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

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

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Proposed Joint USAID-USDHHS-USDOD Operating Plan

I. Introduction

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

LIFE INITIATIVE'S GUIDING PRINCIPLES

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

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

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

The Initiative builds on the existing investment by the US in HIV/AIDS programs in Africa and India and involves an unprecedented collaboration between the United States Agency for International Development (USAID), the Department of Health and Human Services (DHHS), and the Department of Defense (DoD). USAID will have lead responsibility in the facilitation of coordinated action. The Initiative is a significant turning point in the United States Government fight against AIDS and will contribute over the next 3 to 5 years to broad global targets that seek to reduce the transmission of HIV by 25% and provide basic care and support services to at least 75% of infected persons.

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

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

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

WORLDWIDE HIV/AIDS GOALS

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

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

A. Geographic Focus

The initiative focuses on 14 target countries (13 in sub-Saharan Africa and India) as well as on regional activities in western and eastern/southern Africa. In each of these countries, there will be collaborative support from more than one federal agency. Countries were selected based on the magnitude of the epidemic, history of political commitment to fighting the epidemic, anticipated receptivity to US assistance, and presence of existing US implementation mechanisms. Additional criteria are presented below. DoD participation will be dependent on their availability of resources.

***LIFE* Countries ***	**USAID**	**DHHS**	**DoD*** **
Botswana	X**	X	X
Cote d'Ivoire	X**	X	
Ethiopia	X	X	X
India	X	X	
Kenya	X	X	X
Malawi	X	X	X
Mozambique	X	X	
Nigeria	X	X	X
Regional Programs (West Africa and East/Southern Africa)	X	X	
Rwanda	X	X	
Senegal	X	X	X
South Africa	X	X	X
Tanzania	X	X	
Uganda	X	X	X
Zambia	X	X	
Zimbabwe	X	X	X

preliminary list – subject to change ** Botswana and Cote D'Ivoire to be covered by USAID regional programs * The DoD Regional Approach will also cover Benin, Mali, Ghana*

TABLE 1—COUNTRY SELECTION CRITERIA

Criteria used to identify the above countries include the following:

- ✓ The magnitude of the epidemic
- ✓ Country receptivity to assistance from US government
- ✓ Country political commitment to fighting the AIDS epidemic
- ✓ Potential for interventions and unique opportunities
- ✓ Potential for impact
- ✓ Potential for leveraging of other local and donor support
- ✓ Existing U.S. Government implementation mechanisms

II. Program Elements

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

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

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

A. Primary Prevention

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

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

Primary Prevention - Civilian

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

Performance Measures for Primary Prevention

Within three years, monitoring systems will measure the combination of enhanced existing programs and the additional "new" activities that are supported through the initiative. The following performance measures and targets are expected. Actual baselines and targets will be determined for each country.

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

1) Voluntary Counseling and Testing

Counseling sessions (both before and after the actual HIV test) offer an important opportunity for intensive one-on-one prevention education for persons who test either positive or negative.

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

2) Social Marketing

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

Therefore, this initiative will allow USAID to increase their social marketing efforts to improve access to barrier methods.

3) Behavior Change

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

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

4) Mother-to-Child HIV transmission

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

Therefore, this initiative will support USAID and DHHS to assist in implementing programs to design and implement successful interventions to prevent mother-to-child transmission of HIV. At these sites, USAID will provide support for screening of pregnant women, and training of maternal health providers. DHHS will also support this activity by identifying barriers that exist for accessing these services and by monitoring the outcomes of these interventions on both infants and mothers.

5) STD Management

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

Therefore, this initiative will support USAID and CDC to implement new or expand existing STD prevention, diagnostic and treatment services.

6) Blood Safety

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

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

Primary Prevention - Military

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

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

1) Assessment

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

2) Regional specific military-based education.

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

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

DoD will tailor its unique tri-service military education programs developed to prevent alcohol abuse and STDs, as well as the region-specific HIV prevention work by NGOs and USAID, to African contexts. Anonymous serosurveys with risk behavior data collection will begin as

soon as feasible. In addition, locally developed or adapted interventions identified by USAID or DHHS may also be utilized.

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

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

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

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

B. Improving Community and Home Based Care and Treatment

Performance Measures for Community and Home Based Care and Treatment

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

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

Currently in Sub-Saharan Africa and India, care and treatment for HIV infected persons and support to their families is minimal. Less than 5% of persons know their HIV status and health care providers do not have ready access to diagnose and treat HIV and the associated opportunistic infections, let alone use of the latest "state of the art" antiviral treatment regimens. Ideally, there should be a continuum between in-patient and community outpatient treatment, combined with

psychosocial support services utilizing a wide range of community workers, including traditional healers.

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

1. Care and Treatment

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

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

2. Home and Community Based Care and Support

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

C. Caring for Children Affected by AIDS

Performance Measures for Caring for Children Affected by AIDS

Within three years, expected performance measures and targets include:

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

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

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

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

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

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

D. Capacity and Infrastructure Development

Performance Measures for Capacity and Infrastructure Development

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

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

Within the focus countries, it is critical that political commitment is increased and host country capacity to implement effective interventions is strengthened, focusing on government, private

sector, NGOs and research institution capabilities. Key activities are to increase the use of accurate HIV surveillance data to inform decisions on targeting of HIV/AIDS prevention and care interventions, to measure the impact of these interventions, and to support new capabilities for the delivery of care and services.

1. Increasing Political Commitment

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

2. Surveillance

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

3. AIDS Program Strengthening

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

III. Managing and Monitoring the *LIFE* Initiative

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

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

IV. Next Steps

A. Country Level

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

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

B Global/Regional Level

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

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

C. Milestones

1. Country notification and communication – November - January
   - In December, USAID/DHHS is sending a formal cable to the USAID missions and embassies, informing them about the final status of the LIFE initiative, country list, and next steps. DHHS will communicate with its field sites and with embassies regarding establishing NSDD-38 agreements. [Responsibility: USAID; DHHS].
   - In the next month, ONAP will convene a meeting of all African ambassadors to the US to discuss USAID and other programs, with discussion of LIFE [Responsibility: ONAP]

- In the next two months, USAID and DHHS will jointly commence communication with the country governments and respective stakeholders: government, multilateral and bilateral donors, NGOs, communities affected, etc to set the stage for the planning process for the LIFE initiative efforts. [Responsibility: USAID/DHHS]

2. Joint planning assessments – November – March
   - In the next month, USAID with input from DHHS and ONAP, will issue guidance to the field on the planning parameters for the LIFE initiative activities. [USAID, with DHHS and ONAP]
     As part of this, the joint teams (USG, country) will review previously established country profiles (US and donor response information). In close negotiations with countries, USAID, DHHS will determine gaps and response needs to be enhanced. [Responsibility: USAID, with DHHS]
   - Within 6 months, all 14 countries and regional programs will have conducted a participatory needs assessment, identified current responses and gaps, and develop workplans. [Responsibility: USAID and DHHS field staff will have primary responsibility, with USAID lead coordinating role. Additional backup TA from Washington/Atlanta will be available.]

3. Strategies for implementation – Developed November onwards
   - In the next 10 months, activities begin in all 14 countries and regional programs, with phasing in of some countries for some activities. [Responsibility: All partners]

4. Funding and Mechanisms
   - USAID to accelerate its OYB process (e.g. allocations to missions) to allow access to funding by missions.
   - DHHS will develop NSDD-38 agreements with appropriate embassies.
   - In the next two to six months, various mechanisms for implementation will be identified and used. These will vary by country. They include:

   -- USAID contractors: bilateral and field support
   -- USAID/DHHS grants and cooperative agreements to multilateral institutions: WHO, WHO/AFRO, UNAIDS, UNICEF; possibility of others
   -- USAID/DHHS relationships with African institutions
   -- DHHS/USAID relationships with embassies
   -- Use of USAID contractors by DHHS (interagency agreement)
   -- Possibility of detailing DHHS personnel to USAID (to go to the field)
   -- DHHS Cooperative agreements with US based organizations
   -- Other

5. Workshops and partnership meetings on parallel track – November onwards
   - In the next 6-12 months, USAID will organize workshops to discuss technical issues (e.g., VCT, MTCT, care and support). These will include a broad mix of African, donor, and US specific participation. [Responsibility: USAID; DHHS]
     - November 23: USAID convened a working group of DHHS agencies (CDC and HRSA), NORA organizations and USAID to discuss care and support issues.
     - December 6-7, 1999: Private meeting of the UN Secretary General to discuss with key partners (donors, governments, NGOs, private sector) the International Partnership against AIDS in Africa).
     - December 5-8: Paris AIDS conference to focus on AIDS care and support issues.

- January 2000: WHO/AFRO is convening a meeting of all international and national interested parties to discuss HIV/AIDS surveillance programs and issues.
- February 2000: Meeting of the International Partnership Against AIDS in Africa.
- July 2000: International AIDS conference in Durban.

➢ In the next 6 months, USAID will organize a series of key stakeholder meetings to discuss the initiative (US based) [Responsibility: USAID]

➢ In one year's time (approximately), USAID, with DHHS and ONAP, will convene a meeting of all of the partners to assess progress of implementation and to discuss ways to improve. [Responsibility: USAID and DHHS]

6. Coordination at the USG level: Ongoing

➢ In the next month, ONAP will hold its first meeting of the working group of higher level agency representatives to discuss progress and issues. This group will meet periodically to ensure that the initiative is on track. [Responsibility: ONAP]

➢ Throughout the next year, a coordination working group with USG agencies at the working level will meet (USAID-CDC have been meeting informally; need to meet soon with expanded group of other agencies.). [Responsibility: USAID to convene]

➢ Over the next six months, four technical working groups around the four categories of the LIFE initiative will be convened to help inform us about the set of issues and possible interventions. Actual planning to be conducted at the field level. These groups will be time limited. [Responsibility: USAID and DHHS]

7. Indicators/milestones: Ongoing

➢ Broad indicators and targets are already identified.

➢ Based on the joint planning teams and process, each country will develop its own set of monitoring and evaluation indicators, baselines, and targets.

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

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

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

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

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

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

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

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

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

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

U = USAID H = DHHS D = DOD