HEALTH PROFILE

Africa

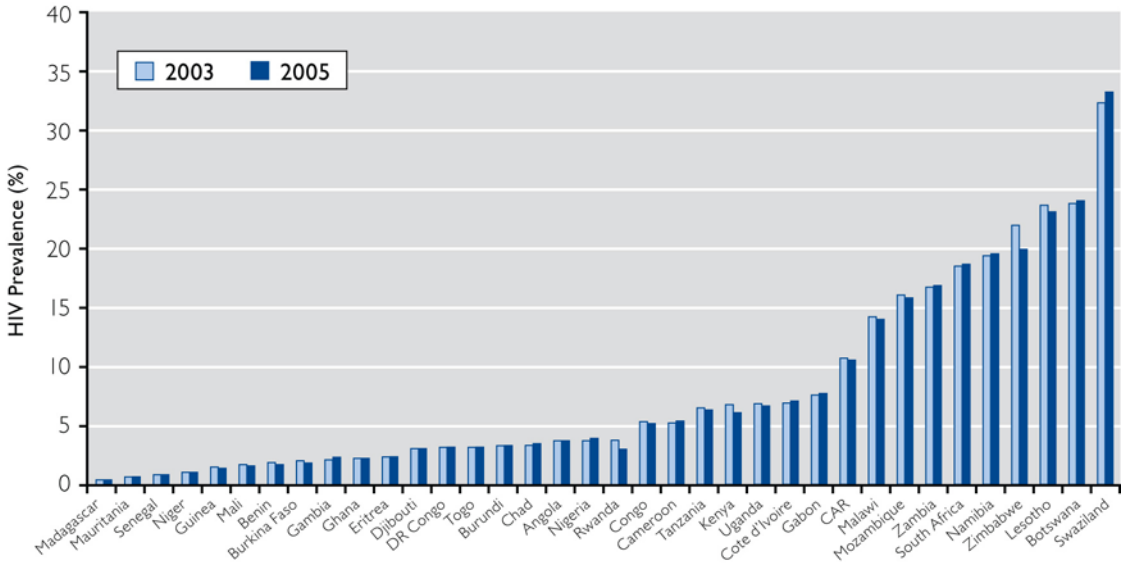
The U.S. Agency for International Development is a key partner in the U.S. President's Emergency Plan for AIDS Relief.

Overall HIV Trends

At the end of 2006, 24.7 million people in sub-Saharan Africa were living with HIV/AIDS. This figure represents nearly 63 percent of the total 39.5 million cases worldwide (UNAIDS, 2006). Nearly 60 percent of HIV infections in sub-Saharan Africa occur in women, a higher percentage than any part of the world. Approximately 72 percent of the 2.9 million AIDS-related deaths worldwide in 2006 occurred in sub-Saharan Africa, where AIDS is by far the most common cause of mortality (UNAIDS, 2006). In addition, the region is home to an alarming 80 percent of the world's children who have been orphaned or otherwise made vulnerable by HIV/AIDS.

With a few exceptions, such as Madagascar, most countries in sub-Saharan Africa have a generalized AIDS epidemic, where more than 1 percent of the population is infected. Most countries in the region appear to have stabilized epidemics, with the number of people being newly infected with HIV roughly matching the number of people dying of AIDS-related illnesses. A recent study that looked at data from countries with three consistent data sets from 2000 to 2005 showed that HIV prevalence has declined in Kenya and Zimbabwe among young women ages 15 to 24 years seeking care at antenatal care (ANC) clinics (UNAIDS, 2006). Some countries, such as Burkina Faso, have experienced declines in urban areas (UNAIDS, 2006). A recent

Trends in HIV Prevalence, 2003–2005 (Adults 15–49 Years)



Source: UNAIDS. 2006 Report on the Global AIDS Epidemic.

development in sub-Saharan Africa is the use of needles for injecting drugs as a potential factor in the HIV epidemics of several countries, including Kenya, Nigeria, South Africa, and Tanzania.

The figure on the previous page shows estimated HIV/AIDS prevalence rates in sub-Saharan Africa in 2003 and 2005. Zimbabwe is the only sub-Saharan African country that has sustained a significant decline in national prevalence levels. National adult prevalence was estimated at 20.1 percent in 2005, down from 22.1 percent in 2003. HIV prevalence among pregnant women fell from 32 percent in 2000 to 24 percent in 2004. The decline is associated with a substantial change in sexual behaviors since the early 1990s, including an increase in condom use, due to a combination of AIDS awareness, a relatively extensive health infrastructure, and a growing fear of AIDS mortality. The extent of the decline, while still significant, is not clear due to inconsistencies in the data (UNAIDS, 2006). An important part of the decline in HIV prevalence is also attributable to the high AIDS-related mortality.

Southern Africa. Southern Africa has the highest HIV prevalence rates in the world and accounts for 32 percent of all HIV infections worldwide. In four countries in southern Africa – Botswana, Lesotho, Swaziland, and Zimbabwe – UNAIDS estimates that 20 percent or more of the population are living with HIV infection. In South Africa, the country in the region with the highest number of people infected, prevalence is close to 20 percent and may be increasing. Among women ages 30 to 34, prevalence is much higher, with nearly one in three women infected (UNAIDS, 2006). Approximately 52 percent of all HIV-positive women 15 years and older, and about 43 percent of all HIV-positive individuals less than 25 years old worldwide, live in southern Africa, which has an untold effect on households, children, and communities where women are responsible for food production and child care.

East Africa. In the countries of East Africa, HIV prevalence has either decreased or remained stable in the past several years. As in southern Africa and many other parts of the world, women in East Africa face considerably higher risk of HIV infection than men, especially at younger ages. In this region, the intensity of national epidemics varies from country to country. Madagascar has the lowest HIV prevalence (estimated at 0.5 percent in 2005), and Uganda and Tanzania have the highest rates at 6.7 and 6.5 percent, respectively. Prevalence rates in Uganda declined over the past decade, but recent data show an increase among specific age groups and in rural areas, and it is unclear whether national prevalence is now increasing (UNAIDS, 2006). Epidemics appear to have stabilized in several countries, including Ethiopia, Rwanda, and Burundi. In Kenya, HIV prevalence in pregnant women has been declining,n and national adult HIV prevalence is estimated to have fallen from 10 percent in the late 1990s to just over 6 percent in 2005 (WHO, 2005; Kenya Ministry of Health, 2005). Factors associated with this decline include a decrease in the proportion of adults with multiple sexual partners, delay in age of sexual debut among women, and an increase in condom use. In addition to these behavioral factors, increased mortality and the saturation of infection among people most at risk of HIV have also influenced the decline in prevalence (Cheluge et al, 2006).

West Africa. West Africa has the lowest HIV rates in sub-Saharan Africa. In many countries, the epidemic appears to be stabilized, although concentrated epidemics do exist (UNAIDS, 2005). In Senegal, for example, national prevalence is less than 1 percent, yet it is as high as 30 percent among commercial sex workers in urban areas. National adult HIV prevalence is yet to exceed 10 percent in any West African country, and there is no consistent evidence of significant changes in prevalence among pregnant women in recent years. Côte d'Ivoire has the highest adult prevalence at 7 percent, yet this represents a significant decline from earlier prevalence levels (UNAIDS, 2006). Significant declines in HIV prevalence among pregnant women in urban areas have been observed in Burkina Faso and Togo as well (WHO, 2005). In Ghana, data from ANC clinics show a decline in prevalence levels from 3.1 to 2.7 percent between 2003 and 2005, while in Mali prevalence may be increasing. Nigeria has the third-largest number of people living with HIV in the world – 2.9 million. National prevalence is estimated at 4 percent, although infection levels across this large country vary (UNAIDS, 2006).

Comprehensive knowledge of HIV remains low in sub-Saharan Africa and is an obstacle to reducing incidence rates. For example, approximately 2 million South Africans living with HIV do not know that they are infected, believe they are not in danger of becoming infected, and are unaware they can transmit the virus to others. Intensified efforts to increase HIV prevention among young people are also required.

Sustained progress in the response against AIDS will only be attained by intensifying HIV prevention and treatment simultaneously. Provision of antiretroviral therapy (ART) has expanded in sub-Saharan Africa – more than 1 million people were receiving ART by June 2006, a 10-fold increase since December 2003. Concerted efforts for a combined prevention and treatment response could reduce the number of AIDS deaths by as much as 27 percent and the number of new infections by as much as 55 percent by 2020 (UNAIDS, 2006).

Economic and Social Impact of HIV/AIDS in Africa

The HIV/AIDS epidemic is erasing 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. Average life expectancy in sub-Saharan Africa, which would be 62 without HIV/AIDS, is now 47 (AVERT, 2006).

The epidemic is also reversing progress in poverty reduction. A study in Burkina Faso, Rwanda, and Uganda has calculated that AIDS will increase the percentage of people living in extreme poverty from 45 percent in 2000 to 51 percent in 2015 (UNDP, 2003). Economic activity and social progress are set back as more of the labor force becomes ill or dies. Agriculture is neglected or abandoned due to household illness, adding to food insecurity in many areas. In Malawi, where the agriculture workforce is expected to shrink by 14 percent by 2020, HIV/AIDS is the source of the country's falling agricultural output. In Mozambique, Botswana, Namibia, and Zimbabwe, the workforce loss by 2020 could be as high as 20 percent (AVERT, 2006).

HIV/AIDS poses increasingly heavy demands on Africa's health systems. Providing antiretroviral treatment to those in need in Tanzania, for example, would require the full-time services of almost half the existing health care workforce. Most health systems in Africa already face labor shortages, however, due to 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. Botswana, for example, lost 17 percent of its health care workforce between 1999 and 2005. In Zambia, a study of midwives found that 40 percent were HIV-positive.

HIV/AIDS can have devastating effects on households. Many families lose their primary income earners, while others lose the incomes of family members forced to stay home and care for the sick. Caring for an individual with HIV/AIDS in sub-Saharan Africa can take up as much as one-third of a family's monthly income. Funeral expenses can be even more burdensome – in South Africa, they can be three times as high as the typical monthly household income (AVERT, 2006).

Finally, AIDS has orphaned more children in Africa than in any other part of the world. Many of these children are raised by their grandparents or live in households headed by other children (AVERT, 2006). As more parents die, the effect of HIV/AIDS on the region's children cannot be overstated. 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 suffer their own increased health problems related to inadequate nutrition, housing, clothing, and basic care. They are also less able than other children to attend school regularly. This in itself indicates an increased risk for HIV infection, as studies suggest that young people with little or no education may be 2.2 times more likely to contract HIV (AVERT, 2006).

Partnering for Success: USAID and the U.S. President's Emergency Plan for AIDS Relief

The U.S. President's Emergency Plan for AIDS Relief (Emergency Plan/PEPFAR) is the largest commitment ever by any nation for an international health initiative dedicated to a single disease – a five-year, $15 billion, multifaceted approach to combating the disease in more than 120 countries around the world, with a special emphasis on 15 focus countries in Africa, the Caribbean, and Asia. In these focus countries, the Emergency Plan has set goals of supporting prevention of 7 million new infections, treatment for 2 million HIV-infected people, and care for 10 million individuals, including orphans and vulnerable children.

The Emergency Plan encompasses all U.S. Government international HIV/AIDS activities, including those implemented by the U.S. Agency for International Development (USAID). Under the Emergency Plan in Africa, USAID's staff of foreign service officers, trained physicians, epidemiologists, and public health advisors work with host governments, nongovernmental organizations, and the private sector to provide training, technical assistance, and supplies – including pharmaceuticals – to prevent and reduce the transmission of HIV/AIDS and provide care and treatment to people living with HIV/AIDS. In fiscal year 2007, USAID will continue efforts to prevent the spread of HIV/AIDS using several interventions:

- The ABC approach to prevent sexual transmission of HIV – Abstinence, Be Faithful, Correct and Consistent Use of Condoms
- Prevention of mother-to-child HIV transmission
- Voluntary counseling and testing
- Injection safety and ensuring the safety of blood supplies

- Provision of therapy for concurrent illnesses and opportunistic infections, as well as palliative care
- Nutritional therapy
- Support for orphans and vulnerable children

USAID is uniquely positioned to support multisectoral responses to HIV/AIDS that address the widespread impact of HIV/AIDS outside the health sector. In particular, USAID is supporting cross-sector programs in areas such as agriculture, education, democracy, and trade that link to HIV/AIDS and mutually support the objective of reducing the impact of the pandemic on nations, communities, families, and individuals. Under the Emergency Plan, USAID also supports a number of international partnerships; provides staff support to the Global Fund to Fight AIDS, Tuberculosis and Malaria; and works with local coordinating committees of the Global Fund to improve implementation of the Fund programs and their complement to U.S. Government programs. Finally, USAID supports targeted research, development, and dissemination of new technologies and new packaging and distribution mechanisms for antiretroviral drugs.

USAID Support in Africa

In Africa, USAID support of the Emergency Plan places special emphasis on 12 focus countries: **Botswana, Cote d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda,** and **Zambia.** In addition, HIV/AIDS programs are also implemented in many other countries, some including Angola, Benin, Democratic Republic of the Congo, Egypt, Eritrea, Ghana, Guinea, Lesotho, Liberia, Madagascar, Malawi, Mali, Senegal, Sudan, and Swaziland.

Examples of USAID assistance include the following activities and interventions:

- Reached 978 persons in Ethiopia and included community discussion on orphans and vulnerable children issues and HIV/AIDS through community mobilization activities
- Assisted in Namibia with the development of the national policy on orphans and vulnerable children, which the Ministry of Women Affairs and Child Welfare completed and endorsed
- Conducted a sensitization workshop in Nigeria for the Federal Ministry of Women Affairs and Youth Development, the lead government agency for national response to orphans and vulnerable children
- Supported 11,000 Kenyans on antiretroviral therapy (ART) and provided ART for another 21,000 through investments in drug procurement, public sector infrastructure, pharmacies, and enhancing the capabilities of health professionals initiating and monitoring ART
- Increased the number of USAID-assisted counseling and testing centers in Malawi from three in 2000 to 51 in 2005 (well over the target of 39) and increased the number of clients assisted at these sites from about 22,000 in 2000 to more than 59,000 in 2005
- Provided direct care and support services to 3,420 orphans and other vulnerable children in Burkina Faso
- Supported 52 Senegalese organizations in conducting behavior change communications interventions, including ABC activities reaching 121,533 persons (of whom 72,379 were women and girls) and distribution of more than 31,500 educational materials (posters, cassettes, etc.) in nationwide prevention and care campaigns
- Provided nutrient-dense take-home food rations to 14,060 people living with HIV/AIDS, orphans, and vulnerable children in Ghana, and psychosocial counseling to 686 others
- As part of efforts in South Africa to improve the quality of care in selected public health facilities, increased the percentage of pregnant women offered HIV counseling and testing at the public health facility in rural Mpumalanga Province (serving a population of about 80,000) from 22 to 72 percent in one year

Prepared November 2006