



HIV/AIDS HEALTH PROFILE

Sub-Saharan Africa



Overall HIV Trends

Sub-Saharan Africa continues to bear an inordinate share of the global HIV burden, though epidemics across countries in Africa vary considerably: 22.9 million people living with HIV/AIDS (PLWHA) live in the region, representing about 68 percent of the total worldwide. The number of new infections in sub-Saharan Africa peaked by 1997 and has fallen by 26 percent since then from 2.6 million to 1.9 million per year¹. In 22 countries, models indicated a decline in the incidence of HIV infection by 25 percent, including those in some of the countries with the largest

epidemics: **Ethiopia, Nigeria, Zambia, and Zimbabwe**. The epidemic continues to be a major challenge to the health and development of many African nations. As antiretroviral therapy (ART) becomes more widely available, more people than ever will be living with HIV. **South Africa** has more PLWHA (5.6 million) than any other country in the world. Prevalence estimates throughout the continent range from 0.2 percent in **Madagascar** to over 25 percent in **Swaziland**. Deaths from HIV continue to decline as ART coverage and prevention of mother-to-child transmission of HIV (PMTCT) coverage increase.

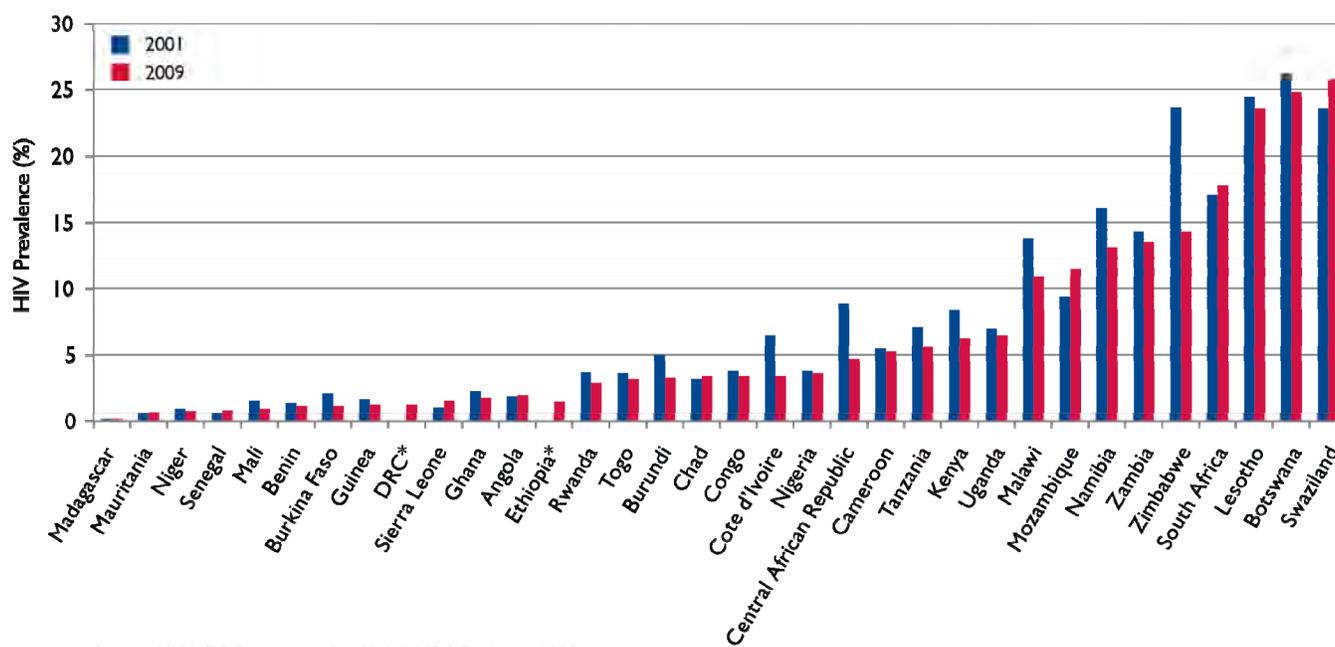
The impact of HIV varies considerably throughout the countries in the region, and most have generalized epidemics. Adult prevalence exceeds 20 percent in countries, including **Botswana** (24.8 percent), **Lesotho** (23.6 percent), and **Swaziland** (25.9 percent)². Others have concentrated epidemics with disease hotspots, such as **Burundi**, where prevalence of 38 percent among sex workers is 16 times higher than general adult HIV prevalence², and throughout West Africa, where general prevalence is markedly lower than in East and Southern Africa, but epidemics among most-at-risk populations (MARPs) are common. Due to this variation, the strategic approaches to combat this disease must be designed to respond to the disease characteristics within individual countries and subregions.

Country Specific Epidemics. Sub-Saharan Africa has a heterogeneous epidemic with distinct patterns in the three different regions. In Southern Africa, prevalence has stabilized at high levels in most countries; prevalence has also declined since 2000 in most East African countries and is now stabilizing at markedly lower levels than in Southern Africa. In West Africa, prevalence rates are markedly lower than in the rest of the Africa region, at less than 2 percent across the region except in **Cameroon** (5.3 percent), **Cote d'Ivoire** (3.4 percent), **Gabon** (5.2 percent), and **Nigeria** (3.6 percent)².

Within countries, there is also a great deal of regional variation, with urban centers often the most affected. Across all three regions, heterosexual sex is the primary form of transmission, though in countries with more concentrated epidemics, high-risk behaviors can play a significant role, including sex work and men having sex with men².

Southern Africa. Southern Africa continues to be the most severely affected region in the world. The number of people living with HIV increased by 31 percent from 8.6 million a decade earlier to 11.1 million people in 2009. According to recent estimates, 40 percent of all HIV-positive women globally live in 10 countries in Southern Africa³. From a global perspective, an estimated 31 percent of people newly infected with HIV and 34 percent of people dying from AIDS-related causes lived in these 10 countries. **Swaziland** has the highest prevalence of any country in the world: Approximately one in every four adults is HIV-positive. Prevalence rates in most countries in the region have stabilized, though **Zimbabwe** is the first country in Southern Africa to sustain a significant decline

HIV Prevalence among Adults 15-49 years in Sub-Saharan African Countries, 2001-2009



Source: UNAIDS Report on the Global AIDS Epidemic 2010.
*DRC and Ethiopia data are from latest DHS.

in HIV prevalence from 29 percent in 1997 to 16 percent in 2007¹. Compared with other countries in the subregion, **Angola** has a remarkably low HIV prevalence (2 percent), in part due to the limited movement during its protracted civil war (1975–2002), which impeded the spread of the virus. Across the region, the epidemic affects individuals in all levels of society, across education, income, and migration strata. Scale-up of prevention programs is necessary to generate continued declines in HIV prevalence and incidence.

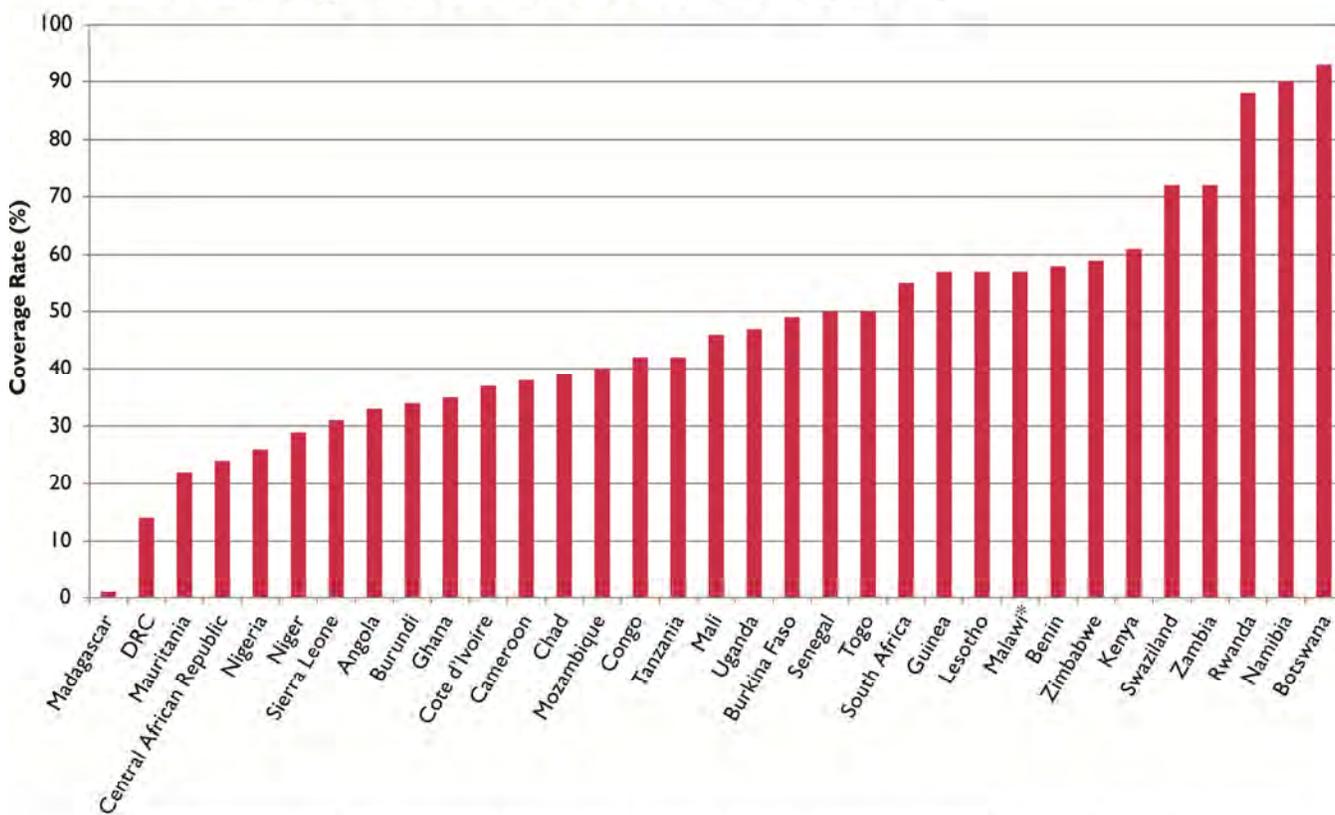
East Africa. In the countries of East Africa, HIV prevalence began declining about a decade ago and has remained stable in many countries. In this region, the intensity of national epidemics varies from country to country, and heterosexual sex is the primary form of transmission. Those who are married or in a committed relationship can still be at an elevated risk if their partners engage in high-risk behaviors. The HIV prevalence in **Kenya** fell from 14 percent in the 1990s to 6 percent in 2006 and has stabilized at that rate since 2006. **Uganda's** prevalence has remained between 6 percent and 7 percent. Similarly, in **Rwanda**, HIV prevalence has remained the same^{4,5}; however, the HIV prevalence in **Rwanda** is over three times higher in urban areas than rural areas. Prevalence in **Kenya**, **Tanzania**, and **Uganda** exceeds 5 percent (6.3 percent, 5.6 percent, and 5.4 percent, respectively)². Geographic variation within countries is common; for example, prevalence varies as much as 15-fold across different provinces in **Kenya**⁶. **Madagascar** has been one of the lowest prevalence countries in East Africa, with an adult prevalence of 0.2 percent, while the limited availability of HIV-related data in the **Democratic Republic of the Congo** makes it difficult to fully characterize the epidemic there.

West Africa. The countries of West Africa have the lowest HIV prevalence in sub-Saharan Africa. Adult HIV prevalence is 2 percent or less in most of this subregion's countries (**Benin**, **Burkina Faso**, **Gambia**, **Ghana**, **Guinea**, **Liberia**, **Mali**, **Mauritania**, **Niger**, **Senegal**, and **Sierra Leone**). Four exceptions of adult prevalence exceeding 2 percent are **Cameroon** (5.3 percent), **Cote d'Ivoire** (3.4 percent), **Gabon** (5.2 percent), and **Nigeria** (3.6 percent)³. In many countries, the epidemic appears to have stabilized, though concentrated epidemics persist among MARPs, such as female sex workers (FSWs) and men who have sex with men (MSM). One study found that four-fifths of prevalent cases of HIV among adult men in Accra, **Ghana**, might have been acquired during unprotected paid sex⁷. Another recent study demonstrated a 12 percent annual HIV incidence in north-central **Nigeria** among FSWs⁸. Provision of antiretroviral drugs (ARVs) for PMTCT services has improved, but coverage of the most effective regimens remains much lower in West and Central Africa (18 percent) compared with East and Southern Africa (64 percent)³. Due to its large population size, **Nigeria** has the second largest HIV disease burden in the world, at 3.3 million, though prevalence is stable (3.6 percent)².

Gender and HIV. Gender inequalities, abuse, and physiological susceptibility to HIV make women more vulnerable to contracting the virus than men; social, legal, and economic disadvantages also increase risk. HIV prevalence among women aged 15 to 24 in sub-Saharan Africa (3.3 percent) is more than twice the prevalence among young men (1.4 percent) in the same age cohort¹. Limited autonomy in making decisions about sex, including condom use, also increases risk, particularly for young women who engage in sexual relations with older men. A recent study in **South Africa** suggested that one in seven cases of young women acquiring HIV could have been prevented if the women had not been subjected to intimate partner violence⁹. In 2010, the first nationally representative survey of violence against children in **Tanzania** found that nearly 3 in 10 females and 1 in 7 males experienced sexual violence prior to the age of 18¹⁰. **Lesotho** continues to have troubling trends in discriminatory attitudes toward women and girls, which fuel gender-based violence and contribute to increased HIV risk. In 2009, 37 percent of women surveyed agreed that there could be at least one reason for a husband to legitimately beat his wife. In the lowest wealth quintile, this rose to 55 percent. Among men, 48 percent agreed that there could be at least one reason to beat their wives. This view was shared by 59 percent of men in the lowest wealth quintile¹¹. In the **Democratic Republic of the Congo**, ongoing sexual violence against women is also still a significant factor in the country's epidemic¹².

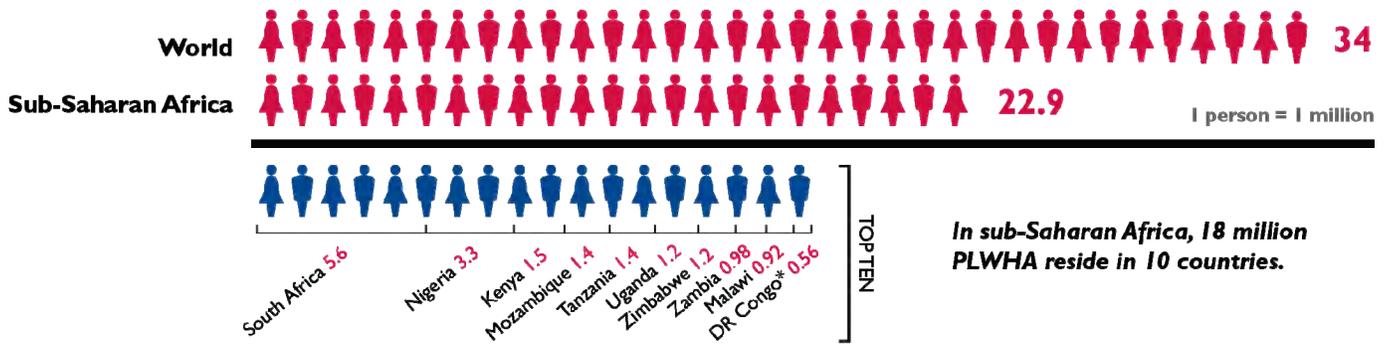
Comprehensive knowledge of HIV remains low in sub-Saharan Africa and is an obstacle to reducing incidence rates. Many people living with HIV in sub-Saharan Africa are unaware of their HIV status. There are sizable variations among countries, from about 30 percent who are unaware of their status in **Kenya** to 70 percent in the Democratic Republic of the **Congo**. Women are more likely to be aware of their status than men. In **Kenya, Lesotho, and Tanzania**, successive surveys between 2003 and 2009 show an improvement in serostatus awareness among PLWHA. The percentage of men living with HIV who knew their status tripled in **Lesotho**, and the percentage among women quadrupled from 2004 to 2009³. Comprehensive correct knowledge about HIV prevention (i.e., knowing two major ways of preventing the sexual transmission of HIV, rejecting the two most common local misconceptions about HIV transmission, and knowing that a healthy looking person could have HIV) is still low. In sub-Saharan Africa, only 26 percent of young women 15 to 24 years old had comprehensive correct knowledge about HIV prevention versus 33 percent of young men³.

Antiretroviral Therapy Coverage in Sub-Saharan African Countries, 2010



Source: WHO/UNAIDS/UNICEF Global HIV/AIDS Response 2011. Coverage estimates are based on 2010 WHO guidelines. No data are available for Ethiopia from this source. *Malawi ART coverage is a confidence interval of 49 to 57 percent.

People Living with HIV/AIDS in Selected Sub-Saharan African Countries (millions)



Source: UNAIDS World AIDS Day Report 2011
 *DR Congo data represent a confidence interval from 430,000 to 560,000.

In sub-Saharan Africa, 18 million PLWHA reside in 10 countries.

Tuberculosis and HIV Co-infection. Tuberculosis (TB) also poses a grave threat in sub-Saharan Africa, especially to populations with high rates of HIV and in areas where there are few health care resources. PLWHA are particularly vulnerable to developing TB because of their increased susceptibility to infection and progression to active TB, and the disease continues to be a leading cause of death for PLWHA. **South Africa** and **Nigeria** have the largest number of PLWHA. In **South Africa**, approximately 60 percent of new TB cases tested for HIV are seropositive, and in **Nigeria** that figure is 25 percent. **Lesotho** and **Swaziland** have high HIV prevalence rates, and the corresponding TB co-infection rates are 77 percent and 82 percent, respectively. In 2010, there was a rapid increase in screening for TB among PLWHA, especially in **South Africa**¹³. Nonetheless, much more needs to be done to reach the Global Plan to Stop TB goal that all TB patients are tested for HIV and that all TB patients living with HIV receive co-trimoxazole therapy and ART¹³.

Scaling Up Antiretroviral Therapy. ART coverage in sub-Saharan Africa has scaled up significantly over the past decade. From 2009 to 2010, ART coverage increased more in sub-Saharan Africa than in any other region. During that time, the number of people receiving ART in sub-Saharan Africa grew by approximately 30 percent from 3.9 million in December 2009 to 5.1 million 1 year later³. Despite these increases, only 49 percent of PLWHA in sub-Saharan Africa eligible for treatment under the 2010 World Health Organization (WHO) guidelines are receiving treatment³. However, ART coverage varies greatly from country to country; current levels of ART coverage are displayed in figure 2.

Economic and Social Impacts of HIV/AIDS in Africa

HIV creates many challenges, particularly for those countries most affected by the epidemic throughout Africa. The HIV epidemic requires responsive health systems and programs to address the health of PLWHA and to implement effective prevention activities. Governments in tight fiscal environments must try to balance increasing public health expenditures on HIV with expenditures in other sectors. Over time, the pandemic can reduce the labor force and productivity, leading to declining welfare of the population and stagnation of the economy. An analysis of countries in Southern Africa found that a significant segment of the labor force has been lost due to HIV¹⁴. In addition to the loss of workers, the cost of caring for AIDS patients has decreased productivity and profitability in the informal and formal sectors.

The HIV/AIDS epidemic set back decades of progress in increasing the life expectancy of the people of sub-Saharan Africa. The vast majority of people in Africa who have HIV/AIDS are between the ages of 15 and 49, and millions of adults are dying young or in early middle age. AIDS-related mortality is increasing among 20 to 49 year olds – adults in their most economically productive years. Average life expectancy at birth in the countries most affected by the epidemic in Southern Africa (**South Africa, Namibia, Botswana, Swaziland, and Lesotho**) was 64 years for women and 59 years for men from 1990–1995. Five years later (2000–2005), it had fallen to 51 for women and 49 for men as a consequence of the HIV epidemic. More recent data (2005–2010) have shown a slight increase in life expectancy (52 for women and 51 for men) as a result of efforts to stem the epidemic and provide life-prolonging ART¹⁵. In East and West Africa, where countries experienced less severe yet still alarming epidemics, life expectancy increased only marginally, but steadily, over the same period, rather than continuing earlier patterns of strong increases¹⁶.



Household-Level Economic Impacts. The epidemic is also reversing progress in poverty reduction. AIDS tends to have an impact on the poor more than the rich due to the costs associated with treatment and the loss of a productive laborer in a household¹⁷. In a **South African** survey, two-thirds of respondents reported a drop in household income due to an HIV-related illness, including the direct loss of income earners, and through increased medical expenses by the household on the AIDS victim¹⁴. In other sub-Saharan African countries, households reported increased expenditures on health diverted resources away from other requirements¹⁷.

Food Security. Agricultural productivity can be impacted due to household illness, adding to food insecurity in many areas. Loss of agricultural labor can lead to switching from cash crops to subsistence farming and within subsistence farming to less intensive crops¹⁸. In **Malawi**, 16 percent of the deaths of agricultural experts in the Ministry of Agriculture were attributed to AIDS¹⁹. In **Malawi**, one study found decreased productivity through declining crop yields among households facing chronic illnesses. AIDS has killed around 7 million agricultural workers since 1985 in the 25 hardest-hit countries in sub-Saharan Africa and an estimated additional 16 million people could die due to complications from infection with HIV by 2020. This is of particular concern for many African nations, where one-third of the gross national product from the most-affected countries comes from agriculture. In **Mozambique, Botswana, Namibia, and Zimbabwe**, the International Labor Organization estimates that the agricultural workforce loss could be as high as 20 percent by 2020; an estimated 25 percent of the agricultural labor force in sub-Saharan Africa could be lost by 2020¹⁶. Therefore, the private sector has a stake in responding to the epidemic, which affects its workforces and can reduce production of and markets for its goods.

Impacts on Human Resources. Other sectors, particularly health and education, are affected by loss of skilled labor to HIV. As health workers either die or leave employment to care for sick family members, clinics are left with low levels of qualified staff. In turn, this undermines preventive health measures and increases the burden on public health structures¹⁴. According to the World Bank, **Zambia** loses approximately half as many teachers as it trains due to HIV, limiting human capital able to train and educate future generations²⁰. HIV/AIDS poses increasingly heavy demands on Africa's health systems. As demand for services increases, countries are losing their capacity to supply them. Providing ART to those in need in **Tanzania**, for example, would require the full-time services of almost half the existing health care workforce²¹. Most health systems in Africa already face labor shortages due to factors such as worker migration to other regions in pursuit of better pay and working conditions. HIV/AIDS is now exacerbating this shortage by affecting large numbers of the remaining health care workers.

Orphans and Vulnerable Children. Sub-Saharan Africa is experiencing an unparalleled orphan crisis as a result of the HIV epidemic, home to approximately 90 percent of HIV/AIDS orphans globally². Globally, 56 percent of children orphaned by AIDS live in six countries in sub-Saharan Africa: **Nigeria** (2.5 million), **South Africa** (1.9 million), **Kenya** (1.2 million), **Uganda** (1.2 million), **Tanzania** (1.3 million), and **Zimbabwe** (1 million). Many of these children are raised by their grandparents or live in households headed by other children. Many children orphaned by AIDS lose their childhood and are forced by circumstances to become producers of income or food or caregivers for sick family members. They may be at increased risk for health problems related to inadequate nutrition, housing, clothing, and basic care. They are also less able than other children to attend school regularly. Children who are orphaned by AIDS are less likely to attend school, though school attendance has been increasing in recent years due to scale up in programs to support orphans with basic health and social services. Those who do not attend school further reduce the potential for developing human capital in future generations¹⁷.

Stigma and Discrimination. Finally, HIV-related stigma and discrimination in sub-Saharan Africa create major barriers to preventing further infection, alleviating impact, and providing adequate care, support, and treatment. Stigma often leads to discrimination and other violations of human rights, which affect the well-being of PLWHA; stigma is also compounded for those individuals who identify with otherwise stigmatized groups or behaviors, including sex workers and MSM. Accepting attitudes toward PLWHA are rare in some countries; in **Lesotho**, for example, the 2009 Demographic and Health Survey found that one-third of men and 4 in 10 women have

accepting attitudes toward PLWHA.¹ In **Rwanda**, the 2010 Demographic and Health Survey demonstrated that approximately half (53 percent) of women and 65 percent of men express accepting attitudes⁵. People living with HIV are denied the right to health care, work, education, and freedom of movement. There is a continued need for a multisectoral response to change social and cultural beliefs and behaviors and modify policies by governments and employers.

National/Regional Responses

Country governments and regional governing bodies throughout sub-Saharan Africa continue to combat the epidemic by providing leadership, drafting and implementing policy, and allocating funding for HIV/AIDS programs. The majority of countries on the subcontinent adhere to the “Three Ones” principle, a commitment to ensure a coordinated response to HIV/AIDS through one national coordinating authority, one national action framework/strategy, and one agreed-upon country-level monitoring and evaluation system. Commitment to achieving universal access to prevention and treatment is another key theme in the region.

In 2011, the Joint United Nations Programme on HIV/AIDS (UNAIDS) released the *Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive*. Within the plan, 22 countries that account for 90 percent of pregnant women living with HIV were identified as priority countries, and 21 of these countries are located in sub-Saharan Africa. A strategic regional framework toward eliminating new HIV infections among children and keeping mothers alive was reviewed in October 2011, and the regional plan for coordinated agency responses to support the implementation of the strategic framework was finalized³.

Southern Africa. Countries throughout Southern Africa have developed key strategic documents, such as national plans, policies, and laws guiding the response to the HIV epidemic. All have adopted multisectoral approaches to prevention, care, and treatment, though there have been some challenges in translating policy into effective programming for stemming the spread of the virus. Specific financial commitments underpin the national response in select countries and speak to the national commitment to promoting a country-owned*, sustainable response. In **Malawi**, for example, all ministries are required to spend at least 2 percent of their budgets on HIV activities²². In **Botswana**, the HIV/AIDS response is funded primarily by public revenue. Of the 2008 funds for HIV/AIDS programs, 66 percent came from public sources, 32 percent from international partners, and 2 percent from private funds²³.

East Africa. Most countries in East Africa have national strategic plans guiding the response to the epidemic, and governments have recognized the challenges HIV poses to future economic development in their home nations. There are particular challenges in the **Democratic Republic of the Congo**, **Madagascar**, and **South Sudan** due to recent and ongoing civil and political unrest, which challenges the sustainability of the response to the epidemic, though all three have strategic plans or frameworks for responding to the crisis.

West Africa. Across the subregion, West African countries coordinate efforts to combat HIV through the Economic Community of West African States and its affiliate, the West African Health Organisation (WAHO). In addition, most countries have their own national-level, multisectoral AIDS councils to steer country HIV programs. National strategic plans are complemented by WAHO’s fiscal years (FYs) 2009–2013 Strategic Plan for the area, which focuses on strengthening health systems, improving delivery of health services, and developing a sustainable financing plan for provision of HIV and other health services throughout the region.

In 2007, WHO and UNAIDS recommended medical male circumcision in settings with high HIV prevalence and low levels of male circumcision. It has been estimated that expanding the coverage of voluntary male circumcision to 80 percent of 15- to 49-year-old men within 5 years could result in 3.5 million fewer people becoming infected in East and Southern Africa. Thirteen countries were identified as priority areas for scaling up medical male circumcision. By 2010, most priority countries had instituted key programmatic elements to support male circumcision programs. More than 550,000 males were circumcised, which reduced risk of HIV transmission in the 13 priority countries between 2008 and 2010³.

Workplace Initiatives. Governments have also formed public-private partnerships (PPPs) as part of their HIV/AIDS responses. The number of workplace programs at private companies that provide HIV prevention information, voluntary counseling and testing, referrals to health facilities, and other services has also increased significantly

*Having an accepting attitude toward PLWHA means the respondent 1) would be willing to care for a family member who became sick with the AIDS virus; 2) would buy fresh vegetables from a vendor whom they knew was HIV-positive; 3) agrees that a female teacher who is HIV-positive but not sick should be allowed to continue teaching in school; and 4) would not want to keep the HIV-positive status of a family member a secret.

as employers recognize the impact of loss of productive laborers to HIV on their businesses. In **Botswana**, a PPP with the Bill & Melinda Gates Foundation and Merck supported HIV/AIDS programs through a \$106.7 million financial commitment and donation of ARVs. In **Madagascar**, for example, free condom distribution, health education, and promotion of voluntary counseling and testing are available for employees of the leading electricity distributor and a major agricultural enterprise. The PharmAccess Foundation, a Dutch nonprofit, supports workplace HIV programs in several African countries to promote HIV awareness and prevention and to offer treatment to groups of HIV-positive people²⁴.

Global Fund Investment in the Sub-Saharan Africa Region. The Global Fund to Fight AIDS, Tuberculosis and Malaria also plays a key role in the response to the HIV epidemic. In East Africa alone, the Global Fund has disbursed more than \$2.2 billion in grant funds for HIV/AIDS programming; in addition, approximately \$1.5 billion in Southern Africa and \$1.1 billion in West and Central Africa bring total disbursements for HIV/AIDS close to \$4.8 billion from the Global Fund's inception in 2002 to 2011. Programs range from prevention with MARPs to treatment, to care for orphans and vulnerable children (OVC). The Global Fund has played a key role in providing ART throughout sub-Saharan Africa, and programs supported by the Global Fund are providing 2.6 million PLWHA in the region with ART in 2012²⁵. The U.S. Government provides nearly 30 percent of the Global Fund's total contributions worldwide²⁶.

USAID Regional and Bilateral Support

The U.S. Agency for International Development's (USAID's) HIV/AIDS programs in Africa are implemented as part of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Launched in 2003, PEPFAR is the U.S. Government initiative to support partner nations around the world in responding to HIV/AIDS. PEPFAR is the cornerstone of President Obama's Global Health Initiative (GHI), which supports partner countries in improving and expanding access to health services. Building on the successes of PEPFAR, GHI supports partner countries in improving health outcomes through strengthened health systems, with a particular focus on improving the health of women, newborns, and children.

Partnership Framework. USAID implements bilateral and regional programs in countries throughout East, West, and Southern Africa. The U.S. Government has signed Partnership Frameworks with a number of countries throughout the subcontinent, including **Angola, Botswana, Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, Tanzania, and Zambia**. These Partnership Frameworks are designed to provide 5-year joint strategic frameworks for cooperation among the U.S. Government, the partner government, and other civil society and private sector stakeholders to combat HIV/AIDS in the host country through improved service delivery, policy reform, and coordinated financial commitments. The emphasis on health systems strengthening and program integration in current HIV programming promotes a more sustainable, country-led response to the epidemic.

The U.S. Government is also working with the private sector in HIV prevention efforts throughout Africa, including through initiatives such as the Together for Girls partnership through PEPFAR. The partnership brings together the U.S. Government with private sector organizations, including the Nduna Foundation, Becton, Dickinson and Company, the Center for Disease Control, and four United Nations agencies. The purpose of Together for Girls is to promote a balance between ending sexual violence through policies and programs targeting prevention and ensuring perpetrators are held accountable. Girls who are survivors of sexual violence are at increased biological risk of contracting HIV and other sexually transmitted infections. Through the Together for Girls initiative, results from a nationwide survey in **Swaziland** created a grassroots movement to change existing legislation to prevent and respond to sexual violence. In **Tanzania**, the rollout of the national survey has been catalytic, supporting the work of a multisectoral task force – composed of government, civil society, and both bilateral and multilateral partners – to launch a data-driven response to sexual violence against girls.

Examples of USAID assistance include the following activities and interventions in the three subregions:

Southern Africa

- In **Malawi**, USAID supported the Ministry of Health in developing new guidelines to implement WHO's 2009 recommendation, known as the "Option B" approach, which makes all HIV-positive pregnant and lactating women eligible for ART regardless of their CD4 count or clinical staging. As part of the PMTCT program, the HIV status of 175,000 women was ascertained and 12,000 HIV-positive women (77 percent) received antiretroviral prophylaxis.
- In **Namibia**, the U.S. Government supported 146,000 PLWHA with care and support services in 2011. USAID focused on provider-initiated counseling and testing for TB patients. The program successfully reached 76 percent of TB patients in 2010.

- USAID provided support to **Botswana** for ART and for HIV/AIDS care and support, including TB-HIV services; OVC and PMTCT services; and HIV counseling and testing, both directly to national programs and through local and international partners. Progress achieved in Botswana through direct PEPFAR support during 2011 included securing ART for 3,900 individuals, providing 48,700 HIV-positive individuals with care and support (including care and support for TB-HIV), supporting 15,600 OVC; and offering counseling and testing to 130,600 individuals.

East Africa

- In **Kenya**, PEPFAR assisted with the scale-up of the national PMTCT program, which has almost reached national scale. PEPFAR ensured that more than 1.1 million pregnant women received counseling and testing services. The 1.1 million women represent 79 percent of pregnant women in Kenya; of these, 67,276 received ARVs to prevent transmission of HIV to their children in 2011.
- PEPFAR funds have built the capacity of more than 740 laboratories in **Ethiopia** through the provision of training, material, and equipment, including the Integrated Pharmaceutical Logistics System. This system has supported 1,500 facilities and pre-service training for 961 health workers and more than 26,122 community health and parasocial workers; it also has supported in-service training of 32,360 health workers, exceeding the planned target by 17 percent.
- USAID enhanced its focus on combination prevention, including behavioral, biomedical, and structural approaches, to reduce transmission of HIV in **Tanzania**. Voluntary male circumcision represents a key biomedical intervention to prevent new HIV infections, and USAID significantly increased its investment in this program area over the past year. USAID partners circumcised 45,649 men, a more than threefold increase from FY 2010 to FY 2011.

West Africa

- In response to epidemiologic trends highlighted by recent surveys, USAID **Mali's** HIV/AIDS program focused its efforts on prevention services for MARPs. USAID reached 8,916 MARPs (6,900 sex workers and 2,016 MSM) with prevention messages, provided counseling and testing services to 37,930 people, and distributed 13,373,909 condoms.
- In **Nigeria**, USAID supported a nationwide decentralization effort to make services more accessible to beneficiaries. For example, the new focus on improving primary health care centers has allowed for the down-referral of patients from overcrowded secondary and tertiary facilities, thus creating new opportunities to start new patients on ART. During FY 2010, 334,700 individuals received ART, and 1,195,900 received care and support services.
- In **Cote d'Ivoire**, USAID supports procurement of all HIV-related drugs and commodities for a program serving more than 71,000 ART patients. The Agency also supports extensive capacity building for the national supply chain; national health information systems (including a Demographic and Health Survey); human resources for health planning and deployment; national and local health communication efforts; the Global Fund CCM; and quality improvement for HIV/AIDS treatment, prevention, and care/support programs. USAID implementing partners support care for more than 35,000 OVC, along with capacity building for local OVC service delivery and coordination.

Important Links

USAID's HIV/AIDS website for Africa:

http://www.usaid.gov/our_work/global_health/aids/Countries/africa/hiv_summary_africa.pdf

For more information, see USAID's HIV/AIDS website: http://www.usaid.gov/our_work/global_health/aids/.

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References

1. Joint United Nations Programme on HIV/AIDS. *UNAIDS World AIDS Day Report 2011*. Geneva, Switzerland 2011.
2. Joint United Nations Programme on HIV/AIDS. *Global Report: UNAIDS Report on the Global AIDS Epidemic: 2010*. Geneva, Switzerland 2010.
3. WHO, UNAIDS, UNICEF. *Global HIV/AIDS Response: Epidemic Update and Health Sector Progress Towards Universal Access*. Geneva, Switzerland 2011.
4. Institut National de la Statistique and ORC Macro. *Rwanda Demographic and Health Survey 2005*. Kigali, Rwanda and Calverton, Maryland, USA: Institut National de la Statistique and ORC Macro;2006.
5. National Institute of Statistics of Rwanda (NISR), Ministry of Health (MOH) Rwanda and ICF International. *Rwanda Demographic and Health Survey 2010*. Calverton, Maryland, USA NISR, MOH, and ICF International 2012.
6. Kenya National Bureau of Statistics (KNBS) and ICF Macro. *Kenya Demographic and Health Survey 2008-09*. Calverton, MD, USA: KNBS and ICF Macro;2010.
7. Cote AM, Sobela F, Dzokoto A, et al. Transactional Sex Is the Driving Force in the Dynamics of HIV in Accra, Ghana. *AIDS (London, England)*. Apr 9 2004;18(6):917-925.
8. Forbi JC, Entonu PE, Mwangi LO, Agwale SM. Estimates of Human Immunodeficiency Virus Incidence among Female Sex Workers in North Central Nigeria: Implications for HIV Clinical Trials. *Transactions of the Royal Society of Tropical Medicine and Hygiene*. Nov 2011;105(11):655-660.
9. Jewkes RK, Dunkle K, Nduna M, Shai N. Intimate Partner Violence, Relationship Power Inequity, and Incidence of HIV Infection in Young Women in South Africa: A Cohort Study. *The Lancet*. Jul 3 2010;376(9734):41-48.
10. U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Addressing Gender and HIV/AIDS. 2012; 2. Available at: <http://www.pepfar.gov/documents/organization/185947.pdf>. Accessed May 7, 2012.
11. Lesotho National AIDS Commission. *Global AIDS Response Country Progress Report: Status of the National Response to the 2011 Political Declaration on HIV/AIDS* March 26 2012.
12. UNAIDS. Democratic Republic of the Congo: Country Situation 2009:2. http://www.unaids.org/ctrysa/AFRCOD_en.pdf. Accessed May 8, 2012.
13. World Health Organization. *Global Tuberculosis Control 2011*. Geneva, Switzerland 2011.
14. Simtowe F, Kinkinginhoun-Medagbe FM. The Impact of HIV/AIDS on Labor Markets, Productivity and Welfare in Southern Africa: A Critical Review and Analysis. *African Journal of Agricultural Research*. 2011;6(10):2118-2131.
15. United Nations Department of Economic and Social Affairs. *The World's Women 2010: Trends and Statistics*. New York, NY: United Nations 2010.
16. Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat. *World Population Prospects: The 2010 Revision*. 2012; <http://esa.un.org/unpd/wpp/index.htm>. Accessed April 3, 2012.
17. Ijumba N. Impact of HIV/AIDS on Education and Poverty. *UN Chronicle*. 2011.
18. Lisk F. *Labour Market and Employment Implications of HIV/AIDS*. Geneva, Switzerland: ILO Programme on HIV/AIDS and the World of Work; June 2002.
19. Food and Agriculture Organization of the United Nations. *AIDS - A Threat to Rural Africa: Fact Sheet*. *Focus*. <http://www.fao.org/Focus/E/aids/aids6-e.htm>. Accessed May 10, 2012.
20. Desai K, Grassly N, Drake L, Bundy DAP. The economic impact of AIDS on the education sector of Zambia: application of the Ed-Sida model. *The XIV International AIDS Conference*. Vol Abstract no. C11067. Barcelona, Spain 2002.
21. Beckmann S, Rai P. *HIV/AIDS, Work and Development in the United Republic of Tanzania*. Geneva, Switzerland: International Labour Organization Programme on HIV/AIDS and the World of Work;2004.
22. Planning, Monitoring, Evaluation and Research Unit of the National AIDS Commission. *Global AIDS Response Progress Report: Malawi Country Report for 2010 and 2011*. March 31, 2012:67.
23. National AIDS Coordinating Agency. *Progress Report of the National Response to the 2001 Declaration of Commitment on HIV and AIDS: Botswana Country Report, Reporting Period 2008-2009*. UNAIDS and NACA;2010.
24. PharmAccess Foundation. About Us: Pioneering New Approaches. <http://www.pharmaccess.org/RunScript.asp?page=261&p=ASP\Pg261.asp>. Accessed May 9, 2012.
25. Global Fund to Fight AIDS, Tuberculosis and Malaria. *Regional and Country Portfolios*. 2012; <http://portfolio.theglobalfund.org/en/Home/Index>. Accessed July 5, 2012.
26. Global Fund to Fight AIDS, Tuberculosis and Malaria. *Donor Government Statistics*. 2012; <http://www.theglobalfund.org/en/donors/statistics/?lang=en>. Accessed June 27, 2012.