effort to get all players feeling ownership of the program

IV. PROGRAM IMPLEMENTATION

To facilitate program implementation from the onset, a process of ongoing communication should be established between USG agencies, host country counterparts and other key partners. Three regularly scheduled meetings are suggested: 1) joint USG team meetings -or regular tele-conferencing; and 2) meetings between the USG joint team and National AIDS Program Officials and primary counterparts. Quarterly or semi-annual meetings with other key partners, including appropriate Embassy staff, will insure ongoing support for program activities.

V. MONITORING AND EVALUATION

As outlined previously, a monitoring and evaluation framework integrated into the country plan will provide the ability to track and report indicators from the onset of the program. Gathering data for select indicators should not result in an overburdening exercise but build a regular feedback system into program activities. Carefully selecting a few key indicators for each program area (e.g., prevention, care, capacity building) will provide program managers/counterparts a means to measure program progress and to make periodic program adjustments. Many countries or existing projects collect data or employ surveys that can be utilized – rather than creating a separate collection instrument. The attached LIFE Initiative Indicators Reference List should provide the primary indicators.

Within the country plan, the monitoring and evaluation framework should outline: indicators, methodology for collecting data, responsible organization/individuals (who will collect, analyze, and utilize data), and benchmarks for data review.

VI. PRINCIPLES OF COLLABORATION

Through successful collaboration U.S. Partners can:

- Work toward the common goal of preventing the spread of HIV/AIDS;
- Achieve synergy and greater impact; and
- Contribute diverse individual and agency skills toward a stronger outcome.

Key Points:

- The success of one agency is contingent on the success of others
- Conflict is natural. Its successful resolution is the key to greater impact for everyone.

VII. CONFLICT RESOLUTION

As stressed throughout this document, building in a structured system of communication (and regular informal communication) with all involved partners will head off potential conflict. If an impasse develops, USAID/W and CDC/Atlanta (or other USG agency headquarters) should be notified and will assist to resolve issues. As stated earlier, conflict is natural. Its successful resolution is the key. Poorly resolved (or unresolved conflicts) inhibit successful work for everyone. If facilitation is needed, request it. Before things get to a head, please involve you headquarters staff. Country programs cannot afford the reduced productivity created by unresolved conflicts.

OHH breaks impasse

CDC Global AIDS Activity
FY2000 Expenditure Projections

Country	Primary Prevention Total	Home Based Care And Treatment	Capacity and Infrastructure	Total by Country
Botswana	$ 2.1	$ 0.5	$ 0.9	$ 3.5
Cote d'Ivoire	$ 1.3	$ 0.7	$ 1.6	$ 3.7
Ethiopia	$ 0.6	$ 0.3	$ 0.4	$ 1.3
Kenya	$ 1.7	$ 0.7	$ 1.4	$ 3.8
Malawi	$ 0.2	$ 0.1	$ 0.2	$ 0.5
Mozambique	$ 0.4	$ 0.2	$ 0.7	$ 1.3
Nigeria	$ 0.3		$ 0.7	$ 0.9
Rwanda	$ 0.3	$ 0.2	$ 1.4	$ 1.8
Senegal			$ 1.5	$ 1.5
South Africa	$ 1.7	$ 0.2	$ 0.9	$ 2.9
Tanzania	$ 0.5		$ 0.7	$ 1.2
Uganda	$ 0.6	$ 1.2	$ 2.4	$ 4.2
Zambia	$ 0.6	$ 0.4	$ 1.3	$ 2.2
Zimbabwe	$ 0.7	$ 0.3	$ 1.2	$ 2.3
India	$ 0.2	$ 0.3	$ 0.3	$ 0.8
Regional				
HdQtrs	$ 1.7	$ 0.7	$ 0.8	$ 3.2
Total	$ 12.9	$ 6.0	$ 16.2	$ 35.0

DRAFT FY 2000 HIV/AIDS Funding

Country Operating Unit	FY 2000 Core	FY 2000 LIFE Initiative	FY 2000 Sub-Total	DCOF * (CHS Account)	FY 2000 AIDS Children Supp. **	FY 2000 TOTAL	Title II Food Aid (BHR)
ANGOLA	1,000		1,000	500		1,500	
BENIN	1,025	0	1,025			1,025	
CONGO	1,500	0	1,500			1,500	
ERITREA	500	0	500			500	
ETHIOPIA	5,000	1,700	6,700	400		7,100	
GHANA	4,000	-	4,000			4,000	
GUINEA	1,725	-	1,725			1,725	
KENYA	3,200	2,500	5,700	500	600	6,800	
LIBERIA	-						
MADAGASCAR	800	0	800			800	
MALAWI	2,200	2,800	5,000	500		5,500	
MALI	2,500	-	2,500			2,500	
MOZAMBIQUE	3,000	2,100	5,100			5,100	
NAMIBIA	1,000		1,000			1,000	
NIGERIA	3,300	3,450	6,750			6,750	
RWANDA	1,500	2,000	3,500		1,000	4,500	
SENEGAL	1,700	2,000	3,700			3,700	
SIERRA LEONE				350		350	
SOMALIA	-	-	0				
SOUTH AFRICA	900	4,800	5,700	750	400	6,850	
TANZANIA	3,500	2,500	6,000		800	6,800	
UGANDA	4,400	2,500	6,900		2,200	9,100	
ZAMBIA	3,500	3,500	7,000	1,000	500	8,500	
ZIMBABWE	2,000	3,000	5,000		500	5,500	
RCSA	-	-	0				
REDSO/E	200	1,000	1,200			1,200	
REDSO/WCA	5,700	1,700	7,400			7,400	
AFR/SD	1,850	1,450	3,300			3,300	
Southern Africa	500	1,000	1,500			1,500	
SAHEL	100	-	100			100	
UNAIDS							
TOTAL AFR	56,600	38,000	94,600	4,000	6,000	104,600	-
India (LIFE)		3,000					
G/PHN (LIFE)**		4,000					
GRAND TOTAL - LIFE		45,000					10,000
GRAND TOTAL - DCOF AIDS Orphans				(4,000)			
GRAND TOTAL - AIDS Children Supplemental (Recoveries)					(6,000)		
USAID Global Bureau Attribution for Africa						19,375	
(USAID Africa TOTAL)***						[123,975]**	
USAID Agency HIV Total						[200.000]	

* = DCOF for AIDS orphans
** = About 50% of the G/PHN LIFE amount is attributable to Africa; 50% of G/PHN HIV/AIDS funds is attributable to Africa
*** = Total of AFR and G/PHN attribution for Africa (including $2 m of $4 m of G/PHN LIFE); $10 m in food aid not included yet;potential total for 2000 is thus $133,975,000

4/24/00

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LIFE Global AIDS Initiative: USAID Country Funding Levels

Note: These figures are very much in draft and will change a number of times.

	DEMOGRAPHIC DATA			BUREAU FUNDING LEVELS: FY 98-2000			Mission Request for Initiative Funding: Total and by Initiative Catenory Breakdown					USAID/W Recommended Funding Levels for Initiative Plus Up		
Country	98 POP. (000s)	98 HIV PREV (%, est.)	98 HIV INCIDENCE (estim.)	FY 98 ($ m)	FY 99 ($ m)	2000 CP ($m)	TOTAL MISSION REQUEST ($m)	Prevention ($m)	Children ($m)	Care ($m)	Capacity ($m)	Non-Title II Level ($m)	Title II Level ($m)	TOTAL ($m)
Botswana	1,448	25.1	26,000											
Cote D'Ivoire	15,446	10.1	75,000											
Ethiopia	58,390	9.3	400,000	5.125	5.540	5.50	7.00	3.50		2.50	1.00	2.00	3.00	5.00
Kenya	28,337	11.6	400,000	3.200	4.450	3.20	5.00	2.50	1.10	1.00	0.40	2.00	2.50	4.50
Malawi	9,840	14.9	90,000	2.600	2.800	2.20	4.50	1.70	1.00	0.30	1.50	2.00	1.00	3.00
Mozambique	18,641	14.2	300,000	3.200	2.820	3.10	4.00	1.50		0.50	2.00	2.00	2.50	4.50
Nigeria	110,532	4.1	530,000	1.900	2.700	3.40	15.50	9.00	3.00	3.00	0.50	4.50		4.50
Rwanda	7,956	12.8	55,000	0.500	3.000	1.50	3.55	1.70		0.35	1.00	2.00	1.00	3.00
Senegal	9,723	1.77	2,800	0.100	2.774	1.70	2.30	0.50		0.60	1.20	2.00		2.00
South Africa	42,835	12.9	550,000	2.000	2.950	0.90	4.00	2.00	1.00	1.00		4.50		4.50
Tanzania	30,609	9.42	150,000	3.600	4.000	3.50	4.50	2.00		0.50	2.00	2.50		2.50
Uganda	22,167	9.0	34,800	4.900	7.010	4.40	3.00	2.00	0.30	0.70		2.50		2.50
Zambia	9,461	19.1	68,300	2.700	4.250	3.50	12.00	3.00	6.50	1.50	1.00	3.00		3.00
Zimbabwe	11,044	25.8	200,000	1.950	1.850	2.00	5.30	x	x		x	3.00		3.00
India	983,377*	0.8	550,000	9.669	5.850	5.50	3.00	0.50	0.50	1.50	0.50	3.00		3.00
West Africa Regional	NA	NA	NA	3.465	3.605	5.80	3.50	1.00	0.50		2.00	2.50		2.50
East/Southern AFR Regional***	NA	NA	NA									3.50		3.50
(Storm Warning)	NA	NA	NA	0.000	0.750	0.00	1.00	1.00						
(REDSO/E)	NA	NA	NA	0.360	0.250	0.20	0.50	0.15			0.35			
(RCSA)	NA	NA	NA	0.000	0.000	0.00	4.10							
USAID/Wash **							5.00					4.00		4.00
Total						46.4	87.75	32.05	13.9	13.5	13.45	45.00	10.00	55.00
Revised ARoss 8/30/99				OMB Initiative Budget Guidelines by Subcategory:			$55 m	$25 m	$10 m	$14 m	$6 m			

*=India program will be active in 2 states only; population is for entire country: Tamil Nadu (63 m pop; Maharastra 89 m pop)

** = USAID/Wash denotes G Bureau, AFR/SD, and ANE

*** = Includes the three programs that follow: Storm Warning, REDSO/E, and RCSA

USAID HIV/AIDS Funding Levels ($000's)

Operating Unit	FY 1997	FY 1998	FY 1999	FY 2000
Africa Bureau	51,101	51,100	56,000	94,600
Asia and the Near East Bureau	14,070	22,800	19,000	25,550
Latin America and the Carribean Bureau	16,061	14,250	13,000	14,500
Europe and the New Independent States Bureau	—	---	—	—
Global Bureau*	35,269	31,900	36,000	38,750
Other Central Bureaus	999	950	1,000	6,600
Children affected by AIDS (CAA)	---	---	10,000	10,000 **
Title II	---	—	---	10,000
TOTALS	**117,500**	**121,000**	**135,000**	**200,000**

* Approx. 50% of the Global HIV/AIDS activities are for the Africa region.

** Includes $4 million from DCOF and $6 million recoveries.

DRAFT FY 1998-2000 HIV/AIDS Funding (in $000)

Country Operating Unit	FY 1998 TOTAL	FY 1999 Core	FY 1999 AIDS Orphans Supp	FY 99 TOTAL	FY 2000 Core	FY 2000 LIFE Initiative	FY 2000 Total	DCOF * (CHS Account)	FY 2000 AIDS Children Supp. **	FY 2000 TOTAL	Title II Food Aid (BHR)	FY 2001 Recommended SEE FOOTNOTE
ANGOLA	0	0		0	1,000		1,000	500		1,500		1,500
BENIN	1,500	1,200		1,200	1,025	0	1,025			1,025		2,054
CONGO	1,000	1,914		1,914	1,500	0	1,500			1,500		3,500
ERITREA	500	217		217	500	0	500			500		1,000
ETHIOPIA	5,125	5,540		5,540	5,000	1,700	6,700	400		7,100		7,500
GHANA	3,700	4,000		4,000	4,000	-	4,000			4,000		4,500
GUINEA	1,300	1,200		1,200	1,725	-	1,725			1,725		2,225
KENYA	3,200	3,300	1,150	4,450	3,200	2,500	5,700	500		6,200		7,500
LIBERIA	0	0		0	-							500
MADAGASCAR	500	500		500	800	0	800			800		1,500
MALAWI	2,600	2,600	85	2,685	2,200	2,800	5,000	500		5,500		6,000
MALI	2,400	2,220		2,220	2,500	-	2,500			2,500		3,000
MOZAMBIQUE	3,200	2,820		2,820	3,000	2,100	5,100			5,100		6,200
NAMIBIA	0	0		0	1,000		1,000			1,000		1,500
NIGERIA	1,900	2,000	815	2,815	3,300	3,450	6,750			6,750		11,897
RWANDA	500	2,000	1,000	3,000	1,500	2,000	3,500			3,500		4,700
SENEGAL	100	2,774		2,774	1,700	2,000	3,700			3,700		4,700
SOMALIA	0	0		0	-	-	0					
SOUTH AFRICA	2,000	1,500	1,450	2,950	900	4,800	5,700	750		6,450		8,000
TANZANIA	3,600	4,000		4,000	3,500	2,500	6,000			6,000		7,000
UGANDA	4,900	6,010	1,000	7,010	4,400	2,500	6,900		2,200	9,100		10,762
ZAMBIA	2,700	3,250	1,000	4,250	3,500	3,500	7,000	1,000		8,000		10,000
ZIMBABWE	1,950	1,550	300	1,850	2,000	3,000	5,000			5,000		6,000
RCSA	0	0		0	-	-	0					
REDSO/E	360	250		250	200	1,000	1,200			1,200		1,700
REDSO/WCA	3,465	3,405	200	3,605	5,700	1,700	7,400			7,400		7,700
AFR/SD	2,500	3,000		3,000	1,850	1,450	3,300			3,300		3,800
Southern Africa	0	750		750	500	1,000	1,500			1,500		4,000
SAHEL	100	0		0	100	-	100			100		
UNAIDS	2,000	0		0								
TOTAL AFR	51,100	56,000	7,000	63,000	56,600	38,000	94,600	3,650	2,200	100,450	-	128,738
India (LIFE)						3,000						
G/PHN (LIFE)***						4,000						
Sri Lanka (DCOF AIDS Orphans)								350				
GRAND TOTAL - LIFE						45,000					10,000	
GRAND TOTAL - DCOF AIDS Orphans								4,000				
GRAND TOTAL - AIDS Children Supplemental (Recoveries)									6,000			
USAID Global Bureau Attribution for Africa	15,950			18,000						17,375		
(USAID Africa TOTAL)****	[67,050]			[81,000]						[119,825]**		
USAID Agency HIV Total	[121000]			[135,000]						[200.000]		

* = DCOF for AIDS orphans

*** = About 50% of the G/PHN LIFE amount is attributable to Africa

Revised 01/06/00 Alex Ross, AFR/SD

** = $3.8 m still to be allocated

**** = Total of AFR and G/PHN attribution for Africa (including $2 m of $4 m of G/PHN LIFE); $10 m in food aid not included yet; $3.8 m in recoveries not included yet (potential total for 2000 is thus $133,625,000)

FY 2001 FOOTNOTE: DOES NOT INCLUDE ANY DCOF OR AIDS CHILDREN SUPPLEMENTAL

FINAL DRAFT

TITLE: FY2000 Increases in Funding for HIV/AIDS for USAID and DHHS/CDC, Including Funds Linked to Administration (LIFE) and Congressional Initiatives

SUMMARY:
The final FY 2000 appropriations bills included unprecedented funding increases for HIV/AIDS efforts in Africa and India for USAID and for DHHS. The LIFE Initiative (Leadership and Investment in Fighting an Epidemic) developed by the White House Office of National AIDS Policy (ONAP) and additional funding supported by Congress demonstrate a very high level of U.S. political support for the fight against AIDS in Africa.

USAID received an additional $63 million for HIV/AIDS efforts above the original FY 2000 request of $127 million. Additionally, the Bureau for Humanitarian Response – Office of Food for Peace is targeting $10 million of Title II, food aid funds at children affected by AIDS in Africa. Some of these funding increases are directly linked to the LIFE initiative in target countries. All of the increases are additive to the core. In addition, the U.S. Department of Health and Human Services (DHHS)/CDC received a separate appropriation of $35 million. Final county levels for the $63 million will be provided by year-end. However, discussions with host country counterparts should begin immediately, at least to establish what program areas are most desirable from their perspective and vis a vis other donors.

The increased LIFE Initiative-linked funding will support four program elements (1) primary prevention which includes mother to child transmission prevention and voluntary testing and counseling, (2) improving home and community based care and treatment, (3) caring for children affected by AIDS, and (4) capacity and infrastructure development (including surveillance systems). The mix of interventions will be determined at the country level. The initiative delineates specific responsibilities for USAID and DHHS (e.g., AIDS orphans, surveillance). LIFE-related funding increases are targeted at 13 African countries, India, and regional African programs selected according to specific criteria. USAID will have lead responsibility for the development of a coordinated country level plan and implementation with DHHS/CDC and country stakeholders. USAID (G, AFR, BHR, ANE bureaus) and DHHS/CDC have established a joint task force to assist planning, and the White House Office of National AIDS Policy (ONAP) will provide broader oversight of the initiative. These funding increases are also designed to help leverage national and other donor resources.

Next steps include country level notification and joint planning, needs assessments, identification of implementation mechanisms, and, where appropriate, expansion or initiation of NSDD-38 and ICASS agreements with Embassies for DHHS/CDC assignees and activities. These efforts are expected to increase our combined ability to reduce HIV transmission and mitigate its worst effects. End summary.

1.Background. In July 1999, Vice President Gore released a new Administration international HIV/AIDS initiative, known as Leadership and Investment in Fighting an Epidemic (LIFE), to address the global pandemic. Congress has increased USAID's HIV/AIDS funding by $63 million in FY 2000 and provided $35 million to DHHS/CDC, for Africa and India. Additionally, Congress has requested BHR re-program $10 million of Title II for this Initiative. These funds supplement the existing FY 1999 USAID HIV/AIDS budget of $125 million worldwide, as well as other U.S. Government (USG) programs. The additional funding is designed to encourage nations, donors, and institutions to match this action, as well as to scale up our own current efforts. Successes in Uganda and Senegal prove that the battle can be won, and challenge us to bring comparable gains to additional countries.

2. Linkage to national and international efforts. Additional USG funds will need to be programmed within the context of national AIDS plans. USG efforts will also strive to contribute to a series of worldwide HIV/AIDS goals and objectives established for the international community by UNAIDS as well as to the International Partnership against AIDS in Africa.

3. Guiding principles. The *LIFE* initiative focuses on a select set of countries in order to significantly scale up the response and to meet the goals and objectives of this initiative in these countries. The initiative was developed based on a set of guiding principles that implementing agencies are expected to follow. These include: country ownership of the activities; complimentarity of existing HIV/AIDS programs with new initiative activities; leverage of and coordination with other donors and organizations; increase in the number of collaborating USG agencies and other partners fighting against AIDS; support for indigenous expertise and institutions in implementing program elements; two-way information sharing to enhance opportunities to learn about new models that will assist US-based HIV programs while sharing US experiences abroad.

4. Target LIFE countries. A selected set of countries has been identified using the following criteria: the magnitude of the epidemic; country receptivity to assistance from US government; country political commitment to fighting the AIDS epidemic; potential for interventions and unique opportunities; potential for impact; potential for leveraging of other local and donor support; existing U.S. Government implementation mechanisms. The selected target countries and programs are: Ethiopia, India, Kenya, Malawi, Mozambique, Nigeria, Regional Programs in west and southern/eastern Africa, Rwanda, Senegal, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe. Botswana and Cote d'Ivoire are also target countries that will be covered by the USAID regional programs and by DHHS/CDC. The USAID West African based Family Health and HIV/AIDS program supporting a number of countries in that region (including Cote D'Ivoire) and the Eastern/Southern African regional program (including Botswana) will participate in this initiative. Botswana, Kenya and Cote D'Ivoire represent countries with strong DHHS/CDC presence. Ethiopia, India, Kenya, Malawi, Mozambique, Rwanda and Uganda are countries with ongoing Title II activities that might be amended to include LIFE initiative activities. US partners utilizing Title II resources will be US PVOs with existing, or pending, Development Activity Proposals (DAPs).

5. Program elements. Much of the funding increase will target specific HIV program components. LIFE is intended to support activities in four program elements: (1) primary prevention, (2) improving community and home based care and treatment, (3) caring for children affected by AIDS, and (4) capacity and infrastructure development. Specific guidance on each of these areas will be forthcoming from USAID/W. Missions are encouraged to tailor their programs to their country needs and existing efforts (including other donor activities). The range of the four LIFE initiative program elements provides significant breadth and flexibility. A starting point for mission planning are the preliminary proposals submitted by missions in July.

6. Innovation in programming. With this new funding the initiatives will facilitate USAID and DHHS/CDC support for a number of new HIV/AIDS areas, such as the provision of care and support for persons living with HIV/AIDS. Other examples of evolving trends and needs include emphasis on voluntary testing and counseling, mother to child transmission prevention, and multisectoral interventions. Missions will need to balance traditional programming areas with new approaches that hold significant promise. Given that the funding increases are expected to continue, this presents an important opportunity to plan for the future.

7. Performance targets. Broad performance goals, covering the next three years, have been established for USAID, DHHS/CDC, and other collaborating partners. In addition, the sum of all USG efforts will contribute to a set of worldwide HIV/AIDS goals. These indicators will be communicated to missions in an email. Monitoring systems will need to measure the overall impact of USG existing programmatic and new activity efforts.

8. Funding. (A) The original FY 2000 LIFE initiative requested an overall increase of $100 million, with $55 million for USAID ($35 million in new funds, $10 million in recoveries, and $10 million of Title II reprogramming to benefit children affected by AIDS), $35 million for DHHS/CDC, and $10 million for DoD (pending reprogramming). Final FY 2000 Foreign Operations appropriations included an increase of $63 million for USAID's HIV/AIDS program above the President's original FY 2000 HIV/AIDS request of $127 million. This increase includes: $35 million for Africa and India for the LIFE Initiative (specific earmark); $13 million general HIV/AIDS increase (some of which is also linked to the LIFE initiative); $5 million ESF funds for HIV/AIDS (non-Africa); $4 million in Displaced Children Orphans Fund and $6 million devoted to children and AIDS. In addition, $10 million of BHR Title II funds will be targeted for HIV/AIDS (a subset of LIFE initiative countries will be eligible for this assistance-see paragraph 4 above).
(B) The new USAID total is $200 million, including the Title II assistance. The Africa Bureau overall level for HIV/AIDS will be $94.6 million in FY 2000 (not counting Title II, DCOF or any of the $6 million for AIDS orphans to be programmed).
(C) USAID/W will make every effort to accelerate the OYB process to the missions to fast-track planning and implementation of this effort. For Title II programs, BHR/FFP will issue revised program guidance to potentially interested PVOs.
(D) Beyond FY 2000, USAID, OMB and others have been clear that this needs to be a multi-year commitment and effort. USAID and DHHS are currently developing FY 2001

budgets that include the new higher levels of HIV/AIDS spending required by the LIFE initiative in their base budgets.

9. Tracking of funds related to LIFE. Although each country need not support each of the four program elements, overall funding totals will need to approach the globally set targets by category (to be provided subsequently). We anticipate that target missions will need to submit to USAID/W their preliminary proposals for funding for LIFE initiative-related activities prior to final implementation. This will allow USAID/W an opportunity to assess how close the totals will be to the original initiative targets. USAID/W's goal is for missions to have maximum flexibility in their programming. USAID/W will issue guidance shortly. Additionally, DHHS/CDC will provide information on CDC-supported program elements. Programs using Title II resources will have to demonstrate a linkage to food security objectives. USAID/W will provide guidance on tracking the LIFE initiative-related funding increases by program element for the target countries.

10. Actions. Target missions are requested to begin planning immediately. USAID and DHHS/CDC will be engaged in a collaborative effort to develop joint management and monitoring plans, achieve consensus on performance measures, and identify areas for cooperative efforts and for complementary programs. Building on established relationships between its Missions and host country partners, USAID will have lead responsibility for facilitating the coordinated US response. The following key actions are required:

A. USAID/W to complete country OYB levels for HIV/AIDS.
B. Missions to immediately begin a dialogue with their host country counterparts to discuss the pending availability of resources and the need to pursue a participatory design process to include DHHS/CDC and other team members. The latter must include government (all applicable levels), other bilateral and multilateral donors, the private sector, PVOs/NGOs, affected communities, persons living with HIV/AIDS, and other stakeholders. Since DHHS/CDC's surveillance technical assistance will invariably include direct ministry involvement, prior consultation with DHHS/CDC is necessary to develop program plans for surveillance, as well as for prevention and care activities to be supported by DHHS.
C. Missions to develop a joint USG team that involves USAID personnel and DHHS/CDC personnel. DHHS/CDC will fund the provision of its technical team to participate. USAID/W and DHHS/CDC will identify the relevant DHHS resources available to work with missions, as well key contact points to facilitate team member identification and deployment. Additional technical assistance will be available from USAID/W and DHHS/CDC and others upon request.
D. As part of the initial planning effort, the joint USG-country teams should review previously established country profiles (US and donor response information) as well as priority country needs and gaps and potential responses. To the extent possible, the new USG funds should be used to leverage increased government and other donor resources for AIDS.
E. All missions should have conducted a participatory needs assessment, identified current responses and gaps, developed workplans, and selected implementation mechanisms within 3 months. If additional time is required, please inform Alex

Ross in AFR/SD (see Points of Contact below). Each country team is requested to develop a proposal that identifies which activities it wishes to pursue according to the four program elements noted above. It is important to note that this is a multi-year initiative.

F. Missions to submit their preliminary funding proposals to USAID/W (derived from discussions with countries and with the planning team) in approximately 3 months time.
G. Missions to notify USAID/W if there are any major problems that could hinder progress on any aspect or phase of the initiative.
H. Missions to consult with DHHS/CDC representatives prior to discussion with ministries about surveillance infrastructure development, or for care and prevention activities to be supported by DHHS.

11. Title II Program. There are special considerations governing the use of the Title II, Food for Peace funds. The funds account for the entire USAID $10 million LIFE initiative contribution for children affected by AIDS. BHR/FFP expects that most of these funds will be used for the direct distribution of commodities, however, it is understood that, depending on the type of activity undertaken, some amount of monetization may be necessary. Further information on this initiative will be forthcoming from BHR/FFP.

12. Mechanisms. Missions are encouraged to channel resources through existing mechanisms, as well as to identify needs for new mechanisms to accomplish specific programmatic goals. These can include mission procurements, field support, USAID/W grants to institutions, or other implementing mechanisms.

13. It is important for Missions to identify a subset of existing activities that could be scaled up immediately. OMB has suggested that USAID and DHHS/CDC will need to show that some of the funds are flowing soon. However, this must be balanced against the need to conduct appropriate planning for the future with all of our partners.

14. Monitoring and evaluation plan. Each mission is requested to submit a monitoring and evaluation plan specific to its HIV/AIDS activities. An update manual on the most appropriate HIV/AIDS indicators for all four program elements will be sent to all missions in January.

15. Personnel: It is expected that missions will be able to hire personnel through various mechanisms to assist in managing this program. Additional communication on options will be forthcoming.

16. NSDD-38 Issues: Embassies are notified that DHHS/CDC will need to initiate or expand NSDD-38 and related ICASS agreements in some of the countries in order to place necessary staff. Missions are requested to facilitate this process where appropriate. In other cases, DHHS/CDC may second DHHS/CDC personnel to USAID to work with governments and other partners (DHHS funded).

17. Coordinating the *LIFE* Initiative. In Washington, the White House Office of National AIDS Policy, with secretariat support provided by USAID, established a coordinating task force of senior agency management. This task force will monitor overall progress on the initiative. A working group has also been established to facilitate USAID (G,AFR,BHR, ANE) and DHHS planning and communication. Missions are encouraged to set up in-country coordination mechanisms of their own, if they do not already exist, including the Ambassador and broader country team.

18. Key contact points and responsible persons. Alex Ross, AFR/SD will be responsible for coordinating the Bureau's role and response to the initiative. Dr. Paul Delay of G/PHN/HIV-AIDS Division will be the key Global Bureau contact point. René Berger and/or Tom Marchione will be the key BHR contacts. Dr. Helene Gayle and Dr. Michael St. Louis will be key contact points for DHHS/CDC in Atlanta. Please let us know if you have any questions or clarification.

19. Conclusion. The fight against HIV/AIDS is not only a top priority for our health programs, but a bureau-wide priority as well because the disease undercuts Africa's capacity to manage, govern, grow and compete in a global economy. Your messages from the field, which have detailed the catastrophic effects of the HIV/AIDS pandemic in Africa, are reverberating throughout Washington. The result is a universal agreement by the White House, the Congress, various executive agencies, the private sector, and NGO's that United States (as well as other donors) must do more. Your efforts, as well as the increasing recognition of the tragedy of this epidemic by Africans themselves, have helped develop the base for the LIFE initiative. We expect that the interest in Africa and in combating the AIDS epidemic will continue and are closely monitoring other proposed initiatives (e.g. Rep. Barbara Lee's bill to enact an "AIDS Marshall Plan").

20. Missions have earned international respect and praise for USAID, the role we play, the effectiveness of our programs, and our ability to quickly respond to the challenge of fighting HIV/AIDS. In sum, USAID is indispensable in the fight against HIV/AIDS, above all in Africa. With AFR, G, and BHR Bureau support we can ultimately conquer this disease. We eagerly await your county-specific plans.

ANE

Draft: Alex Ross, USAID 12/15/99; Revised Carleene Dei, USAID 12/13/99

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO:	FROM
Tom Sheridan	Cheryl Bauerle
COMPANY	DATE: June 11, 1999
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER. 3
PHONE NUMBER	
RE:	

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

Hi Tom-
Sandy is in a meeting at OEOB and so I'm not exactly sure if I should be faxing this information to you or someone else. Please let me know if I need to forward it elsewhere.

Attached is a copy of a letter to President Clinton from the National Urban League. The hope is for the US Conference of Mayors to do something similar. Also, Sandy would greatly appreciate Mayor Webb discussing this issue with the Vice President..

Sandy can be reached at anytime over the weekend via her pager at 202-757-5000. She is scheduled to stay at the Fairmont Hotel (New Orleans) on Sunday night, although she might change her reservations and fly to New Orleans on Monday morning. The hotel number is 504-529-7111.

Thank you so much- it was great seeing you yesterday!!

Cheryl

736 Jackson Place
Washington, DC 20503
(202) 456-2437
(202) 456-2438 (fax)

June 8, 1999

President William J. Clinton
The White House
Washington, DC 20500

Dear Mr. President:

I am writing to urge you to dramatically increase the U.S. response to the global AIDS emergency. Since you took office in 1993, this global pandemic has exploded, with a 300% increase in the number of new HIV infections. Current estimates are that 47 million people worldwide are already infected, and that number will more than double by the year 2005. AIDS now kills more people annually than any other infectious disease, and in many sub-Saharan African nations, one-quarter of all children have already been orphaned by AIDS.

Unfortunately, the U.S. investment in global HIV prevention and AIDS care has fallen far short of keeping pace with this raging pandemic. While the death toll soars, the U.S. global AIDS budget remains largely flat funded – and has for years. If adjusted for inflation, this funding stagnation is actually equivalent to a 25% cut in real spending on our global AIDS effort. In a nation as wealthy as ours, this is unacceptable.

We have followed with interest the Presidential AIDS Mission to sub-Saharan Africa which you charged ONAP Director Sandy Thurman to lead this April. After directing the Administration and the Congress to bear witness to the ravages of AIDS, it is now time for concrete and bold action. On behalf of the Urban League movement, I urge you to amend your FY2000 budget request and push for a $100 million increase in our global AIDS effort. This new investment will put our nation on track toward a global AIDS program that begins to address the magnitude of this pandemic.

If we hope to help stem the rising tide of HIV and bring some modest level of care and support to those who are suffering, we must immediately escalate our current efforts, and continue to do so until we have not only gained ground but begun to get ahead of the curve. A minimum down payment of at least $100 million would do just that. This

investment must be new money, rather than funds shifted from the strapped budgets of other essential development accounts. Health, education, child-survival and micro-finance are all interconnected parts of a comprehensive human investment and AIDS strategy that must not be traded against each other.

Families are being shattered, economies are being decimated, and hundreds of millions of U.S. dollars invested in broad-based development objectives are being obliterated by our failure to fully engage in the battle against AIDS. The global AIDS epidemic has already cost an estimated $500 billion.

Last December on World AIDS Day, you envisioned a world without AIDS and spoke eloquently about our responsibilities as a leader in our global community. One year ago in April, you traveled to Africa and called for new and vibrant partnerships with its many and varied nations. You are a Presidential pioneer in these endeavors, and we applaud you. However, if we fail to put this nation's AIDS effort on the war footing needed to combat this scourge, it will surely devastate this vitally important legacy.

AIDS is a plague of biblical proportions. Every day 16,000 more people become HIV infected – one every 5 seconds. Everyday we wait, children and families pay the price. A new investment of $100 million in our global AIDS programs would not only save lives, it will help to secure our goals of economic growth and political stability.

Every day counts. I urge you to seize this opportunity to secure your legacy of hope in Africa and around the world, through determined leadership in the battle against AIDS, and the commitment of resources needed to win this war.

Sincerely,

Hugh B. Price
President

ANNEX 5: ACTIVITIES SUPPORTED BY THE *LIFE* INITIATIVE IN TARGET AFRICAN AND ASIAN COUNTRIES

COUNTRY	Primary Prevention						Caring for Children Affected by AIDS**		Home and Community Based Care and Treatment**			Infrastructure and Capacity Development**				
	VCT	SM/ Procurement	BC/ SR	MTCT	Blood Supp/ nosocomial / OE	STD	Support to Affected Children **	Comm. Mobilization**	OI/TB/ STD	Drug Supply	Home/ Comm.-Based Care**	Policy/ advocacy **	NGO support **	Training and TA**	Surveill. ***	Multi-sectoral
Botswana	H		H, D1	H		H			H		H				H	
Cote d'Ivoire	H		H	H	H(NS	H			H		H				H	
Ethiopia	U,H	U	U, D2			U	U*		U	U					U,H	
Kenya	U,H		U,H,D1	U,H	U,H	H	U*		U,H		H				U,H	U
Malawi	U,H		U, D2				U*	U			U		U	U	U,H	U
Mozambique	U		U			U	U*		U				U	U	U,H	U
Nigeria	U	U	D1	U		U			U		U	U				
Rwanda	U		U	U		U	U*				U		U	U	U,H	
Senegal			U, D1			U					U	U	U	U	U	U
South Africa	U,H		H, D1	U,H	H(NS	U,H			U,H		H		U	U	H	U
Tanzania	U	U	U		H						U	U,H	U	U	U,H	
Uganda	U,H		U,H, D2	U,H		U,H	U*		H		U,H				H	
Zambia	U,H		U	U		U	U*	U				U,H	U		H	
Zimbabwe	U,H	U	U, D2									U,H	U	U	H	U
India		U	U			U	U*	U	H		U	(H)	U	U	U,H	
REGIONAL																
WAFR/ SAFR/EAFR	(U)	U	(U)									U		U	(U)(H)	
HEAD-QUARTERS																
AID/W			U	U			U		U	U	U			U		U

Notes: * = Ongoing or potential Title II-"Food for Peace" countries.

** = Indicates additional HHS agency involvement (e.g., HRSA, ACF, etc) that may not be reflected on the table

*** = DOD will also implement specific surveillance activities in military populations in selected countries.

( ) = indicates additional linkage between USAID regional program and Botswana and Cote D'Ivoire HHS activities

VCT = voluntary counseling and testing; SM = social marketing; BC = behavior change; SR = stigma reduction; MTCT = mother-to-child transmission; STD= sexually transmitted disease; OI = opportunistic infections; TB= tuberculosis; NS = nosocomial infection control; OE = occupational exposure reduction

U = USAID H = HHS D = DOD

ANNEX 6: GLOBAL PARTNERSHIP MEETINGS.

Partner	Purpose
Washington-based African Diplomatic Corps	To initiate dialogue for individual countries, which would lead to, improved collaborative efforts and mobilization of increased host country resources and commitment.
U.S. AIDS Advocacy Groups	To increase awareness and garner support for the focus and activities of the Initiative.
U.S.-based Faith Groups	To identify U.S. and international faith networks that will ultimately create networks and support for prevention, counseling, psychosocial support and care interventions in sub-Saharan Africa.
U.S. NGOs and CBOs	To provide support and collaborate with other African NGOs
U.S. and International Communities of Persons Living with HIV/AIDS (NAPWA, GNP +, etc)	To ensure that PLWHA needs and priorities are met and to establish processes so that host country PLWHA input is utilized optimally.
U.S. Teaching/Academic Institutions	To identify technical resources within the United States in order to expand the technical assistance resource platform which will be initiated in sub-Saharan Africa.
UNAIDS (including the seven UN Cosponsors: WHO, UNICEF, World Bank, UNFPA, UNDP, UNESCO, UNDCP)	To link with the UNAIDS International Partnership for Africa.
Bilateral Donors (e.g. DFID, SIDA, CIDA, JICA, etc)	To identify gaps and areas for complementary programming in individual countries
Mulitlateral Donors (e.g. EU, World Bank, IMF)	To integrate country plans with overall prevention and care activities.
Congressional members and staff	To maintain dialogue concerning focus countries and activities.
U.S. Diplomatic Corps	To coordinate with U.S. diplomatic AIDS initiatives

LIFE Initiative
THE USAID RESPONSE

The Agency for International Development's (USAID) response to the HIV/AIDS pandemic began in 1986, with the Agency contributing over $1.2 billion to the effort during these last 13 years. Of this total, USAID has programmed over $650 million in sub-Saharan Africa. Since the early 1990's, USAID has been the leading donor to both UNAIDS and to the HIV/AIDS prevention and control effort in the developing world. Since 1993 the USAID budget has remained at approximately $120 million per year. During this time the number of annual HIV infections has risen 300% to 6 million per year, globally.

On July 19, 1999, the Administration announced a new initiative to address the global AIDS pandemic. A central feature of the *LIFE* initiative is a $100 million increase in US support to prevent the further spread of HIV and to care for those affected by this devastating disease. Of this total, $55 million will be programmed through USAID, doubling the resources available through USAID programs in sub-Saharan Africa.

Under the *LIFE* Initiative, USAID will emphasize the following four program elements. Based on the mix of existing activities, not all elements will be provided in all target countries.

- **Primary Prevention** ($25 million) in 13 of the 15 target countries to reverse the trend of rising HIV infection rates through voluntary counseling and testing, prevention of mother-to-child transmission, social marketing, behavior change programs, STD treatment, and blood safety programs.

- **Community and Home Based Care and Treatment** ($14 million) in 7 of the 15 target countries to provide a continuum from community-based to in-patient treatment, with related support services utilizing community workers.

- **Caring for Children Affected by AIDS** ($10 million) in 12 of the 15 target countries to assist children affected by AIDS and their families. Nutritional support through Title II, Food for Peace, programs will strengthen the capacity of families caring for children orphaned by AIDS.

- **Capacity and Infrastructure Development** ($6 million) in 10 of the 15 target countries to increase capacity to respond to the epidemic, focusing on government, private sector, NGOs, and research institution capabilities. Particular focus will be given to expanding the capacity for the delivery of care and services and for the use of surveillance data to target prevention and care.

Building on established relationships between its Missions and host country partners, USAID will take the lead responsibility to facilitate an unprecedented coordinated international US response at the country level (including DHHS and DoD). In addition, USAID will provide support to the Coordinating Task Force, which will be organized under the auspices of the White House Office of National AIDS Policy (ONAP).

Over the next three years, USAID and its partners in the *LIFE* Initiative, will:

- 10% decrease in HIV incidence in 15-24 year olds
- 10% decrease in perinatal infections
- 10% decrease in reported STD prevalence by men/women
- 50% of households caring for children affected by AIDS will receive assistance from an institution or group outside the family
- 50% of district/provincial governments will be able to implement care and support activities
- Surveillance systems will be established in all partner countries.

LEADERSHIP AND INVESTMENT IN FIGHTING AN EPIDEMIC (*LIFE*)

Summary of Operating Plan

Introduction:

The global AIDS pandemic is having a devastating impact on countries, communities, families and individuals. Recognizing this impact and the United States Government role in helping to fight the pandemic, the Leadership and Investment in Fighting an Epidemic (*LIFE*) global AIDS initiative seeks to increase USG available resources, improve and enhance prevention and care efforts, and expand the quality, diversity and number of both USG and local country partners who can effectively respond to the pandemic.

The *LIFE* Initiative provides an initial investment of $100 million (above the current budget levels of participating agencies) to combat the HIV/AIDS epidemic in developing countries, with a special emphasis on Sub-Saharan Africa. The Initiative builds on the existing large USG investment in HIV/AIDS efforts in Africa and India to date (over $1.1 billion since 1986). The Initiative involves an unprecedented collaboration the United States Agency for International Development (USAID), the Department of Health and Human Services (Multiple agencies within DHHS), and the Department of Defense (DOD). The *LIFE* Initiative is a significant turning point in the United States Government fight against AIDS and will significantly contribute to broader global targets over the next 3 to 5 years. These are presented in Annex 1.

Curtailing this epidemic is not just the responsibility of the U.S. Government. The Inititiative will collaborate with UNAIDS and other international and local agencies to leverage additional individual country, multilateral, bilateral, and private resources. At the present time, the UN has estimated that resource needs for *prevention alone* for sub-Saharan Africa total in excess of $600 million per year. *LIFE* will contribute to this goal, but clearly is not fully responsible for this total level of effort.

Geographic Focus:

LIFE focuses on 15 target countries (14 in sub-Saharan Africa and India) and regional activities in western and southern Africa. In each of these countries, there will be collaborative support from more than one Federal Agency. Countries were selected based on the magnitude of the epidemic, their country's political commitment to fighting the epidemic, their receptivity to USG assistance, and presence of existing U.S. Government implementation mechanisms. Additional criteria are presented in Annex 2. Annex 3 presents a description of the regional activities in Africa.

LIFE **INITIATIVE**

COUNTRIES	USAID	DHHS	DOD
1. BOTSWANA	X	X	X
2. COTE D'IVOIRE	X	X	
3. ETHIOPIA	X	X	X
4. INDIA	X	X	
5. KENYA	X	X	X
6. MALAWI	X	X	X
7. MOZAMBIQUE	X	X	
8. NIGERIA	X		X
9. REGIONAL. PROGRAMS	X	X	
10. RWANDA	X	X	
11. SENEGAL	X		X
12. SOUTH AFRICA	X	X	X
13. TANZANIA	X	X	
14. UGANDA	X	X	X
15. ZAMBIA	X	X	
16. ZIMBABWE	X	X	X

LIFE Initiative Program Elements:

LIFE addresses four program elements critical to fighting the AIDS pandemic: primary prevention, caring for children affected by AIDS, capacity and infrastructure development and improving community and home based care and treatment. Each of these elements must be coordinated and integrated within an overall comprehensive response. These activities must be linked together and will be coordinated in each country through USAID Missions. The Initiative will foster the expansion of current activities, as well as provide support for more recently developed interventions (e.g. methods to reduce mother-to-child HIV transmission) that have not yet been incorporated into comprehensive programs. Not every country will have all program elements listed below. Country programs will be tailored to the needs of the country and

existing efforts underway. Annex 4 provides a description of current HIV/AIDS activities in each of the focus countries by each of the three respective Federal Agencies and demonstrates the base of activities that will be enhanced and supplemented through this initiative. Annex 5 presents the enhanced and new activities that will be funded under the ***LIFE*** initiative. These countries reflect only those that will be targeted by this Initiative, not the entire list of USG-assisted countries.

1. Primary Prevention:

Ninety percent of new infections in the developing world derive from either sexual transmission (80%) or mother to child transmission (10%). Contaminated blood transfusions and infected needles account for an additional five percent. This Initiative will expand the scale and quality of primary prevention activities.

Voluntary Counseling and Testing (VCT): USAID will assist 11 countries and the southern Africa region to develop and implement locally appropriate voluntary counseling and HIV testing services. At these sites, DHHS will provide critical technical assistance to ensure the quality and accuracy of HIV testing, identify methods to target high risk groups with VCT services, and assist with developing linkages between VCT and health and social services. Social Marketing: 5 countries will increase their social marketing efforts to improve access to barrier methods to protect oneself. Behavior Change: 15 countries and the regional program will expand behavior change interventions, focusing on youth, male risk behavior reduction, and stigma reduction, which would involve faith communities and other community groups. Mother-to-Child HIV transmission (MTCT): 6 countries will implement programs to provide interventions to prevent mother-to-child transmission of HIV. At these sites, USAID will provide support for screening of pregnant women, and training of maternal health providers. DHHS will identify barriers that exist for accessing these services and the outcomes of these interventions on both infants and mothers. STD Management: 12 countries will implement new and/or expand STD prevention, diagnostic and treatment

services. Blood Safety: 4 countries will implement programs to improve blood collection from volunteer donors, increase the quality of HIV testing of blood and ensure more appropriate use of blood transfusions.

Within three years, monitoring systems will measure the combination of enhanced existing programs and the additional "new" activities that are supported through the initiative. The following performance measures and targets are expected:

- 5% decrease in reported non-regular sex partners over the first year
- 5% increase in reported barrier method use with non-regular/regular sex partners in the first year (25% by 2005)
- 10% decrease in reported STD prevalence for men/women
- 5% decrease in HIV incidence rate in 15-24 year olds by the year 2005
- 5% decrease in perinatal infections by the year 2005

2. Caring for Children Affected by AIDS:

Nearly 25 million children have lost one or both parents to AIDS. Thus far, services for AIDS orphans in developing countries have been minimal. USAID will be primarily responsible for supporting these activities, which seek to implement strategies for children affected by AIDS and for their families - through the use of Title II – "Food for Peace" Programs in 8 countries. In addition, the impact of using Title II resources will be evaluated and the needs of very young children will be assessed.

Expected performance outcomes include:

- % of households in high HIV prevalence communities with increased access to food.
- % of households in high prevalence communities receiving assistance from community based organizations.

3. Capacity and Infrastructure Development:

Within the focus countries, it is critical that political commitment is increased and host country capacity to implement effective interventions is strengthened, focusing on government, private sector, NGOs and research institution capabilities. Key activities are to increase the use of accurate HIV surveillance data to inform decisions on targeting of HIV/AIDS prevention and care interventions, to measure the impact of these interventions, and to support new capabilities for the delivery of care and services.

Increasing Political Commitment: USAID will take the lead in 5 countries and the regional program to implement activities to increase national political commitment towards HIV/AIDS efforts. There will be extensive use of surveillance data in this dialogue, derived from DHHS supported efforts. AIDS Program Strengthening: In 9 countries and 1 regional program, there will be expanded training and support for local NGOs and of government personnel for HIV/AIDS program and service delivery. Surveillance: In all 15 countries and regional programs, DHHS will provide technical assistance and support to improve surveillance programs for HIV, TB and STDs. In addition, new surveillance tools will also be tested and adapted for local application. USAID will also provide funding for activities that will ensure close collaboration with key international partners, such as UNAIDS, WHO and other multilateral and bilateral donors.

Performance Measures and targets will include:

- Increased number of HIV/AIDS/STD/TB information and service delivery points which meet minimum quality standards
- Surveillance plans and survey designs in all focus countries
- Lab capacity for surveillance strengthened
- Training of surveillance managers and key staff in country in at least 8 of the 12 countries.

4. Improving Community and Home Based Care and Treatment:

Currently in Sub-Saharan Africa and India, care and treatment for HIV infected persons and support to their families is minimal. Less than 5% of persons know their HIV status and health care providers do not have ready access to diagnose and treat HIV and the associated opportunistic infections, let alone use of the latest "state of the art" antiviral treatment regimens. Ideally, there should be a continuum between in-patient and community outpatient treatment, combined with psychosocial support services utilizing a wide range of community workers, including traditional healers. Even in the absence of antiretroviral drugs, there is much that can be done to improve the quality and duration of life for HIV infected persons and their families, within the developing country setting. For instance, while the leading killer of AIDS patients in the

developing world is TB, through use of directly observed therapy regimens (DOTS), TB can be cured in HIV infected persons, increasing the both the quality and duration of a person's life.

Care and Treatment: The Initiative seeks to provide medical and social services to HIV infected individuals, including preventive therapy, and early diagnosis and effective treatment of AIDS-related diseases. 10 countries will implement locally appropriate treatment programs for HIV infected persons, linked to voluntary counseling and testing programs. Pilot sites would be established to assess methods to improve TB and respiratory disease care in HIV infected persons and to evaluate the applicability of U.S.-based early intervention care and treatment models in a developing world setting. Home and Community Based Care and Support: 11 countries would institute home and community based care model programs. In addition, indicators for accurately measuring the impact of care services will be developed. USAID will provide support for health provider training, establishing home and community care models, and increasing the involvement of traditional healers. DHHS will focus on developing treatment guidelines, creating training and curriculum materials, increasing the use of DOTS and linking psychosocial support services with improved biomedical interventions.

Expected performance measures and targets include:

- 50 % of local governments will implement care and support activities
- 30 % of primary health facilities will provide quality prevention and treatment (i.e. according to national guidelines) for opportunistic infections
- 10 % of households caring for HIV positive persons will receive help with care from an institution or group outside the family

Management and Monitoring the *LIFE* Initiative:

Because of the expanded number of Federal Agencies involved, the necessity to work collaboratively at country and global level, and the need to link with other critical partners (e.g. UNAIDS, World Bank, EU, donors, etc), a joint management and monitoring *LIFE* Initiative Task Force will be established. This Task Force will be composed of designated focus point persons from each of the relevant Federal agencies. The Task Force will be convened under the auspices of ONAP, with secretariat support provided by USAID.

Additional members will be included as necessary (e.g. UNAIDS representative). The Task Force will meet on a monthly basis over the next year, because of the wide range of issues that must be resolved in a timely way. After one year, meeting schedules can be reviewed.

It is essential that the activities funded through the *LIFE* initiative build on existing resources and programs in order to achieve the maximal coverage and impact. It should be recognized that it is difficult to measure performance, which is attributable to discrete funding sources. Instead, monitoring systems will measure the impact of consolidated programs that have been established in each country.

Next Steps:

COUNTRY LEVEL:

The ultimate success of this initiative will depend on the scale, scope and quality of services delivered in target countries, particularly at the community level. To achieve this, there must be extensive dialogue and collaboration at country level with government, private sector, non-governmental organizations, the faith community and community groups, especially including persons living with HIV/AIDS and their care-givers. Some of the focus countries already have established coordination mechanisms (through the UNAIDS Theme Group, donor coordination groups, the National AIDS Program, etc) These mechanisms will be utilized wherever possible. However, joint country planning teams will also be formed over the next three to six months, in order to work with USAID Missions, HHS and other USG agencies, Host Country Governments, etc, to finalize one to two year workplans, which will include more discrete performance measures. It is necessary to further examine what each bilateral and multilateral donor is planning in the near future and collaborate with local government, non-governmental organizations, PWAs, etc to ensure that the program support responds to priorities and existing gaps.

GLOBAL/ REGIONAL LEVEL:

At global and regional level, multiple partners must be engaged in a collaborative effort to leverage new resources, identify areas for cooperative efforts and areas for complementary programs, and achieve consensus on measurements of performance. A series of "Partnership" meetings should occur over the next three to six months to assure the success of this initiative. Examples of these "Partnership Meetings" are presented in Annex 6

ANNEXES:

1. GLOBAL AIDS TARGETS
2. COUNTRY SELECTION CRITERIA
3. REGIONAL *LIFE* INITIATIVE ACTIVITIES
4. CURRENT USG ACTIVITIES IN TAREGT COUNTIRES AND REGIONS
5. ACTIVITIES SUPPORTED BY THE ***LIFE*** INITIATIVE IN AFRICA AND ASIA IN TARGETED COUNTRIES
6. GLOBAL LEVEL PARTNERSHIP MEETINGS.

ANNEX 1: GLOBAL AIDS TARGETS

UNAIDS, in cooperation with its bi-lateral and multi-lateral partners, has laid out a series of international goals for the next five years as described below. These goals represent the result of the total worldwide contribution of resources and effort. The Administration seeks to further these goals through *LIFE* Initiative.

- ✓ The incidence of HIV infection will be reduced by 25% among 15-24 year olds by 2005. (Currently 2 million young adults are infected each year in sub-Saharan Africa.)

- ✓ At least 75% of HIV infected persons will have access to basic care and support services at the home and community levels, including drugs for common opportunistic infections (TB, pneumonia, and diarrhea). (Currently, less than 1% of HIV infected persons have such access.)

- ✓ Orphans will have access to education and food on an equal basis with their non-orphaned peers.

- ✓ By 2001, domestic and external resources available for HIV/AIDS efforts in Africa will have doubled to $300 million per year. (Currently, approximately $150 million per year is spent on HIV/AIDS prevention in sub-Saharan Africa.)

- ✓ By 2005, 50% of HIV infected pregnant women will have access to interventions to reduce mother-to-child HIV transmission. (Currently, less than 1% of HIV infected pregnant women have access to such services in sub-Saharan Africa.)

ANNEX 2: COUNTRY SELECTION CRITERIA

Country criteria include the following:

1. The magnitude of the epidemic
2. Country receptivity to assistance from US government
3. Country political commitment to fighting the AIDS epidemic
4. Potential for interventions and unique opportunities
5. Potential for impact
6. Potential for leveraging of other local and donor support
7. Existing U.S. Government implementation mechanisms

ANNEX 3: REGIONAL *LIFE* INITIATIVE ACTIVITIES

West Africa Region

The USAID West Africa (Family Health and AIDS) Project provides support to NGOs and communities in several West African nations, including Cameroon, Burkina Faso, Cote D'Ivoire, Togo, as well as other selected countries in the region. DHHS/CDC operates HIV field stations involved in research and technical assistance in Cote d'Ivoire; DHHS/CDC and NIH has presence in Mali and Guinea, as well as a number of other countries. The regional program will expand support for cross border and regional prevention interventions, develop local capacity for AIDS program management, conduct training, increase political commitment for AIDS in the region, mobilize community responses, support programs to assist families and children affected by AIDS, and increase involvement of non-health sectors in anti-AIDS efforts. The program will also expand existing social marketing and behavior change interventions.

Southern Africa Region

The USAID Southern Africa Regional HIV/AIDS effort is supporting HIV/AIDS interventions targeted at cross border population migration (Zimbabwe, Zambia, South Africa), increasing political commitment to fighting AIDS in the region, and bringing together all relevant actors to plan for surveillance activities in the region. DHHS/CDC operates a research station in Botswana (primary TB, with increasing HIV). LIFE Initiative activities will expand regional efforts such as including other target countries in cross border prevention and surveillance efforts, develop multi-sectoral approaches to AIDS efforts, increase political commitment to fighting AIDS, and develop regional training networks for AIDS interventions. A priority is to develop African institutional capacity to respond to the AIDS epidemic.

East Africa Region

USAID provides technical assistance and training for AIDS efforts in the east and southern African regions through its regional office in Nairobi. HHS/CDC operates a research station in Uganda and Kenya (primarily malaria), and other DHHS agencies are active in selected countries. Regional efforts will focus on training and technical assistance for support and local prevention activities.

ANNEX 4: CURRENT USG HIV/AIDS ASSISTANCE IN TARGET COUNTRIES AND REGIONS.

COUNTRY	Primary Prevention							Caring for Children Affected by AIDS*		Home and Community Based Care and Treatment*			Infrastructure and Capacity Development*				
	VCT	SM/ Procurement	BC/ SR	MTCT	Blood Suppl /nosocomial/ OE	STD	Tool Dev.	Support to Affected Children	Comm .Mobilization	OI/TB/ STD	Drug Supply	Home/ Comm.-Based Care	Policy/ advocacy	NGO support	Training and TA	Surveill.	Multi-sectora
Botswana							H			H	H				H	H	U
Cote d'Ivoire		U	U				H	U	U	H				U	U,H	H	
Ethiopia	U	U	U			U	H			U	U	U	U	U	U,H	U	U
Kenya	U	U	U,H	U,H	U,H	U	H	U	U	U		U	U	U	U,H	U,H	U
Malawi	U,H	U	U			U	H	U	U			U	U	U	U,H	U,H	U
Mozambique	U	U	U			U								U	U	U	
Nigeria		U	U					U	U	U		U	U	U	U	U	U
Rwanda		U	U			U		U	U	U				U	U,H	U,H	
Senegal			U				H	U	U				U	U	U,H	U	U
South Africa	U	U	H	U		U,H	H	U	U	U,H			U	U	U,H	H	U,H
Tanzania	U	U	U		U,H	U	H					U	U,H	U	U,H	H	
Uganda	U,H	U	U	U,H		U	H	U	U	U,H	H	U,H	U	U	H	H	
Zambia	U,H	U	U			U	H	U	U	U	U	U	U,H	U	U,H	U,H	
Zimbabwe	U,H	U	U				H	U	U				U,H	U	U,H	H	U
India	U	U	U			U	H	U	U	H		U	U	U,H	U,H	U,H	U
REGIONAL																	
WAFR/ SAFR/EAFR	(U)	U	(U)					U					U	U	U	(U)(H)	
HEAD-QUARTERS																	
AID/W			U	U				U		U	U	U			U		U

Notes: * = Indicates additional HHS agency involvement (e.g. HRSA, ACF, etc) that may not be reflected on the table
( ) = indicates additional linkage between USAID regional program and Botswana and Cote D'Ivoire HHS activities
VCT = voluntary counseling and testing; SM = social marketing; BC = behavior change; SR = stigma reduction; MTCT = mother-to-child transmission; STD= sexually transmitted disease; OI = opportunistic infections; TB= tuberculosis; NS = nosocomial infection control; OE = occupational exposure reduction
U = USAID H = HHS