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HEALTH PROFILE: SOUTHERN AFRICA REGION

HIV/AIDS

Angola	
Estimated Number of Adults and Children Living with HIV/AIDS (end 2003)	240,000
Total Population (end 2004)	14,078,000
Adult HIV Prevalence (end 2003)	3.9%
Botswana	
Estimated Number of Adults and Children Living with HIV/AIDS (end 2003)	350,000
Total Population (end 2004)	1,795,000
Adult HIV Prevalence (end 2003)	37.3%
Lesotho	
Estimated Number of Adults and Children Living with HIV/AIDS (end 2003)	320,000
Total Population (end 2004)	1,800,000
Adult HIV Prevalence (end 2003)	28.9%

Southern Africa remains the region of the world most severely affected by HIV/AIDS. In at least six countries—Botswana, Lesotho, Namibia, South Africa, Swaziland, and Zimbabwe—it is estimated that more than a fifth of the adult population is living with HIV/AIDS, and in Botswana and Swaziland (with prevalence of 37.3% and 38.8%, respectively) nearly two out of five adults may be living with HIV/AIDS. Altogether, the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that at the end of 2003 more than 12 million adults and children in the 10 countries that make up the Southern Africa region were living with HIV/AIDS.

The burden of the epidemic on the region is staggering. With less than 2% of the world's population, the 10 Southern African countries account for 30% of HIV-positive individuals, 27% of children orphaned by AIDS, and 32% of AIDS deaths. Moreover, the epidemic has not yet peaked (except, possibly, in Zambia), and the disproportionate effect on the region is likely to continue. HIV prevalence among pregnant women, an important indicator of the extent to which the epidemic has spread to the general population, has climbed rapidly in the last decade and in many countries is still increasing. In Botswana, for example, HIV prevalence among women attending antenatal clinics in 2002 was 35.4%, with very little difference between urban and rural areas; in Swaziland, it was 38.6%; in Zimbabwe, 30%; in South Africa, 26 to 28%; and in Namibia, 22%. Even in countries with lower HIV prevalence in rural areas, women attending antenatal clinics in urban areas have high HIV prevalence: Lesotho, 30%; Zambia, 27%; Malawi, 21%; and Mozambique, 18%.

HIV/AIDS is thus not confined to discrete vulnerable subpopulations but occurs across populations. Nevertheless, for some the risk is particularly great. In the early stages of the epidemic, the number of men living with HIV/AIDS vastly exceeded the number of women, whereas current HIV prevalence is higher among females than among males. Young women aged 15 to 24 are two to three times more likely to contract HIV than young men of the same age. In some countries, urban women are at double the risk of rural women. In some cross-border areas, truck drivers, migrant workers, and sex workers demonstrate prevalence three to six times that of the general population, whereas in other areas, HIV prevalence in the general population now approaches similar levels. Common patterns of "concurrent" (overlapping) multiple partnerships, unemployment, high mobility between towns and mining areas, population dislocations resulting from drought, and conflict all contribute to the spread of HIV/AIDS.

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Malawi	
Estimated Number of Adults and Children Living with HIV/AIDS (end 2003)	900,000
Total Population (end 2004)	12,337,000
Adult HIV Prevalence (end 2003)	14.2%
Mozambique	
Estimated Number of Adults and Children Living with HIV/AIDS (end 2003)	1,300,000
Total Population (end 2004)	19,182,000
Adult HIV Prevalence (end 2003)	12.2%
Namibia	
Estimated Number of Adults and Children Living with HIV/AIDS (end 2003)	210,000
Total Population (end 2004)	2,011,000
Adult HIV Prevalence (end 2003)	21.3%
South Africa	
Estimated Number of Adults and Children Living with HIV/AIDS (end 2003)	5,300,000
Total Population (end 2004)	45,214,000
Adult HIV Prevalence (end 2003)	21.5%

The consequences of high HIV prevalence are felt in virtually every area of life. After years of steadily improving life expectancy, AIDS is wiping out these gains and causing life expectancy to drop to levels not seen in decades. The U.S. Census Bureau predicts that by 2010, life expectancy in Botswana could be 27 years; in Swaziland, 33 years; and in Namibia and Zambia, 34 years—half of what they would have been without the effect of AIDS. Mozambique's life expectancy, once 50.3 years, is now estimated at 36.5 years. Infant mortality, which had been steadily declining, is on the rise, nearly doubling in Namibia and Swaziland.

In these hardest-hit countries, HIV/AIDS is depleting technical and administrative capacity through illness, death, and emigration. In one Malawi study, one-third of teachers were found to be HIV-positive, and more than 1,400 health sector employees died during the 1990s. More than 5,000 doctors have left South Africa in recent years, and 300 nurses leave every month. Zambia, which once had 1,600 doctors, now has 400. According to UNAIDS, Southern African doctors and nurses are emigrating to Australia, Europe, the Persian Gulf countries, Japan, and the United States, further weakening already inadequate health systems. Agriculture is seriously affected as well—millions of agricultural workers have died of AIDS in societies where up to four-fifths of the population depends on small-scale subsistence agriculture for their families' livelihoods.

REGIONAL RESPONSE

The countries in Southern Africa have all developed organized policy responses to the HIV/AIDS crisis. Some have comprehensive national plans, while others work through a set of laws and policies that respond to various aspects of the epidemic. Whether or not they have a comprehensive plan, all have adopted multisectoral approaches to prevention and care. The challenge now is to translate carefully designed strategies into effective activities and programs.

- ***Angola*** has only limited available surveillance data, but its HIV prevalence is far below those of other countries in the region, perhaps in part because of limited mobility during a quarter century of armed conflict. The government has implemented the National Strategic Framework to Fight HIV/AIDS for 2003–2008. The National AIDS Commission held an open forum to discuss the epidemic with its national partners. Limited human, financial, and infrastructure resources present major challenges.

- ***Botswana*** has among the world's highest prevalence, with an estimated four of every 10 individuals HIV-positive. The National AIDS Council, with technical support from the National AIDS Coordinating Agency, has implemented a wide multisectoral response, with HIV/AIDS as an integral part of the national development plan. The National Strategic Plan on HIV/AIDS for 2003–2009 focuses on expanding the multisectoral response and incorporating civil society and the private sector as well as national and district stakeholders. In 2003, Botswana adopted routine HIV testing to increase the number of people who

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Swaziland	
Estimated Number of Adults and Children Living with HIV/AIDS (end 2003)	220,000
Total Population (end 2004)	1,083,000
Adult HIV Prevalence (end 2003)	38.8%
Zambia	
Estimated Number of Adults and Children Living with HIV/AIDS (end 2003)	920,000
Total Population (end 2004)	10,924,000
Adult HIV Prevalence (end 2003)	16.5%
Zimbabwe	
Estimated Number of Adults and Children Living with HIV/AIDS (end 2003)	1,800,000
Total Population (end 2004)	12,932,000
Adult HIV Prevalence (end 2003)	24.6%

Sources: UNAIDS

know their status, thus potentially increasing demand for antiretroviral treatment.

- ***Lesotho***, with HIV prevalence of nearly 30%, took steps in 2003 to improve and expand its response. The government developed a policy document outlining a plan to scale up HIV/AIDS strategies, established a semiautonomous National AIDS Commission, and, with support from the World Health Organization (WHO), conducted a sentinel surveillance survey.

- ***Malawi*** is home to an estimated 900,000 people living with HIV/AIDS, with prevalence in urban areas (23%) significantly higher than in rural areas (12%). The government has demonstrated high-level political support for addressing HIV/AIDS. In 2001, Malawi adopted the National HIV/AIDS Strategic Framework for 2000–2004 and established the National AIDS Commission, whose oversight was subsequently transferred to the Office of the President, thus expanding its role and effectiveness. A new national HIV/AIDS policy approved in late 2003 addresses expanded HIV testing, increased participation by civil society and the private sector, and a public health approach.

- ***Mozambique*** has demonstrated strong political support for addressing HIV/AIDS. The National AIDS Council chaired by the Prime Minister was established in 2000 to ensure a multisectoral approach and to pursue partnership with civil society. Mozambique drafted its National Strategic Plan and is developing implementation plans and monitoring and evaluation approaches. However, inadequate human, financial, technical, and institutional resources remain challenges.

- ***Namibia*** has declared HIV/AIDS to be its top priority. A 2002 sentinel surveillance survey found 22% HIV prevalence among pregnant women. Priority action areas of Namibia's National Strategic Framework include the prevention of mother-to-child transmission (PMTCT), as well as other prevention efforts, condom distribution, information and behavior change communication, treatment of sexually transmitted infections (STIs), workplace programs, and care and support. In addition to national efforts, individual ministries have initiated sector-specific HIV/AIDS programs. Regional efforts are also under way.

- ***South Africa***, with the largest estimated number of HIV-positive individuals living within one country (5.3 million), has shown high-level commitment to providing care and treatment for those living with HIV/AIDS and prevention interventions for those who are not. The country allocates 15% of government expenditures to health and has drafted a National Strategic Framework involving 16 key sectors and a wide range of partners. The Comprehensive National HIV/AIDS Care, Management, and Treatment Plan aims to provide antiretroviral treatment to 1.4 million people by 2008.

- ***Swaziland*** has the world's worst HIV epidemic to date**.** It is number one in percentage of cases per population. Swaziland has created the National Emergency Response Council on HIV/AIDS, but its capacity to respond effectively is challenged by depleted human resources in health and other sectors. Another difficulty is the growing number of orphans and other affected children, many of whom head households in which children are living on their own or with a sick parent or relative.

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In 2000, USAID launched the Regional HIV/AIDS Program for Southern Africa (RHAP/SA), a set of regional activities intended to complement national and bilateral HIV/AIDS prevention efforts.

- ***Zambia*** has made HIV/AIDS an integral part of its poverty reduction efforts. Its National Strategic Plan for HIV/AIDS consists of seven objectives: promotion of behavior change; PMTCT; safe blood transfusion; counseling and testing; care and support for people living with HIV/AIDS, including orphans and other affected children; an information system database; and multisectoral coordination at the district, provincial, and national levels. Integrating HIV/AIDS into all government sectors is a high priority, but implementation is hampered by a lack of available human resources.
- ***Zimbabwe*** has had a national AIDS policy and strategic framework in place since 1999, when it introduced a 3% levy on all taxable income to finance HIV/AIDS activities. Civil society and the private sector also play an important role in addressing HIV/AIDS, with most support from donors going to nongovernmental organizations (NGOs). In 2002, Zimbabwe declared HIV/AIDS and the lack of access to antiretroviral therapy a national emergency, setting the foundation for an enhanced and expanded effort that remains hampered by declining human capacity. Government commitment and support remain high.

Across the region, countries increasingly recognize the value of sharing information and coordinating responses both within and across countries. The Southern African Development Community (SADC), which consists of 14 member countries (those cited above plus the Democratic Republic of Congo, Mauritius, Seychelles, and Tanzania), works with the U.S. Agency for International Development (USAID) and others to increase awareness of the devastating impact of HIV/AIDS and to address the pandemic. At a high-level summit in July 2003, SADC agreed to a framework and plan of action aimed at reducing the incidence of new infection among its most vulnerable populations, mitigating the socioeconomic impact of HIV/AIDS, achieving consensus on HIV/AIDS-related policies in the region, and mobilizing and coordinating resources for a multisectoral, regional response.

USAID SUPPORT

In 2000, USAID launched the Regional HIV/AIDS Program for Southern Africa (RHAP/SA), a set of regional activities intended to complement national and bilateral HIV/AIDS prevention efforts. The primary objective was to reduce HIV transmission at cross-border sites by focusing on high-transmission populations in those areas. Additional goals were to provide funding to countries that do not receive bilateral USAID support and to improve the capacity of all countries in the region to respond to HIV/AIDS. All 10 countries in the Southern Africa region are currently included in the program, whose funding increased from $750,000 in FY 1999 to $7.95 million in FY 2004. All but Botswana, Lesotho, and Swaziland received additional bilateral HIV/AIDS assistance.

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Successes to date

Between FY 1999 and FY 2003, RHAP/SA achieved the following:

- ***Increased access to comprehensive HIV/AIDS prevention services at cross-border sites.*** Corridors of Hope, a cross-border initiative implemented by Population Services International, has reduced HIV transmission among truck drivers, sex workers, informal traders, military personnel, and youth by focusing on condom social marketing, behavior change, and management of STIs. In FY 2004, more than two million people at 41 cross-border sites received information about HIV/AIDS prevention through a variety of activities implemented by regional and local partners. By promoting condom use (including free distribution, as needed) and care-seeking behavior for STIs, training peer educators, conducting "edu-theatre" events, and providing HIV risk-reduction counseling, along with a variety of other activities, these partners are reaching some of the most-at-risk populations. Because of variations across countries, however, these activities must be geared to the realities and cultures of particular communities.

- ***Improved capacity to respond to HIV/AIDS.*** RHAP/SA has emphasized building the capacity of local implementing partners in activities such as behavior change communication, outreach to vulnerable women, peer education, and monitoring and evaluation. Additionally, RHAP/SA has sought to help countries benefit from each other's HIV/AIDS experiences by facilitating meetings on best practices and lessons learned. Topics addressed include the impact of HIV/AIDS on business and agriculture, the leadership role people living with HIV/AIDS can play in addressing HIV/AIDS, and building the capacity of faith-based organizations in HIV/AIDS prevention and care. Broadening understanding of difficult issues—such as violence against women, improving the quality and use of behavioral surveillance and other data, program monitoring, and increasing women's ability to negotiate condom use—has been a central element of RHAP/SA.

- ***Reduced HIV/AIDS transmission in non-USAID countries.*** The three Southern African countries in which USAID does not have Missions—and that do not receive bilateral assistance—receive technical support through USAID's regional program for HIV/AIDS-related issues. In Botswana, Lesotho, and Swaziland, RHAP/SA has provided support for building the capacity of NGOs and community-based organizations in HIV/AIDS prevention and care, through the U.S. Ambassadors' Initiatives and small grants programs. Sample activities include a strategic planning exercise in Botswana; PMTCT (in partnership with the Elizabeth Glaser Pediatric AIDS Foundation) in Swaziland; and, in Lesotho, expanded HIV counseling and testing, as well as an expansion in the Health Promoting Schools Initiative, which engages communities, families, and students in taking responsibility for community health and well-being.

Looking forward

In 2003, the President's Emergency Plan for AIDS Relief was introduced, providing expanded and intensified U.S. government HIV/AIDS support to 15 focus countries selected from among those most heavily affected by the pandemic. The Emergency Plan focuses on rapid scale-up of interventions and calls on various U.S. government agencies to work together cohesively and collaboratively. With five of the 10 Southern African countries designated as Emergency Plan focus countries, RHAP/SA and the Southern Africa Regional Office of the U.S. Centers for Disease Control and Prevention undertook a joint strategic planning exercise in late 2003 to identify the challenges and opportunities inherent in the expanded resources now available to some of the countries in the region. The resulting new RHAP/SA strategy spells out the issues that must be addressed and a plan of action for maximizing the impact of available resources.

Variation in availability of resources

While all countries are under the authority of the Office of the U.S. Global AIDS Coordinator, an important issue to address is the varying levels of resources available to the five Emergency Plan focus countries (Botswana, Mozambique, Namibia, South Africa, and Zambia) versus the three nonfocus countries (Angola, Malawi, and Zimbabwe), and those countries without USAID bilateral support (Lesotho and Swaziland) but which receive additional Emergency Plan funds. Regardless of their resources, the countries share porous borders, high prevalence, and mobile populations with high-risk behaviors that contribute to the spread of the epidemic.

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The needs of non-USAID countries

Swaziland and Lesotho have among the world's highest HIV/AIDS prevalence, lack the capacity and infrastructure to respond, and are among the poorest countries in the world. One of their great needs is improved capacity for service delivery. Providing assistance in this area will inevitably contribute to Emergency Plan objectives.

Need for regional coordination and capacity strengthening

Because of the complexity of the Emergency Plan, the number of partners, and the large infusion of U.S. government resources to parts of the region, strong communication networks and channels are essential. RHAP/SA can serve as a link both between Washington and the field and between focus and nonfocus countries. Similarly, RHAP/SA is well placed to facilitate partnerships and maximize the use of available resources. Many varied networks and institutions in Southern Africa operate on a regional basis, including regional donors (WHO, UNAIDS, World Bank) and governmental organizations (SADC), as well as nongovernmental, community-based, faith-based, and training organizations. All of these institutions have some capacity to contribute to and collaborate in the response to HIV/AIDS in the region. The RHAP/SA will have a role in leveraging these resources to address immediate needs across the region and will contribute to long-term sustainability of this collective response.

IMPORTANT LINKS AND CONTACTS

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