



Action Plans for HIV/AIDS Prevention and Impact Mitigation

Africa Bureau/SD
20 April 2006



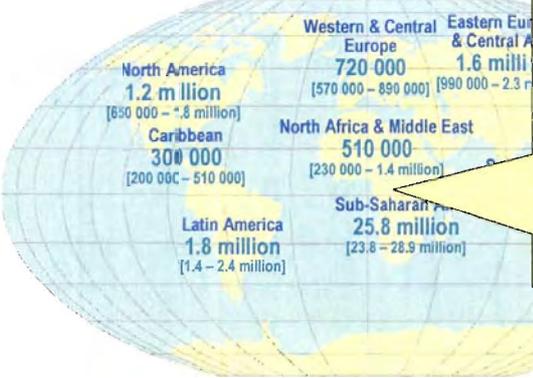

HIV/AIDS

Strategic Planning Presentation
AFR/SD
20 April 2006



Current Situation 

Adults and children estimated to be living with HIV as of end 2005



Region	Estimated HIV Cases (Millions)
North America	1.2 million
Caribbean	300,000
Latin America	1.8 million
Western & Central Europe	720,000
North Africa & Middle East	510,000
Eastern Europe & Central Asia	1.6 million
Sub-Saharan Africa	25.8 million
Total	40.3 (36.7 – 45.3) million

- Africa still faces an unprecedented AIDS crisis.
- In Africa - over 3 million new infection in 2005 - 64% of all new infections globally.
- In Africa - more new infections than in any previous year

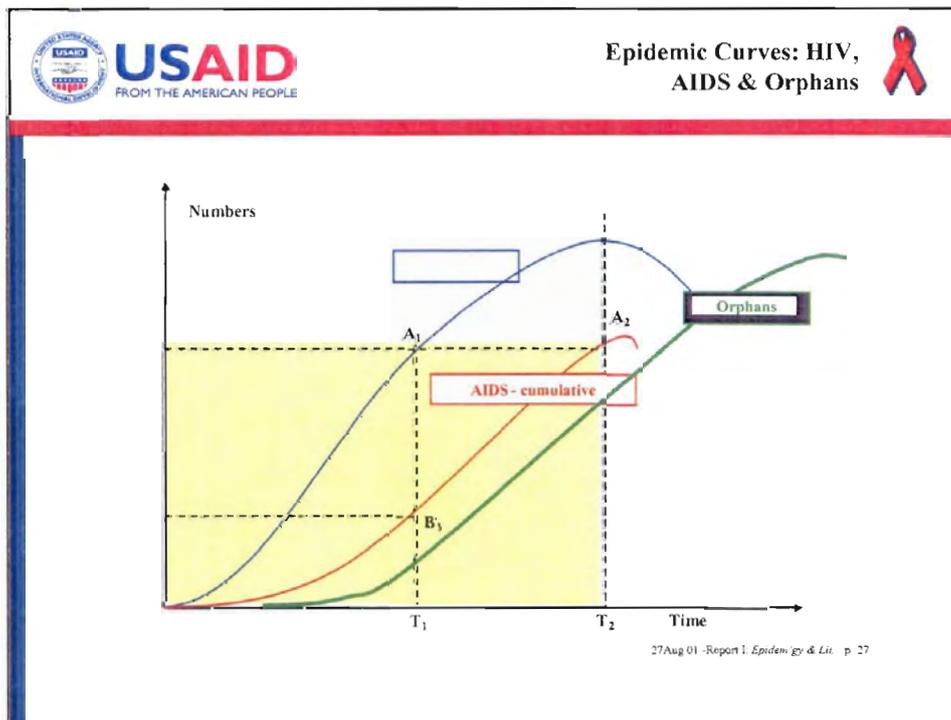
Source: UNAIDS 2005

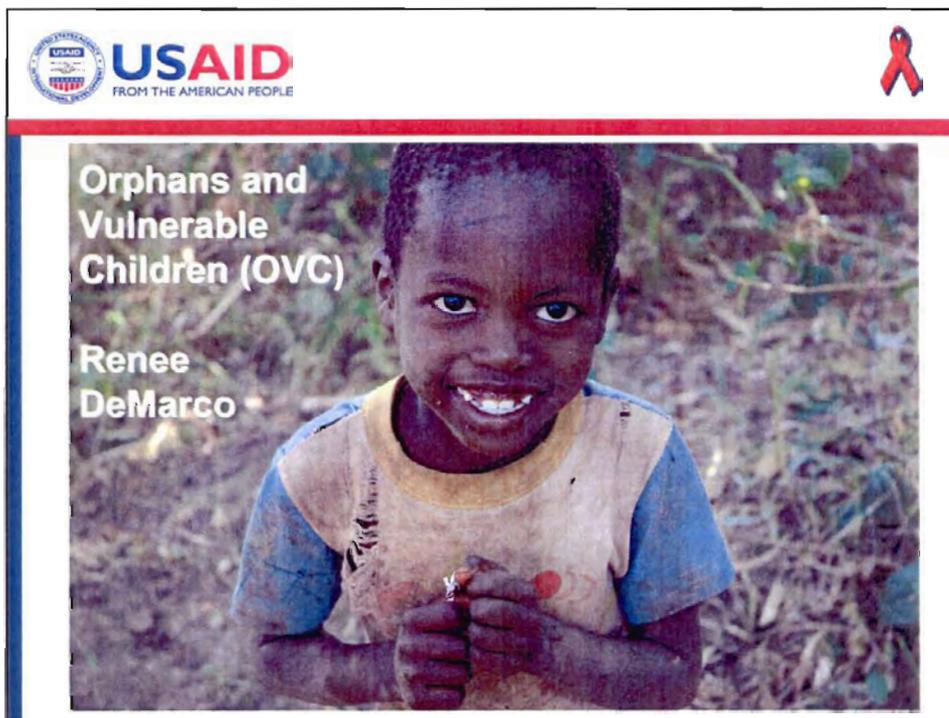
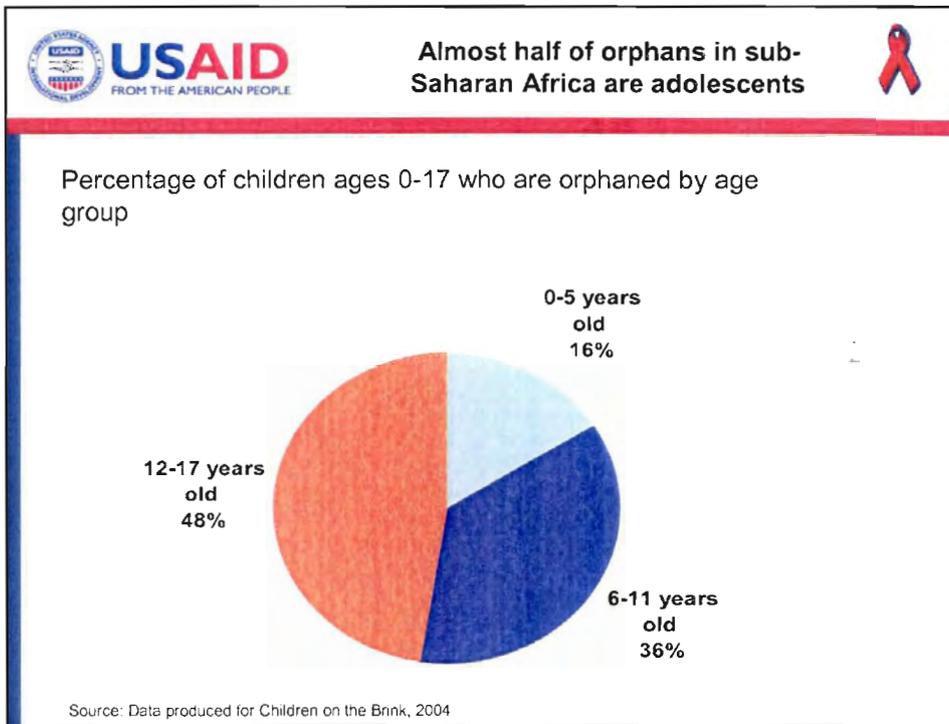
Current Situation 

HIV/AIDS: Sub-Saharan Africa	Total	Sub-Saharan Africa	Percentage
Adults & Children estimated to be living with HIV/AIDS as of end 2005	40.3 million	25.8 million	64%
Estimated number of adults and children newly infected with HIV during 2005	4.9 million	3.2 million	65.3%
Estimated adult and child deaths from HIV/AIDS during 2005	3.1 million	2.3 million	74.2%
Children (<15 yrs) estimated to be living with HIV/AIDS as of end 2005	2.3 million	2.1 million	91.3%
Estimated deaths in children (<15 yrs) from HIV/AIDS during 2005	570 000	520 000	91.2%
Estimated number of children (<15 Yrs) newly infected with HIV during 2005	700 000	630 000	90%

Source: UNAIDS 2005



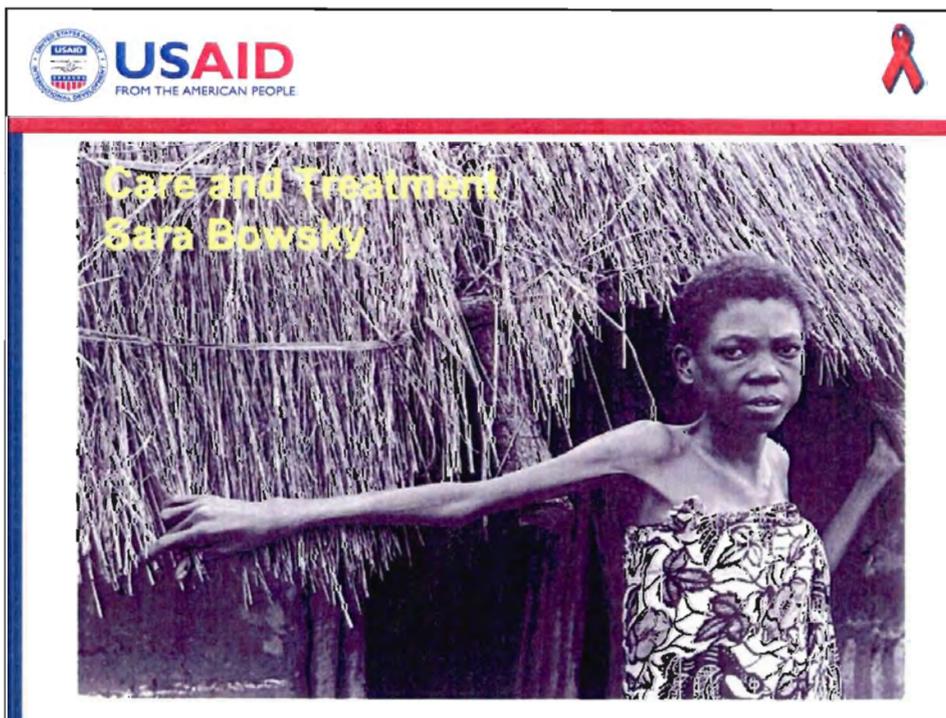






Children in need of treatment:
UNICEF/UNAIDS 2005 Child Estimates; Boerma et al WHO Bulletin 2006

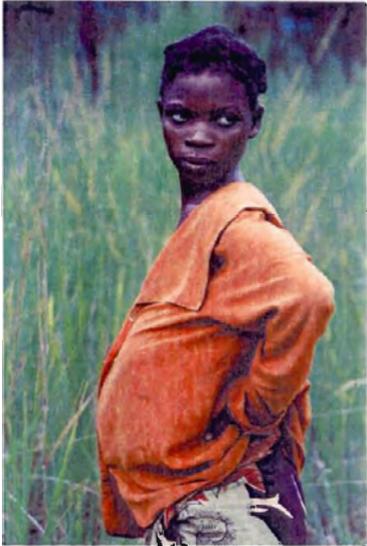
2005 estimates	Child (0-14 years) deaths due to AIDS	Children (0-14 years) in need of ART	Children (0-18 months) in need of ART	Children (0-14 years) in need of cotrimoxazole - diagnosis at 18 months	Children (0-14 years) in need of cotrimoxazole - diagnosis before 18 months
Global	410,000	660,000	270,000	4,000,000	2,100,000
Caribbean	3,100	5,100	1,800	29,000	15,000
East Asia	1,500	1,900	1,700	17,000	7,600
Eastern Europe & Central Asia	1,100	1,600	1,100	18,000	6,200
Latin America	6,000	8,600	400	70,000	35,000
North Africa & Middle East	5,300	7,800	4,400	59,000	18,000
Oceania	<500	<500	<500	2,000	<1000
South & South East Asia	26,000	37,000	21,000	290,000	130,000
Sub-Saharan Africa	370,000	600,000	240,000	3,500,000	1,900,000
PEPFAR countries	250,000	410,000	200,000	2,400,000	1,300,000
Asia	28,000	39,000	23,000	310,000	140,000
Latin America & Caribbean	9,200	14,000	5,800	100,000	50,000



 **USAID**
FROM THE AMERICAN PEOPLE



Prevention
Stella Goings



 **USAID**
FROM THE AMERICAN PEOPLE

Presentation Plan 

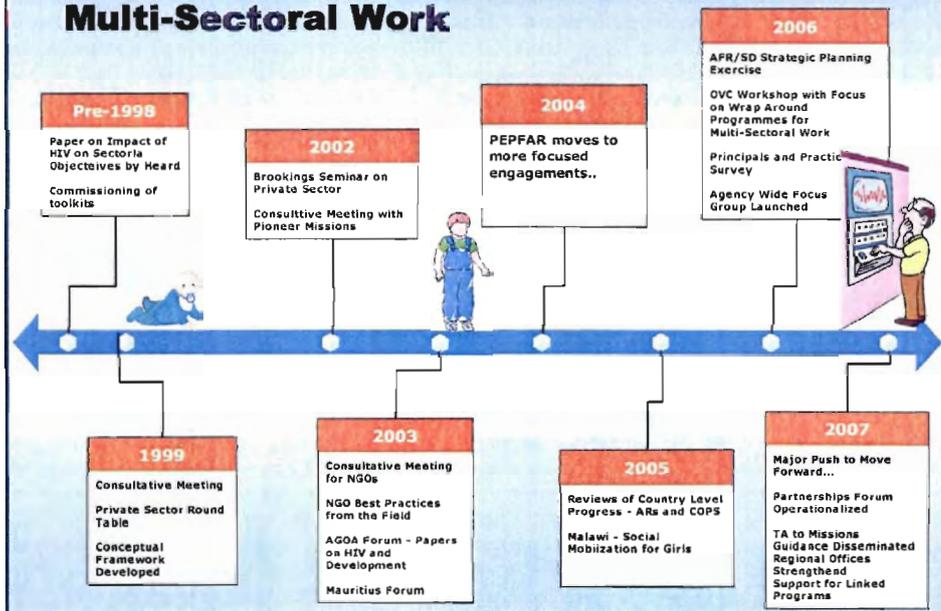
- Brief Overview
- Strategic Plans
 - Multi-sectoral Programs Stella Goings
 - Orphans and Vulnerable Children (OVC) Renee DeMarco
 - Care and Treatment Sara Bowsky
 - Prevention Stella Goings
 - Nutrition and AIDS (Presented) Ellen Piwoz
- Discussion



AFR/SD Multi-Sectoral Interventions to Mitigate the Impact of HIV/AIDS

Proposed Action Plan
20 April 2006

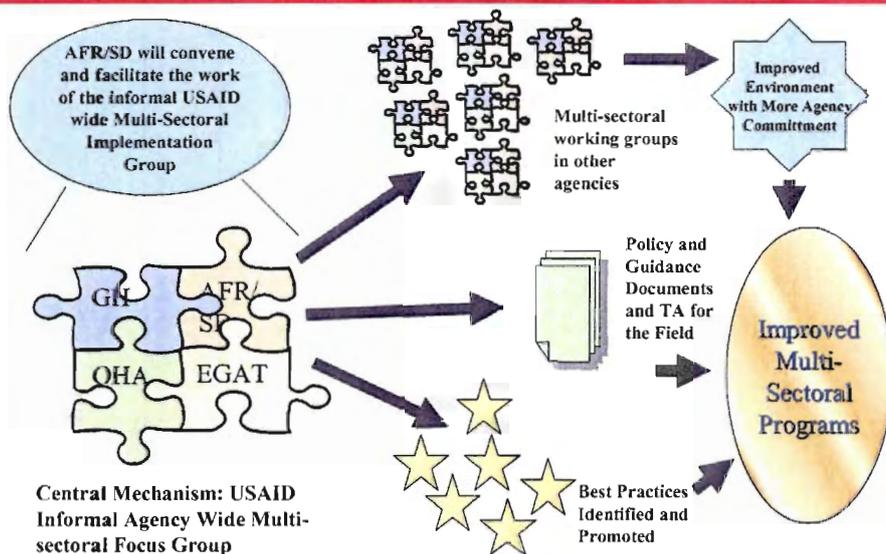
A Brief History of AFR Engagements in Multi-Sectoral Work



Challenges and Obstacles that must be overcome

- Country and US Based Teams lack the **capacity** to plan and implement Multi-sectoral Programs
 - Requires extra-effort and a willingness to share resources and to plan and implement together
- The Operational **Environment** is often a major obstacle
 - e.g. USAID is the only agency on the core team with an organizational mandate for OVC work
 - Funding Guidance often ambiguous
- **Best Practices** are difficult to find and explain
 - Often unclear “why” a multi-sectoral approach is working
 - Assessments rarely examine and document effects of synergy
- Limited Resources for **Scale-up and Replication**

Our Proposed Approach and Results





Issues Ripe for Partnerships

Agriculture and Food Security	Impact of HIV/AIDS on Agricultural Labor Force, productivity and crop selections. Household Food Insecurity and vulnerability Exploitation of Wildlife and Natural Resources.
Education	Child drop outs from school. Loss of Teachers. Erosion of quality of Education. Increased risk to girl child in school environment
Economic Growth and Labor	Loss of workers in most productive years. Loss of skills and know-how. Disruption of workforce and organizations. "Brain Drain". Reduced foreign investment. Decline in GDP. Loss of job slots. Opportunities for public private partnerships.
Health	Loss of Doctors. Overtaxing of health services. Inadequate facilities and staff. Increased per capita cost of health care. Increased cost of drugs.
Democracy and Governance	Loss of trained manpower for social services (Military, Police, Breakdown in Family structure. Increased orphans, street children.
Communication & Social Mobilization	Need for better understanding of social dynamics driving the epidemic and effective schemes for social mobilization and communication of key disease control and prevention messages



Selected Examples

- **Agriculture in High Prevalence Areas**
 - Review best practices in agricultural production and marketing (USAID/AG, Land O'Lakes, NGOs)
 - Monitor impact of HIV/AIDS on crop choices and household food security (US AG, FAO, WFP)
- **Health**
 - Explore alternatives cost sharing options to reduce out of pocket expenses by families with HIV/AIDS (ie. Cooperatives, health savings accounts, NGO community support, cash transfers) (UNICEF, UNDP, NGO)
- **Economic Development**
 - Review lessons learned from social safety net programs with cash transfer components
 - Review lessons learned from "Corridor" projects. (REDSO, WARP, NGOs)

Five Focus Countries shared with Repro. Health

- Fragile States
 - Liberia
 - Burundi
- Transitional Development States
 - Lesotho
 - Tanzania
 - Uganda



Year 1 Budget = \$135,000

Result 1: Missions provides with guidance, best practices, models and other tools to strengthen multi-sectoral programs

- Output/Outcome: Strengthened Mission Level Capacity to plan and implement multi-sectoral programs
 - Focus:
 - Disseminate Policy Guidance
 - Provide stronger feedback on COPS and ARs
 - Supportive Documents from USAID and other Agencies
 - Quarterly Examples sent to Field
 - TA to five countries (Tanzania, Lesotho, Uganda, Burundi and Liberia)
 - Gap Addressed
 - Missions are uncertain about ways to do multi-sectoral programs
 - Provides examples of “Best Practices”
 - Links
 - USAID Informal Multi-sectoral Working Groups
 - OGAC, OHA, WARP, REDSO



Details of Expected Results

Result 2: Focus Group Operationalized and support provided for Network Activities with CAs, NGO, FBOs, etc

- Output/Outcome: Critical mass of technical staff and program managers engaged in focus activities on multi-sectoral programs
 - Focus:
 - USAID Informal Agency Wide Working Group
 - Organizational “Champions” identified and supported
 - Shared Framework for Multi-Sectoral Programs Developed
 - Other Agencies assisted to develop and disseminate guidance on Multi-sectoral programs
 - Gap Addressed
 - Other agencies often unclear about support for multi-sectoral activities
 - Environment becomes more permissive when others share goal of Multi-sectoral engagements
 - Links
 - USAID Informal Multi-sectoral Working Groups
 - OGAC, OHA, WARP, REDSO



Details of Expected Results

Result 3: Innovative, Effective Best Practices Documented and Disseminated

- Output/Outcome: Compendium of Best Practices in Multi-Sectoral Programming and Data Base of Programs
 - Focus:
 - Identification and Analysis of good examples of multi-sectoral engagement
 - Knowledge base created on efficient, effective multi-sectoral initiatives
 - Gap Addressed
 - Improved access to information about multi-sectoral programs
 - Improved knowledge about what works, what does not work and why.
 - Data compiled to facilitate comparative assessments of program costs and benefits in multi-sectoral strategy.
 - Links
 - USAID Informal Multi-sectoral Working Groups
 - OGAC, OHA, WARP, REDSO



Details of Expected Results

Result 4: Scale up and Replication of Best Practices in Multi-Sectoral Programs.

- Output/Outcome: Scales up activities in multiple sectors in five focus countries with good documentation
 - Focus:
 - USAID Missions encouraged and supported to use multi-sectoral programs
 - Funds provided/leveraged for partnerships applicable in Fragile and TD Countries
 - Gap Addressed
 - Inadequate start-up funding.
 - Lack of Support System for those wishing to move to multi-sector approaches.
 - Lack of documented efficiency, effectiveness and cost benefit of multi-sector approaches
 - Links
 - USAID Informal Multi-sectoral Working Groups
 - OGAC, OHA, WARP, REDSO



Challenges to be Overcome

- Success will depend on ability of AFR/SD to provide seed money and support to partners
 - Ultimate objective is to leverage partner funds into activities... but start up may depend heavily on funds from AFR Bureau
- Proposed Mechanisms are very labor and participant intensive
 - Dependent on rapid identification of dedicated staff in partner offices/agencies who are willing to invest effort.
- Multi-sectoral activities require commitment of all parties. (eg. Only USAID has a mandate to support work for OVC... other partners need to address the level of their own institutional commitment and move to match USAID's investment)
- Working Group must compliment (not compete with) the work of TWGs in key program areas.



Strategic Team Members

Those who contributed ideas to this plan.

- AFR/SD: Hope Sukin, Ishrat Husain, Stella Goings, Tye Ferrell, Joe Kitts
- Africa's Health in 2010: Justin Opuku

Multi-sector Programs Action Plan Narrative

Background

In August, 2005 USAID published a pivotal document that makes clear the agency's commitment and support for "Multi-Sectoral" strategies to address the complex social, political, economic, and human tragedy of the HIV AIDS pandemic¹. The "Policy Guidance" added a new dimension to the President's Emergency Plan for AIDS Relief (PEPFAR) -- -- announced by President George W. Bush in his 2003 State of the Union address. With the launching of PEPFAR, the US government catapulted into a leadership role in the global war against AIDS. In many countries, the USAID assume the responsibilities of lead implementing agency.

In an environment with multiple donors jockeying for position and prominence as well as a leadership roles in global initiatives, USAID's strong endorsement of multi-sectoral strategies and partnerships across areas of expertise and territory demonstrated both vision and a willingness to absorb the risks that often accompany innovation. The work proposed in this plan follow-up and builds on the considerable range of activities fostering multi-sectoral approaches that have been spearheaded in recent years by other staff in the Africa Bureau. The HIV/AIDS team has been able to build on the strong foundations laid with collaborators from EGAT, OHA, DG and field offices. In particular we are indebted to Ishrat Husain (USAID/ADR/SD) for her vision, dedication and tireless work. Without her focus the Guidance Document might not have been completed and many strong and supportive partnerships – all endorsing multi-sectoral approaches – might not have been formed.

The strategic principle underlying multi-sectoral programming is that:

- all sectors are affected by the HIV AIDS epidemic,
- all sectors can benefit from a better understanding of how HIV-AIDS affects performance,
- interventions and strategies to mitigate the impact of HIV-AIDS need to comprehensively address the multiplicity of consequences to families and individuals infected and/or affected by the disease, and
- efforts are apt to be more effective and efficient if planning and implementation is done together.

When HIV-AIDS enters a household, it does more than cause illness in an individual. Everyone in the household is eventually affected. Long periods of illness, generally affecting people in the prime of their lives when families depend on them as breadwinners, can have wide reaching affects. Illnesses frequently lead to death and the loss of income for the household. When dependent children are left behind, orphans

¹ Policy Guidance. Mitigating the Development Impacts of HIV/AIDS. U.S. Agency for International Development

suffer physically and emotionally. The economic consequences can be devastating – and often begin to extract a toll long before an AIDS sufferer dies. Children wind up on the street because attending school becomes less of a priority for families without access to adequate food. Surviving spouses, and occasionally orphaned children, resort to high risk activities in an effort to provide for themselves and their households. Businesses lose trained and productive workers. In agricultural communities, cropping patterns may change as ill persons and surviving family members moved to farming less labor intensive crops. Indeed, in South Africa, studies have shown that HIV-AIDS is contributing to a decline of between 1% to 3% of GDP annually. The list of consequences of HIV/AIDS is very long. Indeed, many lengthy books, monographs and scholarly papers have been written on the topic. And, yet, as we near the end of 25 years with the HIV pandemic – new observations are made (almost weekly) on the scale, scope and interconnected list of consequences.

Clearly, better understanding the complex interactions that characterize the impact of HIV has to be a priority if we hope to accelerate interventions that can mitigate that impact. The AFR/SD multi-sectoral action plan details steps to be taken over the next three years to build country level capacity, and headquarters in level commitment to multi-sectoral planning and programming..

Strategic Topics:

1. **Build capacity** of USAID Country teams to undertake multi-sectoral programs to mitigate the impact of HIV/AIDS.
2. **Strengthen operational environment** to support multi-sector approaches
3. **Analyze the impact** of innovative multi-sectoral approaches to identify best practices and extract lessons learned.
4. Promote **Scale-Up and Replication** of successful multi-sectoral approaches

A. BUILD CAPACITY OF USAID COUNTRY TEAMS TO UNDERTAKE MULTI-SECTORAL PROGRAMS TO MITIGATE THE IMPACT OF HIV/AIDS

Rationale

When PEPFAR was launched, so too was a new paradigm for development assistance. Historically, US assistance to countries was coordinated through a primary implementing agency and its cooperating partners. In any country, there might be a dozen or so primary agencies all seeking to address aspects of the HIV-AIDS epidemic. Each contributed its unique perspectives, skills, and programming approach. USAID was often one such primary implementing agency with many others working in overlapping areas.

Often, USAID officers found themselves designing and working on programs that were strikingly similar to those being designed and developed under the auspices of the US national Centers for Disease Control, or the US Department of Health and Human Services, or the U.S. Army, etc. While there was never a lack of good will, good

intentions, and hard work, the reality was that coordination efforts often fell short. Redundancies and duplicative activities occurred, and with these came waste. Perhaps most damaging of all was the impression shared by recipient government, donor partners, beneficiaries and NGO counterparts, that US efforts could have produced significantly better results if only the various branches of the US government could find a way to communicate, set aside their concern about territories, and work together. Given the size and scale of the HIV-AIDS epidemic, it is little wonder that expressions of "Thanks" sent by the grateful recipients of US government assistance also, regularly, included expressions of concern about the lack of harmonization and alignment and an expressed desire to see the US organize its work more efficiently.

PEPFAR changed all that. US partners were asked to work within the administrative umbrella of "country teams" designed to facilitate coordination and promote collaboration. Each core team is strategically linked to a Washington-based team -- -- each with representation from the various arms of the US government working on AIDS or AIDS-related projects. Assisted by technical working group's, PEPFAR has dramatically improved levels of coordinated planning and implementation. Waste and redundancy have been virtually eliminated -- and the process of joint decision-making has facilitated the very rapid scale up of interventions aimed at improving access by HIV sufferers to quality treatment and reducing the risks to those who are still HIV negative.

The rapid change in modus operandi made it necessary for country teams and technical experts to become much more familiar with the work being done by others and of the approaches, strategies, and procedures that differ from those pursued within their own agencies. All this has set the stage for effective multi-sectoral programming. For example, in the past, health and population officers might spend months working in the same community with agriculture officers -- but each might be totally unaware of the working styles, priorities, and program objectives of the other. This lack of awareness is now recognized as a key factor contributing to missed opportunities. Opportunities to work together, to mutually reinforce and experience synergy in working together were too often lost. With PEPFAR, strong mechanisms exist to facilitate a sharing of information at country level and the backstopping processes for each country team virtually assure that programs are better harmonized and aligned.

It follows that the first and most critical undertaking by the team working to promote multi-sectoral activities will be strengthening the capacity of colleagues working in country teams to recognize opportunities for fruitful multi-sectoral collaboration and to be comfortable and confident about the steps needed to forge strong and effective working relationships. Building the capacity of USAID staff will be a critical step in a process that will ultimately strengthen the capacity of all officers, regardless of US government affiliation.

Strategic Objective:

Commitment and capacity of USAID Country teams to develop, coordinate and implement multi-sectoral programming approaches for the mitigation of the impact of HIV/AIDS strengthened.

Intermediate Results:

Greater use of multi-sectoral approaches in HIV/AIDS portfolios of PEPFAR focus countries

Expected Results:

1. USAID Mission have ready access to USAID's policy on multi-sectoral approaches and clear guidance on how to plan and implement multi-sectoral projects/programs.
2. AFR/SD has mapped and analyzed existing efforts at multi-sectoral program development. Obstacles and country level concerns identified.
3. Focused TA provided to five missions expressing a desire to apply multi-sectoral strategies in their HIV/AIDS portfolio.

Specific Indicators

- Number of guidance and technical implementation guidance documents printed and distributed
- Analysis of mission use of multi-sectoral approaches, constraints and concerns completed.
- Number of multi-sectoral projects/programs supported by PEPFAR country offices.
- Number of "models of excellence in multi-sectoral programming" identified.

Proposed Actions

1. Existing “*Policy Guidance on Mitigating The Development Impacts of HIV/AIDS*” made available to all AFR PEPFAR focus countries.
2. Information about current utilization of multi-sector strategies and approaches, potential obstacles and mission concerns extracted from COPS, Strategy Statements and Annual Reports. Five countries identified for focused TA.
3. Development of supportive document on techniques for applying the Policy Guidance. This practical document should include examples and guidelines for “mapping” potential multi-sector partners, planning and funding multi-sectoral approaches. It will be prepared and distributed to country offices.
4. Quarterly publication of information on progress and outstanding examples of innovation in existing USAID field updates.
5. TA to five countries seeking to expand or strengthen existing multi-sectoral approaches and/or proposing new innovative multi-sectoral programs or projects.

Proposed Countries

- Tanzania
- Lesotho
- Burundi
- Liberia
- Uganda

B. STRENGTHEN OPERATIONAL ENVIRONMENT TO SUPPORT MULTI-SECTOR APPROACHES

Rationale

For partnerships to be optimally effective, both partners must be fully committed to an undertaking and empowered to make decisions that will promote and support joint activities. As the US response to the HIV-AIDS pandemic has matured, so to as the experience and perspectives of implementing agencies. In some instances, leadership roles have emerged. In others, supportive relationships have blossomed.

For multisectoral planning and programming to work well, each of the agencies proposing to take on a role in a jointly planned and executed program will need to have project officers fully committed to the endeavor and who can be certain that their headquarters agencies are equally committed. For example, when the issue of orphans (OVC) is raised with country teams, USAID is acknowledged as the partner with the broadest range of technical capacity and experience. USAID is generally asked to assume a leadership role. USAID is also, currently, the only US government agency with a mandate to support OVC programs and funds to support that mandate. As a result, partners seeing opportunities for multi-sectoral collaboration, often have the expectation

that USAID will underwrite the joint venture. Even if the partnership focuses primarily on democracy, governance, education, or agriculture. This is occasionally a dis-incentive for USAID officers. And potential partners may feel disempowered when they are uncertain of the willingness of their agencies to invest in an area where they may have no organizational mandate.

Multi-sectoral planning and programming will be greatly facilitated if all agencies have expressed a shared commitment to working together. And if that commitment is backed up by clear guidance, removal of financial and programmatic obstacles, and a willingness to support creative and innovative approaches – the task becomes even easier. Because the environment is more permissive.

Accordingly, these proposed activities will seek to promote the establishment of a multi-sector working groups within other US government agencies and will ensure the coordination of the US Informal Agency Wide Group with these other groups. A shared objective will be the production of agency specific guidance promoting shared concepts and approaches to multi-sectoral programming to be sent from headquarters offices of all willing agencies to their representatives in the field. Ultimately, this will send a clear signal to field officers of their headquarters willingness and desire to promote and support multi-sectoral undertakings. Project officers should find that this facilitates dialogue and accelerates multi-sectoral planning and implementation at the field level.

Strategic Objective:

Willingness of key partners to participate in and fund multi-sectoral approaches for the mitigation of HIV/AIDS improved.

Intermediate Results

Strategic networks and information sharing mechanisms required to support multi-sector program development strengthened.

Expected Results

1. Field Staff of other agencies/organizations actively encouraged to participate in and co-fund multi-sector programs by their management and oversight offices.
2. Harmonization of approach to multi-sector programming, guidance to the field and performance indicators with potential partners for multi-sector programs.

Specific Indicators

- Number of Information sharing events with USAID/AFR participation
- Number of Joint missions or TA activities focused on multi-sector programs
- Number of advisory and/or guidance messages sent to field counterparts by potential partners in multi-sector programs that can be linked to interest raising activities of AFR/SD

Proposed Actions

1. Engage with and strengthen information sharing mechanism/networks with organizations/agencies identified as potential partners in multi-sector programming

2. Support joint TA for missions seeking to establish or strengthen multi-sector programs
3. Encourage and facilitate sharing of updates and current information on multi-sector activities with partner offices/agencies/organizations by USAID AFR field staff visiting or on TDY in Washington.

Proposed Countries

- Tanzania
- Lesotho
- Burundi
- Liberia
- Uganda

C. ANALYZE THE IMPACT OF INNOVATIVE MULTI-SECTORAL APPROACHES TO IDENTIFY BEST PRACTICES AND EXTRACT LESSONS LEARNED

Rationale

Initiatives in multi-sectoral programming have been underway, with USAID support, since the mid-19 90s. While they are mentioned peripherally in annual reports and work plans, the details of these initiatives are often vague. Indeed, one of the most important gaps identified by the multi-sectoral planning group was the absence of a database on multi-sectoral initiatives, or documentation which allows for comparison of various approaches and the identification of lessons learned and best practices. Accordingly, a major undertaking through this work plan will be a compilation of existing reports and experience in multisectoral programs and analysis of the experience with multisectoral activities in the five selected focus countries.

Another major activity will be the completion of an ongoing analysis of "Principles and Practices" of programming at USAID. This study is already underway and is expected to provide important insights into the steps being taken by project managers who are successfully employing multisectoral approaches to address complex issues. The study will also provide greater understanding of the obstacles and constraints which keep program officers from making greater use of multisectoral approaches.

Strategic Objective:

Effectiveness, efficiency, impact and USAID experience with multi-sector approaches for the mitigation of HIV/AIDS clearly documented

Specific Indicators

- Number of studies examining cost-effectiveness and efficiency of multi-sector approaches.
- Number of studies examining impact of multi-sector approaches
- "Principals and Practices" Completed

Proposed Actions

1. Conduct studies of multi-sector experience in 5 five selected countries (Tanzania, Lesotho, Uganda, Burundi and Liberia) countries
2. Establish data base of innovative and best practices in multi-sectoral programs based on collaborative/joint framework criteria. Disseminate on a quarterly basis.
3. Complete work on "Principals and Practices" study to examine issue and obstacles to mutli-sectoral planning and programing for OVC by staff working in the Africa Bureau

Proposed Countries

- Tanzania
- Lesotho
- Burundi
- Liberia
- Uganda

D. SUPPORT SCALE-UP AND REPLICATION OF SUCCESSFUL MULTI-SECTORAL APPROACHES

Strategic Objective:

Successful (demonstrated cost-effective impact) pilot projects of multi-sector approaches fully funded, accelerated and operating at scale in PEPFAR Countries.

Intermediate Results

Successful pilot projects identified by country offices for funding at scale

Expected Results

1. Increased use of multi-sector approaches by country teams
2. Increased funding available and/or earmarked for multi-sector strategic approaches

Specific Indicators

- Number of PEPFAR focus countries with multi-sector approaches to programs featured prominently in COPs, Strategic Plans and Programme Reviews
- % of PEPFAR funding expended is multi-sector (joint, collaborative or wrap around) programs.
- % of AFR program support budget expended to support multi-sector

Proposed Actions

4. 4.1.USAID Missions and Multi-sector partners encouraged and supported to expand pilot multi-sectoral approaches.

5. 4.2. Successful model project that are candidates for scale up identified in five selected countries (Tanzania, Lesotho, Uganda, Burundi and Liberia) countries. Grants to partners and resources leveraged to provide support.
6. 4.3. Reports on Scale up activities, challenges and successes produced and disseminated. Include success in leveraging inputs.
7. 4.4. Study to document link between scale up of multi-sector activities and outcome/impact acceleration in HIV/AIDS activities

Proposed Countries

- Tanzania
- Lesotho
- Burundi
- Liberia
- Uganda

Results and Activities	Illustrative Budget	Key Outputs	Implementation Mechanism	Potential Partners	Notes (e.g. cross reference)
STRATEGIC AREA: MULTI-SECTORAL PROGRAMES TO MITIGATE IMPACT OF HIV/AIDS - (3 Year Summary)					
Expected Result 1: Guidance to USAID Missions on how to effectively engage in multi-sectoral approaches in HIV/AIDS portfolios for fragile and transformational development countries provided.					
1. Activities or Actions					
1.1. Re-print and distribute existing "Policy Guidance on Mitigating The Development Impacts of HIV/AIDS" to all countries.	\$50,000	Number of guidance and technical implementation documents printed and distributed	Policy II Project		
1.2. Extract Information about current utilization of multi-sector strategies and approaches, potential obstacles and mission concerns from COPS, Strategy Statements and Annual Reports.	\$5,000	Analysis of USAID Missions use of multi-sectoral approaches, constraints and concerns completed	AFRICA 2010	WARP and REDSO, EGAT, AFR/SD, OHA, GH	
1.3. Convene USAID agency-wide focus team (EGAT, GH, Regional Bureaus, etc.) to share views of collaborate on USAID support for multi-sectoral program implementation.	\$3,000	Number of meetings of USAID agency wide focus team on multi-sector collaboration	AFRICA 2010	WARP and REDSO, EGAT, AFR/SD, OHA, GH	
1.4. Collaborate with USAID agency-wide focus group to develop a supportive document on techniques for applying the Policy Guidance. This practical document should include examples and guidelines for "mapping" potential multi-sector partners, identifying op	\$35,000	Guidance document developed	FUTURES AFRICA 2010	Futures Group and USAID agency-wide focus group on multi-sectoral programming	
1.5. Distribute information on progress and outstanding examples of innovation in existing quarterly USAID field updates.	\$15,000	Quarterly information and update note shared with USAID Country Teams	AFRICA 2010	AFR/SD, OHA, GH, EGAT	
1.6. Provide TA to five countries (Tanzania, Lesotho, Uganda, Burundi and Liberia) seeking to expand or strengthen existing multi-sectoral approaches and/or proposing new innovative multi-sectoral programs or projects	\$350,000	TA provided	AFRICA 2010, BASICS, CAPACITY	WARP and REDSO, EGAT, AFR/SD, OHA, GH	
Expected Result 2: USAID agency wide focus group, strategic network of CAs, NGOs, other agencies, organizations and information sharing mechanisms required to support multi-sector program development engaged and strengthened					
2. Activities or Actions					
2.1. Work with USAID agency-wide focus group on multi-sectoral programs to identify and link with potential organizational partners (other agencies/organizations, NGOs, CAs, FBOs, etc) to create and strengthen mechanisms/networks for information sharing.	\$130,000	Number of potential partners identified and engaged in dialogue with AFR on participation in multi-sectoral approached	AFRICA 2010	WARP and REDSO, EGAT, AFR/SD, OHA, GH	
2.2. Identify organizational "champions" for multi-sectoral approaches in programming	\$1,000	List of "Champions" developed	AFRICA 2010	TBD	
2.3. Support establishment of shared framework for identifying elements of success, tracking experiences with multi-sectoral programs and identifying and extracting key lessons learned and best practices.	\$30,000	Number of TA missions undertaken jointly with partners seeking or working on multi-sectoral programs/projects	AFRICA 2010, FUTURES, LINKAGES	WARP and REDSO, EGAT, AFR/SD, OHA, GH	
2.4. Encourage and facilitate sharing of updates and current information on multi-sector activities with partner offices/agencies/organizations by USAID AFR field staff visiting or on TDY in Washington.		Number of official visits, presentations or exchanges on multi-sectoral approaches with Field staff on TDY to Washington	AFRICA 2010	FUTURES, LINKAGES	
2.5. Encourage and facilitate the use of common guidance documents and technical updates for the field by partners working on multi-sectoral programs (i.e., Use of common guidance by Peace Corp, CDC, and USAID for multi-sector approaches).		Number of shared/joint guidance and update documents sent to field offices by partner organizations working with USAID on multi-sectoral programs	AFRICA 2010, FUTURES, LINKAGES	Futures Group and USAID agency-wide focus group on multi-sectoral programming	

Results and Activities	Illustrative Budget	Key Outputs	Implementation Mechanism	Potential Partners	Notes (e.g. cross reference)
Expected Result 3: Examples of innovative, effective multi-sectoral programs documented. Best practices identified, lessons extracted, shared and applied.					
3. Activities/Actions					
3.1. Conduct studies of multi-sector experience in 5 five selected countries (Tanzania, Lesotho, Uganda, Burundi and Liberia) countries	\$200,000	Number of studies on multi-sectoral approaches conducted in five selected countries (Tanzania, Lesotho, Uganda, Burundi and Liberia) countries.	AFRICA 2010	WARP and REDSO, EGAT, AFR/SD, OHA, GH	
3.2. Establish data base of innovative and best practices in multi-sectoral programs based on collaborative/joint framework criteria. Disseminate on a quarterly basis.	\$25,000	Data base established Number of dissemination activities to share data base	AFRICA 2010	Futures Group and USAID agency-wide focus group on multi-sectoral programming	
3.3 Complete work on "Principals and Practices" study to examine issue and obstacles to multi-sectoral planning and programing for OVC by staff working in the Africa Bureau		Principals and Practices study results disseminated and used to propose strategic approaches to strengthen multi-sector approaches to problems			
Expected Result 4: Scale up and replication of best practices of multi-sectoral programs with fully funding in Transformational Development (TD) and fragile states.					
4. Activities or Actions					
4.1. USAID Missions and Multi-sector partners encouraged and supported to expand pilot multi-sectoral approaches.	\$30,000	a) Number of selected countries (Tanzania, Lesotho, Uganda, Burundi and Liberia) with multi-sector approaches to programs featured prominently in COPs, Strategic Plans and Programme Reviews	AFRICA 2010, BASICS, FUTURES, LINKAGES and CAPACITY	WARP and REDSO, EGAT, AFR/SD, OHA, GH	
4.2. Successful model project that are candidates for scale up identified in five selected countries (Tanzania, Lesotho, Uganda, Burundi and Liberia) countries. Grants to partners and resources leveraged to provide support.		a) Pilot projects for scale up identified b) % of AFR program support budget expended to support multi-sector initiatives c) % of five selected countries (Tanzania, Lesotho, Uganda, Burundi and Liberia) funding expended on multi-sector (Joint, collaborati	AFRICA 2010, BASICS, FUTURES, LINKAGES and CAPACITY	WARP and REDSO, EGAT, AFR/SD, OHA, GH	
4.3. Reports on Scale up activities, challenges and successes produced and disseminated. Include success in leveraging inputs.		Report produced	AFRICA 2010	Futures Group and USAID agency-wide focus group on multi-sectoral programming	
4.4. Study to document link between scale up of multi-sector activities and outcome/impact acceleration in HIV/AIDS activities		Study Conducted	AFRICA 2010	Futures Group and USAID agency-wide focus group on multi-sectoral programming	



Mitigating the Effects of HIV/AIDS on Children and Youth

Africa/SD Action Plan
2006-2008
April 20, 2006



Our Goal

Capacities of USG missions and OVC implementing partners strengthened to provide efficient and effective programming that mitigates the effects of HIV/AIDS on the greatest number of children and youth.



Who are we talking about...

Children and Youth, up to age 18, that are:

- Orphans
- Caring for other children
- Living in a chronically ill household
- Living with HIV/AIDS
- Experiencing marginalization, displacement, and/or neglect due to HIV/AIDS



Essential Needs

- Economic Strengthening
- Education
- Food and Nutritional Support
- Health Care
- Psycho-social Support
- Integrated HIV/AIDS Services
- Housing/Shelter
- Protection



Opportunities

- USAID is lead on programming for OVC
- Global momentum (USG, UNICEF, Global Fund, WB)
- More money and talent than ever before
- NGO community advocating USG leadership

Challenges

- Adjust targets for family and community focus
- Optimize resources
- Strengthen weak systems and structures (human capacity, political will)
- Establish standards of practice to achieve quality and outcomes
- Scale up efficient and effective practices



Linking with other action plans.....

Orphans and Vulnerable Children are likely to not:

- Sleep under a bed net
- Get fully immunized or access other health services
- Access continuum of HIV/AIDS services
- Be protected from early-age marriage and pregnancy
- Access family planning
- Be protected from hazardous labor, esp. sex work
- Eat sufficiently
- Receive multi-sector service support
- BE VALUED EQUALLY as their peers



All actions must be done in coordination with USG's OVC Technical Working Group



Expected Result 1: Strengthened USAID, USG, and African partners' leadership in OVC programming

Indicator: # of countries where USG mission and their partners are providing coordinated and collaborative input on OVC policy and programming.

Actions:

- Draft *AFR-SD Principles and Practices for OVC Programming*
- Support development and implementation of USG OVC Strategy (PL 109.95)
- Contribute to OGAC's OVC Technical Working Group
- Provide technical support to follow on USG's OVC Leadership Forum
- Contribute to information and advocacy "campaign" for USG staff
- Develop and implement knowledge management system (track OVC data/research, studies)

Partners:

USAID regional offices, HACI, AIM, USAID missions, DOL, USDA, OHA, OVC-TWG (OGAC), Africa 2010



Expected Result 2: Improved implementation and measurement of quality in OVC programming

Indicator: # of USG missions with guidelines for achieving quality in OVC programming developed and in use.

Actions:

- Facilitate guidelines and consensus on achieving quality improvement based on country context and standards of practice
- Support human capacity and systems development for government ministries, networks, and institutions to achieve National Plan of Actions
- Promote use of formulas to minimize/contain costs (human, financial,) and maximize outcomes.

Partners: Pact, Capacity Project, FHI, HACI, TRACK Ones, UNICEF, ANECCA, SAFAIDS, child protection networks, USAID Regional offices, OHA, OVC-TWG (OGAC).



Expected Result 3: Harmonized M&E practice and data use among USG missions and their implementing partners.

Indicator: # of USG missions and their partners using harmonized M&E system.

Actions:

- Provide technical input to OVC Targeted Evaluation
- Provide technical assistance in outcome indicator development and harmonized program monitoring
- Facilitate development and implementation of M&E resources
- Support generating evidence-based data to improve OVC programming.

Partners: FHI, HACI, MEASURE, UNICEF, OHA, OGAC



Expected Result 4: Strengthened Multi-sector Partnerships

Indicator: # of USG missions with stronger multi-sector OVC programming partnerships.

Actions:

- Develop and facilitate use of tools for “wrap-around” programming (ES, D&G, and Food and Nutrition)
- Map and analyze USG efforts for children and youth
- Operational plan and TA for Africa-SD’s *Principles and Practices for OVC programming*
- Study cross-boarder trafficking to confirm extent and recommendations for preventing and eliminating

Partners: CYES, DCHA, EGAT, HACI, DOL, DOD, HAI, OHA, OGAC, USDA, SADC, USAID regional offices, TIP



Expected Result 5: Result: Improve USG and African partner assistance to OVC in fragile states

Indicator: # of fragile countries with improved OVC policies strategies.

Actions:

- Collaborate and consult with DCOF to map out approaches and actions to assist OVC in fragile states.
- Provide requested TA to countries.

Partners: DCOF, SD colleagues, DOL, RCS, USAID regional offices



Mechanisms and Funding Request for 2007

• Africa 2010	\$300,000
• CARE/HACI	\$200,000
• Capacity Project	\$100,000
• AIDSTAR or AIM(?)	\$100,000
	TOTAL \$700,000

*2005 operating budget-\$400,000 (plus SARA Project)

*2006 operating budget-\$625,000 (plus SARA Project)



Contributing Individuals

Africa 2010: Justin, Antonia, Rougi, Silvio, Winston, Duale, Doyin

Afr/SD: Hope, Stella, Sara, Benedicte, Marie Christine, Ishrat, Renee

OHA: Colette Bottini, Festus Ukwuani

DCOF: John Williamson

Other: Florence Nyangara, Jim Heiby, Dave Nicholas



The potential possibilities of any child are the most intriguing and stimulating in all creation

Mitigating the Impacts of HIV/AIDS on Children and Youth AFR/SD Action Plan

Background and Rationale

The scale and spread of the HIV/AIDS epidemic is staggering. Since 1980 more than 20 million people around the world have died from AIDS and other related causes and over 40 million are currently living with HIV. Of these 65% (more than 25 million) live in sub-Saharan Africa. The most devastating impact of HIV/AIDS is reflected in the lives of children who have been affected by it. Almost 3 million children under the age of 15 are living with HIV or AIDS, over 2.7 million of them in sub-Saharan Africa. Another 14 million have lost one or both parents to AIDS. (UNICEF estimates). Most of the children orphaned by AIDS live in developing countries, the vast majority of them (over 80%) in sub-Saharan Africa. A much larger number of children have been made vulnerable by the impact of HIV/AIDS. This vulnerability is exacerbated by poverty, hunger, armed conflict and harmful child labor practices. The specific difficulties encountered by children made vulnerable or orphaned by HIV/AIDS are multi-sector: economic hardship, lack of parental love, attention and affection, withdrawal from school, psychological distress, loss of inheritance, increased abuse and risk of HIV infection malnutrition and illness and stigma, discrimination and isolation (*The Framework for the Protection, Care and Support of orphans and vulnerable children living in a world with HIV and AIDS UNICEF, UNAIDS, USAID July 2004*).

During the next two years, USAID's Africa Bureau will continue to work with other USAID bureaus, USG agencies, OVC implementing partners, and African partners to support interventions that aim to reduce the impact of HIV/AIDS on children and youth.

A prime focus will be on achieving quality and optimal use of resources. This requires innovative approaches for costing and scaling up effective and efficient programs. There is a need to strengthen human capacity and systems in countries with high HIV/AIDS prevalence rates to sustain successes. Political will and leadership by local and national authorities will be required to create an enabling environment for interventions. The establishment of standards of practice and increasing the involvement of the family and community are pre-requisites for success.

The US government has manifested a commitment to playing a leading role in OVC programming through PEPFAR and the recently passed PL109-95 which earmarks funding and human resources for OVC programming. Over the years, USAID has played a leading role in providing support to orphans and children made vulnerable by a range of causes. In recent years, there has been global momentum by other bi-lateral and multilateral donors (UNICEF, GFATM, DFID, WB) to coordinate efforts for making a measurable difference in the lives of orphans and vulnerable children. USAID has also worked with several partners in sub-Saharan Africa (WHO/AFRO, REDSO, WARP, CYES, BCN, UNICEF, SADC, ANECCA, REPPSI etc.) who are also committed to mitigating the impact of HIV/AIDS on children and youth.

Strategic Topics

- Supporting stronger USAID and USG and African partners' leadership in OVC programming
- Promoting achievement of quality improvement in OVC programming
- Facilitating harmonization of M&E practices and data use among USG Implementing partners
- Strengthening multi-sector partnerships

Expected Results and Outcome indicators:

Expected Result 1: Strengthened USAID, USG and African Partner Leadership in OVC Programming. **Outcome Indicator:** # of countries where USG mission and their partners are providing coordinated and collaborative input on OVC policy and programming.

Expected Result 2: Improved Implementation and measurement of quality in OVC programming. **Outcome Indicator:** # of USG missions with guidelines for achieving quality in OVC programming developed and in use.

Expected Result 3: Harmonized M&E Practice and Data Use among USG Missions and their Implementing Partners. **Outcome indicators:** # of USG missions and their partners using harmonized M& E system for OVC programming; and # of countries in which system is being used.

Expected Result 4: Strengthened multi-sector partnerships for OVC programming.

Outcome Indicator: # of USG missions with stronger multi-sector OVC programming partnerships.

Expected Result 5: Improved USG and African Partner strategic responses to OVC in fragile states (e.g., Liberia, Ethiopia, Cote D'Ivoire, DRC).

Outcome Indicator: # of fragile countries with improved OVC policies and programming strategies

Implications for fragile States:

Vulnerabilities of OVC are usually exacerbated in fragile environments where governments are often unable to provide adequate protection. Responding to OVC in fragile states must ensure that governments provide protection for the most vulnerable children through improved policy and legislation and by channeling resources to families, caregivers and communities.

Cross Cutting Issues: Youth, Urbanization and Gender

The successful growth and development of children, especially the most vulnerable, involves coordinated action across all sectors. Priority issues include youth and girls, especially in urban settings. Children and youth in urban settings and young women and girls tend to be more vulnerable to HIV/AIDS infection than men and boys. While urban youth face increased risk and lack of access to facilities, orphaned young women and girls are often subject to abuse as they are forced to leave their homes to live in unfamiliar places. Many are forced into harmful child labor and/or sexually exploited for cash to obtain protection, food and shelter. OVC programs should incorporate features that empower the youth and ensure that governments protect the most vulnerable through job creation, and the adoption of appropriate policies, strategies and action plans.

Results and Activities	Illustrative Budget	Key Outputs	Implementation Mechanism	Potential Partners	Notes (e.g. cross reference)
STRATEGIC AREA: Orphans and Vulnerable Children (OVCs)					
Expected Result #1: Strengthened USAID, USG and African Partner Leadership in OVC Programming					
1. Activities or Actions					
1.1 Draft and disseminate <i>AFR-SD Principles and Practices for OVC Programming</i> (multi-sector OVC Strategy)		Number of countries where USG mission and their partners are providing coordinated and collaborative input on OVC policy and programming	AFR/SD Staff	USAID Regional Offices, AIM, USAID Missions, BCN, CYES, DoL, USDA, OHA, OGAC, Africa 2010	
1.2 Support development and implementation of New USG OVC Strategy (PL 109.95)			AFR/SD Staff		
1.3 Contribute to OGAC's OVC Technical Working Group			AFR/SD Staff		
1.4 Provide follow on support to USG OVC Leadership Forum follow-up	\$150,000		Africa 2010, FHI, OVC Consultants, PACT		
1.5 Contribute to information and advocacy "campaign" for USG staff	\$50,000		CARE, Better Care Network, Africa 2010, CYES		
a) Develop list of essential information on OVC programming ("OVC 101")					
b) Write and distribute "e-notes" on OVC programming and policy developments					
1.6 Develop and implement knowledge management system (track OVC data/research, studies)	\$80,000		Africa 2010		
a) Develop database of OVC experts and organizations					
b) Document and disseminate a qualitative analysis of promising practices					
Expected Result #2: Improved Implementation and measurement of quality in OVC programming					
2. Activities or Actions					
2.1 Provide TA to missions and implementing partners on USG OVC strategy and OGAC policy guidance			OVC TWG		
2.2 Facilitate guidelines development and consensus building to achieve quality improvement based on country context and standards of practice	\$150,000		PACT URC		
a) Develop facilitation guide for missions to determine standards of practice and achieving quality programming			Africa 2010, Capacity Project, UNICEF		

Results and Activities	Illustrative Budget	Key Outputs	Implementation Mechanism	Potential Partners	Notes (e.g. cross reference)
2.3 Support human capacity and systems development of government ministries, networks and institutions to achieve OVC National Plans of Action	\$200,000	Number of USG missions with guidelines for achieving quality in OVC programming developed in use	FHI, URC	PACT, Capacity Project, FHI, HAI, Track Ones, UNICEF OVC Certificate PROG, ANECCA, SAFAIDS, REDSO, WARP, RHAP, OHA, OGAC, URC, AIDS Alliance	
a) Support USG missions with enhancing government leadership and collaborations to achieve the goals of National Plans of Action			Africa 2010		
2.4 Promote use of formulas to minimize/contain human costs (human, financial) and maximize outcomes	\$50,000				
a) Review and analyze cost configurations (costing) of services provided by child sponsorship/child service organizations					
2.5 Analyze and document standards of care practices for women and children in refugee camps	\$20,000		Africa 2010		
Expected Result #3: Harmonized M&E Practice and Data use among USG Missions and their Implementing Partners					
3. Activities or Actions					
3.1 Provide Technical input into OVC Targeted Evaluation		Number of USG missions using harmonized M&E system for OVC programming; Number of countries in which system is being used	Africa SD Staff	FHI, HAI, MEASURE, UNICEF, OHA, OGAC	
3.2 Provide Technical Assistance in outcome indicator development as part of a package of TA	\$50,000		FHI, URC		
3.3 Facilitate development and implementation of FHI M&E Guide			Africa SD Staff		
3.4 Support generating evidence-based data to improve OVC programming	\$50,000		Africa 2010		

Results and Activities	Illustrative Budget	Key Outputs	Implementation Mechanism	Potential Partners	Notes (e.g. cross reference)
Expected Result #4: Strengthened multi-sector partnerships for OVC programming					
4. Activities or Actions					
4.1 Develop and facilitate use of tools for "wrap-around" programming (ES, D&G, and Food and Nutrition)	\$40,000	Number of USG missions with stronger multi-sector OVC programming partnerships	Africa 2010, CARE, HACL	CYES, DCHA, EGAT, HACL, DoL, DoD, OHA, OGAC, USDA, SADC, USAID Regional Offices, Africa 2010, DCOF, Peace Corps	
a) Test tools and provide other related TA					
b) Produce and strategically disseminate tool					
4.2 "Map" , analyze, and disseminate results on USG agency efforts for children and youth	\$60,000		Africa 2010, CARE/HACL, Africa 2010, OVC Consultant		
4.3 Develop Operational Plan and provide TA for Africa SD's Principles and Practices for OVC Programming			Africa SD Staff		
4.4 Study of cross-boarder trafficking to confirm extent and recommendations for preventing and eliminating (links with DoL, HACL, Transport Corridor Initiatives, gender-based violence)	\$25,000		Africa 2010, DCOF		
Expected Result #5: Improved USG and African Partner strategic responses to OVC in fragile states (e.g. Liberia, Ethiopia, Cote d'Ivoire, DRC)					
5. Activities or Actions					
5.1 Collaborate and consult with DCOF to map out approaches and actions to assist OVC in fragile states		Number of fragile countries with improved OVC policies and programming strategies	Africa SD, Africa 2010	DCOF, USAID Regional Offices, Office of SD Colleagues, RCS, DoL, Africa 2010, CYES, CARE/Better Care Network	
5.2 Disseminate promising approaches	\$10,000		Africa 2010		
5.3 Provide requested technical support to countries	\$25,000		RCS, SD, DCOF, Regional Offices, Africa 2010		
	\$870,000				



AFR/SD Care and Treatment

Proposed Action Plan
20 April 2006



Palliative Care: WHO Definition

“An approach that improves the quality of life of patients and their families facing the problems associated with life threatening illness, through the *prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.*”

Palliative Care requires three essential elements:

- Education
- Policy development (with access to essential palliative care drugs including opioids)
- Government commitment



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Palliative Care Services: The Emergency Plan

Covers and must include a wide range of interventions:

- From the onset of HIV diagnoses through the course of the disease
- Routine clinical care, (including prevention and management of TB and other opportunistic infections, pain and symptoms, and malignancies)
- Psychological care
- Spiritual care
- Social support

Palliative care is not supportive care without pain and symptom control and is not pain and symptom control without supportive care.



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Palliative Care: Background

“Palliative care is a major, largely unmet public health need”¹

- 56 million deaths in the world annually²; more than 3 million people died of AIDS-related illnesses in 2005; of these more than 500 000 were children³
- 33 million (60%) of dying persons may benefit from palliative care
- Add family members/informal carers (1-2 per dying person) = 100 million people could benefit from palliative care

1) Jan. Stjernsward - Former Chief, Cancer and Palliative Care, WHO, International Director Oxford University International Centre for Palliative Care and World Health Organization Collaborating Centre for Palliative Care

2) WHO 2004

3) UNAIDS 2005



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Unmet needs for palliative care for PLHA

Pain in HIV/AIDS is:

- Under-recognized
- Under-acknowledged where it is recognized
- Under-treated where it is acknowledged
- Women, children, the elderly and IDUs are significantly more likely to have pain treated inadequately
- Women and children are 50% more likely to have pain under-treated

And this is in developed countries!



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Unmet needs for palliative care for PLHA

- At least 60% of people with AIDS have at least one site of pain, often more than one site
- Between 80% - 90% of people with advanced AIDS have pain and other distressing symptoms
- Pain, physical symptoms need a whole-person approach
- With introduction of ART palliative care still needed



Global Need for Palliative Care

We know:

- Palliative Care services in many resource-poor settings often do not provide services for people living with HIV/AIDS (PLHA), or are only beginning
- People with cancer and PLHA have similar palliative care needs – pain, distressing symptoms, social, emotional, spiritual, mental health needs



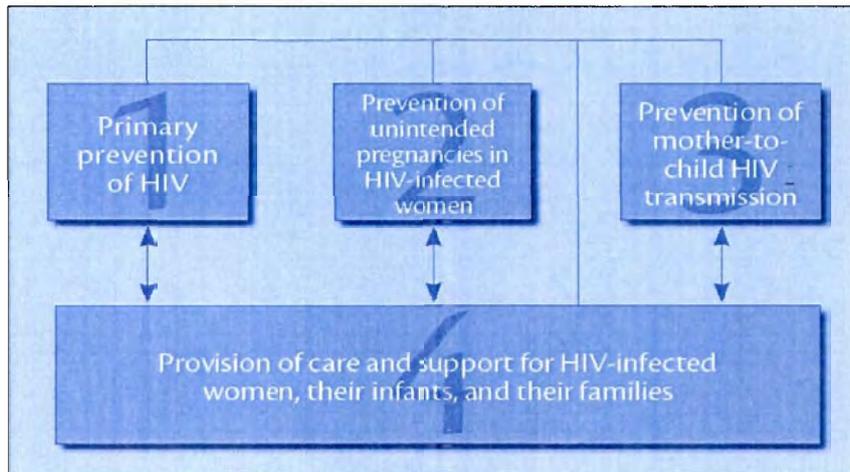
Palliative Care: Challenges

- HIV/AIDS palliative care is a relatively new technical area
- Palliative care in its infancy in most resource-poor settings
- Very few comprehensive palliative care services exist in most resource-poor countries e.g. Cote D'Ivoire – 4 services
- Where more services exist – e.g. South Africa, need is still great
- Serious gaps in pediatrics; pain and symptom management and appropriate use/support of volunteer/community caregivers
- Limited USG agency leadership on care issues
 - Limited ability of USG teams to interact with host country governments on care issues
 - Limited articulation of OGAC expectations in care



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Four-Pronged Approach to PMTCT (WHO)



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PMTCT and Paediatric Care

- 2.3 (2.1 – 2.8) million children living with HIV
- 2.2 million HIV+ women give birth annual
- 700,000 (630,000–820,000) children newly HIV+
- Only 9% of HIV+ women receive ARVs for PMTCT
- < 5% of HIV+ children in need of treatment get ART
- Only 1% of HIV+ children receive CTX prophylaxis
- AIDS already accounts for a rise of more than 19% in infant mortality and a 36% rise in under-five mortality (WHO Health Report, 2004)

Source: WHO/UNAIDS, 2005



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The Postnatal Cascade; The Weakest Link in PMTCT

- Follow-up into the postnatal period is currently the weakest link in most PMTCT programs.
- Postnatal follow-up is essential for several reasons including:
 - Preventing pediatric HIV infections through breastfeeding
 - Improving overall child and maternal survival
 - Infant Diagnosis
 - Linking mothers and children to a continuum of HIV care and treatment services
 - Increased opportunity for male/partner involvement
- Without attention to this period, the PMTCT cascade keeps going downhill!



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Prioritizing Pregnant Women to ART

- Widely recognized that treating pregnant women with AIDS is a great win-win situation
- The MTCT rate is > 50% among pregnant women with a CD4<200
 - When these women receive HAART MTCT rate can be reduced to ~ 2% at 6 weeks
 - Whether or not the provision of HAART prevents MTCT during breastfeeding is still an open question
- **For every two pregnant women with AIDS who receive HAART ~ 1 pediatric infection if averted**
- HIV negative children born to HIV positive mothers with low CD4 counts are at a much higher risk of mortality.
- Excellent attention given in the past year to increase the number of children on treatment and developing pediatric targets
- However, the importance of providing pregnant women with treatment has not been highlighted
- **Overall, pregnant women have disproportionately low access to HAART**



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PMTCT: A Critical Pathway to Treatment, and Care

- Between ~20-40% of HIV+ pregnant women are eligible for treatment depending on what CD4 cut-off is used; all eligible for care
- PMTCT provides a critical opportunities to increase:
 - Eligible women on HAART
 - Eligible children on HAART
 - Exposed children in care including cotrimoxazole
 - Positive mothers infant feeding
 - Women, their male partners, and families in HIV prevention, care and treatment
 - And establish infant follow-up program, including early diagnosis *and* linkages to core maternal and child health interventions (Vitamin A, immunizations, family planning etc.)



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Key Interventions to improve Survival through PMTCT follow-up, diagnosis and care

High Impact HIV Specific Interventions:

- Maternal HAART – dramatically improves maternal and child mortality
- Need to identify, enroll and provide care and HAART to pregnant women who qualify
- CTX prophylaxis – reduces mortality from absolute rate of 42% to 28% among HIV-infected children
- Support for core child survival interventions is also critical (infant feeding, Vitamin A, nutrition, immunizations, etc.)

Build a continuum of care for all of the above

- Maternal and child health services are a key entry point into a continuum of HIV prevention, care, and treatment services.
- Need to strengthen postnatal care
- Expanding child health cards: HIV-exposure status, infant feeding etc
- Infant diagnosis

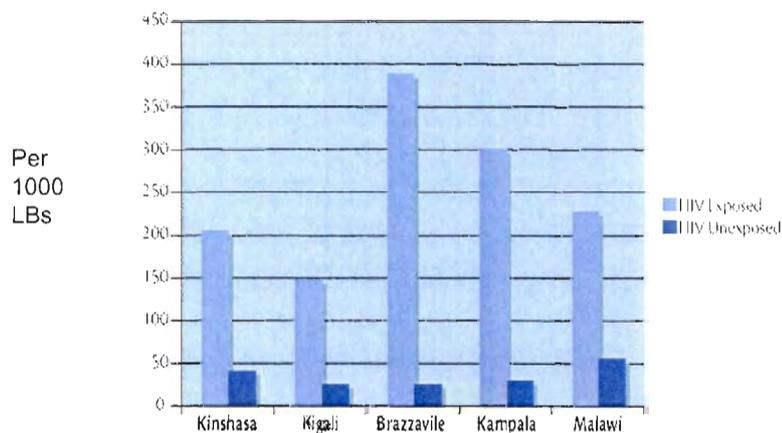


Pediatric HIV

- Disease more aggressive in children – 30% mortality at yr 1, 50% at yr 2 and 60% at yr 5
- 75% of children with HIV present with symptoms in the first or second year of life (most often at the primary level)
- Most children with HIV die of common childhood illnesses rather than of HIV/AIDS
- 80% of infant deaths occur in the home

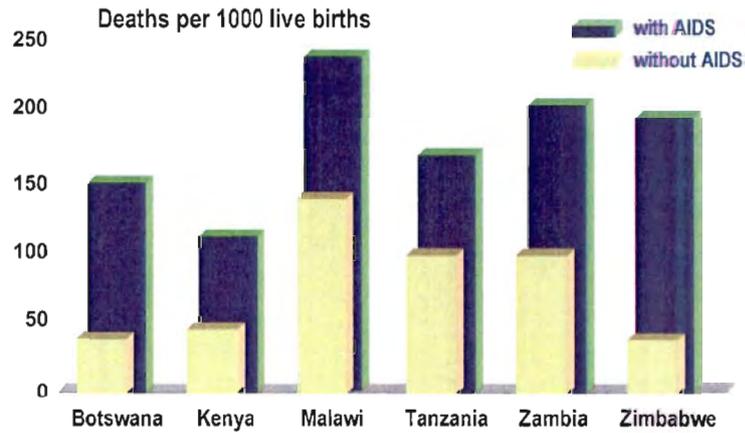


IMR in HIV-Exposed and Unexposed Babies: Data from 5 Cohort Studies



* Source: Sources: Boerma, J.T., et al. *AIDS* 1998; 12 (S 1); Taha, T.E.T., et al. *AIDS* 1996; 10

Estimated impact of AIDS on under 5 child mortality rates: Selected African Countries 2010



Children in need of treatment:

UNICEF/UNAIDS 2005 Child Estimates; Boerma et al WHO Bulletin 2006

2005 estimates	Child (0-14 years) deaths due to AIDS	Children (0-14 years) in need of ART	Children (0-16 months) in need of ART	Children (0-14 years) in need of cotrimoxazole - diagnosis at 18 months	Children (0-14 years) in need of cotrimoxazole - diagnosis before 18 months
Global	410,000	690,000	270,000	4,000,000	2,100,000
Caribbean	3,100	5,100	1,800	29,000	15,000
East Asia	1,500	1,900	1,700	17,000	7,600
Eastern Europe & Central Asia	1,100	1,600	1,100	18,000	6,200
Latin America	6,000	8,800	400	70,000	35,000
North Africa & Middle East	5,300	7,600	4,400	59,000	18,000
Oceania	<500	<500	<500	2,000	<1000
South & South East Asia	26,000	37,000	21,000	290,000	130,000
Sub-Saharan Africa	370,000	600,000	240,000	3,500,000	1,900,000
PEPFAR countries	250,000	410,000	200,000	2,400,000	1,300,000
Asia	26,000	36,000	23,000	310,000	140,000
Latin America & Caribbean	9,200	14,000	5,800	100,000	50,000



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Pediatric HIV: Challenges

- Early identification
- Provision of CARE and treatment for child and family



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Pediatric HIV

- Most children are vertically infected, primary infection around birth:
 - Babies have maternal HIV antibodies
 - Immature immune system but active thymus:
 - CD4 high and variable in young uninfected children; CD4% less so...
- HIV Diagnosis for children below 18 months limited:
- Serology > 18 months or for screening



Pediatric HIV: Entry Points and Links

- Need to expand PMTCT+ and emphasize f/u of infants to 18 months within maternal/infant/child health programs
- Need to use other entry points for identifying CLWHA including pediatric IPD, OPD, diarrhea, malnutrition wards, OVC and adapted IMCI
- Expand facility-based treatment for initiation and begin community-based maintenance, adherence support for families
- Utilization of non-physician cadres including lay counselors for testing and CHW or EPI for cotrimoxazole prophylaxis etc
- Encourage use of a Basic Care Package for CLWHA
 - Includes: ITNs, SWS, nutrition, immunizations (measles, Hib)
 - **Relies on a functional health system for basic primary care**



Pediatric HIV

- Scale-up beyond small-scale, 'boutique'
 - Improve f/u and increase entry points
- Scale up options for early identification and infant diagnosis
- Monitor outcomes for ART in kids
- Develop pediatric HIV effective chronic care model
- Expand community level support
- Incorporate children into:
 - palliative care continuum (OIs, TB, Co-trimoxazole prophylaxis, adherence, end of life)
 - OVC,
 - MCH,
 - child survival projects
- Family-based care models



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Overview of Expected Results

- **Palliative Care**
 - Contribute to significantly scaling up and improving the quality palliative care services for people living with HIV and their families
- **PMTCT Plus**
 - Contribute to significantly scaling up and improving the quality PMTCT + services
- **Pediatric Care**
 - Contribute to significantly scaling up and improving quality of pediatric services for suspected and infected children in at least 5 countries



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Details of Expected Results: Palliative Care (PC)

Result 1: Contribute to significantly scaling up and improving the quality palliative care services for people living with HIV and their families in close collaboration with OGAC and relevant TWGs

- **Focus:**
 - Provide support to the OGAC TWG to:
 - implement Palliative Care workplan, country technical assistance matrix, and COP process
 - TA on key technical areas to increase USG capacity and support quality program implementation through development of tools, guidance and guidelines
 - Enhance M&E, including targeted evaluation
 - Support Regional Trainings & Meetings to Support Quality Implementation
- **GAP Addressed:**
 - Community Home Based Care, pediatric PC, Policy development, spiritual support caregiver roles, support to APCA, USG capacity
- **Links:** Most all action plans



Details of Expected Results: PMTCT and Follow-up Care

Result 1: Contribute to significantly scaling up and improving the quality PMTCT + services in close collaboration with OGAC and relevant TWGs

– Focus:

- Provide support to the OGAC TWG to:
 - implement PMTCT workplan, country technical assistance matrix, and COP process
- TA on key technical areas to increase USG capacity and support quality program implementation through TA, development of tools, guidance and guidelines

– Gaps Addressed:

- Analysis of ANC patterns and national guidelines
- postnatal care for + moms and exposed children
- links between PMTCT and ART services
- mortality and morbidity outcomes of infants given replacement feeding or rapid cessation
- Active male participation

– Links: MNCH, CS, OVC, RH, Prevention, and Gender



Details of Expected Results: Pediatric HIV/AIDS

Result 1: Contribute to significantly scaling up and improving quality of pediatric services for suspected and infected children in close collaboration with OGAC and relevant TWGs

– Focus:

- Provide support to the OGAC TWG to:
 - implement PMTCT workplan, country technical assistance matrix, and COP process
- Expand and accelerate options for infant diagnosis
- Strategic guidance on key issues through technical assistant, analysis, document, and guidance development
- Improved health outcomes for infants and children with HIV in 3 countries.
- Partnership and collaboration with Global Initiative

– Gaps Addressed:

- Presumptive and definitive Infant diagnosis
- Barriers to scale up
- Cotrimoxazole
- Children within other elements of care and support
- HIV Chronic Care Model

– Links: MNCH, CS, Nutrition, OVC, Prevention.



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What we Hope to Accomplish in Year 1

Key Actions

- **Advocacy, guidelines, and training materials developed**
- **Foundation for improved outcomes**
- **Regional and African Institute Capacity and Capability Strengthened**
- **USG leadership in palliative care enhanced**
- **Financial implications:**
 - Year one
 - Three year budget: \$950,000

Partners

- African Palliative Care Association
- ANNECA
- BASICS
- Columbia University
- EGPAF
- End of Life Observatory
- GW University
- Men As Partners
- NCIC
- Open Society Institute
- Pain and Policy Studies Group
- REDSO
- RHAP
- WHO/AFRO
- University of Cape Town
- UNICEF



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STRATEGIC TEAM MEMBERS

Those who contributed ideas to this plan:

- AFR/SD: Stella Goings and Benedicte Moncenis
- Africa's Health 2010
- OHA: Youssef Tawfik

HIV/AIDS Care, Support and Treatment

Background:

Palliative care is “an approach that improves the quality of life of patients and their families facing the problems associated with life threatening illness, through the *prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual*”¹. Palliative care requires three essential elements: education, policies to adequately address palliative care including access to essential palliative care drugs such as opioids and government commitment.

Palliative care services under the Emergency Plan covers a wide range of interventions from the onset of HIV diagnoses through the course of the disease and must include routine clinical care, (prevention and management of tuberculosis (TB) and other opportunistic infections (OIs), pain and symptoms, and malignancies), psychological care, spiritual care and bereavement care, social support, and community mobilization. Palliative care is not supportive care without pain and symptom control and is not pain and symptom control without supportive care.

Palliative care services need to be integrated within existing health care systems (at all levels), into a “network” of HIV/AIDS care and treatment programs and delivered across multiple delivery sites (home, community, outpatient, inpatient, clinics, health centers, hospice settings, and workplaces). Trained palliative care nurses are essential to an effective palliative care system. Physicians, clinical officers, social workers, mental health counselors, spiritual counselors, and other professional and non-professional caregivers constitute a comprehensive, interdisciplinary palliative care team.

Palliative care is often described as hospice or end-of-life care. In many countries, hospice services provide pain control and support services within the last months of life for persons with a fatal and terminal illness. Hospices are primarily a method (or vehicle) for delivering end-of-life care. However, increasingly hospices in sub-Saharan Africa are also providing antiretroviral therapy (ART) and broader palliative care services beyond end of life care. Under the Emergency Plan, palliative care is a continuum of services including but not limited to end-of-life care. It begins at the earliest stages of an HIV-related illness or diagnosis of HIV (when a person may be feeling healthy) and continues through post-death bereavement counseling, identification of and caring for orphans and other children affected by HIV/AIDS, and providing other services for family members and loved ones. End of life care services that are included in a country’s palliative care program can be delivered either at a hospice, in one’s home, or at a hospital or clinic. Is the hope of the Emergency Plan that with successful treatment and appropriate care for HIV-infected individuals, the demand for end of life care services will become less.

¹ WHO definition of palliative care.

Prevention of Mother to Child HIV Transmission and Follow-up Care

Approximately 700,000 children were infected with HIV in 2005 and today 2.3 million children living with HIV. The most efficient and cost-effective way of preventing pediatric HIV globally is to reduce mother-to-child transmission (MTCT) of HIV. However, the reality in resource-limited settings is that of the approximately 2.2 million women with HIV who give birth annually only less than 10% of pregnant women are offered services to decrease HIV transmission to their newborns. Inadequate access to antiretroviral prophylaxis remains a major concern. In South Africa, for example, of some 33,000 pregnant women testing HIV-positive, only 18,857 received antiretroviral prophylaxis. In Kenya and Mozambique, the proportion was similar².

Prevention of mother to child transmission (PMTCT) is a crucial entry point for HIV prevention, treatment, and care for mothers, their male partners, and children. PMTCT provides opportunities to increase eligible women and children on HAART, exposed children in care including cotrimoxazole, positive mothers infant feeding, and opportunities to establish infant follow-up program, including early diagnosis *and* linkages to core maternal and child health interventions (Vitamin A, immunizations, family planning etc). While efforts have been made to scale up PMTCT there is wide consensus that several challenges still exist and are in need of urgent attention.

Pediatric HIV/AIDS

Every single minute of each day a child under the age of 15 years dies of AIDS and every day there are nearly 1,800 new HIV infections in children under 15, (approximately 95% from mother-to-child transmission)³. HIV/AIDS is responsible for up to two thirds of all under-five deaths. Of the 2.3 million children living with HIV more than 85% are living in sub-Saharan.

The progression of HIV in children is more aggressive than in adults. The majority of children who do not receive care and treatment die before their 5th birthday, 50% die before their 2nd birthday, and 30% of infants with HIV die before one year of age. Nearly 80% of these deaths occur at home. Additionally, up to 75% of infants infected with HIV will present with symptoms within the first two years of life⁴.

The clinical, immunologic and virologic aspects of HIV in children are also different than those in adults. Given that most children are vertically infected with primary infection occurring around birth infants have maternal HIV antibodies which pose difficulties with early diagnosis. HIV diagnosis for children below 18 months of age is limited because the clinical disease presentation is most often non-specific. Virological tests such as the polymerase chain reaction (PCR) are expensive and require sophisticated labs and expertise. The use of PCR at central facilities coupled with dry blood spot (DBS) system is one mechanism that only a few countries are starting to employ. Serology (use of rapid

² UNAIDS, *Epidemic Update December 2005*

³ UNICEF *A call to action 2006*, UNAIDS and WHO, *AIDS Epidemic Update: December 2004*

⁴ UNAIDS/WHO *AIDS epidemic Update December 2004*

testing) can be used at 9 months of age to rule out negative children who are not breastfeeding. Otherwise serology can only be done around 15 - 18 months of age. Encouraging the use of rapid tests especially in clinical settings where high case-load of children with HIV is important.

Children also have an immature immune system and active thymus meaning they have a faster rate of clinical disease progression with high HIV-1 RNA viral load (especially in infants). Young uninfected children have high and variable CD4 where as CD4% is less variable. This poses implications for decisions on starting ART and monitoring requiring the use of CD4% for monitoring children under 6 years of age who have HIV. Children have shown to have a very good immunological response to ART and with viral loads often becoming undetectable within 2 months of ART. Despite the knowledge and advances in paediatric HIV there are approximately 660,000 children under the age of 15 who are in need of ART, including 270,000 infants less than 18 months of age. In other words, more than 95% of children living with HIV do not have ART to keep them alive. Almost 60% of these children are living in sub-Saharan Africa.⁵

The lack of pediatric formulations/doses poses another constraint on the provision of paediatric HIV treatment. For instance, the distribution of drugs in tablet form may not be uniform. Therefore using portions of tablets may not provide the adequate dose. Dual fixed dose combinations (FDC) may be better than triple combinations as FDC with nevirapine may not have adequate dose for pediatrics and often need supplementation. Syrups are reserved for children under 10-12 KG due to reasons such as the ease of provision to the child. However the sheer volume needed for a 30 day supply is also cumbersome. Adult formulations are used and must be split for children over 12 KG. Hence, there is a critical need to advocate for inexpensive pediatric ARV formulations, preferably in crushable tablet (optimally FDC) or sprinkle granules/sachets, adult FDC that are scored to allow breaking in half (or even scored to allow split in 3 or 4) and FDC that are in pediatric dosing making it easier to give appropriate dose.⁶

Ten-Point Package for Comprehensive Pediatric AIDS Care

1. Confirm HIV status as early as possible
2. Monitor the child's growth and development
3. Ensure that immunizations are started and *completed* according to the recommended schedule
4. Provide prophylaxis for opportunistic infections (PCP and TB)
5. Actively look for and treat infections early
6. Counsel the mother and family on:
 - a) Optimal infant feeding
 - b) Good personal and food hygiene encourage her to seek prompt treatment for any infections or other related problems
 - c) When the child should be followed up according to the WHO recommendations
7. Conduct disease staging for the infected child
8. Offer ARV treatment for the infected child, if needed
9. Provide psychosocial support to the infected child and family
10. Refer the infected child for higher levels of specialized care if necessary, or for other social-or community-based support programs.

Handbook on Paediatric AIDS in Africa

⁵ UNAIDS/WHO *AIDS epidemic Update December 2004*

⁶ Adapted from WHO Pediatric formulations meeting, 2004

The window of opportunity in which to intervene and provide effective care and treatment for children is limited. However there are evidence based interventions that can reduce morbidity and mortality and delay progression to AIDS, such as Cotrimoxazole prophylaxis as part of package of care (including infant feeding, Vitamin A, nutrition, immunizations, etc.) for exposed and infected children. Cotrimoxazole, which costs roughly \$0.03/day) has been shown to reduce mortality in children with HIV/AIDS by more than 40% among HIV-infected children. Currently an estimated 4 million children are in need of Cotrimoxazole of which 3.5 million or more than 85% are children in sub-Saharan Africa. Cotrimoxazole comes in syrup form and is easy to administer to children. However there are no agreed upon targets for care for children with HIV of which the number of children receiving Cotrimoxazole would be an appropriate proxy indicator.

Despite the progress made in pediatric care and treatment challenges still remain and the concern that pediatric HIV care and treatment is becoming heavily focused on the treatment side and care is lagging behind. For instance, children with HIV experience pain and symptoms for which many options of care are known. However given limited numbers of people with needed skills and the lack of access to tools, information and medications most children with HIV are needlessly suffer. Common symptoms reported among HIV infected children include:

- intractable nausea, vomiting, diarrhea, dyspnea, itching, skin lesions, alterations in cognition, weakness, oral lesions and thrush, and immobility in advanced stages⁷, and
- encephalopathy and wasting syndrome.⁸

Meyers and colleagues in South Africa have shown that as many as 75% of infants infected with HIV will present with symptoms within the first two years of life, with the clinical course of the child with HIV is marked by increasingly frequent episodes of common clinical conditions.⁹ The African Network for Care of Children Affected by HIV/AIDS identifies HIV symptoms as “a major cause of discomfort and poor quality of life during the course of HIV infection and AIDS in children,” and “[often] a direct cause of social isolation.”¹⁰

⁷ Oleske & Czarniecki, *Op. Cit.*, p. 1289

⁸ *Ibid.*

⁹ Meyers, et al, *Op. Cit.* Note: This study did not report on the issue of symptoms that may have been related to ARV therapy.

¹⁰ African Network for Care of Children Affected by HIV/AIDS, *Op Cit.*, p. 185

Goal: Scale up the quality, effectiveness, efficiency, and reach of comprehensive HIV/AIDS care, support and treatment programs supported by USG.

Strategic Topics:

1. Contribute to significantly scaling up and improving the quality palliative care services for people living with HIV and their families under guidance from OGAC and relevant TWGs.
2. Contribute to significantly scaling up and improving the quality PMTCT and follow-up services under guidance from OGAC and relevant TWGs.
3. Contribute to significantly scaling up and improving the quality of pediatric services for suspected and infected children under guidance from OGAC and relevant TWGs.

1. SIGNIFICANTLY SCALE UP AND IMPROVE THE QUALITY PALLIATIVE CARE SERVICES FOR PEOPLE LIVING WITH HIV AND THEIR FAMILIES UNDER GUIDANCE FROM OGAC AND RELEVANT TWGS.

Rationale

Palliative care is a major, largely unmet public health need. With approximately 56 million deaths in the world annually it is estimated that approximately 33 million (60%) of dying persons may benefit from palliative care. Add family members/informal carers (1-2 per dying person) and the number increases to close to 100 million people who could benefit from palliative care. More than 60% of people with AIDS have at least one site of pain, often more than one site. Between 80% - 90% of people with advanced AIDS have pain and other distressing symptoms. Pain and other physical symptoms need a whole-person approach.

Palliative care is complementary and additive to anti-retroviral therapy and prevention and becomes increasingly important as the disease progresses. In fact, the need for palliative care begins with presumed HIV disease (linked to counseling and testing) and continues during and after ART use (if therapy is discontinued). The treatment of OIs can alleviate pain, symptoms and suffering and prolong life. The need for palliative care services and the types of services changes due to the progressive and fluctuating nature of HIV disease and the evolving needs of the individual and family.

Pain in HIV/AIDS is under-recognized, under acknowledged, and under-treated. In developed countries women, children, the elderly and intravenous drug users are significantly more likely to have pain treated inadequately and women and children are 50% more likely to have pain under-treated. In many resource-poor settings palliative care services often do not provide services for people living with HIV/AIDS (PLHA) as palliative care has primarily been provided to people with cancer. However, people with cancer and PLHA have similar palliative care needs – pain, distressing symptoms, social, emotional, spiritual, and mental health needs.

HIV/AIDS palliative care is a relatively new technical area and is in its infancy in most resource-poor settings. Very few comprehensive palliative care services exist in most resource-poor countries (e.g. Cote D'Ivoire – 4 services). Where more services exist such as in South Africa coverage is still limited and the need is still great. There is a limited ability of United States Government (USG) teams to interact with host country governments on care issues, partially due to limited USG agency leadership on care issues. Until recently there has been limited articulation of Office of Global AIDS Coordinator (OGAC) expectations in care (guidance has been developed but not widely disseminated or implemented). Some of the most serious gaps in palliative care include pediatric palliative care, home and community based palliative care, pain and symptom management guidelines for children, documentation on policy barriers, and appropriate use/support of volunteer/community caregivers.

Expected Result:

1. Provide TA to the OGAC TWG: implementation of Palliative Care workplan, country TA matrix, COP development and implementation, and support PC representation at OGAC Annual Field Meeting.
2. Provide TA on key technical issues to support quality program implementation and to build the capacity of USG support teams through development of documents, tools, analysis and guidance
3. Enhance M&E, including targeted evaluation
4. Provide TA to Regional Training (s) & Meetings to Build Capacity for Palliative Care Quality Implementation

Specific Indicators:

- Number of countries using guidance document for program design and implementation
- Number of countries incorporating Spiritual Support in programs
- Number of countries using appraisal document
- Number of countries where communications skills of community caregivers is strengthened
- Number of community caregivers trained

Proposed Actions:

- a) Completion & Field Dissemination of the OGAC Palliative Care Guidance document to USG and African partners
- b) Development and dissemination of the Technical Guidance on quality community home-based care.
- c) Dissemination of Pediatric Palliative Care pain and symptom management documentation.
- e) Finalization of palliative care appraisal instruments.
- f) Development and dissemination of pain and symptom management guidelines for pediatric palliative care.

- g) Policy Barrier Review: Document process of policy change to advance palliative care focusing on opioid access, Cotrimoxazole and nurse prescription.
- h) Development of curricula to strengthen communication skills of community caregivers to address key prevention & care issues.
- i) Technical support for to PC Targeted Evaluation SubCommittee and related activities
- j) Review/evaluation of community caregiver roles; incentives; tasks; training & ethical /use of caregivers
- k) Provide technical and managerial support to the African Palliative Care Association (APCA)
- l) Development of a Palliative Care Technical Field Meeting for USG staff in 2007

2. SIGNIFICANTLY SCALE UP AND IMPROVE THE QUALITY PMTCT AND FOLLOW-UP SERVICES UNDER GUIDANCE FROM OGAC AND RELEVANT TWGS.

Rationale

When considering the PMTCT and follow up care cascade it has become clear that there are many weak links in the continuum of care, both in PMTCT and maternal and neonatal care (MNC) programs which results in a cascading utilization of services in both programs. High ANC coverage means that antenatal care (ANC) is an optimal entry point for PMTCT. However, the high ANC coverage drops precipitously at the time of delivery when less than half the women (47%) choose to give birth in health facilities. Utilization of postnatal services (9% for non-institutional deliveries¹¹) is the weakest link in the continuum of care for women. While most women are lost to the system after delivery, the very high BCG coverage (75%) indicates that infants are within reach of the formal health system. These weak links are a major constraint to both PMTCT and maternal and neonatal care (MNC) health programs causing “cascading” use of services.

When integration of MNC and PMTCT does occur, integration has been stronger at the antenatal rather than at the postnatal period since PMTCT uses antenatal care as its entry-point. Better program integration and use of the “**opt-out**” approach of PMTCT in some PMTCT sites of Tanzania and Malawi have resulted in a very high rate of HIV testing and counseling among ANC clients. However, the cascade reappears again at the time of delivery and beyond; a quarter of infected women in one Tanzanian project site and over half the women in one Malawi hospital did not receive nevirapine and two-thirds of babies exposed to HIV infection did not receive nevirapine. Only 15% and 10% HIV exposed infants received immunization and Cotrimoxazole respectively. Most infants are lost to postnatal follow-up, thus resulting in missed opportunities for essential newborn care, nevirapine, prophylactic care for opportunistic infections, and the link with child health and pediatric AIDS programs among HIV exposed infants and other children. Postnatal care also links newborns and infants to child health services and pediatric AIDS

¹¹ DHS 1998-2003

programs¹². Postnatal care is also essential for improving overall child and maternal survival, infant diagnosis, linking mothers to a continuum of HIV care and treatment services and increased opportunity to address issues related to male partners.

It is widely recognized that treating pregnant women with AIDS is not only ethically correct but is a win-win situation as it can save the lives of both moms and their babies. The MTCT rate is more than 50% among pregnant women with a CD4<200. When these women receive HAART the MTCT rate can be reduced to approximately 2% at 6 weeks. Whether or not the provision of HAART prevents MTCT during breastfeeding is still an open question and under review. For every two pregnant women with AIDS who receive HAART approximately one pediatric infection is averted. HIV negative children born to HIV positive mothers with low CD4 counts are at a much higher risk of mortality. Excellent attention has been given in the past year to increasing the number of children on treatment and pediatric targets are beginning to be developed. However, the importance of providing care to children and treatment to pregnant women has not been adequately highlighted. While between approximately 20-40% of HIV+ pregnant women are eligible for treatment (depending on what CD4 cut-off is used) and all are eligible for care overall, pregnant women have disproportionately low access to HAART.

The coverage, quality and acceptance of PMTCT services need to expand. PMTCT interventions can no longer end at delivery. Both the HIV positive mother and her infant need follow up for diagnosis and care. PMTCT programs urgently need to move away from offering only short term ARV for HIV infected mothers and begin identifying immune-compromised pregnant women, enrolling them in care and providing eligible women with ART. This will achieve a double benefit; extending the life of the mother and prevention of infant infection¹³.

Building a continuum of care for needed PMTCT and follow up care is essential and includes maternal and child health services as a key entry point into a continuum of HIV prevention, care, and treatment services, the need to specifically strengthen postnatal care, expanding child health cards (e.g., to include HIV-exposure status, infant feeding etc) and the scaling up of infant diagnosis. High impact HIV specific interventions include the provision of maternal HAART which dramatically improves maternal and child survival, continued HIV monitoring and case management, psychosocial support for women and families, Cotrimoxazole prophylaxis for exposed children and support for core child survival interventions.

Expected Result:

1. Provide TA to the OGAC TWG: implementation of PMTCT and follow-up care workplan, country TA matrix, COP development and implementation, and support PC representation at OGAC Annual Field Meeting.

¹² Kak, Lily *Integration of HIV/MNCH Activities: Activities, achievements, challenges and lessons learned.*, WHO consultation April 2006

¹³ Y. Tawfik and M. Kieffer, *USAID Trip Report Kenya and Tanzania February 2006*

2. Assist with the provision of strategic guidance on key issues related to PMTCT and follow-up care

Specific Indicators:

- Number of countries where ANC patterns and guidelines are reviewed and programs strengthened
- Number of countries where postnatal care services are improved
- Number of countries where infant feeding counseling provided with CTX prophylaxis
- Number of countries where infant dose is >80%
- Number of countries where PMTCT and ART programs are linked and services quality improved
- Number of countries actively monitoring health outcomes of non-breastfed infants

Proposed Actions:

- a) Provide technical support to US missions to work with national counterparts to accomplish an analysis of ANC patterns and national guidelines, and consider more complex regimens and strategy development on newer regimens where appropriate.
- b) Strengthen basic postnatal care for HIV positive mothers and exposed/infected children.
- c) Strengthen linkages between PMTCT programs and ART programs; support PMTCT TWG to work with the ART TWG to develop strategies and guidance to strengthen linkages between PMTCT and ART programs.
- d) Monitor mortality and morbidity outcomes of infants given replacement feeding or rapid cessation
- e) Involvement of men – identify promising practices, male champions

3. SIGNIFICANTLY SCALE UP AND IMPROVE QUALITY OF PEDIATRIC SERVICES FOR SUSPECTED AND INFECTED CHILDREN UNDER GUIDANCE FROM OGAC AND RELEVANT TWGS.

Rationale

Given the fast rate of HIV progression and high morbidity and mortality in children identifying these children and enrolling them in care should be considered an emergency. This can be accomplished by expanding entry points beyond PMTCT for identifying children with HIV to include pediatric in and out-patient departments, diarrhea, malnutrition wards, orphans and other vulnerable children programs and adapted integrated management of childhood illnesses (IMCI). Another is to immediately start identifying and providing care and support to children of parents and guardians currently enrolled in USG supported activities. Given the multi-generational nature of HIV the use of children as case indexes to other family member and the use of adults as case indexes to identify children is urgently needed to rapidly scale up HIV care and treatment

program and to preserve the family unit. Appropriate care for children with HIV is not possible without the involvement of parents/guardian and siblings hence, it is imperative that all care is as child focused and family centered as possible. Hence, models of family centered care are needed

Additionally the capacities and expertise on pediatric HIV care and treatment are severely underdeveloped and needs strengthening. For instance through increase in-service training in suspecting, diagnosing and managing HIV in children, the utilization of non-physician cadres including lay counselors for testing and community health workers or EPI for Cotrimoxazole prophylaxis etc. Expand facility-based treatment for initiation needs to be expanded and community-based maintenance including IMCI where appropriate, adherence support for families started and strengthened. Over all the lack of infrastructure for chronic care management of children needs urgent attention. This can be accomplished through the provision of support to the appropriate technical working groups and technical assistance key technical issues to support quality program implementation and to build the capacity of USG support teams through development of documents, tools, analysis and guidance. For instance there is an urgent need for a tested algorithm for presumptive diagnosis of HIV in infants < 18 months for use in areas where PCR is not available. Also given the evidence of the importance of Cotrimoxazole prophylaxis USG practices and experiences with provision of Cotrimoxazole need to be documented and disseminated, and principles and best practices on how to best address pediatric HIV issues for exposed and infected children within palliative care, TB, OVC, MCH, and child survival projects do not exist. There is also extremely limited palliative care expertise (see palliative care section above) and children need to be included in the palliative care continuum (including pain and symptom management, social, spiritual and emotional support, adherence and end of life care) as efforts to do so in Africa are still extremely limited.

Overall, PMTCT programs, HIV/AIDS care and treatment sites, and implementing partners, as well as child survival, malaria and other MCH programs need assistance to improve the management of common childhood illnesses in infants/children with HIV, and to develop an effective chronic care model which assures continuity of care over time. Targeting HIV-exposed infants, as well as HIV-positive infants and children before and during the time they receive ART.

Key to this strategy is the need to identify and reach exposed and infected infants and children through diverse entry points: immunization visits, PMTCT program sites, TB treatment programs, ART sites, prenatal or postpartum visits, through home-based care programs and/or through other community health activities (e.g. growth monitoring programs). The implementation of the USG preventive care package of services [CTMZ prophylaxis, early newborn care, infant and young child feeding, routine immunizations, safe drinking water, antihelminthic treatment, vitamin A, iron; growth monitoring] also needs to be conducted to improve outcomes for HIV exposed/infected children. This package can be delivered to children who do not yet “qualify” for ART, as well as those on ART for recommended periods.

Expected Results:

1. Provide TA to the OGAC TWG: implementation of PC workplan, country TA matrix, COP development and implementation, and support pediatric representation at OGAC Annual Field Meeting.
2. Expand and accelerate options for infant diagnosis
3. Provide TA on key technical issues to support quality program implementation and to build the capacity of USG support teams through development of documents, tools, analysis and guidance.
4. Partnerships and Collaboration

Specific Indicators:

- Number of countries with plans for scale-up of infant diagnosis
- Number of USG programs with pediatric HIV scale-up plans
- Number of TB, OVC, MCH project work plans that include pediatric care
- Number of countries with improved health outcomes for infants and children with HIV
- Number of countries with chronic care model developed and implemented
- Lessons learned developed and disseminated
- Number of joint advocacy activities undertaken

Proposed Actions:

- a) Support the TWG activities, to participate in rapidly scaling up options for infant diagnosis.
- b) Test sensitivity of ANECCA's algorithm for presumptive diagnosis of HIV in infants < 18 months, where PCR is not available.
- c) Scale-up pediatric HIV care. Conduct review of pilot projects, barrier/bottleneck analysis, identify realistic targets and work plans.
- d) Document USG practices and experiences with provision of Cotrimoxazole.
- e) Disseminate and advocate for use basic care package to USG missions and African partners
- f) Develop and disseminate Principles and Best Practice document on addressing pediatric HIV issues for exposed and infected children within palliative care, TB, OVC, MCH, and child survival projects.
- g) Develop an effective pediatric HIV/AIDS chronic care model (expand entry points, rapid analysis, implementation of preventive care package & Increase provision and use of Cotrimoxazole prophylaxis in HIV, skills development, adaptation of IMCI chart booklet to include HIV etc), development of lessons learned document on chronic care model.
- h) Collaboration with UNICEF on advocacy for scaling up pediatric HIV Care and Treatment.

Results and Activities	Illustrative Budget	Key Outputs	Implementation Mechanism	Potential Partners	Notes (e.g. cross reference)
Strategic Area: Palliative Care (PC)					
Expected Result 1.1: Contribute to significantly scaling up and improving the quality palliative care services for people living with HIV and their families under guidance from OGAC and relevant TWGs.					
Activities or Actions					
1.1.1 Provide TA to the OGAC TWG: implementation of PC workplan, country TA matrix, COP development and implementation, and support PC representation at OGAC Annual Field Meeting.		Participation on TWG, Palliative Care workplan completed. # of TA requests fulfilled. # COPS including palliative care per guidance. # COPS reviewed.# presentations/abstracts on palliative care presented.	AFR/SD		
1.1.2 Provide TA on key technical issues to support quality program implementation and to build the capacity of USG support teams through development of documents, tools, analysis and guidance.					
a) Completion & Field Dissemination of the OGAC Palliative Care Guidance doc to USG and African partners.		Guidance document disseminated. # countries using it for program design/implementation.	AFR/SD		
b) Develop and disseminate Technical Guidance on quality community home-based care.	\$10,000*	Guidance document disseminated. # countries using it for program design/implementation.	Africa 2010	WHO, APCA, multiple reviewers	Link with OVC, Multi-sectoral, Nutrition, and Prevention Action Plans
c) Dissemination of Pediatric Palliative Care pain and symptom management documentation.	\$2,000	Guidance document disseminated. # countries using it for program design/implementation.	Africa 2010	GW University Multiple reviewers	
d) Support USAID to provide guidance to partners specializing in spiritual support.	\$20,000	Principles of spiritual support defined. # countries incorporating SS in programs	Africa 2010	WCRP, APCA, End of Life Observatory	Link with OVC action plan
e) Finalize palliative care appraisal instruments.	\$5,000*	# countries using appraisal instruments.	Africa 2010	GW University Multiple reviewers	
f) Develop and disseminate pain and symptom management guidelines for pediatric palliative care.	\$75,000	pediatric pain/symptom management guidelines developed, tested and disseminated	Africa 2010	GW University, University of Cape Town, WHO, APCA, Pain and Policy Studies Group, multiple reviewers	Link with Nutrition, Prevention, CS, ID, and MNCH action plans.
g) Policy Barrier Review: Document process of policy change to advance palliative care focusing on opioid access, cotrimoxizole and nurse prescription.	\$60,000	Dissemination of review. # countries where findings used in discussions with partners/development of programs.	Pain and Policy Studies Group	Open Society Institute, APCA, NCIC, WHO	Link with multisectoral action plan.
h) Development of curricula to strengthen communication skills of community caregivers to address key prevention & care issues.	\$75,000	# countries where communications skills of community caregivers is strengthened. # community caregivers trained.	Open Society Institute, Africa 2010	Open Society Institute, APCA, Pain and Policy Studies Group	Link with Prevention action plan
1.1.3 Enhance M&E, including targeted evaluation					
a) Technical support for to PC Targeted Evaluation SubCommittee and related activities			AFR/SD		
b) Review/evaluation of community caregiver roles; incentives; tasks; training & ethical /use of caregivers	\$50,000	Documentation on caregivers roles developed and disseminated	Africa 2010	APCA, Open Society Institute, Pain and Policy Studies Group, IAT	
1.1.4 Provide TA to Regional Training (s) & Meetings to Build Capacity for Palliative Care Quality Implementation					

Results and Activities	Illustrative Budget	Key Outputs	Implementation Mechanism	Potential Partners	Notes (e.g. cross reference)
a) Provide technical and managerial support to the African Palliative Care Association (APCA)	\$80,000	Increased technical & managerial capacity of APCA. # quality of APCA work.	Africa 2010	End of Life Observatory, Pain and Policy Studies Group, Princess Diana Fund, Open Society Institute, NICI, IAT	Link with Nutrition, Prevention and MNCH.
b) Development of a Palliative Care Technical Field Meeting for USG staff in 2007	\$100,000	Recommendations of meeting disseminated, COPS, Annual Reports and Strategies reflect increased capacity and skill.	Africa 2010		
Expected Result 1.2: Nutritional support is integrated into HIV care and treatment programs in 6 countries (See Nutrition Action plan for details)					
Activities or Actions					
1.2.1. Strategic Advocacy to promote understanding and support integrating nutrition into HIV treatment and care programs					
1.2.2. Support to USAID missions/countries in the design of HIV programs/country operational plans to include food and nutritional components as outlined by OGAG food and nutrition strategy					
1.2.3. Support to African partners and regional centers of excellence to provide technical assistance for implementation of nutritional support within HIV care and treatment					
1.2.4. Strengthen evidence base & M&E					
Strategic Topic 2: PMTCT and Follow-up Care					
Expected Result 2.1. Contribute to significantly scaling up and improving the quality PMTCT and follow-up services under guidance from OGAC and relevant TWGs (Cross reference with PMTCT Action Plan)					
Activities or Actions					
2.1.1 Provide TA to the OGAC TWG: implementation of PMTCT and follow-up care workplan, country TA matrix, COP development and implementation, and support PC representation at OGAC Annual Field Meeting.		Participation on TWG, PMTCT and follow-up care workplan completed. # of TA requests fulfilled. # COPS including palliative care per guidance. # COPS reviewed. # presentations/abstracts on palliative care presented.	AFR/SD		
2.1.2 Assist with the provision of strategic guidance on key issues related to PMTCT and follow-up care					
a) Provide technical support to US missions to work with national counterparts to accomplish an analysis of ANNC patterns and national guidelines, and consider more complex regimens and strategy development on newer regimens where appropriate.	\$60,000	# countries where ANNC patterns and guidelines are reviewed and programs strengthened	Africa 2010	UNICEF, WHO, EGPAF, Columbia University	MNCH, CS

Results and Activities	Illustrative Budget	Key Outputs	Implementation Mechanism	Potential Partners	Notes (e.g. cross reference)
b) Strengthen basic postnatal care for HIV positive mothers and exposed/infected children.	\$100,000	# countries where postnatal care services are improved. # countries where infant feeding counseling provided with CTX prophylaxis, Number of countries where infant dose is >80%.	BASICS	BASICS, WHO/AFRO, UNICEF, Columbia University	Linking ANC HIV stressing ARV prophylaxis and postnatal care. Identify and utilize opportunities for CTX and infant feeding counseling and growth and development monitoring, Link with CS, pediatric nutrition/HIV, and MNCH action plans.
c) Strengthen linkages between PMTCT programs and ART programs; support PMTCT TWG to work with the ART TWG to develop strategies and guidance to strengthen linkages between PMTCT and ART programs.		# countries where PMTCT and ART programs are linked and service quality improved.	AFR/SD	WHO	In many cases PMTCT programs and ART treatment are not optimally linked to one another, but instead are being implemented as separate vertical programs.
d) Monitor mortality and morbidity outcomes of infants given replacement feeding or rapid cessation	\$100,000	# countries actively monitoring health outcomes of non-breastfed infants/infants weaned early.	Africa 2010	WHO, UNICEF	Link with nutrition, CS, and MNCH Action plans
e) Involvement of men – identify promising practices, male champions	30,000	# countries where safety of RF/early cessation are appropriately assessed.	Africa 2010	Men As Partners,	Link with Gender Action plan

Expected Result 2.2. Improved infant feeding and nutritional support are incorporated into large scale PMTCT programs in 3 countries (See Nutrition action plan for details)

Activities or Actions					
2.2.1. Strategic Advocacy to promote understanding and support for strengthening the infant feeding, nutritional support and postnatal follow-up components of PMTCT programs in Africa					
2.2.2. Support to USAID country missions in the design of PMTCT programs to insure that appropriate consideration is given to infant feeding and nutritional support					
2.2.3. Support to African partners and regional centers of excellence to provide technical assistance for implementation of infant feeding/nutrition within PMTCT					
2.2.4. Strengthen evidence base & monitoring and evaluation					

Results and Activities	Illustrative Budget	Key Outputs	Implementation Mechanism	Potential Partners	Notes (e.g. cross reference)
Strategic Topic 3: Pediatric HIV/AIDS					
Expected Result 3.1. Contribute to significantly scaling up and improving quality of pediatric services for suspected and infected children under guidance from OGAC and relevant TWGs.					
Activities or Actions					
3.1.1 Provide TA to the OGAC TWG: implementation of PC workplan, country TA matrix, COP development and implementation, and support pediatric representation at OGAC Annual Field Meeting.		Participation on TWG, pediatric Care workplan completed. # of TA requests fulfilled. # COPS including palliative care per guidance. # COPS reviewed. # presentations/abstracts on palliative care presented.	AFR/SD		
3.1.2. Expand and accelerate options for infant diagnosis:					
a) Support the TWG activities, to participate in rapidly scaling up options for infant diagnosis. Specific TWG activities include: <ul style="list-style-type: none"> Consultation meeting in July Hiring part-time senior consultant Develop working collaboration with the EP laboratory groups Draft operational protocol and program documents Share country plans and experiences 	\$20,000	# countries with plans for scale up of infant diagnosis	Africa 2010, AF/SD		Infant diagnosis is now a priority program area for OGAC - as part of efforts to improve follow-up, clinical evaluation and referral to care and treatment, and program evaluation. Under the coordination of the TWG, agencies are working to strengthen the PMTCT EP infant diagnosis program.
b) Test sensitivity of ANECCA's algorithm for presumptive diagnosis of HIV in infants < 18 months, where PCR is not available.	\$200,000	Algorithm tested, finalized and disseminated	WHO/AFRO	REDSO, ANECCA, WHO, WHO/AFRO	Link with CS, MNCH action plans
3.1.3 Provide TA on key technical issues to support quality program implementation and to build the capacity of USG support teams through development of documents, tools, analysis and guidance.					
a) Scale-up pediatric HIV care. Conduct review of pilot projects, barrier/bottleneck analysis, identify realistic targets and work plans.	\$100,000	Reviews of experience completed & disseminated. # of USG programs with pediatric HIV scale up plans	Africa 2010	UNICEF, REDSO, RHAP, WHO/AFRO, University of Maryland	Link with CS, MNCH action plans
b) Document USG practices and experiences with provision of cotrimoxazole.	\$10,000	Best practices documented & disseminated.	Africa 2010	BASICS, with Multiple reviewers	Link with prevention and nutrition action plans.
c) Disseminate and advocate for use basic care package to USG missions and African partners		BCP disseminated & used	AFR/SD		
d) Develop and disseminate Principles and Best Practice document on addressing pediatric HIV issues for exposed and infected children within palliative care, TB, OVC, MCH, and child survival projects.	15,000	# of TB, OVC, MCH, TB project work plans that include pediatric care	Africa 2010		Link with most all action plans.

Results and Activities	Illustrative Budget	Key Outputs	Implementation Mechanism	Potential Partners	Notes (e.g. cross reference)
3.1.4. Improve health outcomes for infants and children with HIV through better care and support in 3 countries					
a) Develop an effective pediatric HIV/AIDS chronic care model (expand entry points, rapid analysis, implementation of preventive care package & Increase provision and use of cotrimoxazole prophylaxis in HIV, skills development, adaptation of IMCI chart booklet to include HIV etc), development of lessons learned document on chronic care model.	\$200,000.00	Number of countries with improved health outcomes for infants and children with HIV, Number of countries with chronic care model developed and implemented Lessons learned developed and disseminated	BASICS	UNICEF, WHO, WHO/AFRO, University of Maryland, Columbia University, ANNECA	Link with ID, MNCH, CS, Prevention, and OVC action plans.
3.1.5. Partnerships and Collaboration					
a) Collaboration with UNICEF on advocacy for scaling up pediatric HIV Care and Treatment.	\$100,000	# joint advocacy activities undertaken	AFR/SD	UNICEF	Link with OVC action plan.
Expected Result 3.2: Nutritional support is integrated into pediatric treatment and care programs in 3 countries (see Nutrition Action Plan for details)					
Activities or Actions					
3.2.1. Strategic Advocacy to promote understanding and support for integrating nutritional assessment and support into pediatric HIV treatment and care programs					
3.2.2. Support to African partners and regional centers of excellence to provide TA for implementation of pediatric nutrition/HIV support					

\$1,397,000



AFR/SD Prevention of HIV/AIDS

Proposed Action
Plan
20 April 2006



**THERE IS NO
“CURE” FOR
HIV/AIDS....**

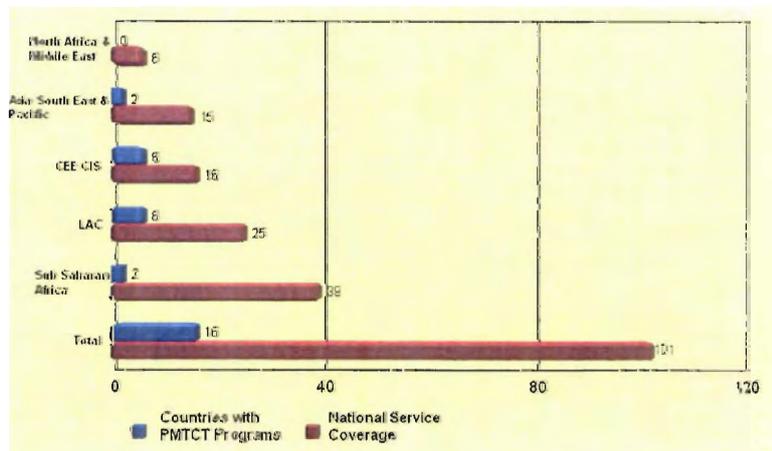
**BUT WE DO
KNOW HOW TO
PREVENT IT...**



Challenges and Obstacles that must be overcome

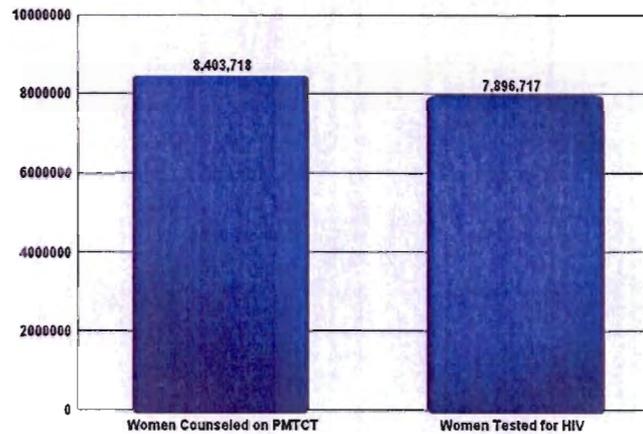
- Urgent need to scale up PMTCT+ services
- Need to accelerate support for goals of AU Declaration of “Year of HIV Prevention”
- Best Practices and Scale up Strategies needed for Success Stories (Zimbabwe, Kenya and Uganda)
- Need effective strategies to meet needs of “high risk” populations
- Need to find “best solution” for breastfeeding option for HIV+ mothers

Countries with PMTCT Programs per Region

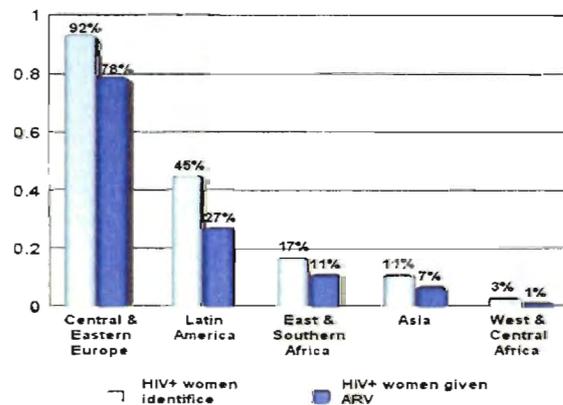


UNICEF Annual Report, 2004

10% of Women giving birth annually are counseled and tested for HIV



Only 9% of HIV+ women globally receive ARV prophylaxis

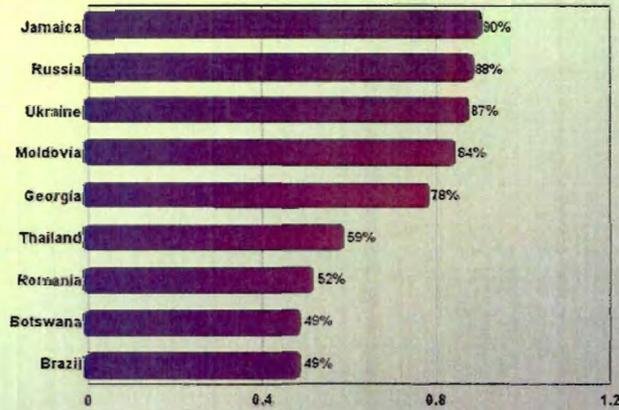




USAID
FROM THE AMERICAN PEOPLE

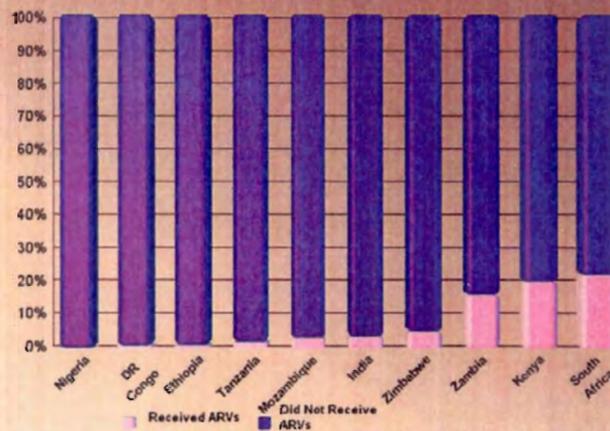
Meeting UNGASS Targets

Only 9 countries met the 2005 UNGASS target to provide ARV prophylaxis to >40% of HIV+ women



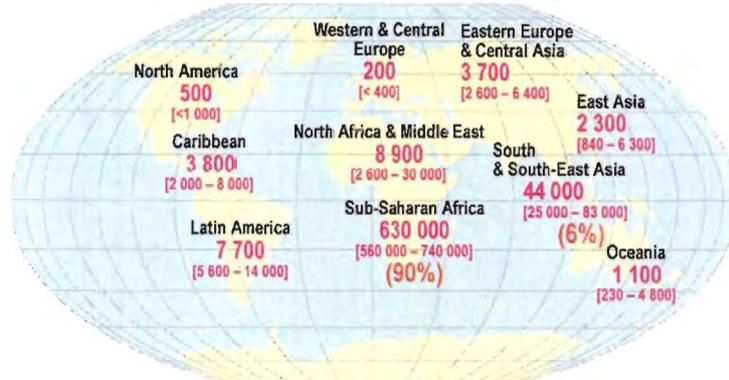
USAID
FROM THE AMERICAN PEOPLE

Proportion of women receiving ARV prophylaxis in 10 highest burden countries accounting for two thirds of all MTCT infections in 2004



2.3 million HIV-infected women give birth every year...

Estimated number of children (<15) newly infected in 2005



Total: 700 000 (630 000 – 820 000)

Source: UNAIDS, 2005 Report on the global AIDS Epidemic, UNAIDS, Geneva, 2005

Details of Expected Results

Result 1: PMTCT+ Services taken to scale in at least 5 countries

- Output/Outcome: Strengthened Mission Capacity to accelerate scale up of PMTCT+ services
 - Focus:
 - Develop better insight into constraints for access and use of PMTCT+
 - Identify and better define “Best Practices” – update field on a quarterly basis
 - Fully engage national counterparts in scale-up activities
 - TA to five countries to facilitate plans for scale up of PMTCT+
 - Gap Addressed
 - Missions need to address obstacles to access and use by women
 - Greater investments needed to scale up services
 - Links
 - OGAC, OHA, WARP, REDSO



Details of Expected Results

Result 2: USAID support for AU Declaration of “Year of HIV/AIDS Prevention”

- Output/Outcome: Active Support for Programs that will move toward targets and fulfillment of AU Declaration
 - Focus:
 - Increase familiarity of Missions and Counterparts with AU Declaration
 - Obstacles to progress and Best Practices Identified
 - USAID Missions assisted to develop creative, effective advocacy programs to promote and accelerate Prevention focus
 - Gap Addressed
 - Increase USG engagement with AU and support for Declaration
 - Gap between policy level commitments and program priorities
 - Links
 - OGAC, OHA, WARP, REDSO



Details of Expected Results

Result 3: Success stories of Reduced Prevalence in Zimbabwe, Uganda and Kenya validated and detailed

- Output/Outcome: Validation of Success Stories and extraction of lesson to be learned from programming and implementation
 - Focus:
 - Independent review of reported successes from Zimbabwe, Kenya and Uganda
 - Knowledge base created on factors contributing to reduced prevalence in high risk populations
 - Gap Addressed
 - Detailed reports of “what worked” and recommendations on “how to replicate” produced
 - TA provided to US Missions wishing to accelerate scale up of successful prevention programs
 - Links
 - OGAC, OHA, WARP, REDSO

Result 4: Prevention programs targeting high risk populations scaled up in 3 selected focus countries

- Output/Outcome: Additional successful strategies identified and scaled up in focus countries
 - **Focus:**
 - Success stories for prevention efforts focused on high-risk populations identified
 - Details of successes and “best practices” shared with countries wishing to scale up interventions for high risk populations
 - **Gap Addressed**
 - Inadequate focus on high risk groups (eg. MSM, CSW, Victims of Violence, etc).
 - Lack of knowledge base about “what works” with prevention for high risk populations.
 - Lack of documented efficiency, effectiveness and cost benefit of prevention approaches
 - **Links**
 - OGAC, OHA, WARP, REDSO

Those who contributed ideas to this plan.

- AFR/SD: Sara Bowsky, Stella Goings
- Africa’s Health in 2010: Doyin Oluwole, Justin Opoku, Holly Stewart



HIV/AIDS Prevention Action Plan Narrative

Background

The global HIV/AIDS epidemic shows no sign of slowing down. Since the 1980s, approximately 25million people worldwide have died of AIDS. Of the 40million people currently living with HIV, more than 65% (over 25million) live in sub-Saharan Africa, and more than 15million children (including 12 million in Africa) have lost one or both parents to AIDS.

Over the years, considerable effort has gone into reducing the spread of the epidemic around the world. However, there has been little consistency in the approaches adopted and no clear documentation of best successful practices exists. While significant improvements in knowledge and attitude have been recorded by various evaluations, change in behavior leading to reductions in prevalence rates has been difficult to achieve. In recent years, intervention programs have shifted their emphases considerably from prevention to treatment. However recent reductions in prevalence rates in Zimbabwe (from 26% to 21%), Kenya (from 10% to 7%) and Uganda, attributed to behavior change (condom use, reduced number of partners, delayed sexual debut, less casual sex) give cause for some guarded optimism. (High death rates have been mentioned as a possible contributor to the reduced prevalence rates, especially in Zimbabwe, a fragile state).

At a meeting of African Ministers of health held in August 2005, the year 2006 was declared the Year for the Acceleration of HIV Prevention in the African Region. Among other things, the Declaration urged Member States of the AU to:

- a. re-emphasize and re-invigorate HIV prevention efforts with a sense of urgency, ensuring the setting of appropriate targets, in synergy with treatment efforts
- b. ensure effective leadership and coordination of HIV prevention efforts and accelerate the implementation of multi-sectoral responses
- c. identify and tackle deeply rooted causes of vulnerability which reduce the ability of individuals and communities to protect themselves and others from HIV infection
- d. to develop appropriate policies and legislation to create a supportive environment for scaling up HIV prevention interventions including addressing issues of stigma and discrimination, and negative cultural values, and protection of vulnerable groups
- e. develop appropriate strategies and plans for accelerated HIV prevention.

The Declaration also requested partners to intensify both financial and technical support to countries to facilitate the scaling up of HIV prevention efforts in order to have the desired impact.

During the next 12 months, AFR/SD will work with African leaders, Regional UN bodies and African partners to achieve the objectives set out by the declaration.

Strategic Topics

In view of the large number of prevention activities already being carried out in sub-Saharan Africa, AFR/SD and its partners will focus on the following:

1. Scale up of PMTCT
2. Support for implementation of the AU Declaration
3. Analysis, documentation and dissemination of Best practices from 3 countries where prevalence rates have been reduced
4. Scale up of prevention programs for high risk populations to include
 - Documentation and dissemination of empirical evidence for successful mitigation of HIV by targeting high risk populations
 - Scale up of prevention programs with key (bridge) populations (eg MSM with female partners, young girls not often accessed by youth programs, OVC)
 - Integration of RH into HIV programs and vice versa
 - STI management and HIV mitigation
 - ABC messages and the enabling environment in which they can be effective
5. Breastfeeding and Nutrition Programs Strengthened

A. SCALE UP OF PMTCT

Expected Results:

PMTCT programs taken to scale in 5 model countries

Proposed Activities:

1. Review PMTCT programs, issues and constraints for 5 selected countries.
2. Identify best practices and common areas of constraint.
3. Prepare detailed analysis and recommendations for acceleration to address specific bottlenecks and obstacles
4. TA to selected countries to assist with implementation of acceleration plans
5. Quarterly updates and progress reports obtained and analyzed for five focus countries
6. Support for participation of national counterparts in regional discussion group on acceleration of PMTCT programs

B. SUPPORT FOR IMPLEMENTATION OF THE AU DECLARATION

Expected Results:

USAID Mission Staff and Government Counterparts are familiar with content of AU Declaration. In five focus countries, demonstrable efforts made actively support work toward compliance with the AU Declaration

Proposed Activities:

1. AU Declaration distributed to USAID Missions in all PEPFAR countries
2. Best Practices in implementation of AU Declaration identified and shared with all PEPFAR countries
3. USAID Missions in five countries assisted to develop implementation plans for AU declaration
4. Report/Analysis of USAID Mission support for AU Declaration prepared and submitted to AU before 2007 Minister's Meeting
5. Internal analysis and report on obstacles to support for AU Declaration prepared.
6. TA to selected countries wishing assistance on implementation of AU Declaration and/or work with multilaterals to support implementation

C. ANALYSIS, DOCUMENTATION AND DISSEMINATION OF BEST PRACTICES FROM 3 COUNTRIES WHERE PREVALENCE RATES HAVE BEEN REDUCED

Expected Results:

Details reviews of literature and documentation from Zimbabwe, Kenya and Uganda undertaken to assure validation of results and conclusions regarding declines in HIV prevalence rates and attribution to HIV/AIDS prevention activities. Best practices identified.

Proposed Activities:

1. Focus group established to review available reports and methodology used to estimate reduced prevalence in 3 focus countries (Zimbabwe, Kenya and Uganda)
2. Relevant reports from 3 countries collected and evaluated

3. Study to validate results and identify contributing factors designed and vetted with focus group
4. Study to validate results and identify contributing factors undertaken in collaboration with Government Counterparts in 3 countries
5. Assessment of reported declines in prevalence completed and report on identification of contributing factors completed

D. SCALE UP OF PREVENTION PROGRAMS FOR HIGH RISK POPULATIONS TO INCLUDE 1) DOCUMENTATION AND DISSEMINATION OF EMPIRICAL EVIDENCE FOR SUCCESSFUL MITIGATION OF HIV BY TARGETING HIGH RISK POPULATIONS; 2) SCALE UP OF PREVENTION PROGRAMS WITH KEY (BRIDGE) POPULATIONS (EG MSM WITH FEMALE PARTNERS, YOUNG GIRLS NOT OFTEN ACCESSED BY YOUTH PROGRAMS, OVC); 3) INTEGRATION OF RH INTO HIV PROGRAMS AND VICE VERSA; 4) STI MANAGEMENT AND HIV MITIGATION ABC MESSAGES AND THE ENABLING ENVIRONMENT IN WHICH THEY CAN BE EFFECTIVE

Expected Results:

Lessons learned from Best Practice Studies in Uganda, Tanzania and Uganda are put to practice and support provided for replication in other countries wishing to scale up effective interventions.

Proposed Activities:

1. Identification of key high risk populations and mapping for focus countries
2. Literature review to identify successful prevention efforts focused on high risk populations in low resource settings
3. Development of strategic planning guidance for scaling up prevention programs for high risk populations
4. TA to selected USAID mission to promote scale up of most promising prevention interventions for high risk populations.
5. Extraction of key lessons learned and sharing of best practices with all PEPFAR focus countries

E. BREASTFEEDING AND NUTRITION PROGRAMS STRENGTHENED

Expected Results:

Strategic links with Nutrition strengthened. Infant feeding and breastfeeding approaches strengthened.

Proposed Activities:

1. Critically analyze, document and disseminate successful examples of integrating nutrition within child survival programs (1.1.c)
2. Utilize advocacy materials to influence new partners about cost-effective interventions to improve nutrition within child survival (1.2.a)
3. Dissemination of existing tools for improved infant feeding counseling and support (3.1.1.c)
4. Support joint missions with other partners support national PMTCT scale up plans - focus IF/N (3.1.2.a)
5. Support training of mid-level program managers on infant feeding/nutrition in the context of HIV/AIDS using existing tools (3.1.3.a)
6. Review and update pre-service curricula relating HIV and infant feeding/nutrition (3.1.3.b)
7. Support program assessments to identify lessons for replication (3.1.3.c)
8. Examine feasibility of linking infant feeding assessment/counseling with postnatal cotrimoxazole prophylaxis (3.1.4.b)

Results and Activities	Illustrative Budget	Key Outputs	Implementation Mechanism	Potential Partners	Notes (e.g. cross reference)
STRATEGIC AREA: HIV/AIDS PREVENTION					
Expected Result 1: PMTCT services taken to scale in 5 countries					
1. Activities or Actions					
1.1 Review PMTCT programs, issues and constraints for 5 selected countries.	\$5,000	Report on PMTCT programs and constraints prepared	AFRICA 2010	WHO/AFRO.UNICEF	
1.2 Identify best practices and common areas of constraint.	\$20,000	Assessment of Best Practices and common areas of constraint prepared	AFRICA 2010	WHO/AFRO.UNICEF	
1.3 Prepare detailed analysis and recommendations for acceleration to address specific bottlenecks and obstacles	\$5,000	Analysis of bottlenecks and recommendations for ways to accelerate prevention programs prepared	AFRICA 2010	WHO/AFRO.UNICEF	
1.4 TA to selected countries to assist with implementation of acceleration plans	\$50,000	TA provided to 5 countries selected on the basis on potential to accelerate prevention activities	AFRICA 2010	WHO/AFRO.UNICEF	
1.5 Quarterly updates and progress reports obtained and analyzed for five focus countries	\$15,000	Quarterly reports received and consolidated report prepared for 5 focus countries	AFRICA 2010	WHO/AFRO.UNICEF	
1.6 Support for participation of national counterparts in regional discussion group on acceleration of PMTCT programmes	\$30,000	Regional discussion group formed and support provided for national counterparts to participate in regional meetings.	AFRICA 2010	WHO/AFRO.UNICEF	
Expected Result 2: USAID Mission Staff and Government Counterparts familiar with and supportive of AU declaration in 5 focus countries					
2. Activities or Actions					
2.1 AU Declaration distributed to USAID Missions in all PEPFAR countries	\$2,000	AU Declaration distributed to all PEPFAR missions	AFRICA 2010	WHO/AFRO.UNICEF	
2.2 Best Practices in implementation of AU Declaration identified and shared with all PEPFAR countries	\$5,000	Analysis of best practices completed and results shared with PEPFAR countries	AFRICA 2010	WHO/AFRO.UNICEF	
2.3 USAID Missions in five countries assisted to develop implementation plans for AU declaration		Implementation plans for accelerated response to AU Declaration developed for 5 focus countries	AFRICA 2010	WHO/AFRO.UNICEF	
2.4 Report/Analysis of USAID Mission support for AU Declaration prepared and submitted to AU before 2007 Minister's Meeting	\$15,000	Reports from USAID mission on support for AU Declaration received, analyzed and summarized for presentation to AU 2007 Minister's Meeting	AFRICA 2010	WHO/AFRO.UNICEF	
2.5 Internal analysis and report on obstacles to support for AU Declaration prepared.	\$5,000	More detailed analysis of USAID efforts to support AU Declaration prepared for missions and AFR-SD consumption.	AFRICA 2010	WHO/AFRO.UNICEF	
2.6 TA to selected countries wishing assistance on implementation of AU Declaration and/or work with multilaterals to support implementation	\$150,000	TA provided to selected countries seeking to accelerate support for the AU Declaration	AFRICA 2010	WHO/AFRO.UNICEF	
Expected Result 3: Factors contributing to reduced prevalence in Zimbabwe, Uganda and Kenya identified					
2. Activities or Actions					

3.1 Focus group established to review available reports and methodology used to estimate reduced prevalence in 3 focus countries (Zimbabwe, Kenya and Uganda)	\$5,000	Focus group established	AFRICA 2010	Linkages, Measure Evaluation	
3.2 Relevant reports from 3 countries collected and evaluated	\$3,000	Reports from 3 countries (Uganda, Kenya and Zimbabwe) collected and evaluated. Report prepared	AFRICA 2010	Linkages, Measure Evaluation	
3.3 Study to validate results and identify contributing factors designed and vetted with focus group	\$25,000	Study designed and vetted with focus group	AFRICA 2010	Linkages, Measure Evaluation	
3.4 Study to validate results and identify contributing factors undertaken in collaboration with Government Counterparts in 3 countries		Study undertaken and report written	AFRICA 2010	Linkages, Measure Evaluation	
3.5 Assessment of reported declines in prevalence completed and report on identification of contributing factors completed	\$5,000	Analysis of factors contributing to declines in prevalence completed and report prepared.	AFRICA 2010	Linkages, Measure Evaluation	

Expected Result 4: Prevention programs targeting high risk populations scaled-up in 3 selected focus countries

4. Activities or Actions					
4.1 Identification of key high risk populations and mapping for focus countries	\$10,000	Map produced showing locations of high risk populations and trafficking corridors	AFRICA 2010	REDSO, WARP	
4.2 Literature review to identify successful prevention efforts focused on high risk populations in low resource settings	\$5,000	Literature review completed and report written	AFRICA 2010		
4.3 Development of strategic planning guidance for scaling up prevention programs for high risk populations	\$5,000	Guidance note on scaling up prevention programs prepared and disseminated.	AFRICA 2010	Linkages, Measure Evaluation, WHO/AFRO, UNICEF	
4.4 TA to selected USAID mission to promote scale up of most promising prevention interventions for high risk populations.		TA provided to two (2) countries expressing interest in scale-up of activities	AFRICA 2010	Linkages, Measure Evaluation, WHO/AFRO, UNICEF	
4.5 Extraction of key lessons learned and sharing of best practices with all PEPFAR focus countries	\$15,000	Report on lessons learned produced and shared with PEPFAR focus countries	AFRICA 2010	Linkages, Measure Evaluation, WHO/AFRO, UNICEF	

Expected Result 5: Strengthened focus on infant and young child nutrition and breastfeeding

4. Activities or Actions					
5.1 Critically analyze, document and disseminate successful examples of integrating nutrition within child survival programs (1.1.c)		Paper prepared and submitted to Lancet or other journal	AFRICA 2010		Linked to workplan for Nutrition
5.2 Utilize advocacy materials to influence new partners about cost-effective interventions to improve nutrition within child survival (1.2.a)		# of partners influenced to adopt cost-effective interventions to improve nutrition within child survival.	AFRICA 2010		Linked to workplan for Nutrition
5.3 Dissemination of existing tools for improved infant feeding counseling and support (3.1.1.c)		Existing tools disseminated. # of countries using existing tools to improve infant feeding counseling and support.	AFRICA 2010		Linked to workplan for Nutrition
5.4 Support joint missions with other partners support national PMTCT scale up plans - focus IF/N (3.1.2.a)		# of national coordinated PMTCT scale up plans with infant feeding/nutrition	Linkages Follow-on		Linked to workplan for Nutrition
5.5 Support training of mid-level program managers on infant feeding/nutrition in the context of HIV/AIDS using existing tools (3.1.3.a)		# of countries with trained mid-level program managers	Linkages Follow-on		Linked to workplan for Nutrition
5.6 Review and update pre-service curricula relating HIV and infant feeding/nutrition (3.1.3.b)		Pre-service training curricula on HIV and infant feeding/nutrition reviewed, updated and disseminated	Linkages Follow-on		Linked to workplan for Nutrition
5.7 Support program assessments to identify lessons for replication (3.1.3.c)		Synthesis of the lessons learned produced and disseminated.	AFRICA 2010		Linked to workplan for Nutrition

5.8 Examine feasibility of linking infant feeding assessment/counseling with postnatal cotrimoxazole prophylaxis (3.1.4.b)		Recommendations used in programming			Linked to workplan for Nutrition
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