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Health Sector Results Reporting

From Annual Reports FY 2006



MAY 2006

AFRICA

Health Sector Results Reporting

Bureau for Africa
Office of Sustainable Development (AFR/SD)
U.S. Agency for International Development (USAID)

**This document includes narrative, tables, and charts
that summarize the 2006 Annual Reports submitted
by USAID's Africa Missions.**

MAY 2006

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Acronyms and Abbreviations

ABC	Abstinence, Being faithful, consistent and correct use of Condoms when appropriate
ACT	Artemisinin-based combination therapy
AFR/SD	Bureau for Africa/Office of Sustainable Development (USAID)
AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ANECCA	African Network for the Care of Children Affected by AIDS
ART	Antiretroviral therapy
ARV	Antiretroviral
BASICS	Basic Support for Institutionalizing Child Survival Project
BCC	Behavior change communication
CBD	Community-based distributor, community-based distribution
CBO	Community-based organization
CBHW	Community-based health workers
CDC	Centers for Disease Control and Prevention
CFA	Communaute Financiere Africaine
C-IMCI	Community Integrated Management of Childhood Illness
CLC	Community leaders council
CORE	Communities Responding to the HIV/AIDS Epidemic
CPR	Contraceptive prevalence rate
CS	Child survival
CY	Calendar year
CYP	Couple-year(s) of protection
DfID	Department for International Development (U.K.)
DHS	Demographic and Health Survey
DOTS	Directly observed treatment, short course (TB)
DPT3	Diphtheria, pertussis, tetanus vaccine, 3rd dose
DRC, DR Congo	Democratic Republic of the Congo
EOC	Emergency obstetric care
FANTA	Food and Nutrition Technical Assistance
FBO	Faith-based organization
FGC	Female genital cutting
FHI	Family Health International
FP	Family planning
FY	Fiscal year
Hib	<i>Haemophilus influenzae</i> type b
HIV	Human immunodeficiency virus
IMCI	Integrated Management of Childhood Illness
IR	Intermediate result
IRC	International Rescue Committee
IPT	Intermittent preventive treatment
ITN	Insecticide-treated net
IUD	Intrauterine device
LLIN	Long-lasting insecticide-treated net
MCH	Maternal and child health

MDG	Millennium Development Goal
MHO	Mutual health organization
MIPESA	Malaria in Pregnancy East and Southern Africa
MMR	Maternal mortality ratio
MOH	Ministry of Health
NAP+	Network of African People Living With HIV/AIDS
NGO	Nongovernmental organization
NHA	National health account
NID	National immunization day
OGAC	Office of the Global AIDS Coordinator
ORS	Oral rehydration solution
ORT	Oral rehydration therapy
PAC	Post-abortion care
PEPFAR	President's Emergency Plan for AIDS Relief
PL	Public law
PLACE	Priorities for local AIDS control efforts
PMI	President's Malaria Initiative
PMTCT	Prevention of mother-to-child HIV transmission
PSI	Population Services International
RBM	Roll Back Malaria
RCQHC	Regional Centre for Quality of Health Care
RH	Reproductive health
RPM Plus	Rational Pharmaceutical Management Plus Program
SAM	Severe acute malnutrition
SBA	Skilled birth attendance
SNID	Subnational immunization day
SO	Strategic objective
STD	Sexually transmitted disease
STI	Sexually transmitted infection
SWAA	Society for Women Against AIDS in Africa
TB	Tuberculosis
TBA	Traditional birth attendant
TFR	Total fertility rate
USMR	Under-5 mortality rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary counseling and testing
WAHO	West African Health Organization
WANASO	West African Network of AIDS Service Organizations
WHO	World Health Organization
WHO/AFRO	World Health Organization Africa Regional Office

Overall Trends in Health

Introduction

Improving the health status of families and communities in sub-Saharan Africa is critical to raising their quality of life and reducing poverty, creating stable societies, and building healthy national economies across the region. Optimistic projections show that large increases in life expectancy are possible for sub-Saharan Africa, but life expectancy has only reached 49 years, compared with a worldwide figure of 64 years in 2006.^{1,2} While health trends vary among countries, reflecting diverse political and socioeconomic situations, sub-Saharan Africa is behind all other regions of the world in several major indicators of health status. Ten percent of the world's population lives in sub-Saharan Africa, yet 42% of the world's child deaths and 90% of the world's malaria deaths occur in the region.^{3,4} Many of the region's child deaths are due to largely preventable infectious diseases, which are responsible for more than half of the disease burden. HIV/AIDS accounts for nearly 25% of adult mortality, while diarrheal disease, respiratory infections, and malaria combined account for 21%. Infectious diseases pose particular problems to pregnant women and infants.

While many countries have improved maternal mortality, only two countries in sub-Saharan Africa (Namibia and South Africa) have a maternal mortality ratio (MMR) lower than the global average of 400 deaths per 100,000

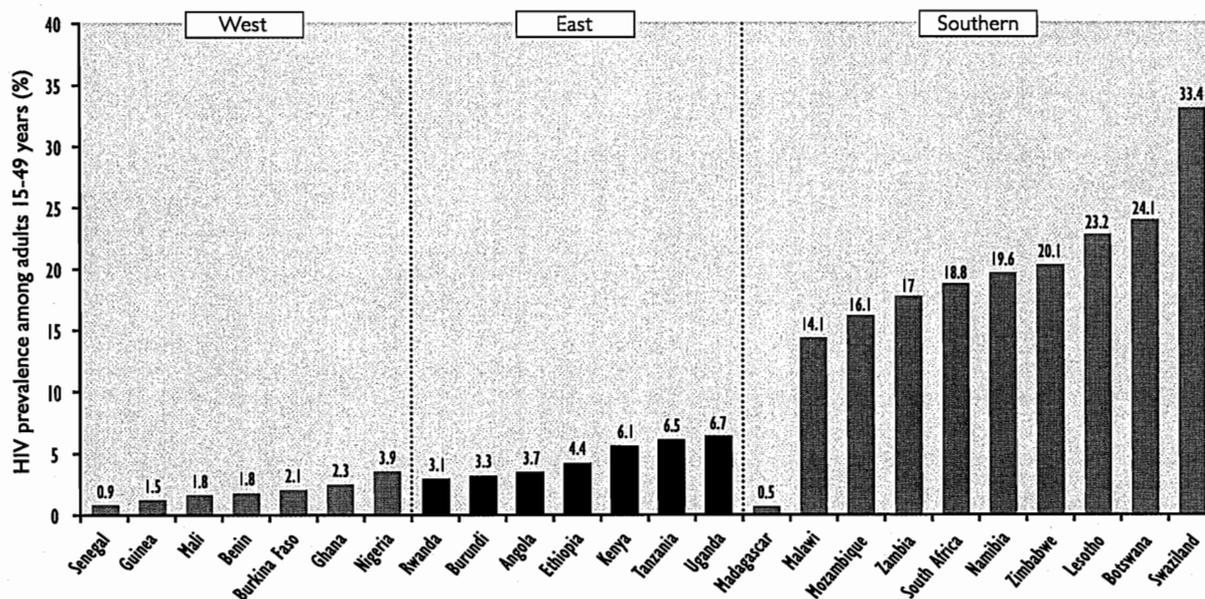
live births. About one in 16 women in sub-Saharan Africa will die from maternal conditions, compared with the average developing-country rate of one in 60 (about four times lower than sub-Saharan Africa's) and the world average of one in 74.⁵

Fertility rates have fallen in sub-Saharan Africa, though the region's total fertility rate (TFR) of about 5.2 children per woman remains higher than the global figure of fewer than three children per woman. Whereas replacement-level fertility is associated with a 65% contraceptive prevalence rate (CPR), and global contraceptive use is approximately 54%, contraceptive prevalence in sub-Saharan Africa is below 20%.⁶ Expanding access to family planning is essential to enable couples to plan how many children they want and when they want them, saving lives and improving the health of millions of women and children. Increased contraceptive use will also contribute to lowered fertility and poverty reduction, which is important because large youth populations can create social instability, and population pressures strain limited resources.⁷

In addition to trailing other regions in important health indicators, sub-Saharan Africa faces a critical resource shortage in skilled human capacity. Skilled manpower in the health sector is critical to reducing the burden of disease and to detecting and responding to outbreaks of

NOTE: References appear on page 12.

Figure 1 | **Estimated HIV Prevalence in Selected Countries in West, East, and Southern Africa, 2005**



Source: UNAIDS. 2006 Global Report.

new and emerging diseases. Trained workers are also needed to manage the large and diverse needs of health systems. Thirty-six countries in the region have critical shortages in skilled health workers (doctors, nurses, or midwives), and the region accounts for 35% of the worldwide shortage of human capacity.⁸ The burden of disease is not spread evenly across African countries, and the different needs of people and institutions within countries thus require a range of responses and targeting of programs.

HIV/AIDS

At the end of 2005, it was estimated that 24.5 million people in sub-Saharan Africa were living with AIDS. This figure represents nearly 64% of the total 38.6 million cases worldwide.⁹ Approximately 25% of all deaths in the region are attributable to HIV/AIDS,¹⁰ and about 80% of the world's AIDS orphans and vulnerable children live in sub-Saharan Africa.

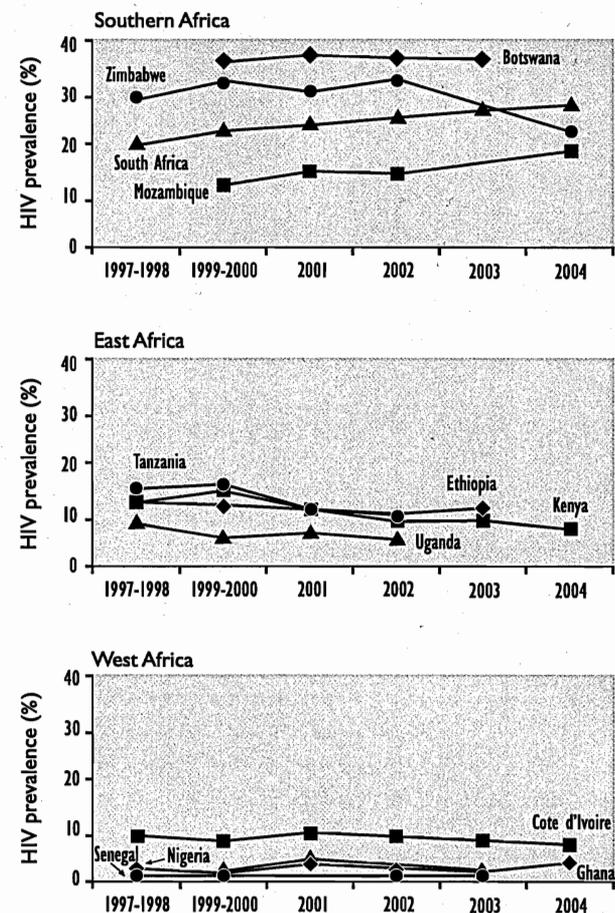
With a few exceptions, such as Senegal, most countries in sub-Saharan Africa have a generalized AIDS epidemic, where more than 1% of the population is infected. Women represent 59% of those infected – a higher percentage than in any other region. This has an untold effect on households, children, and communities where women often are responsible for food production and child care.

Figure 1 shows HIV/AIDS prevalence rates in sub-Saharan Africa.

The highest HIV prevalence levels in the world are found in Southern Africa. In four countries, more than 20% of the population is infected, and in five others between 10% and 20% are infected. Angola, which is emerging from nearly three decades of civil war, remains the country with the lowest HIV prevalence in Southern Africa. In East Africa, Madagascar had the lowest HIV prevalence (0.5%). West Africa has the lowest rates as a region, and in many parts, the epidemic appears to be stabilized, although concentrated epidemics occur.⁹ In Senegal, for example, national prevalence is less than 1%, yet it is as high as 30% among commercial sex workers in urban areas.

Figure 2 shows HIV prevalence among pregnant women tested at antenatal care (ANC) clinics. In East Africa, HIV prevalence rates among ANC clients have fallen recently in Kenya but are increasing in Malawi (not shown), where prevalence among pregnant women ranges from 7% to 33%. In Southern Africa, trends vary widely within and among countries, but there are no clear indications of a decline in prevalence. In Mozambique and South Africa, HIV prevalence among pregnant women receiving antenatal care has reached its highest levels ever. Similarly, rates in Botswana, Lesotho, Namibia, and Swaziland remain high – above 30%. In contrast, testing of pregnant women in

Figure 2 | HIV Prevalence Among Pregnant Women Attending Antenatal Clinics in Sub-Saharan Africa, 1997/98–2004

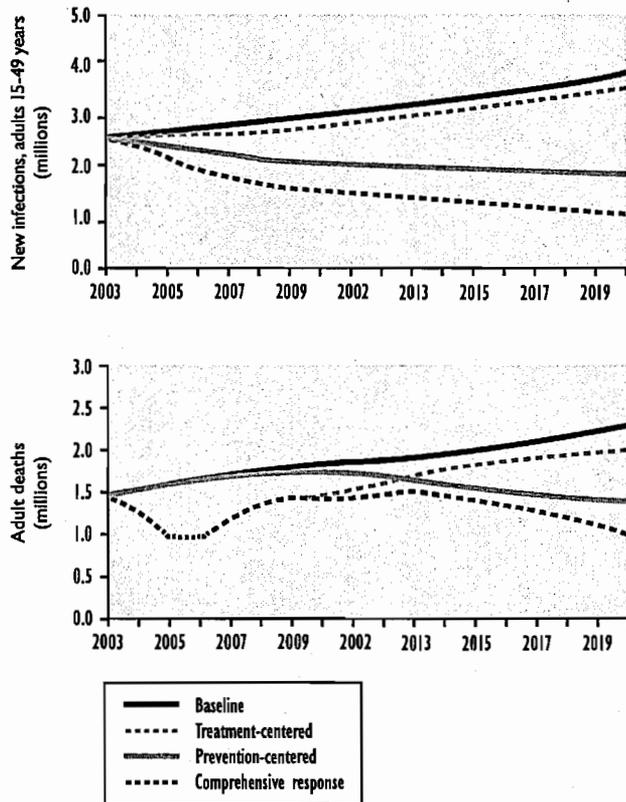


Sources: UNAIDS, *AIDS Epidemic Update*, 2005; Ministry of Health (Mozambique); Department of Health (South Africa); Ministry of Health and Child Welfare (Zimbabwe); Ministry of Health (Kenya); Ministry of Health (Tanzania); Ghana Health Service (Ghana); Centers for Disease Control and Prevention Global AIDS Program (Côte d'Ivoire); Conseil National de Lutte Contre le SIDA (Senegal); Asamoah-Odei, et al, HIV prevalence and trends in sub-Saharan Africa: no decline and large subregional differences, *Lancet*, 2004 (Botswana, Ethiopia, Uganda, and Nigeria).

Zimbabwe showed a decline in HIV prevalence from 26% to 21% between 2002 and 2004. In West Africa, prevalence levels from antenatal testing have yet to exceed 10%.

As seen in figure 3, sustained progress in the response against AIDS will only be attained by intensifying HIV prevention and treatment simultaneously. Concerted efforts for a combined prevention and treatment response could reduce the number of AIDS deaths by as much as 27% and the number of new infections by as much as 55% by 2020.

Figure 3 | **Projected HIV Incidence and AIDS Mortality Among Adults in Sub-Saharan Africa Under Different Intervention Scenarios, 2003–2020**



Source: Salomon et al. Integrating HIV Prevention and Treatment: From Slogans to Impact. *PLoS Medicine*. January 2005.

Knowledge is key to preventing infection. In 21 African countries, more than 60% of young women have either never heard of the virus or have at least one major misconception about how it is spread.¹¹ Information, education, and learning skills for HIV prevention thus form an essential part of HIV programs. Other challenges, such as HIV stigma and discrimination, also exist for those seeking HIV testing and treatment services. USAID and its partners use multisectoral approaches to the prevention of new infections; treatment of those living with HIV to prolong their productivity and improve their quality of life; care and support for those infected and affected by the disease; and research for new tools to fight the HIV/AIDS pandemic.

Reproductive Health

Fertility has declined worldwide from 4.6 children per woman in the 1960s to an estimated 2.6 in 2006. As seen in

figure 4, sub-Saharan Africa remains behind other regions at 5.2 children per woman, twice the rate of the global average.

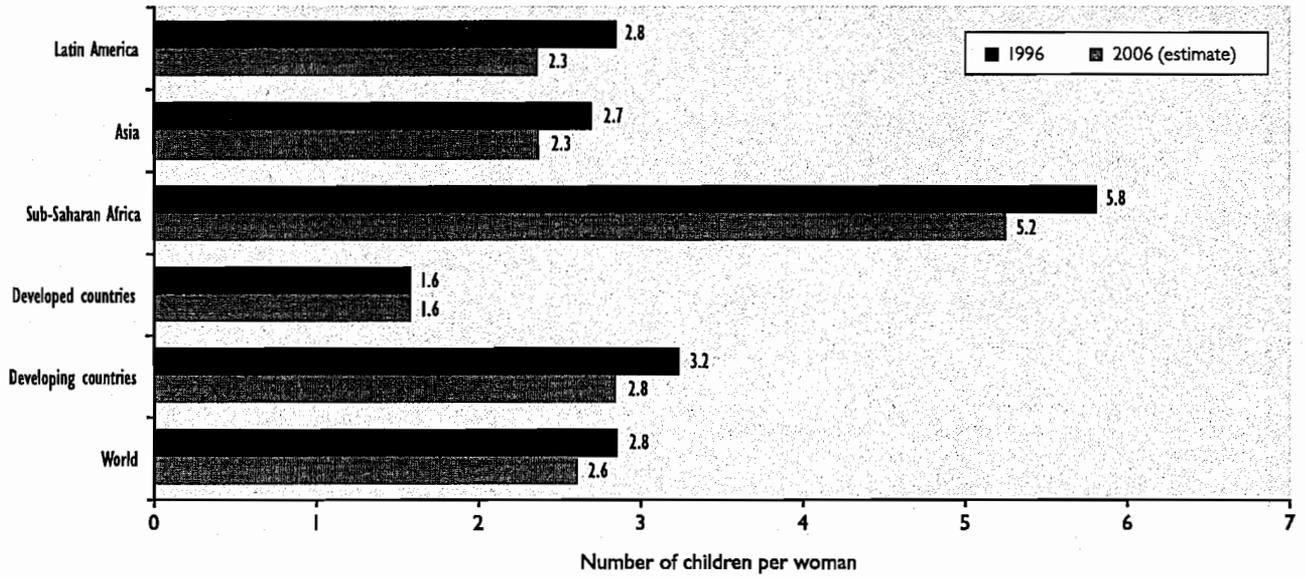
Figure 5 shows changes in fertility rates in sub-Saharan Africa between 1996 and 2006. Throughout the region, fertility rates have either remained constant or declined slightly over the 10-year period, except in Mali and Rwanda, where rates have recently increased. Only one country in the region (South Africa) has a TFR below three children per woman, and most countries range between 5.5 and seven.¹² Uganda has one of the highest rates in the region, at 6.9 children per woman, with Angola (6.7) and Burundi (6.8) close behind. Ethiopia (5.6), Rwanda (5.5), and the Democratic Republic of the Congo (5.3) are also above the regional average.

Even as fertility declines, the number of births each year increases due to population momentum, the effect produced by the increase in the number of women of reproductive age. Ten countries have population growth rates above 3% (compared to a world average of 1.2%), and rates above 2.5% continue in at least eight others.¹³ Several governments have recognized high population growth rates as a challenge to national stability and are addressing them as a development issue.

USAID's efforts promote the development of enabling policy environments and the increased use of contraception to help countries achieve stable populations.

Knowledge about family planning and access to contraception is critical to improving the health status of women and lowering population growth rates. Figure 6 shows modern-method CPRs (the percent of women using a modern method of contraception) among married women of reproductive age. CPR is a measure of the proportion of women who are at a reduced risk of unwanted pregnancy or health problems associated with frequent births. In most sub-Saharan African countries, a 1% to 2% increase in CPR per year is considered significant progress. Trend data show an increase in the number of married women who use a form of modern contraception in most countries in the region. In figure 6, only Rwanda shows a decrease in contraceptive use. Nine countries show increased use of more than 10% between the two survey years. While increases are occurring, 14 countries in sub-Saharan Africa are below the 20% target for the region. In most of West Africa, contraceptive prevalence is below 10%, while countries in Southern Africa generally have higher CPRs. South Africa has the highest percentage of women using contraception (55%), while Namibia has close to 43%. Kenya saw a significant 76% increase from 1989 to 2003. Ethiopia and Mozambique improved their CPR at a rate of about 1% per year, but both remain low at 7.6% and 6.6% respectively.

Figure 4 | **Regional Changes in Number of Children per Woman**

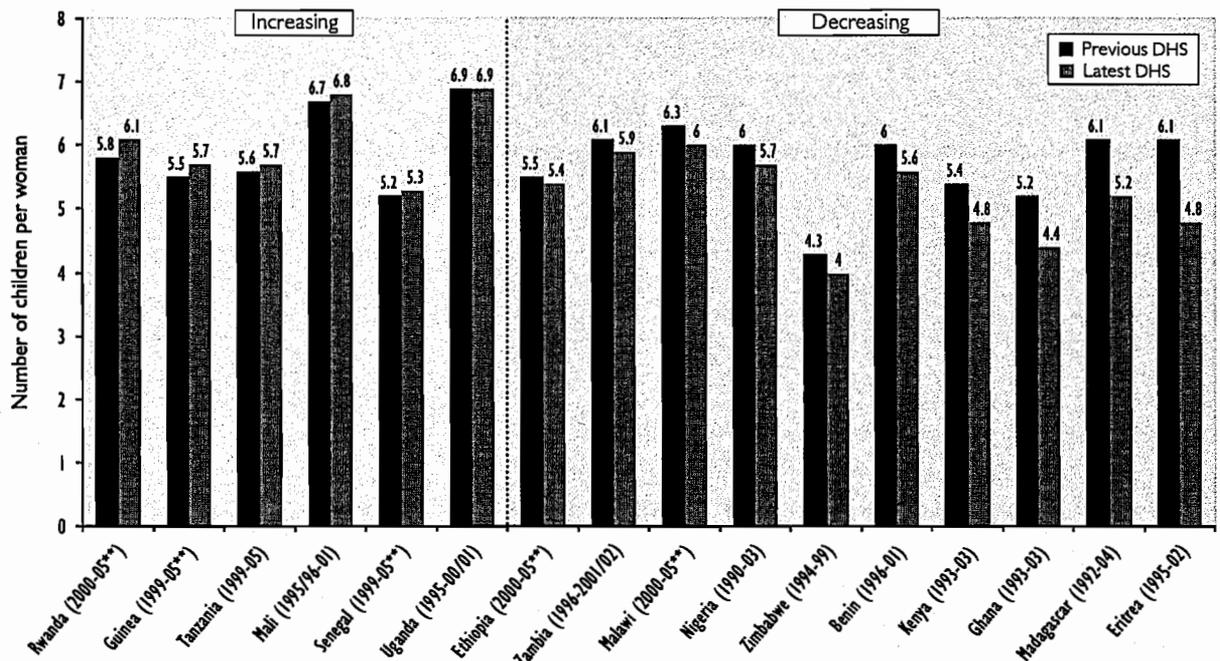


Source: U.S. Census Bureau. 2006.

Despite gains, many challenges still exist. In 2006, a survey of 41 countries in Africa, Asia, and Latin America found that seven of the 10 countries in the world with the highest measured unmet need for family planning (Rwanda, Ethiopia, Uganda, Togo, Malawi, Burkina Faso, and Mali) are in sub-Saharan Africa.¹⁴ Current strategies to improve

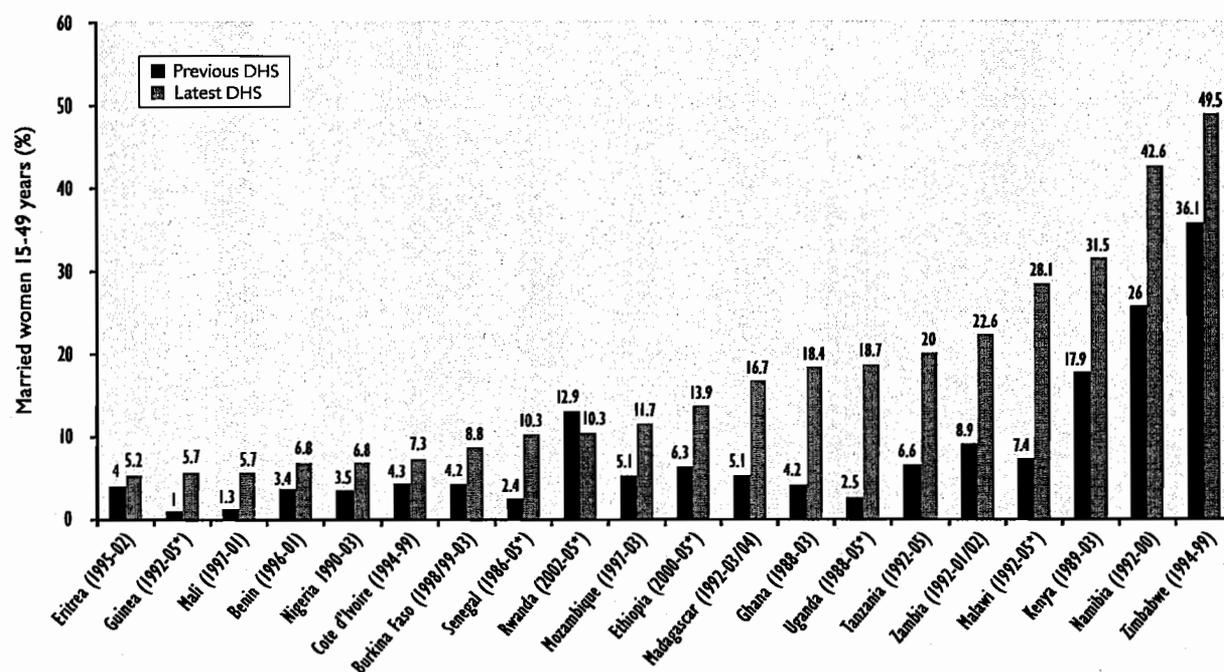
reproductive health and family planning include gender-sensitive training of providers in contraceptive technology, training and supervision of community-based health volunteers, and increased focus on male involvement in family planning.

Figure 5 | **Total Fertility Rates* in Selected African Countries With Two DHS**



Source: DHS of indicated years.
 * Among women 15-49 years of age.
 ** Denotes preliminary DHS data.

Figure 6 | **Contraceptive Prevalence Rates Among Married Women in Selected African Countries With Two DHS**



Source: DHS of indicated years.
* Denotes preliminary DHS data.

Maternal and Newborn Health

Maternal mortality in developing countries remains high, and complications from pregnancy and childbirth are a leading cause of disability among women of reproductive age. Worldwide, more than 500,000 women die during pregnancy and childbirth each year, and the world's highest MMRs are found in sub-Saharan Africa. Of the 20 countries with the highest MMRs, 19 are in sub-Saharan Africa. In USAID-assisted countries in the region, maternal conditions account for 2.2% of total mortality among women, compared with 1.48% in all USAID-assisted countries worldwide.¹⁰

Newborn deaths are also closely related to the health of the mother and whether she has received skilled attendance at delivery and postpartum care.⁶ Between 11% and 17% of maternal deaths happen during childbirth itself and between 50% and 71% occur postpartum largely due to lack of assistance during birth.¹⁵ Skilled birth attendance (SBA) offers the chance for important maternal counseling and the opportunity to provide essential postnatal care services such as vitamin A supplements and neonatal polio immunization. Figure 7 shows progress in Africa toward improving maternal and neonatal health through SBA. Several countries have made remarkable progress, despite the many challenges that exist to increasing the use of skilled professionals during delivery.

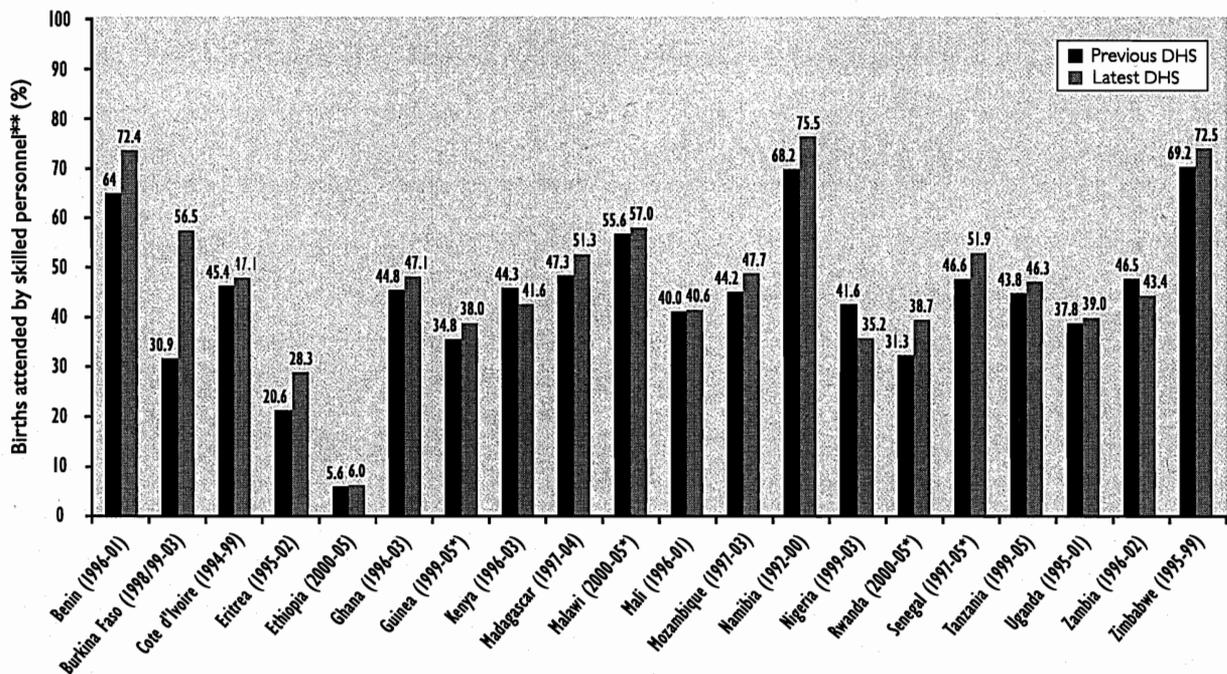
SBA nearly doubled from 30.9 to 56.5% in Burkina Faso between 1999 and 2003, and Benin also showed a significant increase from 64.0 to 76.3%. Recent Demographic and Health Survey (DHS) data from Rwanda and Senegal show increases of more than five percentage points. However, overall SBA increased less than 1% per year in most countries, and in Nigeria and Kenya it declined. In 13 countries, more than half the children born are not delivered with assistance from a trained worker. Meeting the Millennium Development Goal (MDG) of reducing maternal mortality by three-quarters will require greater attention from national leaders and resources for the prevention of common maternal health problems and increased use of health services, including SBA.

Child Health

With only one-fifth of the world's births, sub-Saharan Africa accounts for more than two-fifths of child deaths – 4.8 million children in sub-Saharan Africa die before the age of 5 every year. It is the only region in the world where the number of child deaths is rising.¹⁶ While reductions in under-5 mortality are occurring in several countries in the region, the rate of reduction, as shown in figure 8, is slower than in other parts of the world.

Figure 9 indicates that 10 countries with DHS data have shown marked reductions in their under-5 mortality rate

Figure 7 | **Skilled Birth Attendance in Selected African Countries With Two DHS**



Source: DHS of indicated years.
 * Denotes preliminary DHS data.
 ** "Skilled personnel" refers to a physician, nurse, or nurse-midwife.

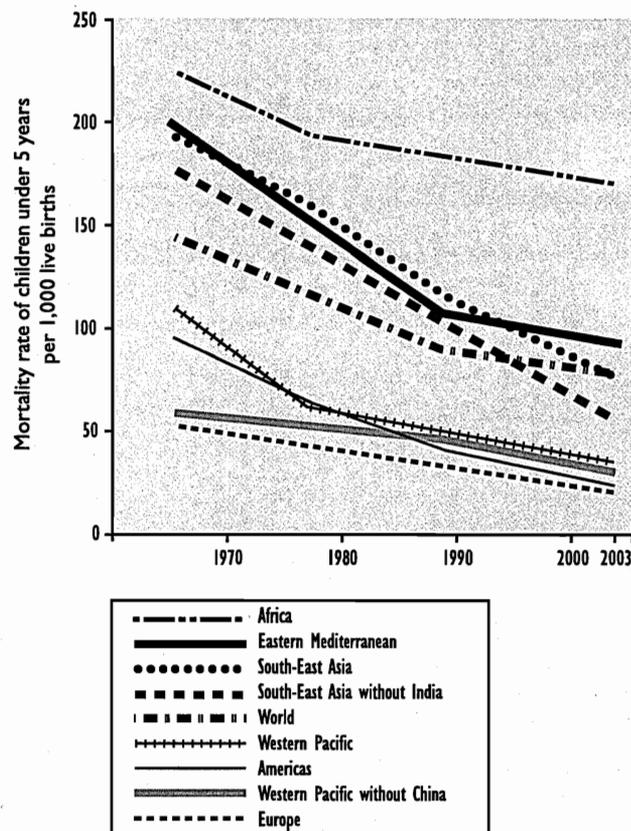
(U5MR), of which Madagascar and Eritrea have reduced it to less than 100 per 1,000 live births. Five countries, including Zambia, Kenya, and Zimbabwe, experienced increases in child mortality between survey years. Another 19 countries are progressing slowly and will miss the MDG target on child mortality.

The major causes of child mortality in sub-Saharan Africa continue to be diarrhea, malaria, and respiratory infections, which account for 39% of child deaths. Neonatal deaths, largely due to infection and birth complications, account for 26%. AIDS accounts for 6%, compared with 25% of adult deaths.

The high burden of diarrheal diseases and malaria compound the problem of malnutrition in sub-Saharan Africa. Malnutrition affects the outcomes of childhood diseases by weakening immune systems, and it is an underlying factor in an estimated 54% of under-5 deaths.¹⁷ It weakens children physically and detracts from their ability to learn, thus affecting their later development as well.¹⁸ Improving nutrition is not just critical to child health; it is also important to the productivity of a population.¹⁹

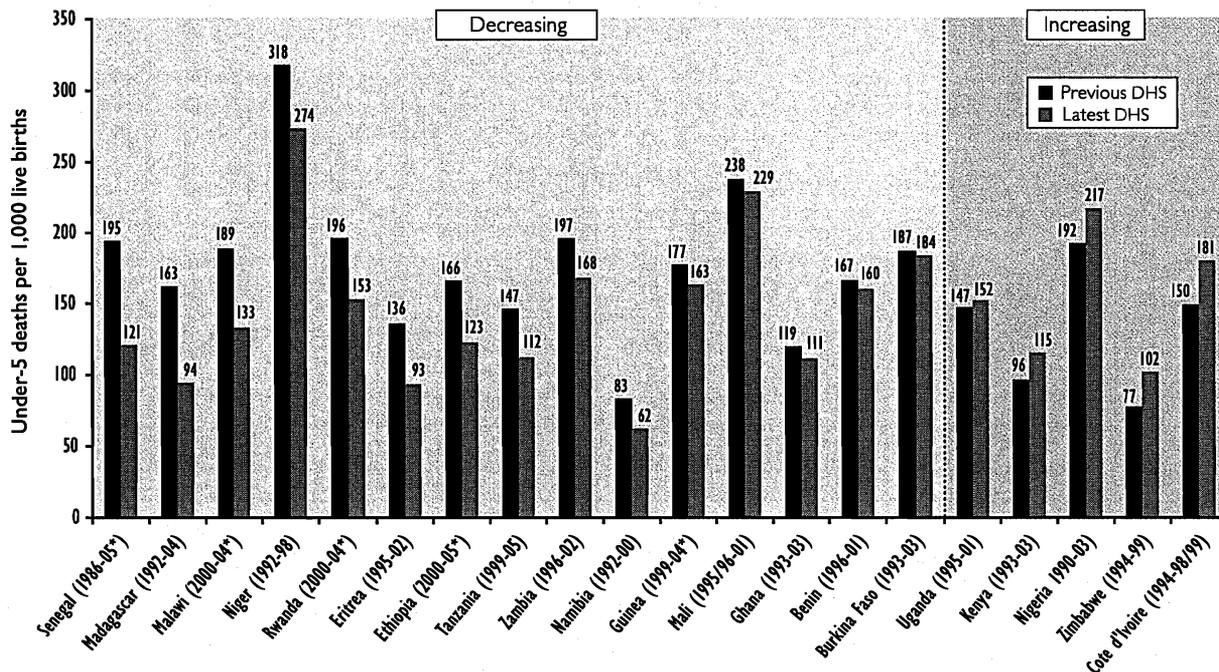
Although several countries in sub-Saharan Africa have made notable progress, malnutrition has increased in the region from 27% in the 1970s to 33% in 2004.²⁰ If current trends continue and the prevalence of malnutrition continues to increase, many countries will miss the MDG target of halving

Figure 8 | **Slowing Progress in Child Mortality: How Africa Is Faring Worst**



Source: WHO. World Health Report. 2005.

Figure 9 | **Under-5 Mortality Rates in Selected African Countries With Two DHS**

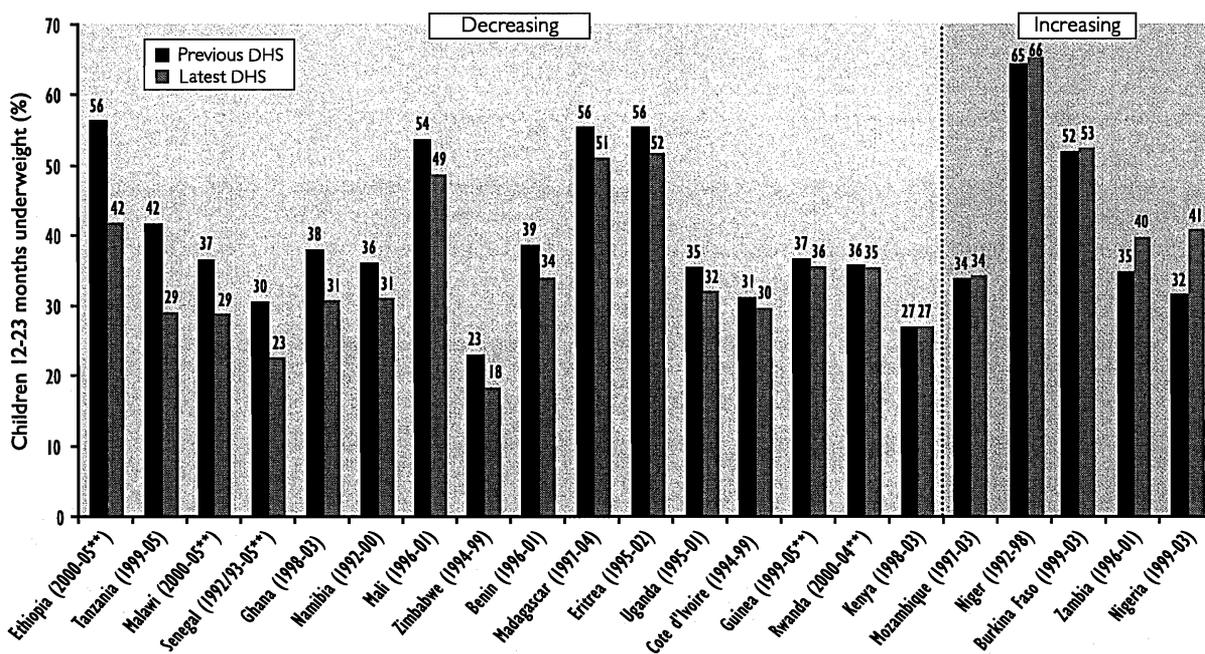


Source: DHS of indicated years.
* Denotes preliminary DHS data.

ing the percentage of malnourished children by 2015. An International Food Program Assessment published in 2005 found that concerted policies and investments to improve agriculture, nutrition, and food security could reduce by

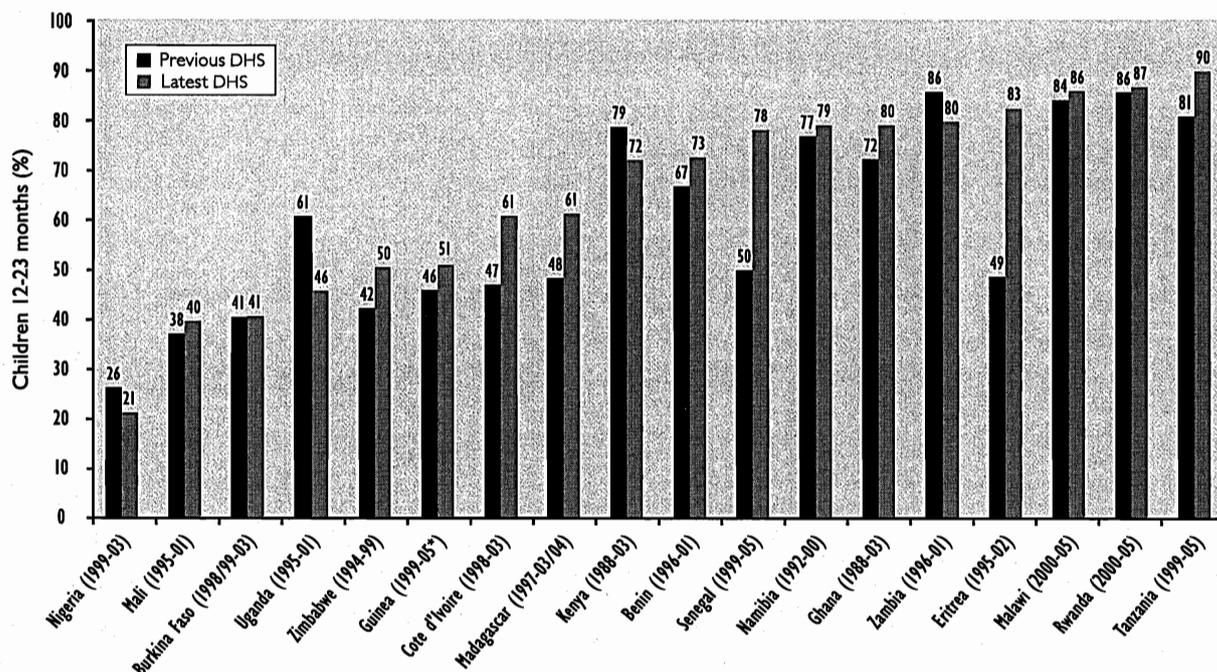
half the percentage of malnourished children from 32.8% in 1997 to 16.9% in 2015 and thus achieve the MDG target.²¹ Figure 10 shows the percentage of children who are

Figure 10 | **Child Malnutrition: Prevalence of Underweight Children in Selected African Countries With Two DHS**



Source: DHS of indicated years.
* Underweight as measured by weight-for-age.
** Denotes preliminary data.

Figure 11 | **DPT3 Coverage in Selected African Countries With Two DHS**



Source: DHS of indicated years.
* Denotes preliminary DHS data.

underweight (low weight for age), a measure of moderate malnutrition.

Ethiopia and Tanzania, two countries that often face food shortages, showed substantial improvement with 14 and 12.5 percentage point decreases, respectively, in underweight prevalence. Malawi, Ghana, and Senegal reduced underweight prevalence by more than seven percentage points. However, the percentage of underweight children in Kenya, Mozambique, and Burkina Faso showed little change, and Zambia and Nigeria had increases of five and nine percentage points, respectively.

Immunization

In light of the challenging conditions in which children in the developing world live, immunizations play a special role in child survival and health. While children in the developed world are generally immunized against deadly diseases such as measles, diphtheria, and pertussis, the threat presented by these preventable diseases remains an ongoing fact of life for children in many developing countries.

DPT3 coverage (the third and final dose of diphtheria-pertussis-tetanus vaccine) reflects a health system's ability to deliver a series of vaccinations and also indicates continuity in the use of immunization services and client satisfaction with services. Figure 11 shows that immunization coverage has been increasing in many sub-Saharan African countries.

East and Southern Africa have achieved the highest levels of immunization, with Tanzania, Rwanda, and Malawi all above 85%. In West Africa, Senegal had the highest increase between surveys, increasing from 50% to 78% between 1999 and 2005. Ghana improved seven percentage points to reach almost 80%, and Benin improved six percentage points to reach 72.5%. Some countries, however, including Uganda, Kenya, and Nigeria, had declines in immunization coverage.

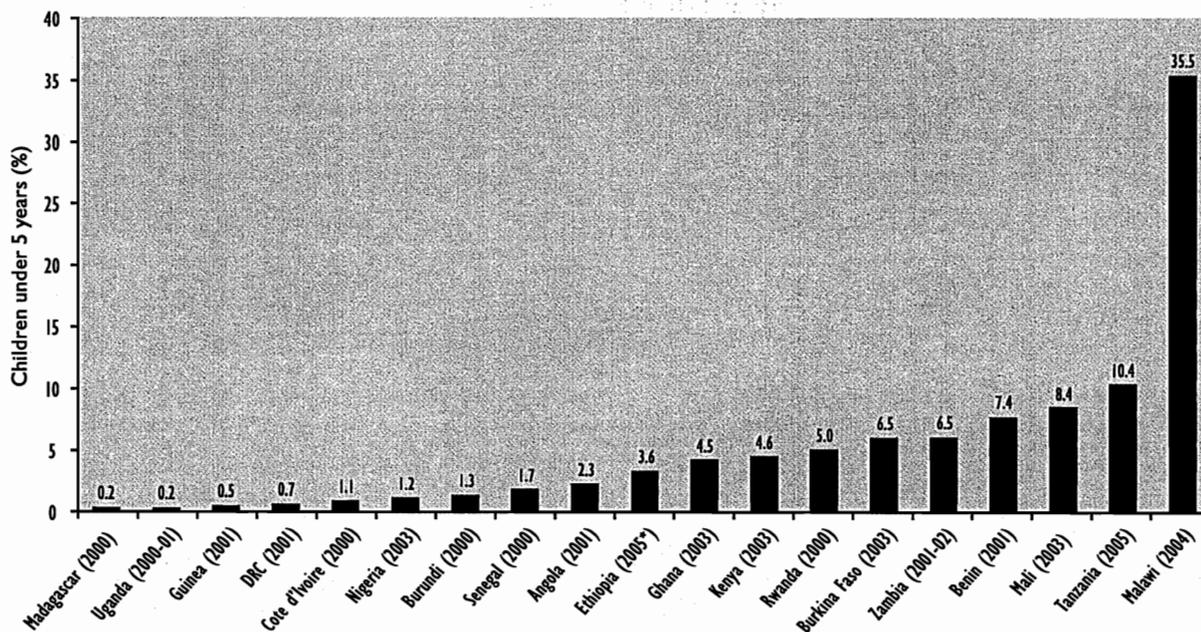
USAID supports regional efforts of the World Health Organization (WHO) to extend immunization coverage and promotes the "Reaching Every District" strategy. USAID also provides resources to the Global Immunization Vision and Strategy of the United Nations Children's Fund (UNICEF), which was launched in May 2005.

Infectious Diseases

Infectious diseases are responsible for more than 55% of deaths in USAID-assisted countries in sub-Saharan Africa, compared with 35% of deaths in other USAID regions. USAID's Infectious Disease Initiative seeks to reduce the threat of infectious diseases of major public health importance, especially malaria and tuberculosis (TB).

Malaria. About 60% of malaria cases and more than 80% of malaria deaths worldwide occur in sub-Saharan Africa. It is estimated that 66% of the region's population is at risk for malaria.²² Every day, nearly 3,000 children in sub-Saharan

Figure 12 | Children Under Age 5 Sleeping Under Insecticide-Treated Bednets



Sources: UNICEF. Global database on malaria, March 2006; DHS.
 * Denotes preliminary DHS data.

Africa die due to malaria.²³ As a major cause of anemia and low birthweight, malaria affects maternal and newborn health. In endemic African countries, it accounts for roughly one-third of all outpatient visits and imposes a great burden on the limited health care resources available.

Figure 12 shows use of insecticide-treated nets (ITNs) by children under 5 in selected sub-Saharan African countries. ITN coverage reflects malaria program efforts to increase distribution of measures that will reduce morbidity and mortality due to malaria. A large body of evidence has documented the substantial impact ITNs can have in malaria-endemic countries. Regular use by children can reduce the risk of dying before the fifth birthday by one-fifth and could save more than 800,000 lives annually.²³ ITN coverage and use remain low; a survey of 34 countries in sub-Saharan Africa found that, on average, only 3% of children under 5 were using ITNs.

Many countries are showing signs of rapid improvement. In the past three years, the number of ITNs distributed increased tenfold in at least 14 countries. Surveys conducted between 2002 and 2004 showed increases in ITN coverage to 10% in Tanzania and 36% in Malawi from baselines of nearly zero. In selected areas of Senegal, household ownership of ITNs increased from 11% in 2000 to 41% by 2004.²² Five other countries (Burkina Faso, Kenya, Malawi, Namibia, and Zambia) have achieved coverage of or above 7%, although they remain far from the 60% target established in the Abuja Declaration of 2000.

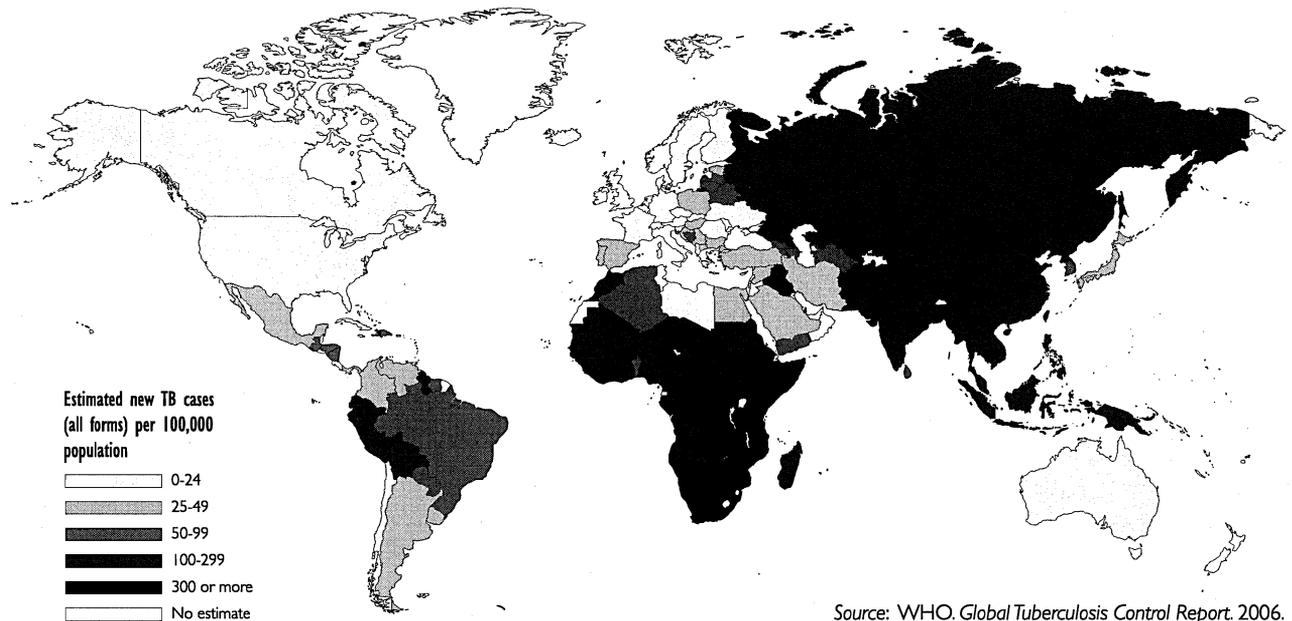
To move toward this target, USAID works in collaboration with the Roll Back Malaria (RBM) partnership and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Currently, 31 USAID-assisted countries in sub-Saharan Africa are monitoring ITN use. ITNs are an important component of the President's Malaria Initiative (PMI), which was launched in three countries (Angola, Tanzania, and Uganda) in 2005. The goal of the PMI is to have 85% of children sleeping under an ITN within five years of program implementation in up to 15 target countries.

In addition to supporting ITNs, USAID supports the use of artemisinin-based combination drug therapies (ACTs) for malaria and intermittent preventive treatment for pregnant women. Recently, USAID also endorsed indoor residual spraying in appropriate contexts and settings.

Tuberculosis. More than 80% of global TB incidence occurs in sub-Saharan Africa, as demonstrated in figure 13. TB incidence is still rising in the region, following the spread of HIV. A re-emerging infectious disease, TB is responsible for 3.14% of all deaths in USAID-assisted countries in the region, compared with 2.81% in all USAID-assisted countries worldwide.

Sub-Saharan Africa currently has the highest TB burden of any region, with 400 cases per 100,000 population, far from the MDG target of less than one case per million per year by 2050.²⁴ Nigeria has sub-Saharan Africa's highest incidence of TB and is ranked fourth worldwide, followed

Figure 13 | **Estimated TB Incidence Rate, 2004**



by South Africa, which is ranked fifth. Six other sub-Saharan African countries (Kenya, Uganda, the Democratic Republic of the Congo, Tanzania, Mozambique, and Zimbabwe) are among the top 20 countries in the world for TB incidence.

USAID supports the use of the DOTS (“directly observed treatment, short course”) program and contributes to the Stop TB Partnership goals of detecting at least 70% of new sputum smear-positive cases and successfully treating at least 85% of these cases. At the regional level, 84% of the general population in sub-Saharan Africa was covered by DOTS in 2004. DOTS case detection increased from 23% to 47% between 1994 and 2004. The DOTS treatment success rate increased from 59% to 72% during the same period.

To address new and emerging infectious disease threats, such as avian influenza, USAID is working with other U.S. Government and international agencies to improve surveillance, increase preparedness, and ensure a coordinated response to epidemics and outbreaks. USAID is working with the International Partnership on Avian and Pandemic Influenza and other partners, including the U.N. Food and Agriculture Organization and WHO, to support prevention and containment efforts in affected countries. This effort focuses on preparedness; animal and human surveillance; rapid response to animal and human outbreaks; communications; and commodities procurement and storage to contain outbreaks.

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USAID Response and Activities in Health

1. Reduce transmission and impact of HIV/AIDS

To mitigate the impact of HIV/AIDS, USAID Missions embrace a multisectoral approach to preventing HIV infections and treating and caring for AIDS-affected and -infected people. Programs work through diverse means to address health and livelihoods activities to respond to the crisis at the community level. Missions integrate cross-sector linkages between HIV/AIDS-specific programs with other health programs, as well as those in education, agriculture, economic, and democracy and governance programs. HIV/AIDS, reduces the number of able and educated workers, decreasing the economic productivity and development of countries. Missions also respond to the need for trained human resources to deal with the AIDS epidemic by training health workers at clinics and in the community. Almost all Missions have helped implement workplace programs to reduce the impact of HIV/AIDS on worker productivity and have been instrumental in guiding policies on HIV/AIDS treatment strategies. USAID is also taking the lead on the impact of HIV/AIDS on orphans and vulnerable children.

USAID's balanced approach to prevention includes the "ABCs" of Abstinence, Being faithful, and consistent and correct use of Condoms when appropriate. USAID supports prevention of mother-to-child HIV transmission (PMTCT); treatment of sexually transmitted infections (STIs) to reduce the chance of HIV infection; and voluntary counseling and testing (VCT). USAID works with community-based organizations (CBOs) and faith-based organizations (FBOs) to provide home-based and palliative care services to communities affected by HIV/AIDS through innovative programs and is also expanding its work with the private sector. USAID programs are working to provide services and positive policies for persons living with and affected by HIV/AIDS.

The following results were reported in Africa fiscal year (FY) 2006 Annual Reports. Focus countries of the President's Emergency Plan for AIDS Relief (PEPFAR), 12 of which are in sub-Saharan Africa, were not required to report separately to USAID.

Prevention, Care, and Treatment

Angola

- VCT clinics were established at four TB centers and hospitals, bringing the number of clinics financially supported by USAID to 10.
- The number of patients tested at VCT clinics increased from 17,706 in FY 2004 to 18,935 in FY 2005, an increase of 7%.

Burundi

- USAID sold 3,077,696 condoms during FY 2005, against a target of 2,400,000. The number of sales points increased from 1,238 at the end of 2004 to 1,990 at the end of September 2005, an increase of 61%.
- USAID-supported networks provided care and support to 1,528 people living with HIV/AIDS.
- A USAID-supported partnership between Family Health International (FHI) and a local nongovernmental organization (NGO) established a youth-friendly VCT center in Bujumbura. The center tested 2,719 clients and trained 20 peer educators.
- USAID funding provided 1,490 orphans and vulnerable children with medical and psychological support; 80 with vocational training support; and 2,500 with educational support.

DR Congo

- Seven USAID-funded VCT sites worked with 32,390 clients. The rate of return for HIV test results increased significantly from 68.2% in 2004 to 92.9% in 2005.
- Beneficiaries of USAID's care and support program for people living with HIV/AIDS increased from 2,677 in 2004 to 5,928 in 2005.
- A total of 90,438 condoms were socially marketed, exceeding the sales targets by 80%.

Ethiopia

- 16,000 people received free treatment in 56 hospitals; they were the first beneficiaries of the free services.
- Prevention messages are now widespread even in rural areas.

Ghana

- HIV/AIDS prevalence among the adult general population declined to 3.1%, compared to 3.6% in 2004.
- Interventions with prostitutes rapidly scaled up and included an additional 3,000 prostitutes during the second part of the year.
- Newly formed national and regional associations and church-based groups supported 3,600 HIV-infected people and their families through programs for people living with HIV/AIDS.
- 281 people received training in care and support for people living with HIV/AIDS and orphans and vulnerable children through the public law (PL) 480 program.
- 686 people living with HIV/AIDS and orphans and vulnerable children received psychosocial counseling, while 14,060 others received nutrient-dense take-home food rations to improve their nutritional status.

Guinea

- USAID opened four urban VCT centers, providing them with trained counselors, laboratory and janitorial staff, and a one-year supply of testing kits. USAID also introduced biohazard protection for all staff, including technology for medical waste handling and incineration.
- STI diagnosis and treatment were integrated into the services provided by 43 health centers within USAID's intervention zones. Through collaboration with the German development agency GTZ, USAID has integrated STI services in all of the 109 USAID-supported health centers in Upper Guinea.
- 73% of STI counseling and treatment services in USAID-supported health centers comply with national norms and procedures.
- USAID is the lead donor in establishing VCT centers. In cooperation with the MOH, four model centers opened in urban hubs. With assistance from the U.S. Department of Defense, a center for the Guinean military and their families opened in the Forest Region.
- More than half of the 663 people receiving counseling and testing at the four urban VCT centers were women.
- The proportion of women with knowledge of appropriate condom use increased from 16% in 2003 to 79% in 2005.

Kenya:

- 11,000 Kenyans began ART.
- USAID contributed to ART for another 21,000 Kenyans through investments in drug procurement, public sector infrastructure (the Kenya Medical Supplies Agency), pharmacies, and enhancing the capabilities of health professionals initiating and monitoring ART.

Liberia

- Africare initiated programs on HIV community awareness, prevention (with an emphasis on STI treatment), VCT, and dual protection with condoms.

Madagascar

- Through FHI, 42,400 orphans and vulnerable children received services and 10 community programs in six districts received support for providing home-based care to 22,000 chronically ill individuals.
- TOP Reseau, USAID's comprehensive STI/HIV prevention and treatment program for vulnerable youth, received recognition and became part of the International YouthAIDS initiative. This was documented through the VH1 music network and news articles. TOP Reseau's successful network of youth-friendly, clinic franchises served more than 44,000 adolescent clients (double the number in 2004), and peer educators reached more than 14,500 youth with key prevention messages.
- The *Youth Alert! Mix* radio program, which focuses on delaying sexual debut and renewed abstinence for youth, reached 10,380 secondary-school students and 279 secondary-school teachers and distributed 7,421 life skills manuals.

Malawi

- The number of USAID-assisted counseling and testing centers increased from three in 2000 to 51 in 2005, well over the target of 39. The number of clients assisted at these sites per year increased from about 22,000 in 2000 to more than 59,000 in 2005.
- The number of sites providing PMTCT services increased from two in March 2004 to nine in 2005. The number of women provided with PMTCT services increased to 564.
- USAID's condom social marketing project sold about 8.3 million condoms, a 46% increase from the 2000 baseline figure of 5.7 million.
- In a pilot project that provided community therapeutic care to treat severe acute malnutrition (SAM) in HIV-positive children, as well as referral for further care and ART, 59% of the children recovered from SAM. The project protocol is being disseminated and will help reduce malnutrition and the impact of HIV/AIDS.

Mali

- Behavior change communication (BCC) messages and activities delivered by NGOs reached more than 600,000 people; 580 peer educators received training in BCC approaches.
- Nearly 90% of groups at the highest risk have access to male condoms through USAID's social marketing program.

- At-risk youth continued to benefit from the “100% Youth” initiative, which reached over 6,000 youth with messages on the importance of abstinence and fidelity.
- VCT services in three sites served 2,318 men and 1,918 women, 10% of whom tested positive.
- An innovative mobile VCT strategy served almost 1,000 most-at-risk clients over a six-month period, which represented a 36% increase in client volume.

Nigeria

- Biologic sentinel surveillance showed a substantial decrease in the syphilis rate among pregnant women, which decreased from 10.6% in 1996 to 5.1% in 2005.
- Among female sex workers, syphilis decreased from 28.4% in 1996 to 16.6% in 2005, and it dropped from 14.7% to 6.8% among STI patients.
- USAID sold and distributed nearly 16.5 million condoms in 2005, an increase of 30% over 2004.
- In USAID-supported clinics, 172,886 clients were treated for gonorrhea and chlamydia, and 144,212 clients were treated for syphilis and chancroid. In Fort-Dauphin, a major mining city, USAID worked with the government and the mining company to establish a comprehensive behavior change, prevention, and care package, including services and education for vulnerable local populations.
- USAID continued to promote abstinence and delayed onset of sexual activity among youth through the *It's My Choice* radio show developed with educators, religious leaders, and social workers.
- USAID continued important behavior change programs with high-risk groups in select “hot zones.” Activities included condom provision and education for miners in Ilakaka, truck drivers, and other transient workers along the main highway from Tamatave to Tana.

Senegal

- National HIV prevalence was 0.7% among the general adult population, one of the lowest rates in Africa.
- In FY 2005, some 52 USAID-supported organizations conducted BCC interventions using the ABC approach, reaching 121,533 persons (including 72,379 women and girls). More than 31,562 educational materials (posters, cassettes, etc.) were distributed in nationwide prevention and care campaigns.
- In FY 2005, nine VCT centers became fully functional, and 10,360 persons (including 6,729 women and girls) used VCT services, exceeding the target of 8,000.
- VCT policy, norms, and protocols were revised following a USAID-supported evaluation.
- Syphilis screening of pregnant women is now effective in 15 health posts.
- STI services for prostitutes and men having sex with men were reinforced in 31 health delivery points.

- NGOs, CBOs, and the HIV/AIDS Ambulatory Care Center began providing nutritional and psychosocial support to people living with HIV/AIDS in five regions.
- 490,200 male condoms and 363,012 female condoms were distributed.

Rwanda

- USAID provided care and support for more than 59,000 people.
- 132,922 pregnant women received PMTCT services.
- 310,577 people received VCT.
- ART sites treated 15,975 patients, compared with fewer than 100 in 2003.
- 26,682 orphans and vulnerable children received care and support.

South Africa

- USAID supported efforts to improve the quality of care provided at selected public health facilities. In rural Mpumalanga Province, which serves a population of about 80,000, the percentage of pregnant women offered HIV counseling and testing at the public health facility increased from 22% to 72% in FY 2005.

Tanzania

- The cumulative number of first-time VCT clients counseled, tested, and receiving results reached 283,491 people, 1.7 times its target of 162,291.

Uganda

- 618,503 adults received VCT services, against a target of 522,580.
- 35,114 individuals received antiretroviral drugs (ARVs), against a target of 36,471.
- The Mission provided support for 118,230, close to the target of 143,975.
- 209,173 individuals were provided with palliative care, just shy of the target of 221,800.

Zambia

- 8,834 individuals received ART in FY 2005.
- 9,388 individuals received care and treatment services.
- 9,942 individuals received palliative care services.
- USAID supported the launch of PMTCT services at 34 facilities and strengthened services at 20 already existing facilities.
- 5,299 pregnant women received USAID-supported PMTCT services in FY 2005.
- 52 programs of *Your Health Matters* and 26 of *Community Health with Sister Evelina* aired to promote positive HIV/AIDS behaviors.

- The *Care and Compassionate Movement* program targeting religious leaders developed and aired four radio and TV spots programs featuring people living with HIV/AIDS.
- 7,643 youth who participated in an HIV information communication contest reached 23,229 other youth, parents, and teachers through their performances. USAID supported the HIV/AIDS Talkline, a 24-hour telephone call service that provides counseling and referrals to callers. The Talkline fielded 13,207 calls from April through September.
- USAID partners reached 206,916 high-risk individuals with prevention interventions, compared with the target of 165,377.
- One-third of AIDS-affected orphans and vulnerable children and 16% of people living with HIV/AIDS received care and support through community-based approaches and food assistance.

Zimbabwe

- In October, the Ministry of Health and Child Welfare announced a substantial decline in the HIV prevalence rate, from 24.6% in 2004 to 20.1%, based on sentinel surveys of pregnant women attending ANC clinics.
- An analysis of the impact of an education and counseling program (which operated from 1990 to 2001) to promote safer breastfeeding practices found that among postpartum women of both known and unknown HIV status, rates of exclusive breastfeeding increased five to eight times and postnatal HIV transmission was reduced. Based on these findings, WHO, with USAID support, disseminated infant feeding guidelines for HIV-positive mothers.

USAID East Africa

- The Organization of African Instituted Churches and the CORE (Communities Responding to the HIV/AIDS Epidemic) Initiative mobilized 47 churches and 310 congregations and CBOs to reach 16,143 people in Kenya and Uganda, including 5,700 orphans and vulnerable children, with prevention, care, and support messages and programs, including reducing stigma and discrimination. Two hundred church leaders received training in HIV prevention and institutionalization of best practices in HIV prevention.
- Results and an assessment to determine the status of TB-HIV collaborative activities in seven countries were presented to the permanent secretaries of health from 14 countries, with the recommendation that countries adopt collaborative services. As recommendations are implemented, persons co-infected with HIV and TB will be identified, placed on lifesaving drugs, and have earlier access to ART.

USAID Southern Africa

- 185,000 men, women, and children benefited from the USAID regional program, compared with the FY 2005 target of 150,000. The program also supported 50 outlets at health clinics and community and commercial sites to provide condoms donated by the Ministry of Health and purchased from Population Services International (PSI)/Uganda.
- 314 people received training in HIV prevention communication skills; they in turn reached 164,595 adults and youth with behavior change messages.
- To improve service provision at nine VCT sites, 32 persons received training as counselors and four as supervisors. The nine sites provided counseling and testing services to 1,726 persons.
- 74 persons received training in logistics and information management skills.
- 52 persons received training in home-based care.

Capacity Building

Burundi

- USAID partners provided training and technical assistance to seven local implementing partners operating throughout Burundi. USAID's health and HIV/AIDS interventions provided community-based health workers and local service organizations with much-needed training and technical assistance that increased the availability of health and HIV/AIDS services in rural areas.
- 307 young people (90 male, 217 female), 60 religious leaders (all men), and 30 association leaders (11 men, 19 women) received training on HIV prevention.
- At the newly opened youth-friendly VCT center, 626 peer educators (256 men, 370 women), including internally displaced persons, students, and condom distributors, received training.
- USAID partners trained 94 health workers (53 men and 41 women) on HIV/AIDS and communication skills; these community-based health workers in turn held 428 sensitization trainings on the disease in three communities.

Ghana

- Nearly 300 health care providers were trained and mobilized to provide quality services.
- USAID continued to support the Community-Based Health Planning and Services initiative in the seven southern regions of the country. In 2005, USAID supported the development of protocols, curricula, and training manuals for all relevant services and established training sites in eight districts as demonstration sites for in-service training.

Guinea

- 875 community and religious leaders were trained in family planning and STI/HIV/AIDS prevention.
- 38 community health committees were set up in three prefectures (Kankan, Kérouane, and Faranah). USAID trained 2,947 committee members, of whom 63% were men, in family planning, STIs, and HIV/AIDS to increase men's awareness, support, and participation in reproductive health. Members are selected through a democratic process and work in close collaboration with local health centers.
- In partnership with UNICEF, USAID assisted with the development of national PMTCT guidelines, which will increase the capacity of health professionals to deliver quality PMTCT services.
- USAID provided training and technical assistance to 13 local NGOs, including several FBOs, and supported training religious leaders from the Christian and Muslim communities to design and disseminate HIV/AIDS prevention and ABC messages targeting high-risk groups. These messages reached more than 400,000 persons.

Kenya

- 80 leaders of the National Muslim Women's Network to Fight AIDS received training on how to provide home and community support and reduce stigma in their communities. Ten Muslim women's HIV support groups have been established and strengthened. They address issues such as stigma, orphans and vulnerable children, and women's property and legal rights in their communities.

Liberia

- The Mission signed an agreement with PACT to build the capacity of FBOs to prevent HIV infection in commercial sex workers and to provide home-based care, VCT, and care for children orphaned by AIDS and other vulnerable children.

Madagascar

- USAID helped 20 local AIDS coordinating committees in high-risk zones conduct an HIV mapping exercise and develop strategic frameworks and operational plans.
- The local AIDS coordinating committees in the seven cities where the site-specific PLACE behavior survey was conducted used the information for their strategic plans and to mobilize funding.
- USAID supported the establishment of the national HIV second-generation surveillance system. Use of this information on HIV and STI prevalence and risk behavior data will increase the capacity of the MOH to provide an effective response to HIV.

- The national AIDS program disseminated the behavioral surveillance survey and preliminary biological surveillance results.

Malawi

- Through FHI, 42,400 orphans and vulnerable children received services and 10 community programs in six districts received support for providing home-based care to 22,000 chronically ill individuals.
- USAID funded a behavioral surveillance survey to monitor behavioral aspects of the pandemic, which showed the median age for first sexual activity increasing from 12 to 16 years of age.

Mali

- The Alliance of Religious Leaders in Mali was formed in FY 2005, bringing together Muslim, Catholic, and Protestant religious leaders, male and female, to advocate for HIV prevention and acceptance of persons living with HIV/AIDS.
- Malian religious leaders finalized for use a Muslim advocacy model, which was shared throughout West Africa as a means to engage religious leaders in the fight against HIV transmission and AIDS-related discrimination.
- Nearly 700 religious leaders received training on advocacy for HIV/AIDS issues.

Nigeria

- USAID partners trained 32 trainers and 60 facilitators, who in turn reached 1,140 at-risk children in 19 communities with home-based, prevention-focused nutrition programs.
- With PEPFAR Plus-Up funding, USAID is expanding faith-based prevention efforts through a platform of religious leaders that brings together Christians, Muslims, and traditional leaders, and mobilizes communities to fight HIV/AIDS and other STIs. This use of FBOs expands the capacity of the health system to deliver prevention messages.

Senegal

- USAID trained 32 health personnel in providing nutritional support and provided psychosocial and nutritional support to 797 people living with HIV/AIDS (including 492 females) in Dakar.
- To reinforce the decentralization of ART, USAID provided technical assistance to revise treatment guidelines and develop training materials on logistics and distribution of ARVs and other essential commodities. More than 1,000 treatment guides were distributed.

- Norms and protocol guides for STI management among high-risk groups were revised, and 500 guides were printed and distributed throughout the health delivery system.
- USAID helped develop capacity building tools, such as policy guidance, reference materials, and training manuals for a PMTCT rollout plan. The documents were finalized and 6,500 copies reproduced and distributed. Ten PMTCT sites received formative supervision.

Zambia

- 186 health care workers received training, and job aids were developed to enhance the quality of ART services, including ART adherence counseling. The ART outreach model is an innovative approach that will enable the MOH to increase access to ART and reduce the number of people on waiting lists.
- 75 community motivators and 151 health providers received training on care and support to strengthen the linkage between maternal and child health (MCH) services and PMTCT.
- 205 health care providers received training in PMTCT skills; 20 trainers underwent “training of trainers.”
- USAID trained 272 men and women in the Zambian police force, prisons department, revenue authority, and immigration department to be peer educators for HIV/AIDS; the trainees then provided HIV/AIDS education to 5,204 individuals.
- USAID sponsored the Better Health Campaign, which was aired on television and radio with spots on HIV/AIDS, water and sanitation, TB, and malaria.
- USAID completed integration of the counseling and testing, PMTCT, and commodity and information systems into the government’s health management information system; 64 health workers and 74 data management specialists received training in its use.
- USAID provided training in HIV/AIDS for 456 graduating medical, paramedical, and nursing students. USAID also provided support to develop the National In-Service Training Coordination System, which outlines strategies, coordination roles, and training responsibilities at all levels of the health system.

USAID East Africa

- Through a partnership with the African Network for Care of Children Affected by HIV/AIDS (ANECCA) in Kampala, Uganda, the first *Handbook on Pediatric AIDS* was published. The *Handbook* will increase the capacity of health workers to diagnose and care for children in the region who are infected with HIV. More than 10,000 copies of the *Handbook* have been published, and 8,000 have been distributed in more than 17 African countries. 178 health providers from Uganda, Kenya, Tanzania, Ethiopia, Rwanda, Malawi, and Zambia received training on the curriculum developed from the *Handbook*.

- ANECCA, the National Institutes of Health, and the University of Bordeaux’s Institute for Public Health, Epidemiology, and Development initiated a research collaboration to gather clinical and programmatic information on children receiving ART at sites across Africa. 28 sites have joined the collaboration, which is called KIDS-ART-LINC.
- 59 participants from 12 East, Central, and Southern African countries attended the regional workshop on Strategic Communications for Care, Support, and Treatment held by AfriComNet, a behavioral communications network. Eight countries implemented 31 innovative care and treatment communication practices.
- USAID/East Africa cosponsored the President’s Emergency Plan’s Regional Meeting on Alcohol and HIV/AIDS Risk Behaviors in August. Eighty participants from 12 countries attended the meeting to increase the capacity of the health systems in their home countries to respond to the pandemic.
- The Rational Pharmaceutical Management Plus Program (RPM Plus) established learning sites for ARV services in Tanzania, Zambia, and Kenya. Two sites trained 26 staff on the use of an electronic dispensing tool to monitor and record ARV use, which has improved service quality.
- Technical leadership from RPM Plus helped develop a generic preservice curriculum for pharmaceutical management in support of ART. The curriculum is undergoing field testing at universities in Kenya, Uganda, Tanzania, Ethiopia, Rwanda, Malawi, Zimbabwe, and Zambia. ECSA-HC also trained 80 participants from three countries on HIV/AIDS drug procurement and logistics.
- The Food and Nutrition Technical Assistance (FANTA) program completed a set of six counseling materials for nutritional care and support of people living with HIV/AIDS; the materials were disseminated to governments, NGOs, multilateral programs, and service providers in the region. The materials were adapted to local contexts and used to train 130 nutritionists and health workers in Uganda, Kenya, Malawi, Rwanda, Zambia, Burkina Faso, and Ethiopia.
- The regional workshop led by FANTA on Food Aid and HIV/AIDS improved the capacity of participating aid agencies, PVOs, and other stakeholders to identify opportunities to integrate food aid interventions into HIV/AIDS programs and led to a new partnership with the World Food Program on HIV prevention.

USAID West Africa

- USAID’s partners conducted training of trainers for the national population commissions of 15 countries and six regional networks. In coordination with regional interagency working group partners, USAID facilitated training in orphans and vulnerable children situation analysis for Francophone consultants, significantly strengthening regional planning capacity for these programs.

- USAID strengthened the advocacy capacity of eight regional networks: the Forum of African and Arab Parliamentarians on Population and Development, the Network of African People Living with HIV/AIDS (NAP+), the Network of Religious Leaders, the Network of Journalists, the Pan African Writers Association, the Society for Women Against AIDS in Africa (SWAA), and the West African Network of AIDS Service Organizations (WANASO).
- In coordination with regional interagency working group partners, USAID facilitated training in orphans and vulnerable children situation analysis for Francophone consultants, significantly strengthening regional planning capacity for these programs.
- Memoranda of understanding were finalized with four technical leadership institutions – the Cameroon Baptist Convention Hospital Board, the Center for Information, Counseling, and Documentation in Burkina Faso, and the infectious disease units of two teaching hospitals in Senegal and Ghana – and with NAP+, SWAA, and WANASO. This assistance increased visibility and credibility for these institutions and networks.
- USAID supported two regional meetings of the Global Fund to Fight AIDS, Tuberculosis and Malaria, establishing collaborative technical assistance mechanisms to channel support in FY 2006.
- USAID also supported a multiagency effort to provide 4 million condoms for refugees in Côte d'Ivoire, Ghana, Guinea, and Sierra Leone through the United Nations High Commissioner for Refugees.

AFR/SD

- In partnership with UNICEF, USAID completed a rapid assessment of the status of orphans and vulnerable children in 17 countries. More than 250 participants from 40 countries attended and gained skills in planning responses to the orphan and vulnerable children situations in Lesotho, Uganda, and Senegal.
- AFR/SD provided support for producing and disseminating guidelines on nutrition and HIV/AIDS throughout the lifecycle. The USAID-supported training manual *Counseling Materials for Nutritional Care and Support of People Living With HIV/AIDS* was the basis for training programs in Tanzania (for a national training curriculum and materials in ART and home-based care); Kenya (for a national training curriculum and for training approximately 100 nutritionists); in Uganda (for training 27 health workers in ART centers); and in Rwanda (for training more than over 20 private voluntary organization staff working with people living with HIV/AIDS).
- Responding to expressed demand from Francophone countries, the Support for Analysis and Research in Africa (SARA) project translated the HIV stigma toolkit *Understanding and Challenging HIV Stigma* into French.

Wraparound Activities

Burundi

- Livelihoods partners supported the food security of HIV/AIDS-afflicted families through the distribution of improved seeds and by raising awareness of HIV/AIDS issues in targeted communities.

Ethiopia

- New initiatives linking health and education, including the Champion Community initiative, are working to prevent early marriage and include HIV/AIDS prevention in extracurricular materials and activities in primary schools.
- At the secondary-school level, USAID is supporting a “Sports for Life” program targeting youth 15 to 20 years of age through in- and out-of-school HIV/AIDS clubs.

Kenya

- USAID’s “Nimechill” youth abstinence campaign, the first of its kind in Kenya, was launched.
- The Mission and USAID/Washington developed a Global Development Alliance activity with Land of Lakes and Hoops 4 Africa. Under this activity, a group of professional basketball players and coaches from the NBA and WNBA delivered social messages on healthy living, HIV/AIDS, and nutrition.

Nigeria

- USAID support led to the drafting, review, approval, and dissemination of infant and young child feeding guidelines that include recommended feeding practices for children in special groups, including low-birthweight babies and infants of HIV-positive mothers.
- USAID’s “Ankoay” scouting program combined participatory life skills, peer education, and community outreach activities with the Scout Merit Badge system. It trained 100 scout troops in nine of the 22 regions. The World Bank will take Ankoay to scale nationally.

Malawi

- USAID operations research on the female condom suggested that the level of protection against STIs among prostitutes is increased with the female condom as a back-up to the male condom.

Senegal

- USAID collaborated with two Food for Peace recipients, CRS and Counterpart International, to help individuals and families affected by HIV/AIDS and improve nutrition training and counseling for affected groups.

2. Prevent and control infectious diseases of major importance

USAID supports activities to expand malaria and TB prevention and treatment efforts; strengthen surveillance; build capacity; and improve detection of and response to emerging infectious disease threats. USAID works closely with African partners, countries, and regional institutions to develop local capacity to analyze data and evaluate policy options in preparation for and response to emerging infectious diseases and disease outbreaks. Programs provide training and information systems to build improved institutional monitoring and treatment programs that will increase the national capacity of African countries for disease detection, prevention, and control. At the end of FY 2005, USAID Missions helped support the PMI launch.

Malaria

Angola

- The percentage of children under 5 sleeping under a bednet increased to 56% from 29% in FY 2004.
- The new ITN program, launched in 2005, increased attendance at targeted antenatal clinics by 33.5%.
- 585 health care providers received training in treating uncomplicated malaria with combination therapy, severe malaria case management, presumptive treatment of malaria in pregnant women, and use of malaria rapid diagnosis tests.
- Malaria community education activities, including bednet treatments, reached 6,931 people.
- USAID received \$450,000 from ESSO/Angola, a subsidiary of ExxonMobil, to support malaria activities in targeted areas.
- A spraying campaign began in two provinces in southern Angola, areas prone to periodic epidemics of malaria. 210 people were trained in spraying techniques and safety.

Burundi

- USAID funding supported ACT drug treatment for 121,212 individuals.
- From 2003 to 2005, USAID partners distributed more than 91,000 ITNs to pregnant women and children in the target provinces of Kirundo and Muyinga. Funding was provided to purchase supplies of ACT drug combinations to treat more than 200,000 Burundians.

DR Congo

- USAID expanded its malaria activities to 41 health zones, and coverage reached 21% of the population in these areas.

- 83% of children under 5 received prompt malaria treatment.

Ethiopia

- 80,000 ITNs were sold commercially nationwide. Preliminary 2005 DHS data showed an increase in the percentage of households with bednets from 1.1% in 2000 to 5.7% in 2005 as a result of donor-subsidized ITN activities and recent commercial sales.
- To facilitate commercial market development, USAID continues to work at the policy level with the MOH, the Drug Administration and Control Authority, the Ethiopian Customs Authority, and the Ministry of Agriculture to reduce or eliminate taxes and tariffs on ITN-related materials and streamline the registration of ITN-related products.

Ghana

- 505,000 ITNs were sold, exceeding the target of 480,000.
- USAID supported the development and launch of a communications campaign on the new artesunate-amodiaquine drug combination and is promoting ITN availability.
- USAID has been supporting the Ghana Food and Drug Board through training, capacity building, procurement of state-of-the-art equipment, and assistance in monitoring malaria drug quality.
- In collaboration with the NetMark project, a voucher system was designed to help women (especially pregnant women) gain access to ITNs. As a result, ITN ownership among pregnant women at USAID-selected sites increased from 2.9% in 2004 to 17.1% in 2005.
- USAID is working with the Global Fund to Fight AIDS, Tuberculosis and Malaria and the U.K. Department for International Development (DfID) to scale up to national coverage an ITN voucher system designed to help women (especially pregnant women) gain access to ITNs. ExxonMobil is also supporting this scale-up in the Brong Ahafo Region.
- Therapy protocols and guidelines, including a communication strategy focused on treatment adherence and prevention, for using the new ACT drug regimen have been developed for health care providers.

Kenya

- USAID collaborated with the U.K. DfID on social marketing of SupraNet bednets and on the initial distribution of long-lasting ITNs (LLINs), which do not need re-treatment.
- ITN sales grew from 635,000 nets in FY 2004 to 3.2 million in FY 2005. Rural sales, especially through clinics in conjunction with their maternal and child health

programs, were particularly successful, accounting for 90% of total sales.

- USAID worked with the MOH to change the national malaria policy to use ACT as the first-line drug treatment; implement the transition to the new drug regimen; train pharmacists; and quantify national drug needs.
- The Mission supported strengthening of the MOH malaria information system based on the RBM monitoring and evaluation framework. This will improve the ability to track progress on diagnosis, treatment, and ITN use.

Liberia

- USAID's support for malaria control included training for 90 physician assistants, registered nurses, certified midwives, and licensed practical nurses in the ACT treatment protocol.
- In Bong and Nimba counties, more than 10,250 ITNs were distributed to 26 facilities supported by the Integrated Community Health Program for use by pregnant and lactating women and children under 5.

Nigeria

- ITNs are now available in all five of the major textile markets in Nigeria.
- In FY 2005, USAID partners sold 1,370,279 ITNs and 442,088 re-treatment kits, a 23% increase from FY 2004.
- USAID is building the capacity of 17 Nigerian net manufacturers to adopt new LLIN technology.
- Because Nigerians seek treatment for routine illness such as malaria largely through the informal private sector, USAID trained more than 500 vendors to provide correct treatment advice to drug purchasers. These vendors and other outlets sold 1,725,541 prepackaged malaria treatment kits in FY 2005, exceeding the target by 38% and the previous year's sales by 58%.
- USAID collaborated with ExxonMobil to issue 75,000 vouchers to pregnant women, enabling them to purchase an ITN at a subsidized price. Fifty thousand of the vouchers have been redeemed to date, and 150 ITN sales outlets have been established adjacent to health facilities in support of the scheme.
- At the national level, policy changes include facilitating the approval of the revised ACT-based malaria treatment policy and the finalization and approval of national guidelines for NGO participation in RBM.
- Africa Malaria Day information activities included road shows, televised discussions, a school debate competition, 3,600 radio spots, 120 television spots, and market-based awareness programs. These communications reached an estimated 2 million Nigerians in seven states with prevention and treatment messages.

Malawi

- Preliminary DHS data show that the percentage of children sleeping under an ITN reached 26% in 2005, more than three times the 2000 figure of 8%.
- The percentage of households with at least one ITN also tripled, from 13% in 2000 to 42% in 2005.

Madagascar

- USAID worked closely with the Ministry of Health and Family Planning to develop the national malaria policy and plan the transition to ACT for malaria treatment and intermittent preventive treatment (IPT) with Fansidar for pregnant women.
- USAID trained more than 1,900 health staff in IPT implementation in public health care in more than 110 health districts.
- By the end of 2004, 21% of households had ITNs; in 90% of these households, the ITNs were funded by USAID.
- USAID sold 433,148 ITNs in 2005, a 14% increase from 2004.

Mali

- Commercial sales of ITNs increased from 38,313 in FY 2004 to more than 110,000 in FY 2005. Commercial sector ITN sales grew rapidly, increasing almost 300% over sales in FY 2004.
- ITN distribution, including subsidized ITNs for pregnant women receiving antenatal care, reached 200% of the target number and service attendance increased significantly in areas where ITNs were made available.
- USAID provided subsidized re-treatment kits for sale in pharmacies and by community health volunteers; more than 350,000 were sold, surpassing the target.
- The number of women receiving two IPT doses during pregnancy increased from 872 in FY 2004 to almost 50,000 women in FY 2005.

Mozambique

- Sales of subsidized bednets reached 8,500 in two provinces.
- In support of a draft national policy on ITN use, USAID helped draft a new training manual for health workers and NGO staff on the use of LLINs, which require less maintenance than conventional ITNs.
- In 2005, community health agents in one district of Maputo Province sold 2,000 nets to households with pregnant women and/or children under 5 years old. In Zambezia Province, USAID supported the sale of 6,491 subsidized ITNs for use by pregnant women and children under 5.
- Technical assistance and financing for the African Rainbow Expedition in Support of Malaria Prevention, a

private sector initiative to raise awareness of the effectiveness of ITNs, provided nearly 3,000 free ITNs to pregnant women and young children in dozens of rural villages along the eastern coast.

Rwanda

- USAID helped the World Health Organization's Africa Regional Office (WHO/AFRO) and the African Development Bank design a regional malaria epidemic prevention and control initiative focusing on eight countries of East Africa and the Great Lakes Region, including Rwanda.
- USAID provided the MOH with a resident technical advisor to help implement IPT for pregnant women; 546 health care providers (370 females and 176 males) received training in this area.

Senegal

- According to DHS results, the percentage of households owning a net increased from 34% in 2000 to 56% in 2004, with little difference between urban and rural areas.
- Among all households, the percentage of children under age 5 sleeping under a net reached 35% in 2004 (double the number in 2000) and the percent of women sleeping under a net reached 42% in 2004.
- Sales of ITNs reached 397,917 through October 2005, compared with 125,914 in 2004.
- The National Malaria Control Program found that communication tools for malaria outreach were effective and used them in prevention campaigns.

Sudan

- The International Rescue Committee (IRC) reported treating close to 19,000 cases of malaria at one of the USAID-supported primary health care centers (25% of the total 75,720 cases).
- IRC trained 20 staff in diagnosis and treatment of complicated and uncomplicated malaria.
- 6.2% of women received the second dose of IPT, higher than the target of 4%.

Tanzania

- Results from a 2005 survey indicated that malaria treatment coverage of all pregnant women in Tanzania increased to nearly 50% from less than 30% in 2001.
- With PMI funds, 130,000 LLINs were distributed at public clinics; net distribution was accompanied by a communications campaign to educate the population on proper use of LLINs.
- USAID continued to invest in a multiyear research project to test the effectiveness of ACT in four districts. At

the end of 2005, 320,000 patients had been effectively treated, and 120 health workers trained. Use of health facilities had increased by 96%.

Uganda

- Subsidized ITNs increased access to malaria protection in northern conflict districts; the commercial ITN market also strengthened, with overall distribution tripling to more than 1.2 million, surpassing the target of 1 million.
- A shift from the use of matching funds to commodity procurement helped overcome stock constraints faced by partners.
- USAID trained 22,400 new village-based drug distributors to detect malaria, distribute Homapak malaria treatment, and implement referrals. The trained volunteers treated 249,369 children; 60% received treatment within 24 hours.
- The National Malaria Control Program, which was supported by USAID, developed the final draft of a communication strategy; developed and translated malaria fact sheets into nine languages; finalized the national Web site; developed a media relations curriculum for commissioners to better communicate strategies and policies to governmental and nongovernmental partners; and developed an education video on the basics of malaria prevention, diagnosis, and treatment.
- Under PMI, free distribution of LLINs began in internally displaced person camps in northern Uganda.

Zambia

- USAID provided technical input to the development of the 2006–2010 national malaria strategy, which calls for the rapid scale-up of malaria control interventions. USAID continues to be the National Malaria Control Center's primary implementing partner for the malaria-in-pregnancy program.
- USAID developed materials to train 174 health workers from the Zambian Defense Forces, private companies, and NGOs in the use of Co-Artem to treat malaria.
- In the malaria-in-pregnancy program, social marketing sales through public health clinics of Mama Safenite ITNs for pregnant women and children under age 5 reached 174,396, surpassing 2004 sales.

USAID East Africa

- Documentation of malaria-in-pregnancy "best practices" showed that the five countries in the Malaria in Pregnancy East and Southern Africa (MIPESA) coalition (Kenya, Malawi, Tanzania, Uganda, and Zambia) attained high coverage of pregnant women with the first dose of IPT; coverage increased from a baseline of 0% to 49% to 93% for the five countries.

- The use of ITNs by pregnant women in the MIPESA coalition increased from a baseline of 0% to between 4% and 38%.
- MIPESA, with technical support from the Regional Centre for Quality of Health Care (RCQHC) and JHPIEGO, has significantly increased collaboration between malaria and reproductive health programs, with interventions provided through antenatal clinics.
- Through RCQHC, Zambia used the performance improvement assessment method to improve the quality of malaria-in-pregnancy interventions in three districts; IPT rates in these districts went from a baseline of 6% to 93%; ITNs purchased from antenatal clinics went from a baseline of 9% to 24%. These improvements prompted the MOH to expand the initiative using its own resources.

AFR/SD

- With USAID support, 17 countries have revised their malaria drug policies and adopted the recommended ACT therapy for treating uncomplicated malaria.

Tuberculosis

Angola

- Four of the five TB clinics that received support from USAID incorporated VCT into their routine procedures.

DR Congo

- With support from USAID and partners, TB case detection continued to improve from 51% in 2001 to 70% in 2004. The treatment success rate increased from 70% in 2001 to 83% in 2004.

Mozambique

- USAID, WHO, the Centers for Disease Control and Prevention (CDC), and the MOH negotiated the design of a new TB activity that will provide support to TB laboratories, support the expansion of the DOTS approach, and facilitate integrated TB-HIV activities.

Nigeria

- 522 local government areas were implementing DOTS at the end of 2005, an increase of 51 (11%) over the previous year.
- Nigeria now has 1,949 DOTS treatment centers and 589 participating microscopy centers, up from 1,847 and 538, respectively, in 2004.
- TB notification increased from 46,473 cases in CY 2003 to 59,493 in CY 2004, and the case detection rate for

new smear-positive cases increased from 23% to 26.7% for the same period.

- USAID supported training for 352 health workers to implement collaborative TB-HIV activities at the health facility level and is now implementing joint TB-HIV activities in six states.

Senegal

- The treatment success rate was 76% for patients undergoing treatment in the first half of 2004. The default rate was 10%, slightly lower than the 2003 rate of 11%, which shows that both the treatment success and default rates are on track toward achieving the respective targets of 85% and 5%.
- More than 4,350 education sessions and 9,170 home visits were completed to inform citizens about malaria and TB.

South Africa

- The recently implemented TB project is now operating in 160 facilities in three provinces.
- Baseline assessments of TB laboratory services were conducted in two provinces.
- USAID supported an NGO to provide DOTS to TB patients from a large, highly mobile population. The NGO trained 15 treatment supporters, who helped provide treatment for 7,131 patients. These trained workers reached 12,500 people with educational messages about TB, including the issue of stigma.
- To help foster integrated TB-HIV treatment, USAID supported the development of guidelines to set up TB-HIV collaboration at the district and provincial levels. To date, 453 health care providers, including 98 medical doctors, have received training in TB and TB-HIV management.
- 25 DOTS “treatment supporters” received training, resulting in treatment support for 7,131 patients, 73% (5,179) of whom completed treatment. The treatment supporters also reached 12,500 people with TB messages to increase early case detection, improve treatment outcome, and address stigma.

Uganda

- Among TB patients, 89% completed treatment – 67% through DOTS, 18% at health facilities, and 4% with traditional healers.
- USAID-supported TB activities included increased focus on integrated, TB-HIV diagnosis, testing, and referral in partnership with HIV-specific activities.
- The number of USAID-supported TB-HIV sites increased from four in 2004 to 68 in 2005. Specific interventions included training on diagnosis and management of co-infection and improved reporting.

AFR/SD

- The number of countries submitting the recommended monthly *Integrated Disease Surveillance Reports* increased from 13 in 2003 to 23 in 2005.
- A USAID grant to WHO/AFRO increased the number of countries implementing community TB care and scaling up collaborative TB-HIV activities. Community TB activities are being implemented in at least one district in 20 countries; Malawi and Uganda have countrywide coverage.
- Burkina Faso, Côte d'Ivoire, the Democratic Republic of the Congo, Ethiopia, Kenya, Malawi, Rwanda, Tanzania, Uganda, and Zambia expanded collaborative TB-HIV interventions. More than 70% of registered new smear-positive TB cases were successfully treated in the implementing areas. In implementing areas, 53% of notified TB cases and HIV-infected clients were screened for TB, up from the 50% baseline in 2003.

Capacity Building

Angola

- In response to an outbreak of Marburg virus, 41 in-service training sessions were conducted on infection prevention.

Ethiopia

- The Oromiya, Amhara, and Southern Nations, Nationalities and Peoples regions adopted the new policy for health sector finance that allows hospitals and health centers to retain locally generated revenues. This contributes to health system sustainability by allowing alternative financing and management mechanisms that are appropriate for the local context, such as fee revisions, waivers for service, and promotion of the private sector in health care delivery.

Mozambique

- A new computerized logistics management system was introduced and will allow the MOH to monitor drug and medical supplies around the country, reduce shortages, and improve procurement planning.
- USAID partners supported the development of strategic plans in Zambezia and Sofala provinces.
- Because of its visible achievements in strategic planning and the commitment of MOH staff to USAID's management and leadership program activities, Mozambique was a focus of a virtual forum titled "Strategies for success in low-resource settings: Stories from Mozambique"; 25 Mozambican participants shared and exchanged their experiences in quality management with 93 people from 17 countries.

- With USAID support, MOH committed to rolling out an improved logistics management system.

Rwanda

- To address the shortage of trained public health professionals, USAID scaled up assistance to Rwanda's School of Public Health through an innovative capacity building program for district health officers. USAID trained 90 public health certificate students, 40 masters degree students, and 16 doctoral candidates in public health courses.

Sudan

- In partnership with UNICEF, USAID supported the U.S. Census Bureau in providing technical assistance to the South Sudan Center for Statistics and Evaluation to prepare for the Sudan Household and Health Survey. Together, both agencies have achieved significant results – questionnaires are in final form; a sampling strategy has been approved; data entry, editing, and tabulation systems are finalized; and Center staff have received training in preparation for the survey. The data from the household survey will be vital to South Sudan's new government as it attempts to prioritize resource allocations.
- USAID is working with a variety of partners to strengthen the capacities of five regional training centers. To date, USAID has completed the review and revision of South Sudan's nursing and laboratory technician curricula with the expectation that the Secretariat of Health and Federal Ministry of Health implemented the new curricula by the end of 2005.
- USAID and CDC are helping to develop surveillance systems and capacities in the Secretariat of Health and county health departments.

Zambia

- USAID has taken a leading role in addressing the human resource crisis in the health sector. This effort included developing a management information system that tracks human resource needs.
- Sustained advocacy mobilized significant funds for addressing the human resource crisis through such methods as rural health worker retention schemes.

USAID West Africa

- USAID West Africa launched a new partnership with the Global Fund to Fight AIDS, Tuberculosis and Malaria to provide technical support to governments in West Africa to manage and implement Fund activities. This new partnership will facilitate more effective use of the almost \$1 billion the Fund currently provides throughout West Africa.

- Youth livelihood activities have been increased by launching the Young Professionals' Internship Program and the Applied Health Research Small Grants programs.
- USAID-supported regional partners provided 62 person-weeks of technical assistance, exceeding by far the target of 29 person-weeks.

AFR/SD

- For three years, more than 40% of countries in the Africa region have been able to sustain over 70% coverage of the third dose of diphtheria, pertussis, and tetanus (DPT) vaccine. Another 12 countries have increased coverage by 4 to 20 percentage points in the past three years.
- Through support to WHO/AFRO, 264 epidemiology managers, 38 tutors from health training institutions, personnel from 54 national logistics offices, eight logistics consultants, and 71 WHO/UNICEF focus persons attended midlevel management and logistics courses.
- 60% of reported epidemic-prone disease outbreaks were responded to within two days of notification, up from 50% in 2004. 100% of reported outbreaks were confirmed at laboratories, up from 30% in 2004.

3. Reduce child mortality

USAID supports the development and implementation of programs delivering proven, high impact interventions that prevent and reduce illness, mortality, and malnutrition among newborns, infants, and children under the age of 5 years. The strategy focuses on a select group of priority interventions for high impact and strengthens systems to ensure sustainability. These priority interventions include the delivery of critical micronutrients, including vitamin A and promotion of appropriate infant and young child feeding to prevent malnutrition; immunizations; prevention and treatment of diarrhea and pneumonia; promotion of appropriate newborn and infant child feeding practices; and improved hygiene behaviors. In environments where HIV is prevalent, USAID supports linkages of child survival programs with HIV interventions and programs.

Child Survival

Angola

- From 2003 to 2005, caregivers increased their use of oral rehydration therapy (ORT) for children with diarrhea from 25% to 36%.

Benin

- Through PL 480 Title II resources, USAID supported 85 maternal and child health centers that served 401 communities in six departments, allowing women to access basic health and nutrition services that had not previously existed.
- USAID's partner in the Title II program trained 85 supervisors and 1,200 community animators who conducted interactive education sessions that reached approximately 22,500 women.

Burundi

- USAID partners trained 1,313 community-based health workers (CBHWs) – 821 men and 492 women – on such topics as the importance of vitamin A supplementation and fever management.
- The CBHWs gave 2,429 health sensitization sessions in their communities and went on 11,568 home visits.
- At the community level, health knowledge and health-seeking behaviors increased in target communities. At the beginning of the USAID-sponsored program in Muyinga Province, only 25.3% of the targeted population could identify two actions parents could take to care for a child with simple diarrhea; by September 2005, this had more than doubled to 59.3%.

Djibouti

- 55 health post staff from three target sites in rural areas completed 11 of 15 training skill modules for child and maternal health and are on target to complete the remaining modules in the coming year.
- 588 health messages on child and maternal health were developed from the findings of a USAID survey of communities and broadcast on radio throughout Djibouti in the three main local languages.

Ethiopia

- USAID is supporting the capping of springs, construction of hand-dug wells, masonry reservoirs, pit latrines, roof rain water harvesting schemes, and community education in hygiene, sanitation, and the operation and maintenance of water systems.
- Community health initiatives in the Southern Nations, Nationalities and Peoples Region increased pit-latrline coverage from 20% in 2002 to more than 80% in 2005.

Ghana

- USAID carried out facility-based surveys to assess overall service quality. Subsequent interventions focused on strengthening Integrated Management of Childhood Illness (IMCI), quality assurance, integrated disease surveillance and response, and supportive service management to strengthen service delivery and enhance child health.
- Through the PL 480 Title II program, USAID constructed 75 wells and boreholes in 70 program communities primarily to reduce waterborne infections, such as guinea worm disease. Eighty thousand people benefited from these water sources across the country.
- To improve sanitary conditions, 429 two-seater household pit latrines were constructed, with 83 committees mobilized and trained in good sanitation management.

Guinea

- To build the capacity of local health care providers to improve the quality of services, USAID trained 71 care providers in Upper Guinea in Community IMCI (C-IMCI) and 700 in general nutrition and communications.

Liberia

- 24 community health workers received training in diarrhea management, and six ORT corners were established.
- A pilot program linking reconciliation of youth soldiers and psychosocial healing trained 150 beneficiaries in vocational skills and cultural activities.

Madagascar

- USAID continues to be a leader in offering simple, effective, and cheap potable water solutions for the Malagasy people. In 2004, USAID developed Sûr'Eau Vaovao, which has a higher-concentration solution than the previous product and comes in a smaller bottle, which reduced production costs and the consumer price. From October 2004 to September 2005, 601,372 bottles were sold, an increase of 10% from the previous year.

Mali

- The Population Media Center produced 144 episodes of a radio soap opera in two languages (Bambara and Dioula) that provided messages on child trafficking; HIV/AIDS prevention, especially among youth; and other child welfare topics.

Malawi

- The U5MR declined from a high of 189 per 1,000 live births in 2000 to 133 in 2005, well below the 2005 target of 175.
- The expansion of IMCI and programs to improve supervision of health facility visits reached 95% coverage in the eight target districts.
- At the national level, USAID partners provided input to IMCI policy development and assisted the Kamuzu College of Nursing to incorporate IMCI into the preservice curriculum. In the eight target districts, USAID provided financing and technical support to train and supervise clinical staff in IMCI.
- In three districts, USAID piloted a pediatric hospital initiative that included introducing guidelines for managing severely ill children. The initiative has had a substantial impact on improving the care of children under 5. From December 2004 to September 2005, pilot hospitals reported a 35% decrease in their U5MRs.
- USAID supported the introduction of community-based initiatives, including C-IMCI, in 20 villages in each district targeted by the Red Cross. The activity engaged local surveillance assistance, village health committees, and specially trained village volunteers to promote sales of ITNs, ORT for diarrhea, and prompt care seeking at health centers for more seriously ill children.
- At the facility level, USAID support for logistics and training for pharmacy technicians, followed by on-the-job training of health center staff, led to fewer stock-outs of key child health drugs across the eight target districts.
- Three districts initiated a "community therapeutic care" program to improve case management of malnourished children by health centers and families and strengthen the nutrition and rehabilitation of acutely malnourished children. Since the program was initiated, 96 children have been admitted; all are being managed at the community

level by families, thus reducing costly hospital-based rehabilitation.

- With USAID financing, PSI achieved sales of 1,075,217 oral rehydration solution (ORS) packets. DHS results show that ORS use increased from 48% in 2000 to 61% in 2004.
- USAID assistance to the Malawi Health Commodities Logistics Management Information System helped develop a recording/reporting system for “drug boxes” for use by health service assistants during community treatment of sick children.
- USAID supported improved quality of case management of pediatric fever/malaria through the expansion of facility-level IMCI and improved supervision visits, which reached 95% coverage in the eight target districts.

Mozambique

- 26 people received training and supervised an additional 94 community health workers in C-IMCI.
- 81 community leaders councils (CLCs) received support, and 11 new CLCs were formed under the Revitalizing and Strengthening CLCs program, which improves community participation in managing local health activities.

Senegal

- The successful pilot program to introduce antibiotics at health huts for use by community health workers to treat pneumonia underwent an evaluation, with the results shared with regional and international partners. USAID entered into a partnership with Pfizer, Inc., and UNICEF to expand the pilot program.

South Africa

- The number of USAID-supported facilities treating children under 5 according to Department of Health IMCI guidelines increased from five to 17, surpassing the target of seven. USAID began reporting under this performance indicator in order to better track improvements in treating infant and childhood illness.
- USAID helped 14 health care facilities meet South African IMCI standards, exceeding the planned target of seven facilities.
- In compliance with the Government’s new primary health care standard treatment guidelines, more than 250 doctors, pharmacists, and nurses received training in the efficacy, safety, and quality of primary health care medicines, and in adverse drug event reporting.

Sudan

- More than 765 vaccinators; maternal and child health and community health workers; and other health staff received training in routine immunization, cold chain

management, IPT malaria treatment, basic IMCI, and traditional birth attendant (TBA) refresher courses.

- USAID established 13 water and sanitation committees and trained their members. There are 51 operational boreholes (46% of target) and 66 functional latrines (60% of target) at health facilities in the first six counties.
- USAID supported the establishment of 34 health management committees.

Tanzania

- USAID support contributed to reductions in infant and under-5 mortality rates, which decreased 31% and 24% respectively in five years according to the 2005 DHS.

Zambia

- 134 district health team members, community health worker trainers, and tutors received IMCI training.
- USAID continued to support social marketing of the Clorin home water-treatment product to reduce diarrheal diseases. The Society for Family Health distributed 1,777,020 bottles, missing the target of 2 million due to production constraints and a national fuel crisis that affected product transport.

USAID East Africa

- In the area of pharmaceutical management, USAID supported the development of a Coordinated Informed Buying (CIB) Web page that allows countries to monitor pharmaceutical prices and guide pooled drug procurement.
- 30 participants representing health ministries of eight countries (Kenya, Mauritius, Mozambique, Seychelles, Tanzania, Uganda, Zambia, and Zimbabwe) attended the fourth annual national health account (NHA) training program. Countries with NHAs have a more robust basis for requesting increased health resources.
- A regional assessment of current child health practices was completed in eight countries (Madagascar, Malawi, Zambia, Uganda, Ethiopia, Tanzania, Eritrea and Kenya). The assessment’s findings shaped the agenda for the RCQHC-led Child Survival Forum in Tanzania in June.
- Representatives from 11 countries and 16 organizations identified a minimum package of care for children focused on neonatal mortality and nutrition, leading to the development of an advocacy statement for actions to address childhood illnesses. The statement was presented at the East, Central and Southern Africa Health Community Secretariat Joint Consultative Committee meeting for adoption at the country level.
- USAID funded hospital costing systems in Moi Teaching Hospital and Mulago Teaching Hospital, which enabled six tertiary facilities in the region to compare unit costs across departments and increase operational efficiency.

- 2,475 people received training in technical skills and regional-level analysis of 15 policy issues.
- Two or more countries in the region have implemented 10 selected best practices; the region is on track to meet the FY 2008 target of 25.
- Five regional strategies to address health systems have been implemented
- USAID programs and policies have incorporated gender concerns.

AFR/SD

- USAID invested resources in accelerating and expanding the IMCI approach in Africa – 43 countries are now implementing IMCI, and 19 have expanded implementation in more than 11 districts. Community approaches to child health are expanding, and 10 countries have adopted community strategies in more than five districts.
- Annual IMCI program reviews in Ghana and the Democratic Republic of the Congo resulted in expanded preservice IMCI training in medical and paramedical schools. Botswana, Ethiopia, Ghana, Malawi, Mali, and Zambia also initiated preservice courses, bringing the number of countries with preservice programs to 12.
- With USAID support, WHO/AFRO trained community health workers in community IMCI planning and implementation in 20 countries.

Nutrition

DR Congo

- With USAID assistance, national distribution of vitamin A reached 87% of the target population.

Ethiopia

- USAID supported the design of the first national nutrition strategy; national measles vaccination and vitamin A supplementation campaigns; and the continued development of a health management information system.

Guinea

- Through USAID's Micronutrient Initiative, vitamin A distribution reached 100% of the targeted populations.
- Community-based nutrition education programs funded through PL 480 partners demonstrated declines in severe malnutrition from 16% in 2004 to 4.5% in 2005 and a reduction in low weight for age from 15% in 2000 to 11% in 2005 among 0- to 36-month-old children.

Madagascar

- About 3.5 million children aged 6 to 59 months received vitamin A, for a coverage rate of 97%.

- Breastfeeding practices improved significantly as the percentage of women initiating breastfeeding within one hour of delivery increased from baseline rates of 34% in 2000 to 78%.
- 68% of women exclusively breastfed infants under 6 months of age, compared with the baseline rate of 46%.
- Under the Essential Nutrition Actions program, the proportion of postpartum women receiving vitamin A supplementation increased from 15% at baseline in 1999 to 48%.

Malawi

- Partners in the PL 480 Title II Development Assistance Program supported 170 growth monitoring volunteers to identify and refer cases of malnutrition. Some 4,200 mothers in 82 villages received training on breastfeeding and the use of nutrition weaning foods.

Mali

- Vitamin A supplementation provided during the national nutrition week achieved 78% coverage of children 6 to 59 months of age.
- 2,000 nutritional counseling cards were produced and distributed for use by community health volunteers.
- Almost 80,000 postpartum women (96%) received vitamin A supplements during the national nutrition week.
- USAID helped the MOH's Division of Nutrition plan the national nutrition week and develop and validate the national strategic plan for food and nutrition.

Mozambique

- At the central level, USAID provided technical assistance for preparing the national nutrition strategic plan and a national policy on infant and young child feeding.
- USAID supported the development and production of 1,000 copies of a manual and trainers guide for community participation in nutrition, as well as job aids and educational materials on vitamin A, iron/anemia, and iodine deficiency. These will be used to train MOH staff and NGO health workers.

Nigeria

- Behavior change communications materials on exclusive breastfeeding reached 35,500 mothers and young women during World Breastfeeding Week.

Senegal

- A 12-month pilot program that reduced malnutrition among children under age 2 by 37% is expanding to eight districts and will be included in the national nutrition program.

Sudan

- Vitamin A supplementation for children under 59 months reached 100% and exceeded the target.

Tanzania

- Vitamin A coverage for children 6 to 59 months reached 85% in the six months preceding the survey, thus surpassing the 80% coverage target.

Zambia

- USAID provided the National Food and Nutrition Commission with technical input to develop a proposal to the Global Alliance for Improved Nutrition.
- During the semiannual national child health week, 82% of children ages 6 to 59 months received one dose of vitamin A, exceeding the 80% figure in the previous child health week.

Immunization

Angola

- With FY 2005 polio funding, USAID supported work in 33 municipalities in six provinces. Nearly 12,000 community volunteers conducted 90,010 house visits to identify children who had not been vaccinated against all childhood diseases, including polio, or had incomplete vaccinations and referred them to the nearest health facility with vaccination services.
- USAID funding helped the MOH identify four of the nine new polio cases in the polio outbreak.

DR Congo

- The number of AFP cases reported by the WHO surveillance system continued to decrease, from 324 cases in 2001 to 15 in 2005 (through October).
- No new cases of polio were reported despite the reintroduction of wild polio virus in neighboring countries to the north and south. Polio vaccination campaigns in the two northern provinces targeted 2.6 million children and achieved 90% coverage. The campaign in the South targeted 7.4 million children and achieved 96% coverage.
- DPT3 coverage is 70% at the national level and 75% in USAID-assisted health zones, up from 61% in 2004.
- Measles vaccination coverage is 68% countrywide and 70% in USAID-assisted health zones.
- The number of districts with over 80% DPT3 coverage increased from 66 in 2003 to 199 in 2005.

Ethiopia

- At the national level, DPT3 immunization coverage increased significantly from 18% in 2000 to 32% in

2005. In USAID focus regions, DPT3 coverage between 2000 and 2005 increased from 16.6% to 33.2% in the Southern Nations, Nationalities, and Peoples Region; from 20.3% to 31.5% in Amhara; and from 16.2% to 28.5% in Oromiya.

- National measles coverage increased from 21% in 2000 to 35% in 2005.
- Nearly 9 million children in hard-to-reach districts inside the country and more than 3.5 million children in the Sudan and Eritrea border areas received polio immunizations.
- Nearly 15 million children received polio vaccines during three national immunization days (NIDs).

Ghana

- Coverage with a new vaccine series that combines DPT3 with hepatitis B and *Haemophilus influenzae* type b (Hib) vaccines increased from 80% in 2003 to 88% in 2005.

Guinea

- In partnership with WHO and UNICEF, USAID supported NIDs for polio immunizations and vitamin A distribution with technical and logistical support. The NIDs reached 100% of children 6 to 59 months old, including refugee children.

Liberia

- Vaccination activities were scaled up in the Improved Community Health project's communities. As a result, Bong County received a 94% rating from the National Immunization Survey and Nimba County 89%, compared with a national 93% rating.
- USAID supported WHO and collaborated with other donors in supporting the government in its efforts to eradicate polio. More than 1 million children received immunizations in four rounds of nationwide campaigns.
- The polio campaign in Toliara covered 92.9% of children up to 11 months of age and 100% percent of children 12 to 59 months in the targeted region.

Madagascar

- Vaccination efforts in USAID target zones reached 91% coverage of children ages 12 to 23 months, compared with the national rate of 53%. Approximately 3.5 million children between the ages of 6 and 59 months received vitamin A for 97% coverage.

Mali

- USAID supported technical guidance for microplanning and routine immunizations in 11 districts and two communes of Bamako. Additional support through mobile

vaccination teams helped increase immunization coverage in two additional remote districts.

- DPT3 vaccination of children less than 12 months of age increased from 56% in FY 2004 to 90% in FY 2005.
- Four NIDs and two subnational immunization days (SNIDs) in three regions covered more than 90% of children under age 5.

Mozambique

- USAID played a major role in the successful implementation of a national vaccination campaign for measles and polio in the program's four target provinces by providing trained workers, supporting supervision and logistics management, and carrying out community mobilization activities. The campaign's coverage rate for measles in USAID's target provinces averaged 98%.

Nigeria

- Between January and October 2005, 522 cases of wild poliovirus were identified and confirmed in 21 states, a 20% decrease from 650 cases in 30 states between January and October 2004.
- With all Nigerian states once again participating in immunization efforts, USAID partners deployed nearly 4,000 field personnel in the eight highest-risk states in the north of Nigeria.
- USAID supported five rounds of NIDs and SNIDs, during which 5 million children under age 5 received at least one dose of oral polio vaccine. To publicize the immunization effort and encourage participation, mobilization activities included innovative and culturally acceptable strategies such as town criers and media messages.
- USAID assisted the rehabilitation of the system of routine immunization in key states through training for 105 master trainers, 794 service providers, and 176 local government officials. 347,809 children under age 5 received DPT, BCG, and measles vaccinations in USAID-supported facilities.

Rwanda

- The national immunization program has been a model for Africa. The program met the DPT3 vaccination target of 75% in Kigali and national coverage improved slightly from 86% in 2004 to 87% in 2005.

Senegal

- Preliminary 2005 DHS results show immunization coverage increased from 49% in 1992 to 59%. DPT3 immunization coverage grew dramatically from 59% in 1992 to 78%.

- In the USAID-assisted areas of Ziguinchor and Louga, 74% and 71% of children are fully vaccinated, respectively, compared with 59% countrywide.
- While nationwide DPT3 coverage is 78.3%, coverage was significantly higher in Louga (86.3%) and Ziguinchor (85.5%).

Sudan

- USAID continued to finance part of the national polio eradication campaign. Since the program started in 1998, there have been 18 rounds of NIDs and 12 rounds of SNIDs in Southern Sudan.
- USAID support is helping the national immunization campaign approach the target AFP rate. Southern Sudan's AFP rate for 2005 was 2.37/100,000 among children under age 15, close to the target of less than 2/100,000.
- UNICEF reported DPT3 coverage for January-August 2005 was 16%, above the target of 9.5%.
- Through funding to UNICEF, USAID helped the Secretariat of Health and Federal Ministry of Health plan a national measles campaign for FY 2006.

Uganda

- DPT3 coverage remained high at 89%, surpassing the 84.5% target.
- USAID supported the MOH's polio immunization campaign in 15 districts, attaining coverage of more than 95%.
- Coverage with a new vaccine series that combines DPT3 with vaccines for hepatitis B and Hib increased from 81% in 2003 to 88% in 2005, with coverage for hepatitis B and Hib increasing from 63% to 88%.

Zambia

- USAID trained 1,300 front-line health workers, 216 district health management team supervisors, and 18 provincial team members in new vaccine administration and the Reach Every District immunization strategy for underserved areas.

AFR/SD

- With support from USAID, WHO/AFRO and UNICEF polio eradication activities resulted in a 31% reduction in the number of confirmed wild poliovirus cases in the Africa region, from 787 cases in 11 countries in 2004 to 599 confirmed cases in eight countries in 2005.
- As a result of continued surveillance and vaccination activities, 29 African countries have been polio-free for at least three years.

Health Systems

Benin

- In 2004, USAID helped the Ministry of Public Health launch community health insurance *mutuelles* in two communes in the Alibori region. The two *mutuelles* have 2,738 households enrolled with 8,780 beneficiaries and 2,359 paid-up members. In 2005, 1,187 of the paid-up members received health care services paid for by the *mutuelles*.

Djibouti

- USAID started social mobilization work in five communities to enhance local capacity to sustain health services.
- USAID arranged a study tour to Ethiopia and Madagascar for health workers at the community, district, and central levels to observe “best practices” in other countries. Five model communities were selected to apply strategy guidelines on community participation in maintaining and sustaining health services.

Liberia

- Africare implemented USAID/Liberia’s support for the Improved Community Health project; subgrants to CBOs and local NGOs benefited 500,000 people in 450 communities in Bong, Nimba, and Montserrado counties.

Mali

- The Keneya Ciwara Project, which emphasizes improving the quality of facility-based services, increased outreach services, trained 3,800 female and male community health volunteers, and reached 800,000 people through community education sessions.

Rwanda

- USAID continued to encourage the growth of the national community health insurance program, which achieved a membership of 2.8 million due to strong government leadership. Rwanda’s program is a model for the region.
- USAID launched its flagship decentralization and health program, which will improve capacity to offer services at decentralized levels as well as support health and decentralization policies at the central level.
- USAID target districts reached 57% participation, compared with 31% nationally.

Senegal

- Efforts to decentralize and strengthen local community ownership and financial support for health programs

resulted in more than 150 communities drafting, implementing, and financing their local health plans.

- Eight health centers and 82 health posts were rehabilitated and 121 health huts, located in the most rural areas, were built and equipped.
- USAID helped establish 123 associations of community health care promoters who delivered key health messages to 110 communities in 15 health districts. Health care associations signed contracts to perform these tasks and, as a result of their successful performance, received more than \$400,000 in disbursements.
- The number of beneficiaries in the community insurance system increased from 45,000 in 2004 to approximately 54,000, involving 25 health mutual insurance cooperatives, in 2005.

South Africa

- USAID supported the national Department of Health, municipalities, and districts to strengthen a network of primary health clinics in five priority provinces to enable these facilities to make available the full range of maternal, child, reproductive health, and HIV/AIDS services at least 80% of the time at a consistent standard of care.
- USAID collaborated with national and provincial health officials to select five target districts for USAID assistance. Based on initial assessments conducted in 124 clinics in these districts, USAID supported a health services costing exercise of district health expenditure reviews. The implementing partner then negotiated “district charters,” or memoranda of understanding, with eight district health teams and health departments. These charters spell out the responsibilities of each party and outline performance improvement strategies to improve local ability to account for funds and plan future health budgets.
- To improve district planning and budgeting, USAID trained 296 district staff on how to improve compliance with South Africa’s budgeting requirements.
- At the request of South African health officials, USAID supported the development of a comprehensive audit toolkit, trained 329 pharmacists in eight of nine provinces to use the toolkit, and supported audits of 1,161 health facilities.

AFR/SD

- As result of USAID efforts to expand the role of the private sector, the *Toolkit to Improve Private Provider Contributions to Child Health* was published and widely disseminated. It was also used at a meeting for 10 country teams from both the public and private sectors. For this meeting, USAID leveraged \$100,000 from a public-private partnership with the Gates Foundation.

4. Reduce maternal and newborn mortality

USAID promotes safe motherhood and neonatal health by supporting quality antenatal care; safe delivery; postpartum and newborn care; and emergency obstetric care (EOC), including lifesaving skills. USAID also supports increased access to quality family planning and post-abortion care (PAC) services; the elimination of early marriage and other harmful traditional practices such as female genital cutting (FGC); and repair of obstetric fistula. Programs train health care providers to ensure quality services; provide community-level services to improve maternal and neonatal health and nutrition; and work with governments to improve policies, norms, and protocols.

Angola

- A community-based survey conducted in target areas showed the percentage of women having at least four prenatal visits increased from 56% to 65% from 2002 to 2005. This survey also showed that the number of women giving birth at health centers increased from 56% to 73%.
- Vitamin A coverage given after birth increased from 49% to 62% in target areas between 2002 and 2005.
- The percentage of women receiving two tetanus toxoid immunizations during pregnancy increased from 66% in 2002 to 95% in 2005.
- During the year, there were 10 formal training courses and 875 in-service training sessions in malaria, obstetrics, prenatal care, infection prevention, and quality improvement techniques.

Benin

- A low-cost intervention to manage the third stage of labor in childbirth was introduced in pilot sites, and plans are under way to introduce the intervention throughout the country. This will help prevent postpartum hemorrhage, a leading cause of maternal death.

Burundi

- USAID supported training for 1,313 community-based health workers, 821 men and 492 women, and 1,562 traditional female birth attendants. These workers offered 7,998 health sensitization sessions in their communities and visited 12,650 homes.
- The number of expecting mothers attending prenatal visits increased in USAID-targeted areas. In Kirundo, for example, there were 5,277 prenatal visits in target health centers in September 2005, compared with 3,633 in September 2004, a 45% increase.

- The percentage of assisted deliveries in one targeted area increased from 60% to 86%.
- USAID supported training on emergency obstetric care for 303 nurses (131 male, 172 female) from 10 of Burundi's 17 provinces; the purchase of 1,200 image boxes on complications in pregnancies for use by TBAs; and the printing of 300,000 antenatal care cards and their distribution to health centers nationwide.

Ethiopia

- PAC services reached 4,825 women, exceeding program expectations.
- Behavioral change messages on family planning, HIV/AIDS prevention, and elimination of female genital cutting reached nearly 6.7 million people.
- Community-based interventions involving health workers, schools, girls clubs, and parent-teacher associations stopped 18,000 early marriages.
- The 2005 DHS showed a decline in women who support female genital cutting from 74.3% in 2000 to 28.8% in 2005.
- At the national level, the draft national nutrition strategy includes maternal nutrition, as do the health sciences curricula at five national universities.
- Training on gender mainstreaming, including abandonment of harmful traditional practices and exposure to violence, took place in more than one-third of the country's district. National and local discussions of trafficking, early marriage, female genital cutting, rape, abduction, violence against women, and inheritance laws are taking place.

Ghana

- USAID supported the redesign of key protocols, standards, and guidelines for safe motherhood practices at the national and regional levels. More than 200 service providers from all 10 regions received training in their use.
- Results from formative research on maternal health issues supported the development of an advocacy tool, which was used in advocacy campaigns on maternal nutrition and disseminated at the national and regional levels.
- USAID assessed the government's human resource management systems and training curricula; procured and distributed medical equipment, anatomical models, textbooks, and other materials to 42 preservice nursing and midwifery training institutions; and helped finalize the national reproductive health strategy for 2006 to 2010.

Guinea

- In Upper Guinea, USAID trained and equipped 48 TBAs in three prefectures, bringing the number of USAID-

trained TBAs to 156 and expanding access to maternal health services in rural communities.

- USAID expanded quality EOC services (including training of service providers and supplying facilities with basic equipment and management tools) to 39 health centers in six targeted prefectures.
- USAID expanded its private social health insurance scheme to 12 additional communities to assist with transportation and hospital costs for EOC and well-baby immunization services. To date, USAID has helped establish 30 private social health insurance programs with more than 10,000 members.
- 138 intermarrying villages committed to end interfamilial violence against woman and children and learned about the health consequences of child marriage and FGC. A public declaration to end FGC is scheduled for spring 2006.

Malawi

- USAID supported the MOH's initiative to conduct maternal death audits in two districts, the development of functioning district referral systems, and improved radio communications and emergency transport management.
- Community leaders, including some 300 chiefs, village headmen, religious leaders, and TBAs, were sensitized about the importance of early antenatal care attendance and delivery at a health facility.

Mozambique

- Outreach teams in Zambezi Province assisted 529 villages that are more than 5 kilometers from a health center by offering maternal health, antenatal care, and health education services.
- USAID supported the purchase and distribution of bicycle ambulances to target communities; the bicycle ambulances transported 1,679 sick children and 1,233 pregnant women to health facilities.

Senegal

- In pilot sites where USAID provided basic equipment to six rural health facilities and trained community health care personnel in essential care, the percentage of women who gave birth in a health facility increased from 53% to 74%. Based on the program's success, the government is revising its norms and standards to include a new essential newborn care policy.
- The preliminary 2005 DHS results show that nationwide births at a health facility increased nationally from 48% in 1997 to 62% in 2005.
- The 2005 DHS indicated that 92.9% of women who gave birth in the past five years had at least one prenatal visit prior to delivery.

- The percentage of women who received at least four prenatal visits increased from 28% in 2004 to 39% in 2005.
- Maternal mortality declined in Senegal from 530/100,000 in 1992 to 450/100,000 in 2005, as estimated in the DHS.

South Africa

- In 121 facilities, 49,196 women made their first antenatal care visits at health care facilities that integrated primary care with HIV/AIDS testing; 25,141 pregnant women who received their HIV test results were counseled at these facilities.

Sudan

- USAID trained 249 maternal health workers, including TBAs; the counties recorded 1,744 assisted deliveries, a 6.7% increase from the 5% FY 2004 baseline.

Zambia

- A needs assessment of essential emergency obstetric care reviewed the skills and training required to fill the gap in supervised deliveries with an expanded cadre of health workers.
- USAID supported distribution of a maternity counseling kit to health workers in all 72 districts and aired TV and radio spots on reproductive and maternal health and gender-based violence.

AFR/SD

- USAID supported development of the "Road Map for Accelerated Maternal and Newborn Morbidity and Mortality in Africa," which the African Union adopted for its maternal health strategy at the 54th WHO Regional Committee of the Ministers of Health. As of 2005, 23 countries had drafted national plans to expand and improve services for mothers and newborns.
- Following a USAID-supported workshop on how to use an assessment tool designed to improve curricula for teaching clinical skills to midwives, Ghana, Ethiopia, Malawi, and Tanzania began using the tool.
- USAID supported a policy communication workshop in Burkina Faso on abandoning FGC. The workshop increased the number of skilled professionals and led to new advocacy practices in nine countries. As a result, more than 40 social sector leaders and NGO representatives from high-FGC prevalence zones in Benin mapped out future actions for reducing FGC. In Nigeria, the Enugu State House Assembly passed legislation prohibiting FGC.

5. Improve reproductive health

USAID's reproductive health program is founded on the principles of voluntarism and informed choice and seeks to enhance the ability of couples to decide the number and spacing of their children. Missions make substantial contributions to improving the health status of families by reducing maternal mortality due to unintended pregnancy and abortion; to reducing infant and child mortality through birth spacing; and to reducing population pressures on natural resources. Program support for the key elements of effective reproductive health (RH) includes integration of STI/HIV/AIDS prevention programs with family planning and maternal and child health programs; strengthening regional and national capacities to plan and implement family planning programs; and advocacy for increased support for and improved coordination among family planning partners.

USAID supports a mix of natural and modern family planning methods and provides support for family planning technology, contraceptive security, training programs, and behavior change communications. USAID focuses on the needs of at-risk populations by developing strategies to address the needs of adolescents, empower women, increase male involvement, and improve urban family planning services. In recognition of the need for youth-friendly services, Missions offer technical assistance to support cross-sectoral pilot programs to holistically address the needs of youth.

Angola

- The number of new family planning clients increased from 13,531 in October 2004 to 31,018 in September 2005; returning users increased from 30,456 to 70,448 during the same period.
- Village health committees, traditional authorities, and TBAs implemented community family planning education. TBAs delivered 1,221 community lectures to 160,972 participants.
- Men's knowledge with respect to exclusive breastfeeding as a family planning method rose from 55% in 2004 to 80%. Support for program efforts to involve men in family planning decisionmaking was so strong that program participants created a local NGO to continue the work.

Benin

- Condom sales exceeded the target of 9 million, reaching 9,011,936.

DR Congo

- Female condoms were introduced to the market in early 2005. A total of 90,438 were sold through social marketing exceeding the target by 80%.
- USAID added 907 new clinics and 228 new pharmacies providing family planning services to a target population of 1.6 million women of reproductive age. The program continues to offer a mix of natural methods, including the Standard Days Method, and modern methods.
- 1,500 rural and urban clinicians received training in family planning technology, contraceptive security, and behavior change communications.
- To address the problem of stock-outs of contraceptive commodities, USAID is working with the Ministry of Public Health and other donors to develop and implement a long-term commodities security strategy.

Ethiopia

- At the national level, the TFR decreased slightly from 5.9 in 2000 to 5.7 in 2005. In urban areas, the fertility rate showed a more significant decline, from 3.3 in 2000 to 2.4 in 2005.
- Use of modern contraceptive methods more than doubled from 6% of currently married women in 2000 to 13.9% in 2005.

Ghana

- USAID provided 1.2 million CYP to couples wishing to postpone or prevent unintended pregnancies.

Guinea

- In the USAID target zone of Upper Guinea, contraceptive prevalence rose from 2.7% in 1999 to approximately 5.5% (not including the Lactational Amenorrhea Method) in 2005, thus surpassing the national average.
- 423 community-based distributors (CBDs) in five prefectures in Upper Guinea provided oral contraceptives to rural women.
- The resounding success of the CBD program is reflected in the increase in the percentage of first-time family planning users from an average of 3% of the target population in mid-FY 2005 to 30% by the end of the year.
- Seven new USAID-supported sites for long term and permanent methods opened, contributing to a 49% increase in clients using these methods.
- As a result of USAID investment in training and supervision, 90% of family planning clients served in USAID-supported health centers received treatment that complied with national quality norms, a 20% increase from FY 2004.
- In USAID's target zones for health programs, progress was significantly higher than national averages. For instance, by the end of FY 2005, all health centers sup-

ported by USAID in Upper Guinea had received training and were fully stocked with the required equipment and pharmaceuticals to provide STI diagnosis and treatment services.

- The quality of services provided in USAID-supported health centers exceeded national compliance rates, as determined in the national reproductive health standards document.
- The social marketing program sold more than 7.7 million condoms, surpassing the sales target.

Kenya

- AMKENI, USAID's integrated family planning, reproductive health, child survival, and HIV/AIDS project, covered 97 public and private sector facilities and supported 32,000 skilled assisted deliveries, almost 4,000 of which were complicated deliveries.
- These sites also provided potentially lifesaving services to 2,800 PAC clients.
- The Mission supported the development of the national reproductive health policy, preservice training curriculum, and guidelines for service delivery.
- AMKENI provided family planning services to 185,000 clients, a 4% increase over 2004, and trained 281 health workers in 2005.
- AMKENI contributed to 94,000 CYP and conducted community mobilization activities reaching 165,000 people.
- The public sector provided 2.3 million CYP.
- Social marketing sales of USAID-DfID Femiplan contraceptive pills and injectables and Trust condoms made up 14% of national CYP.
- USAID support for the Implementing Best Practices Initiative helped train 168 providers in Central, Nyanza, and Rift Valley provinces. Another project trained 238 private nurse-midwives from 122 sites in family planning and PAC.
- With USAID technical assistance, the MOH's health commodity distribution system delivered 67 million male condoms; 3.4 million doses of injectable contraceptives; 7.6 million oral contraceptive cycles; 38,000 intrauterine devices (IUDs); and 42,000 contraceptive implant sets.

Liberia

- USAID, the MOH, and other key players collaborated on the design of a reproductive health care curriculum. The curriculum will be used to train service providers, after which supplies and equipment will be issued to project clinics.
- USAID provided more than 2,540 CYP from unwanted pregnancy as well as protection from HIV/AIDS and other STIs.

Madagascar

- Rapid Assessment Procedure survey data demonstrated improvements in family planning, with 33% of mothers with infants practicing the Lactational Amenorrhea Method, up from 2% in 1999.
- 22% of women are using modern contraceptives, compared with the national CPR of 18%.
- USAID sold 1,383,363 cycles of oral contraceptives (for 111,547 CYP) and 544,401 doses of injectable contraceptives (160,414 CYP), increases of 11% and 21% respectively from 2004.
- As a result of strong program performance, Madagascar was selected as one of two Africa region USAID "focus countries" for family planning and awarded an additional \$350,000 in population funding.
- USAID is working with FBOs to expand services to underserved populations. USAID supported a platform of religious groups to expand family planning services through faith-based service arms and reproductive health education through the churches.
- Through USAID efforts, all the main national and regional radio and television stations are broadcasting daily spots on the health and economic benefits of family planning and birth spacing.
- USAID supports the population activities of two conservation organizations, Conservation International and World Wildlife Fund for Nature, which continued to operationally link health, nutrition, and family planning activities with conservation efforts in communities near biodiversity priority areas.

Malawi

- Contraceptive prevalence increased from 26% in 2000 to 33% in 2005, exceeding the 2005 target of 31%.
- The proportion of married women using injectables increased ninefold, from 2% to 18%, between 1992 and 2004.
- CYP for the year were more than 1 million, an increase of 13% from 2004 and 42% above the 2005 target of 710,000.
- 100% of the health facilities in USAID-supported districts had no stock-outs of contraceptive supplies, exceeding the 80% target.
- DHS data showed that the TFR decreased from 6.3 in 2000 to 6.0 in 2004.
- The PAC project trained 27 district family planning coordinators to enable regular supervision of service providers. As a result, 82% of PAC clients received family planning counseling.
- Emergency contraception was extended to 29 additional sites, bringing the total to 76 sites.
- 13 sites introduced cervical cancer screening. Quality scores showed improvements in performance standards and infection prevention.

Mali

- USAID supported the national family planning campaign through training for 128 service providers, provision of technical equipment to five training sites, and the development and broadcast of radio messages by 97 community radios.
- More than 3,100 community health volunteers received information, education, and communications materials and contraceptive commodities; a family planning model was validated and disseminated to almost 400 religious leaders.

Mozambique

- 171 out of a planned 260 community health agents received training in reproductive health and interpersonal communication; 124 health care providers received training in maternal and reproductive health.
- A formal working group was established to regularly review the status of condom inventories and ensure condom quality and supplies.
- In the first year of contraceptive commodity CBD, community-based networks distributed an estimated 850 pill packs and 170,350 condoms.
- More than 2,300 women started using a modern contraceptive method.

Nigeria

- Under its peer education strategy, USAID trained 264 youth peer educators in family planning, on ABC, and on delaying marriage and first pregnancy to promote informed and responsible reproductive decisionmaking early in life.
- 100% Youth, a USAID-supported radio theater program, began covering reproductive health and HIV/AIDS topics.

Rwanda

- USAID support contributed to increases in CPRs from 13.5% in FY 2004 to 18.8% in FY 2005 in Kigali and from 4.3% to 10.3% nationally.
- In response to demand for family planning products, 132,000 doses of Depo-Provera and 212,400 cycles of Lo-Femenal were provided to women, yielding 66,589 CYP.
- More than 90% of health districts filed commodity reports on a timely basis, ensuring that a steady supply of family planning commodities were consistently available nationwide.

Senegal

- Religious organizations introduced a number of family planning innovations, including a checklist to facilitate the use of IUDs, cycle beads, and updated natural family planning methods.
- 30,908 community members participated in reproductive health dialogue sessions that focused on gender differences and issues related to women's health and status.
- USAID supported 627 sessions on reproductive health issues using a life skills manual; 5,958 youth (of whom 3,131 were female) attended these sessions.
- USAID worked with 3,530 religious youth leaders (2,022 female), who participated in training sessions using an Arabic-language faith-based life skills manual.
- All nurses and midwives in targeted districts received training, and the number of women presenting for PAC more than doubled from 786 in 2004 to 1,933 in 2005.
- The percentage of women receiving a contraceptive method before discharge from maternity care increased from 30% in 2004 to 56% in 2005.
- Based on recommendations from USAID-supported pilot programs, the MOH improved and adopted critical policies, including IPT malaria treatment for pregnant women; PAC; a neonatal care package targeted at preventing infant deaths; postpartum hemorrhage prevention; and PMTCT.
- For the first time, the MOH established a budgetary line item dedicated to the purchase of contraceptives. The MOH approved an action plan to raise awareness and increase IUD use, an underutilized method in Senegal.
- The social marketing program contributed 40,075 CYP through increased sales of Protec condoms and Securil pills; total CYP were 235,527.
- Senior MOH officials, religious leaders, journalists, legislators, and NGO leaders attended a USAID-sponsored conference in Ghana and followed up with the development of plans for a multisectoral approach to promote the role of the private sector, civil society, and other ministries in family planning.
- Preliminary DHS results show contraceptive use had a modest increase from 8% in 1997 to 10% in 2005.
- Through support for women's associations, 227 women undertaking income-generating activities achieved financial profitability, which allowed them to join health insurance organizations and improve their own health and their family's health status.

South Africa

- USAID provided assistance to 18 primary health care facilities, an increase from four in FY 2004, to improve the delivery of youth services, including family planning, upgrade clinic staff skills, and assess the facilities' ability to meet standards for adolescent-friendly clinics.

- The number of USAID-assisted programs providing youth and adolescent reproductive health services increased from six in FY 2004 to 18 in FY 2005.
- A network of 47 local organizations and NGOs is implementing the innovative Men as Partners program, which aims to increase male involvement in reproductive health, HIV prevention, and reducing gender-based violence.
- USAID-funded mobile health teams provided STI diagnosis and treatment, reproductive health services, and minor ailment care to more than 35,000 clients in rural communities. They also distributed more than 1.6 million male condoms and 20,000 female condoms to at-risk individuals.
- An innovative USAID-funded clinic in an at-risk urban area with a transient population provided comprehensive reproductive health, STI, and HIV services to a large, highly mobile, sexually active population.
- A USAID-funded awareness campaign on violence against women and children reached 325,446 schoolchildren.

Tanzania

- The CPR for currently married women increased from 16.9% in 1999 to 20% in 2004, meeting the CPR target.

Uganda

- USAID supported development of the national family planning advocacy strategy, the family planning advocacy kit, and a reproductive health communications strategy.
- Condom sales among high-risk groups (prostitutes, their clients, and military personnel) increased from 10 million in 2004 to 15.9 million in 2005.
- CYP exceeded the 2005 target by 17% to reach 637,053.

Zambia

- Sales of Maximum male condoms increased to 14,683,104, above the target of 12,600,000. Sales of Care female condoms reached 239,064, above the target of 200,000.
- Nine trainers and 20 providers from four provinces received training in administering the Jadelle implant and IUD insertion.
- 522 new clients received the Jadelle implant.
- USAID procured 750,000 vials of Depo-Provera for the public sector and trained 60 maternal/child health coordinators to ensure appropriate use of this contraceptive.
- Socially marketing sales of oral contraceptives reached 874,560 cycles, surpassing the target of 790,000.
- A CBD training manual was developed to expand community-level access to and quality of family planning services.

USAID East Africa

- In September, USAID funded a groundbreaking three-day conference on “Traumatic Gynecologic Fistula as a Consequence of Sexual Violence in Conflict Settings.” More than 75 medical practitioners and activists from 11 countries discussed the effects of war on women, the need for long-term counseling for women and children who have been raped, and fistula repair. Meeting participants pledged to promote model policies regarding fistula prevention and treatment in their respective countries.
- USAID sponsored special training on gender, gender-based violence, and male involvement for USAID’s three regional African partners: the Regional Centre for African Family Studies; the Regional Center for Quality of Health Care; and the Commonwealth Regional Health Community Secretariat. As a result, these institutions are incorporating these critical topics into their policies and training activities.
- To improve the access to family planning information and services for the vulnerable populations, training courses were developed for health staff in refugee camps of Uganda and Rwanda.
- Provider training courses and program design activities along transport corridors began incorporating emergency obstetric services, emergency contraception, prevention and treatment of gender-based violence, and male involvement in reproductive health.

USAID West Africa

- USAID led a major high-profile international campaign to strengthen family planning programs in the region.
- 16 countries developed national “repositioning family planning” plans, which included massive national public awareness campaigns, increased access to services for youth and women, and reintroduction of long-term family planning methods.
- USAID launched a regional reproductive health commodity security initiative that will bring about urgently needed reforms in commodity policy.
- USAID cosponsored the “Repositioning Family Planning in West Africa” conference. More than 250 participants from 16 countries (Benin, Burkina Faso, Chad, Côte d’Ivoire, Eritrea, Ghana, Guinea, Guinea Bissau, Madagascar, Mali, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, and Togo) and 26 partners gathered to reposition family planning as a strategic objective within countries’ national goals. Countries developed draft action plans, and USAID and the West African Health Organization (WAHO) cohosted a donors meeting to discuss implementation support for the plans. Subsequently, USAID provided technical assistance to Chad, Niger, and Sierra Leone to conduct repositioning family planning workshops, finalize their national plans, and begin implementation.

AFR/SD

- The improved capacity of Africans to take the lead in improving reproductive health and family planning was a major result. USAID supported WAHO in its efforts that led to the development of repositioning action plans in 14 countries.
- WAHO drafted a strategy for improving reproductive health commodity security in West Africa. As a result, West African health ministers are considering pooled procurement of reproductive health commodities for the region.
- USAID-supported actions for positive reproductive health policy environments have resulted in high levels of government commitment in Ghana, Madagascar, and Rwanda to strengthening and expanding family planning services.
- With USAID assistance, WHO/AFRO efforts to provide information to youth on safe reproductive health practices led to the new “Alliance of Parents, Adolescents, and the Community” coalition. The Alliance has formed in eight West African countries.
- The USAID-supported Regional Center for Research in Population and Development held an adolescent health forum in Senegal that resulted in action plans to address adolescent reproductive health needs in five Sahel countries.

Annexes

Africa Missions and Regional Programs: Areas of Health Activities

		Objective 1 HIV/AIDS	Objective 2 Infectious Diseases			Objective 3 Improve Child Survival, Health, and Nutrition		Objective 4 Improve Maternal Health and Nutrition	Objective 5 Support Family Planning
			TB	Surveillance	Malaria	Primary Causes	Polio		
Missions	Angola	✓	✓	-	✓	✓	✓	-	✓
	Benin	✓	✓	-	✓	✓	✓	✓	✓
	Burundi	✓	-	-	-	✓		✓	-
	DR Congo	✓	✓	✓	✓	✓		-	
	Djibouti	✓	-	-	-	✓	-	-	-
	Ethiopia	✓	✓	✓	✓	✓		✓	✓
	Ghana	✓	-	✓	✓	✓		✓	✓
	Guinea	✓	-	-	✓	✓	✓	✓	✓
	Kenya	✓	-	-	✓	✓	-		✓
	Liberia		-	-	✓	✓		-	✓
	Madagascar	✓	✓	-	✓	✓			✓
	Malawi		✓	-	✓	✓	-	-	✓
	Mali		-	-	✓	✓		✓	✓
	Mozambique	✓	✓	✓	✓	✓		✓	✓
	Namibia	✓	✓	-	-	-	-	-	-
	Nigeria			-	✓			✓	
	Rwanda		✓	-	✓	✓	✓	✓	✓
	Senegal	✓	✓	-	✓	✓		-	✓
	Sierra Leone	✓	-	-	-			-	-
	Somalia	-	-	-	-	-	-	-	-
South Africa	✓	✓	-			-	✓	✓	
Sudan		-	✓	✓		✓	✓	-	
Tanzania	✓	✓	✓	✓	✓	-	✓	✓	
Uganda	✓	✓	-	✓	✓	-	✓	✓	
Zambia	✓	✓	-	✓	✓		✓	✓	
Zimbabwe		-	-	-	-	-	✓		
# Missions With Each Activity	Total # Missions = 26	25	15	6	20	22	18	16	20
Regional Programs	AFR/SD	✓	-	✓	✓	✓	✓	✓	✓
	USAID East Africa	✓	✓	-	✓	✓	✓	✓	✓
	USAID Southern Africa	✓	-	-	-	-	-	-	-
	USAID West Africa	✓	-	-	✓	✓	-	✓	✓
# Programs With Each Activity	Four Reg. Programs	4	1	1	3	3	2	3	3
Total Missions and Regional Programs	30	29	16	7	23	25	20	19	23

Annual Report Reviews

Strategic Objective	Comments
<p>Angola</p> <p>SO 654-007: Increased Use of Maternal/Child Health and HIV/AIDS Services and/or Products and Improved Health Practices</p>	<p>The Mission is commended for its work on and achievements in polio, increasing the use of ITNs and ORT, and immunization outreach. The panel also recognizes the Mission's success in leveraging the private sector in its health programs overall.</p> <p>Challenges: Postwar Angola has a weak economy, rapid population growth, limited infrastructure, pervasive corruption, and a shortage of skilled staff at the MOH. Within HIV/AIDS programs, there is a need to strengthen the linkages with behavior change communication strategies. USAID/Washington would also appreciate more descriptive program information in the future.</p>
<p>Benin</p> <p>SO 680-002: Increased Use of Family Health Services and Preventive Measures in a Supportive Policy Environment</p>	<p>The Mission's overall performance is on target. There were several interventions that led to excellent achievements in health, such as those for diarrhea and fever, maternal care, and the complementary work through PL 480 Title II-funded programs. It is difficult to fully assess performance, however, without a more in-depth program description that uses more quantitative data. The panel acknowledges that the Mission has taken efforts to improve the quality of information, and full reporting is encouraged.</p> <p>Challenges: Constraining factors in Benin's development are its high population growth rate, slow pace of economic reforms, and corruption. Programmatically, challenges include increasing the CPR and improving the ITN social marketing program.</p>
<p>Burundi</p> <p>SO 695-008: Access to Basic Services Increased</p>	<p>The Mission's health program results were solid despite considerable constraints. Burundi is still facing considerable challenges, including conflict and political fragility, while the Mission is faced with limited program resources.</p> <p>Challenges: Security concerns and low funding limit further expansion into safer areas. The increasing numbers of refugees and the demobilization of armed forces are ongoing challenges to moving forward.</p>
<p>DR Congo</p> <p>SO 660-002: Use of Key Health Services Both in USAID-Supported Health Zones and at the National Level Increased</p>	<p>The Mission is commended for its overall performance, especially for the national-level immunization rates (national coverage for DPT3 has gone up dramatically, from 44% in 2003 to 70% in FY 2005), given that the Mission is working in a fragile environment with no infrastructure. The Mission's five-year HIV/AIDS strategy looks comprehensive and well-written.</p> <p>Challenges: There is a lack of donor coordination, and this is affecting family planning commodities and HIV/AIDS program implementation. The malaria program faced stockouts in sulfadoxine-pyrimethamine, and increasing coverage of ITNs will be challenging. Ongoing gender-based violence exists in the eastern part of the country.</p>
<p>Djibouti</p> <p>SO 603-002: Expanded Coverage of Essential Health Services</p>	<p>The Mission achieved good results including declining infant mortality and under-5 mortality rates. The comprehensive health program effectively integrates water supply and sanitation into its activities. The panel commends the Mission for its excellent coordination with the MOH, and other donors. The Mission support for the national polio campaign, community mobilization, and health and gender in education are also notable.</p> <p>Challenges: Djibouti has a large refugee population and chronic food insecurity. The government capacity to provide social services is nearly absent, and threat of famine and the high cost of doing business constrain work in Djibouti. Other areas of concern are child protection, female circumcision, orphan and vulnerable children issues, and a high TB burden.</p>

Strategic Objective	Comments
<p>Ethiopia</p> <p>SO 663-008: Improved Family Health</p> <p>SO 663-014: Human Capacity and Social Resiliency Increased</p>	<p>Despite historical constraints and current political fragility, the Mission achieved an excellent performance with many successful health interventions, such as those to increase immunization coverage and improve contraceptive security. USAID/Washington found that the Mission had addressed the health issues in a comprehensive manner. However, it would be appreciated if more meaningful and consistent data were included in the report</p> <p>Challenges: Famine, drought, chronic malnutrition, and persistent poverty are issues that continually afflict the country. It is recommended that the famine prevention programs be strengthened. There has been an increase in the modern CPR, although more effective strategies are necessary to meet the population's contraceptive needs. The declining capacity of the public health system constrains development.</p>
<p>Ghana</p> <p>SO 641-003: Improved Family Health</p> <p>SO 641-007: Health Status Improved</p>	<p>The Mission was very effective in a number of areas, particularly in working with the MOH on the successful TB and HIV/AIDS proposal with the Global Fund, a national scale advocacy campaign to promote ITNs, and the partnership with Exxon/Mobil. USAID/Washington agrees with the Mission that overall achievements were modest based on the annual report indicators.</p> <p>Challenges: A clear challenge for the Mission is working with the MOH due to its interest in basket funding rather than targeted funds. A major health insurance initiative has been initiated by the government, and this will require trained human resources. Corruption and bribery are systemic issues.</p>
<p>Guinea</p> <p>SO 675-002: Increased Use of Essential Family Planning, Maternal and Child Health, and STI/HIV/AIDS Services, Products, and Practices</p>	<p>The Mission's overall performance had progressed but was difficult to assess without a more in-depth description and quantitative program data. USAID/Washington recognizes the challenging implementation environment of Guinea. Under the new strategy, the panel finds that performance could be improved by realigning the programs with the diseases causing the majority of the morbidity and mortality, i.e., diarrheal diseases and malaria.</p> <p>Challenges: Constraining factors are the devaluation in the Guinean franc, few development partners in country, political instability, and widespread malnutrition. The immunization program is facing vaccine shortages and has a weak national outreach program. The panel expressed concern over the decrease in measles immunization and the increase in maternal mortality.</p>
<p>Kenya</p> <p>SO 615-003: Reduce Transmission and Impact of HIV/AIDS and Improve Reproductive, Maternal, and Child Health</p>	<p>The Mission's overall performance is excellent, and the staff has managed to perform well, despite the large and diverse portfolio and new reporting requirements of the President's Emergency Plan for AIDS Relief. The Mission has outlined an excellent and comprehensive strategy in health that holds promise for better results.</p> <p>Challenges: Meeting the demands of the President's Emergency Plan and other health goals will be challenging. Commodities procurement continues to be a challenge, and both public and private sector condom supplies have decreased. There is a need for additional population funding to expand community-based activities, such as family planning information campaigns, and increase the effectiveness of family planning and child survival programs. The Mission should also continue its focus on youth. Corruption throughout the health system impacts all activities.</p>

Strategic Objective	Comments
<p>Liberia</p> <p>SO 669-003: Increased Use of Essential Primary Health Care Services Through Civil Society</p> <p>SO 669-006: Community Revitalization and Reintegration</p> <p>669-008: Increased Access to Essential Services</p>	<p>The review panel found that the program performance was good, despite the difficult environment, but there are many areas that need clarity. Although the Mission has met or exceeded most of its targets, it was difficult to understand how results were being measured within the framework. The Mission exceeded its targets for household ITN use and is supporting MENTOR for training activities in malaria, including training midwives in ACT delivery.</p> <p>The Mission also worked alongside USAID's Office of Foreign Disaster Assistance to host a workshop on transitioning from relief to development</p> <p>Challenges: The review panel recognizes that Liberia is still in transition from humanitarian to development assistance and the challenges posed by this environment, including destruction of health facilities and a severe shortage of trained health workers. RH activities have been slow to start up, and the RH strategy needs strengthening. The Mission should examine its ability to support NGO programs, primarily through Africare, and should request better reporting from Africare.</p>
<p>Madagascar</p> <p>SO 687-005: Use of Selected Health Services and Products Increased and Practices Improved</p>	<p>The overall presentation and performance of the Mission's health program is impressive. The extent of the reduction in the U5MR is commendable. Notable achievements have been made in nutrition (particularly the Essential Actions for Nutrition program), STIs, water and sanitation, and the integration of Title II partners. The Mission manages a portfolio that is complex and comprehensive and continues to be a leader in implementing innovative pilot programs, such as the Champion Communes program and integration of environment and family planning activities.</p> <p>Challenges: The production delays and funding issues for the safe water solution Sur 'Eau may be part of a larger procurement problem. The review panel is aware of this and plans to provide assistance to investigate the issue. The panel encourages the Mission to examine ORS promotion and facilitate policies to increase use.</p>
<p>Malawi</p> <p>SO 612-008: Increased Use of Improved Health Behaviors and Services</p>	<p>The Mission achieved impressive results, has met or exceeded all its targets, and produced a high quality report. The 2005 DHS results show that among other improvements, there was a decline in the TFR and U5MR and an increase in modern CPR. The orphans and vulnerable children program is quite impressive. Other valuable activities are the continued technical assistance to the National Malaria Control Program and the support for the drug efficacy study.</p> <p>Challenges: Maternal mortality rates and malnutrition remain high, and there is a need for increased access to RH services. Broader contextual challenges exist in the country, such as corruption, high poverty, and limited qualified health professionals. The panel recognizes that many health facilities in Malawi are dysfunctional. In this context, non-facility-based approaches would be appropriate.</p>
<p>Mali</p> <p>SO 688 006: High-Impact Health Services</p>	<p>The Mission is commended for the progress it has made in specific intervention areas (e.g., increasing ITN and IPT distribution, vitamin A supplementation, and DPT3 vaccination). The panel would like to commend the Mali health team for its strong partner and CA coordination. In HIV/AIDS prevention, training of religious leaders and finalization of the Muslim advocacy model are significant accomplishments</p> <p>Challenges: There is a concern that the Mission did not achieve the targets set for its three health indicators in 2005. Stock-outs of commodities remain a serious problem. There will be no additional funding from the Global Fund, and this will likely lead to a gap in provision of services/commodities. There has been a lack of MOH leadership, especially in the areas of malaria and vitamin A. The lack of funding from the Global Fund has meant that ACT has not yet been introduced in Mali; this is especially of concern given resistance to chloroquine. Despite significant Mission investment, fertility and growth rates are increasing and CYP remains low.</p>

Strategic Objective	Comments
<p>Mozambique</p> <p>SO 656-003: Increased Use of Essential Maternal and Child Health and Family Planning Services in Focus Areas</p>	<p>Many changes have taken place in Mozambique in the past year, and the review panel applauds the Mission's efforts and achievements amidst the transition to a new government. The technical assistance and financing to the "African Rainbow Expedition in Support of Malaria Prevention" is a good public-private partnership and has improved ITN use. The Expanded Program on Immunization guidelines for outreach and services and the "Community Participation in Nutrition" document are key technical resources. The Mission's overall success is difficult to fully evaluate without a more quantitative description of the scope and scale of program coverage.</p> <p>Challenges: The new government is just getting off the ground and is inexperienced in many areas. Working within the government's new sectorwide approach and ensuring funds for health will be a challenge as more donors are putting funding toward general budget support. There is a concern that family planning may be facing many challenges. Drought and malnutrition have affected many parts of the country.</p>
<p>Namibia</p> <p>SO 673-005: Increased Service Utilization and Improved Behaviors Related to STDs and HIV/AIDS in Target Communities in Namibia</p> <p>SO 673-008: Reduced Spread and Impact of HIV/AIDS in Namibia</p>	<p>The Mission's Annual Report is well written and comprehensive. The health programs are clearly integrated into the narrative, especially the inclusion of HIV/AIDS activities. Regarding SO 5, the panel found that the Mission had achieved its objectives under each IR and has laid the groundwork for a multisectoral approach. Regarding SO 8, the panel noted that the narrative demonstrated good HIV integration throughout the Mission's activities (e.g., democracy and governance activities, and in the education sector). The Mission is also addressing the role of women, and the orphans and vulnerable children programs demonstrate commitment to this very challenging issue.</p> <p>Challenges: While the Mission has sought to increase the health program's sustainability, continuing the advances will be a challenge. In the new fee-for-service insurance program, maintaining or increasing health service utilization will be a challenge. There are few other donors or partners to support child survival or basic health services. Training and increasing the human resource capacity of the country are crucial. High socioeconomic disparities and a high TB burden continue to be challenges.</p>
<p>Nigeria</p> <p>SO 620-013: Increased Use of Social Sector Services</p> <p>SO 620-014: Reduced Impact of HIV/AIDS in Selected States</p>	<p>There has been progress in implementing health activities under difficult conditions, although the report does not present a clear picture of tangible results. The outputs that have been achieved in the areas of malaria prevention, immunization, nutrition, TB, and family planning are in the right direction. The magnitude of the programs' impact, however, is difficult to judge without a more quantitative description of the coverage actually achieved. The panel recommends that next year's report contain more information on the scale and scope of program efforts.</p> <p>Challenges: Nigeria has a number of overwhelming challenges in the health sector in addition to the challenges of operating in a fractionalized health system and problematic corruption at all levels. The Mission deals with a country with multiple, large, and varied needs, including polio and avian influenza. Controlling and preventing polio remains a serious problem. The overall response to the situation is ineffective and symptomatic of the larger problem of a lack of donor and government coordination. Additional monitoring, evaluation, and data analysis by partners would enhance the Mission's ability to provide better data and interpretation next year. The panel recommends moving forward on the recommendations made for the COMPASS polio program, (i.e., linking polio activities with other project activities) to improve performance.</p>

Strategic Objective	Comments
<p>Rwanda</p> <p>SO 696-006: Increased Use of Community Health Services Including HIV/AIDS</p>	<p>Despite a year of substantial challenges, the Mission has produced an impressive report and achieved strong progress in a number of areas. There were several concrete results such as the significant increases in CPR and ART, especially in rural areas. The panel appreciated the linking of HIV/AIDS results into the narrative, which provided a more comprehensive picture of the overall program.</p> <p>Challenges: The redistricting of local government units will probably disrupt programs, but hopefully, the disruption will be temporary. The severe shortage of public health workers is affecting delivery of basic health services and also impacts health service distribution geographically. The drain of available health personnel from basic services to better-funded HIV/AIDS programs is a serious problem that is resulting in a lack of basic services. Gender-based violence and unmet need for family planning is still a challenge, and DPT3 coverage has not improved.</p>
<p>Senegal</p> <p>SO 685-003: Increased Use of Decentralized Health Services in Target Areas</p>	<p>The Mission is commended for the successes achieved to date. The strong health program illustrated by the Mission should be used as a model for other countries. There have been decreases in IMR and MMR, as noted in the latest DHS. The community-based management approaches to malaria and acute respiratory infections are excellent; these successful innovations should be shared with more districts. The Mission's efforts to promote and improve public and private partnerships have proved successful.</p> <p>Challenges: There is a lack of focus on family planning issues, and the CPR target has not been met. There is some concern for the level of attention to VCT and youth prevention, but preventing an increase of HIV among the youth population is important.</p>
<p>Sierra Leone</p> <p>SO 636-001: Reintegration of War-Torn Populations in Targeted Communities Advanced</p> <p>SO 636-002: Democratic Governance Strengthened</p>	<p>The panel found it was difficult to determine what is happening in the country's health system. The Mission's program is designed to address important inequity and instability issues in Sierra Leone. The review panel appreciates the hard work that the Mission has done. The panel recognizes that the Mission has chosen to fold health activities under the new Democracy and Governance SO. Although the Mission has no child survival or maternal health funds, it has redirected funds earmarked for health from the Economic Support Fund, but no health report was included.</p> <p>Challenges: Sierra Leone is coming out of an 11-year civil war that ended in 2002. The war has clearly devastated the country, constraining social services and contributing to the significant youth unemployment. The programs described in the report appear to be working well, though the impact is not yet evident. The Mission is encouraged to report results in future documents.</p>
<p>South Africa</p> <p>SO 674-008: Increased Use of HIV/AIDS and Other Primary Health Care Services</p>	<p>The overall performance of the Mission's health program was very good. The Mission presented a robust yet succinct narrative of its challenges and accomplishments, and the panel appreciates the inclusion of the PEPFAR activities. The Mission is working in a difficult environment and using innovative programming to meet the country's challenges, including the need for primary health services and health systems strengthening.</p> <p>Challenges: South Africa continues to face a number of challenges including poor local service delivery, crime, violence against women, unemployment, and the residual effects of apartheid. The Mission is facing new challenges in the integration of TB and HIV/AIDS activities, and the Mission is addressing this challenge by developing collaboration guidelines.</p>

Strategic Objective	Comments
<p>Sudan</p> <p>SO 650-003: Enhanced Primary Health Care Through Greater Reliance on Local Capacities</p> <p>SO 650-007: Increased Use of Health, Water, and Sanitation Services and Practices</p>	<p>The Mission's health program performance was on track overall, and the Mission is achieving modest levels of success. The health team is split between two locations because of the security situation, but the Mission is communicating well within this difficult environment. The panel found the polio immunization campaign to be very positive, with no polio cases since February 2005.</p> <p>Challenges: Sudan suffers from the effects of war trauma, ongoing gender-based violence, and the transition from war to peace. The large numbers of refugees continues to impact activities. There has been a lack of donor coordination. There are logistical challenges in the water and sanitation program. Communication in the field and between the field and USAID/Washington has been hampered since there was no health officer.</p>
<p>Tanzania</p> <p>SO 621-001: Increased Use of Family Planning, Maternal and Child Health, and HIV/AIDS Preventive Measures</p>	<p>The Mission's health program is comprehensive and is commended for meeting most of the targets. The health program's successes were recognized, such as lowering under-5 (infant and child) mortality, but reviewers note that there are areas that need improvement. Although many of the targets have been achieved, there are somewhat mixed results in other areas, such as the family planning program.</p> <p>Challenges: The growing orphans and vulnerable children population, population demographic shifts, high fertility rates, increasing poverty, and political turmoil are all challenges facing the Mission. It was unclear how the Mission plans to increase government capacity. As the Mission focuses its portfolio on commodity-based programs, such as permanent and long-term contraception and bednet distribution for malaria, greater support may be needed to improve supply chains and delivery systems. Improving maternal health should be more strongly pursued.</p>
<p>Uganda</p> <p>SO 617-008: Improved Human Capacity</p>	<p>The Mission's results were impressive and on track. There was substantial progress in its indicators, achieving four out of seven targets. Where targets were not met, it was a function of target-setting issues as opposed to deficiencies in results. Of particular note are the number of ITNs distributed and the policy dialogue with the government, which has resulted in the family planning advocacy strategy and the updated antimalarial drug policy.</p> <p>Challenges: Uganda has a number of significant challenges – continuing conflict in the North, refugees, widespread corruption, declining economic growth, and an increasing number of poor. The population growth rate is also very high. Despite limited access to maternal health care, maternal health is not a program component. The focus of the child health program is unclear. More information on the synergies between health and education would be helpful.</p>
<p>Zambia</p> <p>SO 611-007: Improved Health Status of Zambians</p>	<p>The Mission is commended for its overall performance, in particular, the strong relationship built with the government. This relationship is a model of how donors can develop close alliances with governments. The Mission has successfully leveraged additional resources from the Gates Foundation and other donors, and the coordination with the Japan International Cooperation Agency to fill funding gaps is a remarkable achievement.</p> <p>Challenges: The human capacity development crisis is having a serious negative impact on the health sector. Maternal health activities are missing from the Mission's portfolio despite the fact that childbirth is the main cause of maternal mortality. Immunization coverage should also be included in the report. The local currency has appreciated considerably, curtailing in-country funding.</p>

Strategic Objective	Comments
<p>Zimbabwe</p> <p>SO 613-009: HIV/AIDS Crisis Mitigated</p>	<p>The Mission's health program had a generally positive performance in the past year. Working in an unstable environment has been difficult, but the Mission kept its focus on its priorities of democracy and governance and HIV/AIDS. The creativity in programming is notable. The panel found the Mission to be well leveraged across its partners and working closely with CDC.</p> <p>Challenges: Zimbabwe is undergoing economic, political, and social upheaval, and hyperinflation continues to reduce the purchasing power of the dollar. Other challenges include the weak capacity of the system, the high incidence of malaria, and the immediate need for food assistance. Though mortality due to HIV/AIDS is high, HIV tests are difficult to obtain. A consolidation of activities is necessary in the future.</p>
<p>USAID East Africa</p> <p>SO 623-007: Enhanced Regional Capacity to Improve Health Systems</p> <p>SO 623-008: Strengthened Programs for HIV/AIDS in the Region</p>	<p>The Mission has achieved considerable successes overall and has supported a broad range of activities in the region. While many achievements were evident, such as the support for expanding ITNs and IPT, the maternal health assessment, and gender-based violence, in others, especially HIV/AIDS, they were not always clearly identifiable. It would be helpful if USAID East Africa could provide additional information and reports in a number of areas, such as the results of the of child health practices assessment and the AMTSL study.</p> <p>Challenges: Funding cuts from the Office of the Global AIDS Coordinator (OGAC) are likely if programs cannot report demonstrable outcomes. Detailed information on actions taken by the Mission to achieve PEPFAR goals should be provided to OGAC. USAID East Africa activities address a broad range of regional health needs; a better focus on key areas may strengthen the Mission's work. The panel recognizes the challenges of being a regional program and recommends establishing a better process for monitoring and evaluation and for reporting the outcomes to USAID/Washington. A general lack of baseline data for many program areas was noted.</p>
<p>USAID Southern Africa</p> <p>SO 690-019: Strengthened Response to HIV/AIDS in Southern Africa</p>	<p>The panel found that the report could benefit from more information regarding the full range and magnitude of USAID Southern Africa's activities. The Mission is a unique program with a strong emphasis on customer service, and the panel recognizes its success in the area of technical assistance to many countries, the development of the PACT agreement for orphans and vulnerable children grants, and the regional capacity building workshop for the Global Fund grants.</p> <p>Challenges: There is a need to document technical assistance successes from a quantitative and qualitative aspect and to document performance in terms of presence vs. nonpresence countries and focus vs. nonfocus countries. Additional staff may be needed to respond more fully to its requests for technical assistance, specifically in the areas of pediatric care, TB, ART, and orphans and vulnerable children. OGAC is reviewing the five-year plan, which creates an uncertain funding situation as to the regional assessment.</p>
<p>USAID West Africa</p> <p>SO 624-005: Increased Adoption of Sustainable Family Planning/ Reproductive Health, STI/HIV/AIDS, and Child Survival Policies and Approaches in West Africa</p>	<p>The Mission's health program is generally on the right track, and the panel agreed with the Mission's assessment that it has met many of its objectives. USAID West Africa should work to more clearly prioritize its approaches, technical areas, and countries, putting emphasis on its comparative advantage and unique role as a regional program.</p> <p>Challenges: Distinguishing between regional and bilateral approaches is a major challenge (many of the indicators and programs reported are geared towards bilateral programs). New cross-border sites have been added, yet most do not provide STI or VCT services. The expansion of service delivery may not keep pace with expansion of BCC activities.</p>

Strategic Objectives and Intermediate Results in the Health Sector

Angola 2001–2006

SO 7: Increased Use of Maternal/Child Health and HIV/AIDS Services and/or Products and Improved Health Practices

IR 7.1: Increased awareness/knowledge/demand for maternal and child health services

IR 7.2: Increased access to quality care maternal and child health services

IR 7.3: Increased demand/awareness/knowledge for HIV/AIDS services

IR 7.4: Increased access to HIV/AIDS products

Angola 2006–2009

SO 11: Provision of Essential Services by Local and National Institutions Increased

IR 11.1: Targeted local and national institutions delivering quality health care services

IR 11.2: Increased knowledge and practice of positive health behaviors

IR 11.3: Increased access to electricity for unserved populations

IR 11.4: Community/civil society activity to provide needed social services increased

Benin 2006–2010

SO 5: Benin Integrated Family Health

Burundi 2003–2005 Interim Strategic Plan

SO 8: Access to Basic Social Services Improved

IR 8.1: Increased availability of client-oriented health services

IR 8.2: HIV/AIDS and infectious disease prevention, care, and support programs expanded

IR 8.3: Safe water and sanitation more widely available

Democratic Republic of the Congo (DRC) 2004–2008

SO 2: Use of Key Health Services and Practices Both in USAID-Supported Health Zones and at the National Level Increased

IR 2.1: Increased availability of key health services and practices

IR 2.2: Improved financial access to key health services

IR 2.3: Enhanced quality of key health services

IR 2.4: Increased awareness and practice of healthy behaviors

IR 2.5: Increased access to quality HIV/AIDS prevention and mitigation services

DRC 2006–2008

SO 10: Increase Access to Essential Services

Djibouti 2003–2006

SO 2: Expanded Coverage of Essential Health Services

IR 1: Increased supply of essential health services

IR 2: Improved quality of services

IR 3: Enhanced local capacity to sustain health services

Djibouti 2006–2010

SO 4: Foster a Healthier Society

IR 1: Strengthen health systems

IR 2: Improve access to and promotion of primary health care

IR 3: Enhance local capacity

Ethiopia 2001–2006

SO 8: Improved Family Health

IR 8.1: Increased use of high-impact child survival interventions, including nutrition

IR 8.2: Increased use of high impact reproductive health interventions, including maternal nutrition in focus regions and target areas nationwide

IR 8.3: Reduced HIV/AIDS prevalence and increased mitigation of the impact of HIV/AIDS

IR 8.4: Increased health sector resources and improved systems in focus regions

Ethiopia 2004–2008

SO 14: Human Capacity and Social Resiliency Increased

Eritrea 2003–2007

SO 4: Increased Use of Priority Primary Health Services

Ghana 2004–2010

SO 7: Health Status Improved

IR 7.1: Individuals and communities empowered to adopt positive health practices

IR 7.2: Access to health services expanded

IR 7.3: Quality of health services improved

IR 7.4: Institutional capacity to plan and manage programs strengthened

Guinea 1998–2005

SO 2: Increased Use of Essential Family Planning, Maternal and Child Health, and STI/HIV/AIDS Services, Products, and Practices

IR 2.1: Increased access to essential FP/MCH and STI/AIDS prevention services and practices

IR 2.2: Improved quality of FP/MCH and STI/AIDS prevention services, products, and practices

IR 2.3: Increased behavior change and demand for FP/MCH and STI/AIDS prevention services, products, and practices

IR 2.4: Increased effective response among donors, the government of Guinea, community organizations, NGOs, and the private sector in addressing critical health systems constraints

Guinea 2006–2008

SO 6: Advanced Democratic Reform

Kenya 2001–2008

SO 3: Reduce Fertility and the Risk of HIV/AIDS Transmission Through Sustainable, Integrated Family Planning and Health Services

IR 3.1: Improve enabling environment for the provision of health services

IR 3.2: Increased use of proven, effective interventions to decrease risk of transmission and mitigate the impact of HIV/AIDS

IR 3.3: Increased customer use of FP/RH/CS services

Liberia 2001–2004

SO 3: Increased Use of Essential Primary Health Care Services Through Civil Society

IR 3.1: Strengthened capacity of civil society to achieve sustainable primary health care delivery, including access, quality, and demand of services

IR 3.2: Improved policy framework for primary health care service delivery in Liberia

IR 3.3: Increased availability of resources, including non-USAID resources for health sector development in Liberia

Liberia 2001–2004

SO 8: Increase Access to Essential Services (Health and Education)

IR 8.1: Increased access to quality basic education

IR 8.2: Strengthened capacity of civil society to achieve sustainable primary health care delivery, including access, quality, and delivery of services

IR 8.3: Increased availability of resources, including non-USAID resources for health sector development

IR 8.4: Improved policy framework for promoting health care service delivery

Liberia 2006–2008

SO 8: Increase Access to Essential Services Provided by Local and National Institutions

Madagascar: 2003–2011

SO 5: Use of Selected Health Services and Products Increased and Practices Improved

IR 5.1: Demand for selected health services and products increased

IR 5.2: Availability of selected health services and products increased

IR 5.3: Quality of selected health services improved

IR 5.4: Institutional capacity to implement and evaluate health programs improved

Malawi 2001–2007

SO 8: Behaviors Adopted That Reduce Fertility and Risk of HIV/AIDS and Improve Child Health

IR 8.1: Behavior change enabled

IR 8.2: Quality of health services improved

IR 8.3: Access to services increased

IR 8.4: Health sector capacity strengthened

Mali 2003–2012

SO 6: Increased Use of High-Impact Health Services

IR 6.1: Policy environment for high-impact health services established

IR 6.2: Demand for high-impact health services increased

IR 6.3: Access to high-impact health services increased

IR 6.4: Quality of reproductive health and child services improved

Mozambique 2004–2010

SO 8: Increased Use of Child Survival and Reproductive Health Services in Target Areas

IR 8.1: Increased access to quality child survival and reproductive health services in target areas

IR 8.2: Increased demand at community level for child survival and reproductive health services

IR 8.3: More accountable policy and management

SO 9: HIV Transmission Reduced and Impact of the AIDS Epidemic Mitigated

IR 9.1: Civil society linked effectively to national HIV/AIDS response

IR 9.2: Behavior change enhances HIV/AIDS prevention and care

IR 9.3: Essential services utilized

Namibia 2000–2005

SO 5: Increased Service Utilization and Improved Behavior Related to HIV/AIDS in Target Communities in Namibia

IR 5.1: Increased quality and availability of information to improve sexual risk behavior in target community

IR 5.2: Increased quality and availability and demand for services to improve sexual risk behavior in target communities

IR 5.3: Strengthened capacity of institutions to plan and implement HIV/AIDS interventions in target communities

IR 5.4: Increased community awareness and comprehensive support for orphans and vulnerable children in target communities

Namibia 2004–2010

SO 8: Reduced Spread and Impact of HIV/AIDS

No IRs identified in FY 2006 Annual Report.

Nigeria 2004–2009

SO 13: Increased Use of Social Sector Services

IR 13.1: Improved quality of social sector services

IR 13.2: Strengthened enabling environment

IR 13.3: Expanded demand for improved social sector services

IR 13.4: Increased access to services, commodities, and materials

Nigeria 2004–2009

SO14: Reduced Impact of HIV/AIDS in Selected States

IR 14.1: Increased use of quality HIV/AIDS and TB prevention services and interventions

IR 14.2: Increased use of quality HIV/AIDS and TB care and support services and interventions

IR 14.3: Increased use of quality HIV/AIDS and TB treatment services and interventions

IR 14.4: Strengthened public, private, and community enabling environments

Nigeria 2006–2009

SO 15: Increased Use of Child Survival and Reproductive Health Services in Targeted Areas

Rwanda 2004–2009 Interim Strategic Plan

SO 6: Increased Use of Community Health Services Including HIV/AIDS

IR 6.1: Reinforced capacity for implementation of decentralization policy in target districts

IR 6.2: Increased access to selected essential health commodities and community health services

IR 6.3: Improved quality of community health services

IR 6.4: Improved community-level response to health issues (HIV/AIDS, family planning, child survival, malaria)

Senegal 1998–2006

SO 3: Increased Use of Decentralized Health Services in Targeted Areas

IR 3.1: Improved access to quality reproductive health services

IR 3.2: Increased demand for quality reproductive health services

IR 3.3: Increased financing of health services from internal sources

Senegal 2006–2010

SO 12: Improved Health Status of Families

Sierra Leone 2004–2006

No health SO. The following SOs were reviewed in FY 2006:

SO 1: Reintegration of War-Torn Populations in Targeted Communities Advanced

IR 1.1: Micro-enterprises established/expanded

IR 1.2: Agricultural production and marketing increased

IR 1.3: Community infrastructure and services improved

SO 2: Democratic Governance Strengthened

IR 2.1: Broadened political participation

IR 2.2: Citizens, local government, and civil service organizations better informed

IR 2.3: Improved management and accountability over national resources

Sierra Leone 2006

No health SO.

SO 3: Enhance Democratic Governance

Somalia 2004–2006

No health SO. The following SOs were reviewed in FY 2006:

SO 4: Strengthened Capacity for Local Governance and Conflict Mitigation

SO 5: Increased Opportunities for Productive Livelihoods

SO 6: Critical Needs Met for Vulnerable Groups

IR 6.1: Improved quality and availability of health care services

IR 6.2: Increased access to safe water and sanitation

IR 6.3: Effective targeting and delivery of food aid to vulnerable groups

IR 6.4: Improved capacity for disaster preparedness and response

Somalia 2006–2007

SO 8: Improve Access to Essential Services

South Africa 1996–2006

SO 8: Increased Use of Primary Health Services and HIV/AIDS Prevention/Mitigation Practices

IR 8.1: HIV/AIDS prevention measure strengthened

IR 8.2: Management of STIs improved

IR 8.3: Treatment for TB and AIDS improved

IR 8.4: HIV/AIDS care and support expanded

IR 8.5: Selected primary health care systems and services improved

South Africa 2007–2011

SO 10: Strengthened Capacity to Deliver Sustainable and Integrated Primary Health Care and HIV and AIDS Services

South Africa 2004–2009

SO 19: Southern Africa Regional HIV/AIDS (Regional HIV/AIDS Program)

Sudan 2004–2006

SO 3: Enhanced Primary Health Care Through Greater Reliance on Local Capacities

IR 3.1: Increased Sudanese participation as a foundation for sustainability

IR 3.2: Improved and expanded delivery of services

Sudan 2004–2006

SO 7: Increased Use of Health, Water, and Sanitation Services and Practices

IR 7.1: Improved access to high-impact services

IR 7.2: Increased Sudanese capacity, particularly women's, to deliver and manage health services

IR 7.3: Increased demand for health services and practices

IR 7.4: Improved access to safe water and sanitation

Sudan 2006–2008

No health SO.

SO 9: Avert and Resolve Conflict

SO 10: Promote Stability Recovery and Democratic Reform

Tanzania 1997–2004

SO 21: Increased Use of Family Planning, Maternal and Child Health, and HIV/AIDS Preventive Measures

- IR 1.1: Policy and legal environment improved
- IR 1.2: Availability of quality services increased
- IR 1.3: Demand for specific quality services increased

Tanzania 2005–2014

SO 10: Enhanced Multisectoral Response to HIV/AIDS

- IR 1: Improved HIV/AIDS preventive behaviors and social norms
- IR 2: Increased use of HIV/AIDS prevention to care services and products
- IR 3: Improved enabling environment for HIV/AIDS responses from community to national levels
- IR 4: Enhanced multisectoral response to HIV/AIDS

Tanzania 2005–2014

SO 11: Health Status of Tanzanian Families Improved

- IR 1: Communities empowered to practice key behaviors and use services for target health problems
- IR 2: Family level access to target services increased
- IR 3: Sustainability reinforced for target health program

Uganda 2002–2007, 2009–2010

SO 8: Improved Human Capacity

- IR 8.1: Effective use of social sector services
- IR 8.2: Increased capacity to sustain social sector services
- IR 8.3: Strengthened enabling environment for social sector services

Zambia 2004–2010

SO 7: Improved Health Status of Zambians

- IR 7.1: Zambians taking action for health
- IR 7.2: Achievement and maintenance of high coverage for key health interventions
- IR 7.3: Health services strengthened

Zambia 2004–2010

SO 9: Reduced Impact of HIV/AIDS Through a Multisectoral Response

- IR 9.1: Reduced HIV/AIDS transmission
- IR 9.2: Improved care and support for people living/affected by HIV/AIDS
- IR 9.3: Strengthened capacity of key sectors to mitigate the HIV/AIDS Impact
- IR 9.4: Improved policy regulatory and environment

Zimbabwe 2000–2010

SO 9: HIV/AIDS Crisis Mitigated

- IR 1: Reduced high-risk sexual behaviors
- IR 2: Enhanced capacity to formulate, advocate and implement improved HIV policies
- IR 3: Increased care and support for orphans and vulnerable children and others infected with HIV

USAID East Africa 2001–2007

SO 7: Enhanced Regional Capacity to Improve Health Systems

- IR 7.1: Improved viability of regional partner institutions
- IR 7.2: Broaden technical resource base
- IR 7.3: Expanded utilization of critical information
- IR 7.4: Expanded policy dialogue

USAID East Africa 2004–2010

SO 8: Strengthened Programs for HIV/AIDS in the Region

- IR 8.1: Strengthened USAID Mission technical and strategic leadership
- IR 8.2: Enhanced human and organizational ability to respond to the epidemic
- IR 8.3: Information exchanged, lessons learned, and best practices disseminated
- IR 8.4: Effective programs implemented in target populations

USAID East Africa 2006–2010

SO 11: Healthier Population in the East and Central Africa Region Achieved Through African Leadership

USAID Southern Africa Regional HIV/AIDS Program 2004–2010

SO 19: Strengthened Response to HIV/AIDS in Southern Africa

- IR 1: Increased access to select HIV/AIDS services in target populations across the region
- IR 2: Improved quality of Mission programs to combat the HIV/AIDS epidemic in the region
- IR 3: Increased participation of regional networks and institutions in combating the HIV/AIDS epidemic

USAID West Africa 2001–2008

SO 5: Increased Adoption of Sustainable FP/RH, STI/HIV/AIDS and CS Policies and Approaches in West Africa

- IR 5.2: Increased regional stakeholder advocacy for policy change
- IR 5.3: Increased capacity of regional institutions and networks
- IR 5.4: Health sector reform models developed and disseminated region wide

USAID West Africa 2006–2009

SO 9: Regional Health Program

Success Stories

Ethiopia

Making the Best of a Bad Situation

Muti Tolcha has learned many lessons from his difficult life – most importantly, to make the best of a bad situation. A former inmate, Muti was released from prison, only to learn that he was HIV-positive. He decided to turn his life around and went to the local Hope Center, an organization funded by International Orthodox Christian Charities (IOCC) and its partner, the Ethiopian Orthodox Church's Development and Inter-Church Aid Commission (EOC-DICAC). There, he received counseling and a \$115 donation to start a business.

He learned to weave the traditional white Ethiopian cloth called gabi. Now he weaves beautiful gabis and has even hired two assistants to help with his workload. IOCC-DICAC, with funding from President Bush's Emergency Plan for AIDS Relief through USAID, has given him a future and the possibility of passing on the kindness he has received. "My hope is to live long to educate my children," says Muti, "to teach people the consequences of stigmatizing people with HIV and teach people to be tested for HIV."

Hope Center Provides Support for HIV-Affected Women

With funding for a small business, Tadeleu keeps busy with orders on her self-powered sewing machine. Tadeleu contracted HIV from her husband, who recently died. Her two children, who are HIV-negative, live with their grandmother. She tells of the stigma she faces, both emotionally and socially. "When I found out I had the disease, all I could think about was how much I hated myself, and I kept denying that I had the disease," she says. "I do not want to become intimate with people, because I fear they will find out my status."

When Tadeleu discovered she had HIV, she started attending support meetings at the Hope Center, established by the Ethiopian Orthodox Church's Development and Inter-Church Aid Commission (EOC-DICAC) and International Orthodox Christian Charities (IOCC). She found a sense of community and a program that would change her life. IOCC-DICAC provided skills training and start-up capital for her to begin a small business. She is now too busy to feel stigma from her neighbors. Because she does not want to deal with local people, her buyers are often from markets several towns away. Despite the stigma, she finds relief in the Hope Center. "I am happy that the Church has provided support," she says. "They keep our secrets."

Vibrant fabrics grace the wall behind Tadeleu, who has been hard at work from sunrise to sunset at her self-powered

sewing machine. Orders come in regularly, giving Tadeleu confidence in her work and a sense of security. Amidst her tears, a smile breaks out and she says, "This program has given me life."

Journalists Interview Beneficiaries of ART During Visit to Local NGO

Local media have the potential to play a significant role in helping Ethiopians cope with the challenge of HIV/AIDS. It is important that they are correctly informed on facts and issues about the disease and available treatment. "Local Voices," a project sponsored by the international nonprofit organization Internews, helps local media both increase the frequency and improve the quality of their reporting and programming on HIV/AIDS issues. The project collaborates closely with the Ethiopia's AIDS Resource Center and receives funding from USAID through the President's Emergency Plan for AIDS Relief.

Local Voices aims to create a more supportive social environment for preventing and mitigating the impact of HIV/AIDS through an informed and committed local media community. Internews trains journalists from private and government newspapers in reporting techniques and writing skills as health reporters. Its greatest impact has been its ability to reach the public with accurate information about HIV/AIDS through the journalists it trains. Through improved reporting and programming, approximately 6 million Ethiopian media consumers received the information they need to protect themselves against the virus and to care for those who are infected.

The project provides a five-day practical training workshop where participants interact with people living with HIV/AIDS at a local NGO facility that provides care and antiretroviral treatment (ART) to the community. This is followed by several days of individual work with a health journalist/trainer to finalize stories and plan for future HIV reporting.

At the end of the workshop, each trainee has articles ready for publication and plans for future articles. "Journalists can make a tremendous change in society by informing and educating," says one participant. "I can upgrade my knowledge and influence others about AIDS."

Recently, Internews provided a 10-day training workshop for three radio talk show hosts, who are now providing information about HIV/AIDS issues on their shows.

Woman Speaks Out on Early Marriage

"I teach from experience. I know the hardships of raising many children." – Yeshi Alem, marketplace family planning/reproductive health agent and women's association representative

Trained by Pathfinder International-Ethiopia, Yeshi Alem is a family planning/reproductive health agent in Kemissie village. As a member of the early marriage committee, the *Woreda* advisory council, and the women's association, she has helped prevent more than 300 early marriages in her community. Early marriage and harmful traditional practices such as rape, abduction, wife inheritance, and unattended births are prevalent in Ethiopia.

"I teach from experience. I know the hardships of raising many children," Yeshi says. "My husband now sees the benefits of what I started eight years ago, even though he wasn't convinced of it then."

In certain regions of Ethiopia, parents consent to their daughters' consummated marriages when the girls are as young as 10 to 12 years old, despite the legal marriage age of 18. The young wives are subjected to early years of child-bearing without ever understanding that it violates their human rights; that it increases the risks of poverty and not completing their education; and that it could have devastating health consequences.

Pathfinder International-Ethiopia, which receives funding from USAID, works in collaboration with implementing partners with the aim of preventing harmful practices through community and legal interventions, thereby improving the status of young girls' reproductive health and having an added impact on women's empowerment. In advocacy sessions with Pathfinder and partners, the Ethiopian Orthodox Church and Ethiopian Islamic Affairs Supreme Council developed and signed statements of action condemning early marriage and other harmful traditional practices and outlining punishments for such offenses.

"When girls are married at a young age, they get hurt because their bodies have not matured yet," says a Muslim leader at an advocacy session. "We as religious leaders should be serious about this."

Coffee Ceremonies Provide Means to Deliver Health Messages

"Today is the first time I have been seen by health personnel. Thanks to our community core team members, I understand how HIV is transmitted from mother to child." – Fatuma Nuru, coffee ceremony participant

Coffee ceremonies are an integral part of social and cultural life in Ethiopia. Community "core team" members organize coffee ceremonies in villages to discuss health issues and

provide messages about partner empowerment, antenatal care, family planning, alleviating HIV/AIDS-related stigma, decreased discrimination, and male involvement in reproductive health.

Fatuma Nuru attended a coffee ceremony to discuss issues related to antenatal care and preventing mother-to-child HIV transmission (PMTCT). She attended an additional forum to be sure she heard the information correctly and to understand HIV/AIDS transmission.

Pregnant with her fourth child, Fatuma was referred by the community core team members and is receiving antenatal care, which includes PMTCT services, at the local health center for the first time. "Today is the first time I have been seen by health personnel. Thanks to our village community core team members," says Fatuma, "I understand how HIV is transmitted from mother to child." Fatuma delivered her other three children at home in the village with only the help of her neighbor.

IntraHealth has been working to help the community understand the complex nature of mother-to-child HIV transmission by ensuring the rights of women and utilizing PMTCT services rendered by the health centers. IntraHealth currently supports 81 health centers in Ethiopia, with the intention to scale up to 267. IntraHealth International supports the program's implementation with the financial support of USAID through the President's Emergency Plan for AIDS Relief.

Ghana

Sara Helps Youth Confront Issues

Esi is a teenager attending school in Ghana. She faces many challenges as she struggles to complete her basic education. She feels shy asking or answering questions in class, and she is exposed to sexual exploitation by peers and adult males, which could lead to pregnancy and/or a sexually transmitted infection. Many Ghanaian girls like Esi face similar problems that affect their school performance and sometimes stop them from completing their basic education.

To help girls stay focused on education and effectively handle schooling and sexuality issues, USAID supported an expansion of Sara, a UNICEF project. Sara, a fictional adolescent role model, is popular among young people and educators in promoting positive behavior. In 2002, USAID sponsored the training of educators to use "Sara clubs" to address issues like sexual harassment, teen pregnancy, and HIV/AIDS. This year, Sara clubs have continued to expand their reach in schools, allowing girls and boys to discuss together how Sara and her friends handled challenges and never gave up even in difficulties. The clubs turned Sara's stories into plays, told the stories in local languages, and

used her adventures in puppet shows. They produced club kits, including books, posters, videos, and games, to stimulate discussions and promote healthy and safe behavior.

Sara clubs have raised awareness among youth, especially girls, about sexual relations and the importance of HIV/AIDS prevention. Girls now freely share ideas and problems with their parents and teachers, particularly female teachers, and report cases of sexual harassment. In addition, girls are now confident in asking and answering questions in class. For parents and teachers, the Sara slogan "I know my goal" has renewed interest in learning among girls. Girls are now more focused on their education and some of them top boys in academic performance. Sara is helping girls stay in school, and the approach is contributing to keeping teen pregnancy and HIV/AIDS rates low.

"Now I freely share ideas and problems with my parents and teachers, who are my trusted friends," says Dela, a student at Kpando's Immaculate Conception Junior Secondary School in Ghana's Volta region.

Madagascar

Transforming Malagasy Youth Programs Into Frontline Leaders in the Fight Against AIDS

Although Madagascar has been less affected by HIV/AIDS than many of its neighbors, the epidemic has worsened significantly in recent years. Sentinel surveillance of pregnant women indicates that between 2002 and 2003 the HIV prevalence rate more than tripled from 0.33 percent to 1.1 percent. Among women under 15 years of age, 1.64 percent were found to be HIV-positive.

In response to this situation, the National Anti-AIDS Committee, together with the USAID-funded Health Communication Partnership and the SanteNet program has designed and launched the *Ankoay* (eagle) approach. The program's goal is for youth groups to earn the distinction of being an *Ankoay* group, which requires completing a series of life skill exercises, a peer education program, and community outreach activities.

The *Ankoay* approach includes a diverse educational mix that speaks to a variety of learning styles and personality types. To successfully complete the program, youth groups work through 20 highly participatory activities developing skills such as decisionmaking, goal setting, and effective communication. These activities are part of a kit that also includes "Youth Passports," a tool designed to promote individual reflection, and a role-play booklet containing scenarios reflecting situations typically encountered by youth. The drama component helps youth to emotionally connect with vital issues in a safe environment. Finally, community out-

reach activities serve to reinforce learning and promote a sense of group efficacy.

The primary target audience is youth ages 15 to 18. Originally launched in spring 2005 through the scout troops of the Madagascar Scout Federation, the program has expanded to include other youth groups, sports teams, and schools.

Once a youth group reaches *Ankoay* status and has assumed a community leadership role in the fight against AIDS, it celebrates its success with a community festival. Mass media broadcast the news around the country, create enthusiasm, and in turn drive the program's expansion.

Based on the success of *Ankoay*, other partners such as the World Bank, UNICEF, and the United Nations Population Fund have committed to explore potential future collaboration and to support certain parts of the program.

The *Ankoay* project is now recognized as an HIV youth model by the National AIDS Committee, and other partners also support parts of the program.

Malawi

New Incinerator Reduces Threat of Disease

While an incinerator doesn't seem like an exciting development project, for the community around Kasungu District Hospital it meant the difference between sickness and health. For years, Kasungu District Hospital was using a makeshift incinerator to dispose of used needles, syringes, glass, gloves, and bandages. Unfortunately, the incinerator did not function properly, causing damage to the environment and posing a health threat to the people living and working around the hospital. Improper disposal of the medical equipment put adults and children at greater risk for disease. With immune systems already compromised from malnutrition and the effects of HIV/AIDS, this was a very dangerous situation.

With funding from USAID, Management Sciences for Health helped Kasungu District Hospital staff build the incinerator and train staff on how to effectively dispose of medical equipment. The harmful medical waste is now adequately incinerated, thereby reducing the polluting particles in the air and the risks posed by partially burnt materials such as needles and other hazardous waste on the ground in areas where children play. The new incinerator reduces the risk of infection while also protecting the environment.

Mothers Group Takes HIV/AIDS Pandemic Into Its Own Hands

Before 2004, Chambwe Primary School had six male teachers who all ignored the danger and impact of HIV/AIDS on their students and community. The teachers did not tell their students about the pandemic. Because the people in the surrounding villages did not know much about HIV/AIDS, few cared about the increasing number of children orphaned by AIDS in their community and did little to prevent more deaths from AIDS.

By facilitating discussions in communities throughout Malawi, including Chambwe, USAID's Malawi Education Support Activity (MESA) ensures that HIV/AIDS education reaches not only students but also their communities.

Following one MESA community discussion, a group of women from Chambwe decided they could not wait for someone else to educate their children about the dangers of AIDS – it was time to do it themselves. Seven women began to counsel students on the dangers of risky sexual behavior. In addition, the group, led by Mai Nalinde, speaks to everyone in the villages around the school. They visit homes of persons living with HIV/AIDS, providing moral support and financial assistance when possible. The mothers group talks about HIV/AIDS at any gathering where people will listen – funerals, maize mills, markets, water wells, and churches.

What the mothers group does for students has touched the hearts of many people in the area. The group goes to Chambwe School twice a week to counsel and teach students about HIV/AIDS. “Many students at the school have really changed their attitudes and behaviors,” commented J.R. Chagwanjira, Deputy Head Teacher. Inspired by the mothers group, some students formed a drama troupe that supplements the efforts of the mothers group. The drama troupe performs both at the school and in the surrounding villages. “Many people around the school now appreciate the gravity of the AIDS pandemic and that time has come to stop playing games,” said D. Chakungwa, the group's facilitator.

Radio Show Encourages Youth to Pursue Their Dreams and Preserve Their Health

It is 6:40 on a Saturday evening and *Youth Alert! Mix (YAM!)*, the most popular youth radio magazine program in Malawi, is blazing across the airwaves. In a remote area of the country, at least one young woman is listening.

Carol Tambala, 18, comes from a poor family from Mtelera village in southern Malawi. At 16, Carol became pregnant and dropped out of school. For the past two years, she has been imploring her parents to let her return, to no avail.

Carol has one ambition in her life – to become a nurse – and she knows school is the only way.

“During my antenatal visits I met a lot of nurses, and they told me I had to complete my education if I wanted to pursue a career in nursing,” she says. “That's why it was painful to see my fellow girls carrying books going to school every morning, knowing that staying at home would take me nowhere.”

One evening she was listening to *YAM!* with her parents, and the presenters talked about the importance of returning to school after becoming pregnant.

The young mothers featured on *YAM!* who managed to continue their studies and attain their goals gave Carol courage. The program also moved her parents. “The interview with a girl who had gone back to school was touching,” Carol's mother recalls. “Soon after the program, we made a decision to allow our daughter to go back to school.”

USAID funds Youth Alert!, a program about making good health and life decisions and promoting HIV prevention among young people. Operating in Malawi since 2001, USAID supports all four of Youth Alert's key components:

- Youth Alert! schools program – This program targets secondary-school youth with interactive methods like role playing and participative drama. The program educates and motivates youth to adopt responsible sexual behaviors.
- *YAM!* – This three-times-a-week radio show promotes the importance of making good decisions and interpersonal communication.
- Youth Alert! listeners clubs and teacher training – Two hundred youth listeners clubs congregate to listen to *YAM!* together and discuss reproductive health issues raised in the radio show in a small-group format.
- Youth Alert! peer education – After peer education training, 160 exemplary youth leaders are now leading discussions among their peers about HIV/AIDS and how to make difficult decisions about their health and future goals.

“I am very happy that our daughter has gone back to school,” says Carol's mother. “Maybe after completing her education, our daughter will get a good job and will take care of us ... but I am very happy that she is now back in school.”

Carol is elated about returning to school. “Now I am back at school, my goal is to become a nurse one day, and I am working hard to achieve this goal.”

She has this message to her friends: “Fellow young people, please avoid having unprotected sex. Unprotected sex can

lead to unintended pregnancies; you can contract sexually transmitted infections and even the HIV/AIDS virus.”

Malawian Deejay Teaches Self-Respect

USAID and its partner organization Population Services International (PSI)/Malawi launched the “Real Man/Real Woman” delayed sexual debut campaign in September 2005. The goal of the campaign is to change the behavior of Malawi’s youth by encouraging them to postpone their first sexual encounter until they are ready both mentally and physically. The campaign is based on research from eight African countries, including Malawi, that showed that many young people in Africa view sexual intercourse as a rite of passage from childhood to adulthood, i.e., they want to have sexual intercourse in order to prove they are “real men” or “real women.”

The Real Man/Real Woman campaign focuses on changing the perception of attaining adulthood through becoming sexually active and replacing it with responsibility, respect, and attention to achieving future goals.

This story profiles one such “real woman” – a young Malawian woman who has concentrated on her future, kept her promise to herself, maintained her self-respect, and achieved her goals in life. This is her story:

My name is Carol Maziya. I am 19 years old and one of six children raised by my single mother in Blantyre. Throughout my childhood, my mother struggled to put enough food on the table, send us to school, and keep us healthy. For a long time, I wanted to show her how much I appreciate the sacrifices she made for us. I knew that the only way I could do that was by studying hard and being a daughter she could truly be proud of.

In 1999, I was selected to attend Njamba Secondary School in Blantyre. While in secondary school, I faced a lot of challenges. Some of the older boys were always asking me to be their girlfriend. After class, they would follow me home teasing me about not having a boyfriend. I would walk on the other side of the road just to avoid them. Soon, I got a reputation for being rude and a tattletale. Some of my classmates even spread rumors that if a boy even approached me then I would rush home and tell my mother. I was an outcast at school.

One day a classmate told me she had a boyfriend and asked if I had one. I told her I didn’t want a boyfriend. I was focusing on my future, and boyfriends only want one thing – sex. I was shocked when she said, “Carol, you are a very strange girl.” I was confused; I couldn’t believe she thought I was weird by not having a boyfriend. Why should I compromise my values to “fit in” with others? Waiting was my decision. My education was my number-one priority.

While at secondary school, I listened to the radio a lot, and the majority of the deejays were male. I decided I want-

ed to become a deejay, but my classmates said journalism was “only for men.” But I knew journalism was in my blood. I stood my ground and attended the Malawi Institute of Journalism, graduating in 2005. My first job out of school was as a part-time deejay with MIJ FM, one of Malawi’s premier private radio stations. Being on air was such a thrill. My dreams had come true. This is exactly what I wanted to be – a strong and independent young woman, a role model for other Malawian young women.

After 11 months with MIJ FM, I joined PSI/Malawi as a producer and deejay of the most popular youth radio show in Malawi, *Youth Alert! Mix*. Now, I’m on air three times a week on Malawi’s two state radio stations, MBC1 and MBC2. I get to talk to youth all over the country about reproductive health and life skills and encourage them to adopt safe sexual behaviors.

When I look back on those difficult days at secondary school, I wonder what my friends are doing now. I sincerely hope they have succeeded in their chosen professions. I know I have. By concentrating on my future, respecting myself, and being responsible, I have achieved my goals and consider myself a real woman.

Mali

Imams Advocate for HIV/AIDS Prevention and Family Planning

Religious leaders in Mali have a significant influence on decisionmaking about contraceptive use, including condoms. The belief by many imams in Mali that Islam forbids contraception has posed considerable obstacles to increasing contraceptive prevalence and the prevention of HIV/AIDS in Mali. Although Mali has a relatively low HIV seroprevalence of 1.7 percent, the rate is much higher among high-risk populations, which could potentially increase the spread of the virus if unchecked. In addition, Mali’s consistently high maternal mortality rate is facilitated by the low use of modern contraceptives – only 5.7 percent of women of reproductive age in Mali use a modern contraceptive.

USAID is working in collaboration with the POLICY Project to empower religious leaders and decisionmakers to advocate on behalf of family planning and HIV/AIDS prevention. POLICY has developed two advocacy models that quote verses from the Koran and the Hadiths that support family planning to promote the quality of life over quantity of children. The project works with the Ministry of Health, the Malian High Islamic Council, and a research team to develop models that serve as teaching tools and platforms for discussions with religious leaders and decisionmakers. The project provides training to build capacity, leadership, advocacy, and implementation skills among imams. POLICY has also developed a model to target Mali’s Christian population.

Champion religious leaders such as Imam Cherif Haidara are well known and celebrated by a large Muslim following in Bamako, the capital. He and other religious leaders have inspired public demonstrations for HIV/AIDS prevention and family planning from the Islamic population. During an advocacy presentation in June 2005, one religious female participant took the floor and expressed to a room of Islamic leaders and scholars that she was now convinced she could use family planning. Before the presentation, she had believed that Islam opposed family planning and would never have used it, regardless of her health. After attending the advocacy presentation and listening to religious leaders discuss family planning, she was convinced controlling her reproduction is compatible with her religious beliefs.

Namibia

Teachers Develop HIV/AIDS Stories for Young Learners

“Working in groups to write a story was also challenging. It is a very useful strategy for cooperative learning.” – Writing camp participant

Can teachers become writers? At the August 2005 USAID-funded Writing for Kids Camp II, teachers took the first important steps to becoming published writers of children’s books. The writing camp, attended by 29 primary-school teachers and language advisory teachers from Namibia’s six northern education regions, offered participants training in developing good stories for young learners on important concepts and issues related to the impact of HIV and AIDS on their lives. Now these teachers will be able to read to their learners stories written by themselves that reflect strong local input and understanding of Namibia’s HIV/AIDS crisis.

This is one way that USAID’s support to strengthen the quality of basic education in Namibia involves innovative activities that improve teacher instruction skills while providing locally relevant learning materials. Staff from USAID’s education project worked with the teachers on the wide range of writing skills needed to develop a sense of audience; to understand and apply the concepts of plot and setting; and to use local knowledge, problem-solving situations, dialogue, and illustrations to bring stories alive for children.

Although the major outcome of the writing camp was the first drafts of stories for learners, one very important objective was to provide teachers with improved skills to teach writing in their classrooms. The workshop will add four to six more titles in the Writing for Kids series of books that began during the USAID-funded basic education project. With USAID funding, the books will be illustrated by local artists, printed in major local languages, and distributed to

schools in the six target regions for use by teachers in grades one through seven.

Many stories focused on the difficulties and challenges faced by children who have lost one or both parents in recent years and by families with more children to care for due to illness and death caused by HIV/AIDS. They also addressed ways in which children can begin to cope with these serious issues. By the end of the camp, the participants had written personal narratives and poems, as well as their stories.

Namibia has worked hard to improve the quality of its public education, which suffers from a lack of trained teachers, culturally appropriate quality curriculum, and resources. The writing camps are opportunities to address some of these legacies from the apartheid era.

New Start Centers in Namibia

In Namibia, approximately one in five pregnant women is HIV-positive, and one in three mothers will pass HIV on to her child, either during pregnancy, childbirth, or through breastfeeding. For pregnant women, HIV infection can be devastating for both mother and child.

Living in an informal settlement on the outskirts of the formerly black township of Katutura, 30-year-old Celia stands at an important point in her life. She is pregnant, unemployed, unmarried, and without any financial resources. Encouraged by her sister to go for a free HIV test, Celia visited a New Start Center that offers HIV counseling and testing services.

Funded by USAID under President Bush’s Emergency Plan for AIDS Relief, the New Start center Cecilia visited makes it possible for young women to learn their status. Through advances in drug therapy, the risk of mother-to-child transmission of HIV during delivery can be halved. New Start Centers provide access to these therapies – more than 40,000 people have received counseling and testing at 14 centers throughout Namibia. Innovative radio, television, and other media campaigns inform individuals about the availability of this valuable resource and educate Namibians about the importance of knowing their status. After undergoing pretest counseling, Celia received a test and was found to be HIV-negative. She was encouraged to return in 90 days for a follow-up test to be sure about her status because there is a “window” period when an individual may become HIV-positive after an initial negative test result.

If Celia is found to be HIV-positive, she will be referred to a local hospital where, thanks to the partnership between Namibia’s government and the Emergency Plan, she will be able to obtain comprehensive services, including counseling, information, and medicines to help reduce the risk of her child being infected and her own risk of developing AIDS.

In addition, she will have the opportunity to enroll in one of the many post-test clubs throughout the country that have been established to provide support for those living with HIV.

If Celia is found HIV-negative, post-test counseling at the New Start Center will review strategies aimed at preventing HIV infection in order to help her and her child to continue to live HIV-free and build their future.

Rwanda

Living With HIV

When Eleda Mukamurara arrives at Biryogo Community Clinic, she is greeted like an old friend by the staff. In 2003, she became the first antiretroviral (ARV) drug therapy patient in Rwanda treated with U.S. Government assistance. She is also proud to be a representative for the progress Rwanda and Rwandans have made in the fight against HIV.

"I forget that I have HIV, I feel so well. Then I hear that it is World AIDS Day and I remember that includes me!" she exclaims with a laugh.

In 2003, this was not the case. Eleda weighed just 37kg (81 lb) and needed a stick to walk. She was lonely, having lost her husband four years earlier to an undiagnosed illness. She was battling TB. When she discovered that she was infected with HIV, she shared the news with her family and neighbors. The neighbors rejected her and refused to allow their children to play with her eight children, and her brother accused her of being a prostitute. She was plagued by a recurring nightmare about her own death. She would wake up terrified about her children's future.

At Biryogo Community Clinic, USAID supports training for the nurses who care for the patients on ARVs. For Eleda, this meant that she was seen by a nurse every day for the first six weeks of her treatment. She was encouraged to bring a friend with her. These daily visits helped Eleda adjust to the discipline of taking the ARVs daily. They also provided vital emotional support. A social worker came to her home on a number of occasions to see how the rest of her family was coping. After six weeks, Eleda started visiting the clinic once a week. Within six months, she was showing a marked improvement.

Biryogo Clinic is considered a model for community health care in Rwanda. The thorough follow-up provided by the nurses has resulted in patients with a very high adherence to ARV treatment. The nurses and doctor offer in-house training for other health workers, who come and work at the clinic for two or three weeks and then return to their health centers with new knowledge and skills to care for ARV patients.

Eleda belongs to an association of people living with HIV/AIDS, from which she receives a food ration. The association's meetings provide a good opportunity for members to support one another. For both the clinic and the association, Eleda talks to people who have recently found out that they are HIV-positive, "I tell them, look at me! I am well. Don't worry, you can be healthy and carry on with your lives."

Eleda has seen a big change in HIV awareness since 2003. Today, she says everybody knows how HIV is transmitted, and people talk freely about their HIV status. Her neighbors are once again her friends and she has rebuilt her relationship with her brother. "Now we share the same plate to eat, and he greets me the way a brother should," she remarked.

Eleda's laugh is infectious, and she enjoys describing the transformation of her life since starting ARVs. Her nightmares have gone away. Life is still a struggle because she is very poor. But now that she is healthy, she is able to make some money washing and ironing clothes.

In 2005, 15,900 people like Eleda received ARVs provided by the U.S. Government to Rwanda's HIV/AIDS treatment program.

Senegal

Community Tackles Infant Mortality

For every 100 Senegalese babies born, six of them die before their first birthday. Although this rate has consistently improved over the years, it is still unacceptably high. USAID, the government of Senegal, and Senegalese communities are working to change that.

At the District Health Center in Ziguinchor, the locally elected health committee has just bought a warming table for newborn babies. In response to USAID's hope that communities would supply warming tables as their contribution to local nurse training, Ziguinchor, led by its health committee, jumped at the chance and commissioned a local carpenter to build the table – all before the nurse training even began. The carpenter crafted the table, copying from a photograph of one designed as part of another USAID-supported project. Midwife Bintou Ndour said she hadn't realized that locally made warming tables were feasible and added, "This is the first time we have had a useful tool to warm babies."

Ziguinchor is in the beginning phase of training all its nurses in essential newborn care techniques. One of the critical elements of caring for a newborn is keeping it warm in the critical hours after birth. Essential newborn care also includes everything from basic preventive care during and

immediately after birth, to resuscitation of babies with birth asphyxia, to identification of danger signs and management of infections after birth and in the first year of life. After a successful USAID-supported pilot activity in Kebemer district in 2004, the government of Senegal adopted a package of essential newborn services that is now in use nationwide. So far, training of medical personnel on essential newborn care practices has started in nine districts in three of Senegal's regions.

"Ziguinchor picks up technology faster than other regions," said Matar Camara, child survival specialist at USAID/Dakar. "This community has already made an investment to improve newborn survival, even though the people had just learned about the project and training."

Madame Sao, the president of the health committee that bought the warming table, humbly smiled as her fellow committee members, midwives, and USAID representatives applauded her and admired the new table. "We are collecting money to improve health care in this health center. This money belongs to the patients of the center, and we wanted to use the money by giving them back something that will help them," she said.

Youth Line Up for HIV Tests at USAID-Backed Center
Outside the Guédiawaye Youth Center in Dakar's sprawling and densely populated suburbs, dust rises from a football game while a group of girls sit and plait one another's hair. Inside, boys and girls are practicing kung fu in the big hall as they wait their turn to see the counselor. This is a typical day at the center, where the youth of Guédiawaye learn the importance of HIV/AIDS and the key messages of abstinence, being faithful to one partner, using contraceptives, and being tested for HIV.

USAID/Senegal and the local NGO Synergie pour l'Enfance have collaborated at the Center since 2003 to offer youth-friendly HIV/AIDS testing and counseling services that are integrated into the Center's mix of activities targeting the constantly growing youth population. Since the collaboration began, partnerships with other NGOs, other donors, and community groups have taken root and expanded the range of related activities to include prevention of mother-to-child transmission (PMTCT) and a "continuum of care" bundle of interventions to respond to the prevention, treatment, and care and support needs of youth and their families.

Youth-specific counseling and testing centers, when tried elsewhere, have often been unsuccessful, but the Guédiawaye center seems to be working. "I think the success resides in the integration of activities, which minimizes the stigma around testing for HIV," commented Dr. Ngagne Mbaye, Synergie's coordinator. "We have the center

within an adolescent reproductive health center, which is in turn a component of a large adolescent center where youth come for cultural activities, sports, or informal training in things like sewing. And nobody knows who's coming for what."

This has encouraged youth to get tested. From January through November 2005, the center counseled and tested 827 youth for HIV/AIDS, up from 485 in 2003. Counseling and testing is one of the many ways Senegal and its partners are working to keep HIV prevalence low – the national prevalence among adults is 0.7 percent, one of the lowest in sub-Saharan Africa. Other components of prevention include promoting safe sexual practices to reduce HIV transmission, strengthening blood safety, improving the treatment for other sexually transmitted infections, and PMTCT. USAID and other U.S. Government partners have long supported the government of Senegal in these areas.

In the process of expanding its services deeper into the communities that need them most, Synergie remains true to its name, always seeking to move forward with other actors to ensure a comprehensive response to AIDS. Synergie's innovative model for integrating HIV counseling and testing within the public sector youth centers, developed with support from USAID, has been officially adopted by the Ministry of Youth and is currently being replicated in eight other centers with funding from the Japan International Cooperation Agency, the United Nations Population Fund, and USAID.

Watching Children Grow in Senegal

Malnutrition is a serious issue in Senegal – 22 percent of children under age 5 are stunted and 20 percent are underweight. In response, USAID's BASICS project, in partnership with the Ministry of Health and NGOs, helped set up essential nutrition activities and growth monitoring as a national strategy. Its success has caught the eye of national health officials.

Traditionally, growth monitoring involves weighing infants and children under 3 years old each month, plotting their weights on a chart, and advising mothers on improved feeding when the child's growth pattern falls below an acceptable range. The government of Senegal currently provides these services to children under age 3 in 34 districts covering 20 percent of the population.

Recently, however, research has shown that it is much more difficult for children who fail to achieve normal nutritional status by age 2 to achieve it later in life, so growth monitoring has less benefit after 3 years of age. And, mothers do not always respond well to standard feeding advice, often finding it overwhelming.

In light of these findings, USAID's BASICS project developed a "community-based growth promotion" pilot program to enhance growth monitoring in Senegal by 1) focusing all efforts on children younger than 2 years; 2) using minimum weight gain rather than the pattern of the growth line as the trigger for intervention; 3) negotiating simple changes in feeding practices with mothers rather than promoting more complicated feeding approaches; and 4) engaging the entire community to ensure proper child growth. In fact, it is the communities that support the volunteer health workers who carry out the growth monitoring.

Community health workers first ask mothers of underweight children about current feeding practices and health problems. Then they discuss simple options, such as breastfeeding two extra times each day. Together, the mother and the volunteer "negotiate" a written agreement for one new action, and at the next monthly weighing session, the volunteer reviews this agreement to see if the mother was able to follow through on it. If the child's growth recovers, the mother takes pride in her own success and ability to respond to her child's needs. If the mother could not keep the agreement, workers help her find other options.

In Senegal, community-based growth promotion was introduced in the areas surrounding the health post in the village of Affé, in the Louga region. After only 12 months, the pilot showed impressive results – more than 90 percent of mothers regularly brought their children for weighing; 70 percent of children showed adequate weight gain each month; and malnutrition decreased by 37 percent among children less than 2 years old.

One mother stated that she noticed improvements in many of the children in Affé as a result of the community-based growth monitoring. "Many babies were very thin when they were enrolled, and are now big," she said.

The community-based approach also produced other important benefits for child health in the communities. For example, frequent counseling had the result that more than 95 percent of mothers recognized "danger signs" for serious illness, and the proportion of pregnant women who attended the recommended three antenatal visits increased from 3 to 62 percent.

The pilot is now expanding to eight districts. Its overwhelming success also caught the attention of the national nutrition program, which has decided to introduce the community-based growth promotion concepts on a national scale in February 2006.

Women's Groups Net Profits While Fighting Malaria

The women of Bignona in Senegal's lush Ziguinchor region have been particularly hard hit by malaria. They have suffered greatly because of this disease – losing children, nursing sick family members, spending scarce finances, and missing out on work.

That is why hundreds of small community-based organizations have teamed up with USAID to help prevent malaria. One way is to sleep under an insecticide-treated bednet at night when malaria-carrying mosquitoes are most active.

In Ziguinchor and other regions of southern Senegal, the community approach to bednet promotion doubles as an income-generating activity. Many Senegalese communities have long-standing traditions of financial solidarity systems. Local women's associations (to which almost all rural women belong) set up revolving funds, for example, in which each woman contributes a small amount every month. When a member finds herself in need, she borrows from the fund.

Allabatou, one of Bignona's women's groups fighting against malaria and other health and socio-economic problems, has taken advantage of this tradition and brought bednets into the picture. Through a grant to Africare, USAID provides bednets to the group at 3,500 CFA francs (about \$6) each. Each woman in the group then buys nets on credit from the group, at a cost of 3,750 CFA francs each, and pays them off over a five-month period. The group keeps the profit and uses some of it to support community health volunteers working in malaria and on other health issues. Experience and input from community leaders have shown that systems like these make distribution of nets more sustainable, and coverage greater, than they would be if the nets were given away free.

"We, the members of Allabatou, know perfectly why malaria prevention is important," said group president Fatimata Diara Coly. "Even if you stop funding, we'll continue to inform our community members and support the community workers."

Lessening the impact of malaria has far-reaching benefits for these communities. Having fewer malaria cases to care for frees up women to find other ways to productively use their time. The Allabatou group has begun a new small business unit to prepare and sell dried mangoes, an activity that is expected to bring them annual revenue of more than 150,000 CFA francs (about \$280). Mango processing, consisting of peeling, dicing, and drying, is labor-intensive and requires the participation of all association members.

"We appreciate better than you the impact of this program," said group member Khady. "Let me tell you that before this program, every week three or five of us used to spend

two or three days caring for our children or husbands or other family members sick with malaria. Now, with this program, we're all here at work and everybody participates in the daily activities."

Malaria is a major killer of children in Senegal and a leading cause of illness among adults. USAID supports a comprehensive package of clinical services and community interventions to prevent illness and death due to the disease.

Clear Water for Carabane

Abdou Diatta has a new task on Senegal's remote island of Carabane – he guards the pump that brings residents their first clean drinking water. From morning to night, he opens the gate and unlocks the pump to allow people to fill their buckets and bottles. Some stop by just for a drink. It's still hard for the people to believe that this water doesn't make them sick.

For decades, the 500 people living on Carabane Island – an old stopover along a slave trade route to the Americas – have had to buy and transport their drinking water from the mainland. Large motorized canoes called pirogues brought it from Elinkine, a small town about a half hour away. Elinkine's water also comes as a result of USAID assistance; the Agency paid to rehabilitate two wells and provided one pirogue for Carabane. Water obtained this way from the mainland cost 60 cents for 20 liters, but rice farmers and fishermen with limited means could not afford it. Consequently, they had to run the risk of getting diarrhea and other stomach ills from water from contaminated sources, which many did.

Village chief Ibrahima Gueye was one of them. He searched for solutions for a long time and finally learned about the USAID-supported project implemented by EnterpriseWorks/Vita (EWV) in Ziguinchor to train local pump manufacturers. After collecting funds from the community and receiving additional financial support from the Rotary Club, he got in contact with EWV technicians and the local craftsmen they trained in May 2005. The pump, which is constructed with an old motor scooter wheel, plastic pipes, and other locally available parts, was installed a month later.

Good reports keep streaming in. "This water pump is something highly valuable for us. This is why we fenced it and designated a person to take care of it because our kids might break it," Mr. Gueye said. "Since we've had this pump, diseases related to contaminated water have disappeared, and potable water is available for all without discrimination." Mr. Gueye also noted that the pump has been his greatest success as a village chief.

But you don't have to take his word for it. Binta Seck, a 40-year-old mother of six, is equally pleased. "I'm very proud of this pump," she said after taking a long drink. "Before, my family couldn't afford to buy water from the mainland, but now we have good clean water – for free. My family comes here to fill up every day, and we've never had a stomach ache drinking this water."

A laboratory in the capital Dakar analyzed the water, and tour operators also paid to have a sample tested in France – results indicate the water is potable. In addition, a customer survey of 232 islanders showed high levels of user satisfaction.

The savings mean a lot to the islanders. Pape Ndiaye, a tall teenager, fetches 40 liters of free drinking water a day for his family of 11. It would cost his family \$36 a month if they bought it in Elinkine.

The good news has traveled swiftly by pirogue to the nearby islands of Diogué, Kassel, Saloulou, and Niomoune, which have also sent in requests for the locally produced pumps. With USAID-financed technical training, local craftsmen have constructed and sold 90 pumps and 100 tube wells since 2004, benefiting more than 7,000 people. With their new know-how, local manufacturers continue to help ensure potable water supplies for Senegalese villages.

Tanzania

Saving Children's Lives With Low-Tech Interventions

"The Government of Tanzania should be very proud of the major declines in child deaths during the last five years."

– USAID Mission Director Pamela White

Tanzania has made impressive gains in improving infant and child health, according to the latest Demographic and Health Survey (DHS). The DHS, originally developed by USAID, is a survey conducted periodically in many developing countries to provide accurate measures of child survival, family planning, and other important health indicators. Compared with the previous 1999 Tanzania DHS survey, in 2004 the infant mortality rate plummeted by 31 percent to 68 deaths per 1,000 live births – one of the lowest rates in East Africa. Deaths of children under age 5 declined by 24 percent to 112 deaths per 1,000 live births.

"The Government of Tanzania should be very proud of the major declines in child deaths during the last five years," says USAID Mission Director Pamela White. "Increased government investment in essential health services for children, improved health policies, and decentralization empowering districts and communities to deal with health needs have really paid off." These changes have broadened access to essential drugs and increased training of health workers

in integrated management of child illnesses. Recent low-tech interventions include vitamin A supplementation, intermittent preventive treatment of malaria for pregnant women (two doses of antimalarials are provided irrespective of symptoms to prevent malaria), and increased use of insecticide-treated bednets. Donors, including USAID, have provided significant support during the last five years. To build on these results, USAID is planning to increase support for child survival in the future, especially through President Bush's malaria initiative.

The DHS and other surveys show significant progress in many indicators that influence child health and survival. For example, most babies and toddlers now receive vitamin A supplementation in twice-yearly campaigns supported by USAID. A special 2004 survey showed that 85 percent of Tanzanian children ages 6 to 59 months received supplements of this essential micronutrient in the six months preceding the survey.

More Tanzanian children are also being protected from malaria, a major killer throughout the subcontinent. Inexpensive mosquito nets reduce transmission of malaria and other insect-borne diseases. The 2004 Tanzania DHS showed that more than one-third of children under age 5 slept under a bednet the night before the survey, compared to about only one in five children in 1999. Close to half of all pregnant women now receive intermittent preventive treatment with effective antimalarial drugs. Malaria in pregnant women is a significant cause of maternal mortality, pregnancy loss, and prematurity.

Exclusive breastfeeding, wherein babies are nourished only on the nutrient-rich, immunity-building milk from their mothers, is much promoted but not commonly practiced in most of the world. Tanzania's 2004 DHS showed, however, that 70 percent of new mothers (compared to 58 percent previously) exclusively breastfed their babies for the first two months of life, providing babies with an essential healthy start to life.

Mosquito nets, intermittent preventive treatment of malaria in pregnancy, breast milk, and vitamin A – low-tech interventions with big payoffs – are saving children's lives and building the foundation for a healthier future.

Zambia

HIV Pastor Comes Out

Stigma and discrimination are major impediments to tackling HIV/AIDS in Zambia. Some elements of society still consider HIV/AIDS a disease that results from immoral behavior, and churches throughout the country discuss it as such. Many churchgoing Zambians refuse to even discuss HIV/AIDS, and matters are made worse when the victim

is a leader within the church. Leaders are hesitant to be tested in fear of the high price to pay in stigma and discrimination.

Reverend Annie Kaseketi has been an ordained pastor in the Apostolic Church of Zambia since 1995. She came to know her HIV/AIDS status in August 2003. Reverend Kaseketi and her only surviving child, an 11-year-old boy, are on antiretroviral therapy (ART). She is currently providing HIV/AIDS training programs and counseling for a World Vision program while preaching in Chibombo district of Central Province. She travels widely in and outside the country advocating for better policies and the rights of people living with HIV/AIDS.

Despite the fear of "coming out," Reverend Kaseketi shocked participants attending workshops organized by Unaided Patients Aided, a recipient of a grant through USAID from President Bush's Emergency Plan for AIDS Relief, when she revealed that she was living with HIV/AIDS. The workshops were focused on parliamentary leadership and NGO capacity building in Kabwe Central Province. Participants included a member of Parliament; a mayor, a deputy mayor, and two former mayors; councilors; and leaders of civil society organizations. The Kabwe district commissioner was the guest of honor.

Reverend Kaseketi shared the story of how she lost her husband, a trained pastor, in 1999 and three children before she came to know her positive status. Leaders attending the workshops resolved to fight all forms of stigma and discrimination through information and advocacy at the grassroots level. They also agreed to address other aspects of stigma that inhibit counseling and testing, the gateway to ART treatment. Soon after the workshops, 16 participants went for counseling and testing.

USAID East Africa

Pediatric HIV/AIDS Handbook for Africa

"I love this handbook. People in offices will use it, but those of us in the clinics will carry this in our pocket so that we can refer to it many times each day." – Dr. Haby Sy, Senegal

Nearly 200,000 African infants are born each year infected with HIV. About half that number die before their second birthday. In 2001, a group of African pediatricians formed the African Network for Care of Children Affected by HIV/AIDS (ANECCA) to make HIV prevention, treatment, and care a reality for all children in Africa. ANECCA brings together clinicians and social scientists committed to improving the quality of clinical and nonclinical care of children affected by HIV/AIDS in Africa. The network has grown to more than 800 members in 20 African countries. National chapters have been established in five countries.

In February 2005, ANECCA launched the first *Handbook on Pediatric AIDS in Africa*, a practical and handy resource for all categories of health workers written by leading African experts in pediatric HIV/AIDS care.

Before publication of this handbook, no tools or information for care of children in the African setting existed. The first printing of 5,000 copies was completely disseminated in several months, and a second printing of 5,000 copies was completed in June 2005. ANECCA quickly developed a training curriculum based on the handbook and began Africa-wide tutorials on the material. The ministries of health in Kenya, Rwanda, and Tanzania adapted the ANECCA curriculum for their national training curricula for care of HIV-infected children. For those who are dedicated to caring for children, the handbook provides vital information and guidance. Around Africa, the demand for the handbook and training grew rapidly. In addition, there were multiple requests for a French version of the handbook for health care workers in Africa's Francophone nations.

In November 2005, ANECCA produced a draft of a French translation and convened a meeting in Lome, Togo, with 18 pediatric HIV experts from 11 countries in Francophone Africa.

The sense of excitement among the Francophone health care workers was palpable. One after another, members of the group stood up to tell how important they felt the handbook is for Africa. "This is information that we need desperately to take care of our children," said Dr. Louise Wemin of Côte d'Ivoire. "This handbook is excellent. It is practical, it is easy to use, and the language is simple enough for all types of health workers to benefit from it," said Dr. Phillippe Mselatti of Burkina Faso. "I love this handbook. People in offices will use it, but those of us in the clinics will carry this in our pocket so that we can refer to it many times each day," added Dr. Haby Sy of Senegal.

An ANECCA chapter has already been approved by the Minister of Health in Senegal, and a secretariat is being established in Côte d'Ivoire to coordinate the work that ANECCA could do in Francophone Africa. USAID's Regional Economic Development Services Office initially funded ANECCA. Since the publication of the handbook, the network's role and visibility in Africa have grown tremendously. USAID/West Africa funded the Lome workshop through its AWARE project.

USAID East Africa, USAID West Africa

Malaria Ensnared in New Net

"I came to this meeting thinking that I would never have an LLIN technology. Now I find I am shopping among different options." – Nigerian net manufacturer

Ninety percent of the world's malaria deaths occur in sub-Saharan Africa. Every 30 seconds, an African child dies of the disease. More than 3 million people contract malaria every year, and more than 2 million die. Most severely affected are children under 5 and pregnant women. These deaths are literally losses to the future of a nation.

Insecticide-treated nets are recognized as an important component in the antimalaria effort. They provide a much higher degree of protection against malaria than non-treated nets. Besides offering protection from mosquito bites, the treated nets also repel or kill mosquitoes. However, treated nets need to be re-treated every six months.

Unfortunately, however, net owners must have money and access to the appropriate re-treatment mixture, and most nets go untreated after six months.

A new technology in the antimalaria battle is the development of long-lasting insecticide nets (LLINs), in which the insecticide is incorporated into the netting at the factory. The net continuously releases insecticide, repelling and killing mosquitoes for four to five years.

The problem for Africa, and the rest of the world, is a global shortage of LLINs that has created ordering delays of six to 18 months. No one is mass producing the nets because until recently the treatment process was not mechanized. A new plan for mechanization, allowing for the mass treatment of finished nets, is under development by two international companies brought together by the USAID NetMark project. The project encouraged the firms to place the mechanization process in the public domain, where it can be shared by all companies, particularly those in Africa.

Funds from USAID/Eastern and Central Africa and USAID/West Africa will be used to disseminate the treatment technology and help transfer it to African companies willing to invest in new equipment and staff training. At a recent meeting of African net-producing companies, 29 firms quickly realized the need to organize and market themselves if they wanted there to be any African ownership of the lucrative LLIN market. Their association has been invited to become a member of WHO's Roll Back Malaria program. African net manufacturers are determined to improve the quality of their nets and, thanks to USAID and NetMark, gain access to treatment technology so that regional and global competition will be stimulated and sup-

ply expanded. African countries can then compete for a piece of a market that rightly belongs to them.

USAID West Africa

Combating Maternal Mortality

“Before our training, we did not know how to detect when our wives were having complications of pregnancy. Now we know what to look for. Also, our wives say that they are being treated better by the staff when they go to the clinics for visits and for treatment.” – School teacher/community health volunteer

Maternal mortality and morbidity rates in the West Africa region are among the highest in the world. Too often, pregnant women are unable to access quality prenatal and delivery services, with dire results. Even where delivery services are available, traditional practices and lack of knowledge and resources limit women’s access to services at critical moments. To combat these problems, USAID has partnered with the Ministry of Health and UNICEF in Cameroon and Mauritania to support implementation of the “community-to-facility continuum” model for maternal and neonatal care.

The model focuses on community social mobilization and facility strengthening. Community health workers and leaders are now trained to plan and conduct community social mobilization activities, helping to raise the awareness of families and communities of warning signs for complications in pregnancy and the need to seek services early when they see any of these signs. The communities are organizing to be ready with resources (human, material, and financial) to assist members who need services. At the facility level, USAID is strengthening the skills of providers – doctors, midwives, and midwifery assistants – and the infrastructure, including equipment, so that clients who come to facilities receive timely and quality maternal and neonatal services. Providers from the facilities meet regularly with the community health workers and community leaders to strengthen the link between the facility staff and the communities they serve.

In Ngaoundere, Cameroon, and Kaedi, Mauritania, USAID and UNICEF trained more than 40 doctors, midwives, and midwifery assistants in delivery and newborn care, including interpersonal communication, active management of the third stage of labor, and infection prevention practices. At the same time, UNICEF provided state-of-the-art medical equipment in the health facilities.

USAID West Africa

Affordable Health Care Saves Lives

“Recently, a child in our community died from a treatable disease because her parents could not afford the hospital costs. If the family had been members of our health financing scheme, the plan would have taken care of the costs and maybe she would still be alive today.” – President of Bangwa MHO management committee

USAID supports the creation and expansion of mutual health organizations (MHOs) in several countries in West Africa. The costs of health care services to clients have been rising in this region because governments no longer can provide free care to their populations. Unlike most developed countries, the formal health insurance sector in West Africa can cover only a small minority of the population, primarily those working directly for governments or large corporations. This leaves most of the poor rural population – those most in need – unable to pay for health services, especially in emergency situations. MHOs are non-profit community- or business-based health financing plans that provide a way to increase financial accessibility to health care services among underserved rural populations and informal sector workers. They are voluntary and autonomous. Individuals or households join and pay reasonable up-front contributions to finance part or all of their basic health care services when they become ill. The members of the MHO help manage the plans and determine which health services will be covered and then negotiate this care package with public or private health providers.

In Cameroon, USAID has launched three new MHOs. USAID provides technical assistance to a local NGO, Service d’Appui aux Initiatives Locales de Développement, to integrate a health financing component into existing community credit union financing schemes that support development of microenterprises for its members. The new MHOs are active in Bameka, Bangwa, and Galim, and already have more than 700 member families with an average of five dependents each.

The increased access to health care can have a critically important impact. At the launching ceremony in Bangwa, the president of the management committee told the story of a child who died from gastroenteritis because the parents did not have money to take her to the hospital. Establishing an MHO in this community will enable parents to save the lives of their children through adequate health care.

USAID West Africa

Meeting Demand for Reproductive Health

"The involvement of the Ministry of Finance in the development of the reproductive health commodity security strategic plan has helped raise their awareness of the need to provide funding for contraceptives in the national budget. Following the validation of our plan, the Ministry of Finance immediately requested that I submit budget estimates for up to 50 million [CFA francs] for the purchase of contraceptives."

– Dr. Aboudou Dare, Director of Family Health, Togo

Contraceptive prevalence in West Africa is among the lowest in the world, yet studies consistently demonstrate that there is a very high unmet need for family planning in this region. During a USAID-supported West Africa regional conference on "repositioning family planning," held in Accra, Ghana, in February 2005, participants identified shortages in supplies of contraceptives as one of the key reasons for low use of family planning methods.

USAID has been working to address this issue in several ways. USAID directly supplies contraceptives to countries most in need, such as Burkina Faso, Cameroon, and Togo.

In addition, USAID provides support to these countries, plus the Gambia, to strengthen their capacity in forecasting their contraceptives needs. However, if a sustainable solution is to be found to the problem of shortages in contraceptives, the countries in this region have to take ownership and responsibility for ensuring the availability of reproductive health commodities. One way of doing this is through the development of national reproductive health commodity security strategic plans. The plans include the strategy for forecasting, financing, and procuring contraceptive and other reproductive health commodities and distributing them to the places where they are needed at the time they are needed.

USAID, through its partners, provided technical assistance to Burkina Faso, Cameroon, the Gambia, and Togo to help them develop national reproductive health commodity security strategic plans. As a result, the governments of these countries are more aware of their responsibility for ensuring reproductive health commodity security. Burkina Faso, Cameroon, and Togo have increased the number of partners that support funding for contraceptives and are working with their governments to allocate funding for contraceptives in their national budgets.

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