HIV/AIDS HEALTH PROFILE

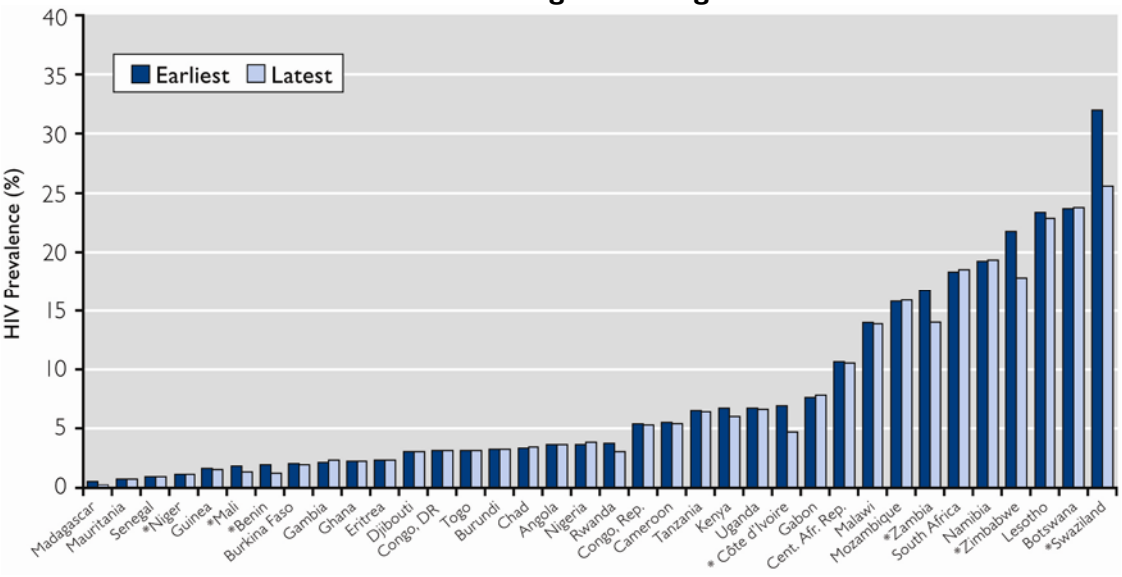
Africa Region

Overall HIV Trends

In 2007, UNAIDS reported that 22.5 million people in sub-Saharan Africa were living with HIV/AIDS. This figure represents nearly 68 percent of the total 33.2 million cases worldwide. New infections of HIV among children and adults in Africa in 2007 numbered 2.5 million. Nearly 61 percent of HIV infections in this region occur in women, a higher percentage than any part of the world. Approximately 76 percent of the 2.1 million AIDS-related deaths worldwide in 2007 occurred in sub-Saharan Africa, where AIDS is by far the most common cause of mortality, according to the UNAIDS 2007 *Epidemic Update*. 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.

The region's HIV/AIDS epidemiological profiles vary considerably. Many of the hardest-impacted countries have generalized epidemics; others have concentrated epidemics with disease hotspots. The strategic approaches to combat this disease must be designed to respond to the disease characteristics in a particular country or region. Prevalence estimates range from less than 2 percent in the Sahel to more than 15 percent in most of southern Africa. 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 reported by UNAIDS that looked at data from countries with three consistent data sets from 2000 to 2005 showed that HIV prevalence declined in Kenya and Zimbabwe among young women ages 15 to 24 years who

HIV Prevalence Rate Among Adults Aged 15 to 49 for 2003–2007



Source: UNAIDS 2006 Report on the Global AIDS Epidemic.
* Niger, Mali, Benin, Côte d'Ivoire, Zambia, Zimbabwe, and Swaziland use more recent data from 2005/06 and 2006/07 Demographic and Health Surveys.

sought care at antenatal care (ANC) clinics. In both countries, a proportion of the decline may be due to a reduction in risky behaviors. Some countries, such as Burkina Faso, have experienced declines in urban areas.

As a result of unequal power relations, young women and girls in Africa are particularly vulnerable to HIV. Women are infected more often and earlier in their lives than men, and young women ages 15 to 24 are between two and six times more likely to be HIV positive than men of a similar age. Researchers believe that young women's relationships with older men contribute to their increased risk of infection. A literature review from sub-Saharan Africa revealed that 12 to 25 percent of young women's partners were 10 or more years older than they were.

The figure on the previous page shows estimated HIV/AIDS prevalence rates in sub-Saharan African countries from 2003 to 2007. Zimbabwe and Swaziland are the only sub-Saharan African countries that demonstrate a significant decline in national prevalence levels National adult prevalence in Zimbabwe was estimated at 18.1 percent in 2005, down from 22.1 percent in 2003. HIV prevalence among pregnant women fell from 26 percent in 2002 to 18 percent in 2006. UNAIDS suggests that this trend reflects a combination of high mortality and declining HIV incidence in part due to behavior change. In Swaziland, HIV prevalence declined from 32.4 percent in 2003 to 25.9 in 2006–2007, according to the most recent data from the Swaziland Demographic and Health Survey (DHS). UNAIDS, however, indicates that the extent of these declines in Zimbabwe and Swaziland, while still significant, is not clear due to inconsistencies in the data. An important part of the decline in HIV prevalence is also attributable to high AIDS-related mortality.

Southern Africa. Southern Africa has the highest HIV prevalence rates in the world. According to UNAIDS, the subregion accounts for 35 percent of all HIV infections worldwide. National adult HIV prevalence exceeded 15 percent in seven countries in 2005 (Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, and Zimbabwe). South Africa has the largest number of HIV infections in the world. However, HIV infection levels might be leveling off, with prevalence among pregnant women at 30 percent in 2005 and 29 percent in 2006. Mozambique is the only country in southern Africa to demonstrate an increase in prevalence over the previous surveillance period, according to the 2005 DHS. Recent data from pregnant women using ANC services in Madagascar show the national prevalence was 0.2 percent in 2005, the lowest in southern Africa. UNAIDS data show that 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. This 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. Uganda and Tanzania have the highest rates at 6.4 and 7 percent, respectively. Prevalence rates in Uganda declined over the past decade, but recent UNAIDS data show an overall leveling off of the prevalence rate in this decade and an apparent increase in risky sexual behavior. Since the population size is growing rapidly, a stable HIV incidence rate means that an increasing number of people acquire HIV each year. The epidemic in Rwanda appears to have declined among pregnant women in urban areas in the late 1990s, but infection levels have subsequently stabilized. HIV prevalence is still high in the capital, Kigali. In Ethiopia, based on data collected in ANC clinics, adult HIV prevalence is more than five times higher in urban areas (10.5 percent) than in rural areas (1.9 percent). In Kenya, HIV prevalence in pregnant women has been declining, and information from UNAIDS and the Ministry of Health indicates that national adult HIV prevalence is estimated to have fallen from 10 percent in the late 1990s to just over 5 percent in 2006. According to UNAIDS, a recent research study reported that 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. Despite this decline, Kenya continues to have a serious AIDS epidemic.

West Africa. UNAIDS data show that 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. 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 exceeds 3 percent only in Côte d'Ivoire and Nigeria and is 2 percent or lower in several other countries in the region. HIV prevalence in urban areas appeared to decline from 10 percent in 2001 to 6.9 percent in 2005. Data from the 2005 DHS show that Côte d'Ivoire has the highest adult prevalence in West Africa at 4.7 percent, yet this represents a significant decline from earlier prevalence levels of 7.0, which were based on data from UNAIDS. Significant declines in HIV prevalence among pregnant women in urban areas have been observed in Burkina Faso and Togo as well. In Ghana, prevalence data from ANC clinics ranged from 2.3 to 3.6 percent between 2000 and 2006, and, according to the 2006 DHS, HIV prevalence in Mali is also declining. UNAIDS, however, indicates that the extent of the declines is not clear due to a refined methodology that was used to develop the prevalence rate estimates. Nigeria has the largest epidemic in the subregion, with 2.9 million people living with HIV. Although the HIV prevalence is relatively low at 3.1 percent, Nigeria has the second largest HIV disease burden in the world due to its large population. UNAIDS estimates national prevalence among pregnant women varies considerably from 1.6 percent in the west to 10 percent in the southeast.

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.

The detection of extensively drug-resistant tuberculosis (XDR-TB) in sub-Saharan Africa also poses a grave threat, especially to populations with high rates of HIV and in areas where there are few health care resources. People living with HIV are particularly vulnerable to developing drug-resistant TB because of their increased susceptibility to infection and progression to active TB. Furthermore, TB is one of the main causes of death for people living with HIV. According to UNAIDS, this is particularly an issue in South Africa, where an estimated 44 percent of TB patients are also HIV-infected. Recent World Health Organization (WHO) data show that HIV prevalence in incident TB cases is also very high in other African countries, such as Zimbabwe (43 percent), Mozambique (30 percent), Tanzania (18 percent), and Kenya (52 percent). Although HIV testing for TB patients is increasing quickly in the Africa region, HIV-infected people are not typically screened for TB, though this is a relatively efficient method of case finding. There is an urgent need for improved access to TB culture and drug sensitivity testing, and the introduction of effective infection control practices in HIV care clinics to prevent the spread of TB.

Sustained progress in the response to 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 tenfold increase since December 2003. However, ART coverage varies greatly from country to country. Nigeria has the second largest number of people living with HIV in the world, but, according to UNAIDS and WHO, in 2006, only 15 percent of those in need were receiving treatment. By contrast, Botswana has almost universal coverage. In UNAIDS' view, 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.

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. According to the World Bank 2006 publication *Disease and Mortality in Sub-Saharan Africa*, life expectancy peaked in the early 1990s at 50 years and has since fallen by almost four years. In Swaziland, life expectancy fell from 60 years in 1997 to 31.3 years in 2004. With the increase in AIDS-related mortality among 20- to 49-year-olds, adults in their most economically productive years are most affected.

The epidemic is also reversing progress in poverty reduction. AIDS tends to affect the poor more heavily than other population groups. A study in Burkina Faso, Rwanda, and Uganda reported by the United Nations Development Program has calculated that AIDS will increase the percentage of people living in extreme poverty from 45 percent in 2000 to 51 percent in 2015. Swaziland's Human Development Index has fallen considerably, with 69 percent of the population living below the poverty line. 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 International Labor Organization estimates that the agricultural workforce loss could be as high as 20 percent by 2020; therefore, businesses have a stake in responding to the epidemic, which affects their workforces and can reduce markets for their goods. A study funded by the U.S. Agency for International Development (USAID) to assess the impact of AIDS on the education sector in Swaziland found that with the AIDS epidemic, 13,000 teachers would need to be trained during the projection period of 2003–2011, compared with 5,093 without an epidemic.

The U.S. Government (USG) is working with the private sector in HIV prevention efforts as shown through the following examples from Zambia and Kenya. In Zambia, the USG is collaborating with the tourism industry to host a series of music events that call for social and behavioral change to reduce sexual transmission of HIV. In Kenya, the USG has partnered with the Kenya Medical Research Institute and four sugar companies to expand HIV treatment and care for approximately 60,000 people, including 16,000 workers, their families, and other community residents.

HIV/AIDS poses increasingly heavy demands on Africa's health systems. In Swaziland, rising morbidity is increasing patient loads at all levels. As demand for services increase, 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 workforce. Most health systems in Africa already face labor shortages 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. A study conducted by the Joint Economic Aids and Poverty Program in South Africa found that it cost the country's citizens seven times more to bury a person than to care for a sick relative. Research studies show that the heaviest impact of HIV/AIDS tends to fall on widows and their family members.

According to UNAIDS and UNICEF, 80 percent of all the world's children orphaned by HIV/AIDS are in sub-Saharan Africa, more than half of whom are between the ages of 10 and 15. More than 11.4 million children under the age of 18 in sub-Saharan Africa have lost at least one parent to HIV/AIDS. The orphan crisis is expected to worsen considerably in the coming years. Many of these children are raised by their grandparents or live in households headed by other children. 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. A recent *Literature Review on the Impact of Education Levels on HIV/AIDS Prevalence Rates* by the World Food Program found that rising HIV rates were correlated with lower levels of education. A Zambian study from the same source found that AIDS spread twice as fast among uneducated girls.

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 people living with HIV. People living with HIV are denied the right to health care, work, education, and freedom of movement. Therefore, there is a need for a multisectoral response to change social and cultural beliefs and behaviors and modify policies by governments and employers.

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. To date, the U.S. has committed $18.8 billion to the fight against the global HIV/AIDS pandemic, exceeding its original commitment of $15 billion over five years.

Reauthorized on July 30, 2008, the U.S. is continuing its commitment to global AIDS in the amount of $39 billion for HIV/AIDS bilateral programs and contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Working in partnership with host nations, the initiative will support antiretroviral treatment for at least 3 million people, prevention of 12 million new HIV infections, and care and support for 12 million people, including 5 million orphans and vulnerable children.

The Emergency Plan encompasses all USG international HIV/AIDS activities, including those implemented by 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 (NGOs), 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 (PLWHA). In fiscal year 2008, USAID continued efforts to prevent the spread of HIV/AIDS using several interventions:

- The ABC (Abstinence, Be faithful, correct and consistent use of Condoms) approach to preventing sexual transmission of HIV
- Research and interventions on the prevention of AIDS through male circumcision
- Prevention of further HIV transmission with PLWHA
- Prevention of mother-to-child HIV transmission (PMTCT)
- Voluntary counseling and testing (VCT)
- 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
- Provision of ART for PLWHA
- Support for OVC

USAID is uniquely positioned to support multisectoral responses to HIV/AIDS that address the widespread impact of the disease 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 USG programs. Finally, USAID supports targeted research on vaccines, the development and dissemination of new technologies, new packaging and distribution mechanisms for antiretroviral (ARV) drugs, training for improved local responses to the epidemic from NGOs and faith-based organizations, and infrastructure development for appropriate clinical design and laboratory facilities.

USAID Country Support in Africa

In sub-Saharan Africa, USAID support of the Emergency Plan places special emphasis on 12 focus countries: **Botswana, Côte 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, including Angola, Benin, the Democratic Republic of the Congo (DR Congo), Eritrea, Ghana, Guinea, Lesotho, Liberia, Madagascar, Malawi, Mali, Senegal, Sudan, Swaziland, and Zimbabwe.

Examples of USAID assistance include the following activities and interventions:

- In Ethiopia, 516,800 people received counseling and testing to detect HIV and prevent further spread of the infection.
- In Kenya, 239,600 OVC received direct care and support services.
- In South Africa, the cumulative number of HIV-positive pregnant women receiving ARV prophylaxis increased from 76,000 by the end of 2004 to 251,400 by the end of 2006, averting an estimated 47,700 infant infections.
- USAID assisted Namibia with the development of the national policy on OVC, which the Ministry of Women Affairs and Child Welfare completed and endorsed. In 2006, 88,700 children were served by an OVC program.
- In Lesotho, USAID supported an assessment of the national PMTCT program, resulting in a follow-on request for increased support to the national program. In response, USAID funded and organized a partnership to coordinate PMTCT activities with government counterparts. By the end of 2008, the partnership will provide PMTCT services in seven of 10 districts nationwide, including seven hospitals, three filter clinics, and 47 health centers.
- In Ghana, USAID supported nutrient-dense take-home food rations for 14,000 PLWHA, OVC, and their family members, and psychosocial counseling for 686 people.
- Expanded VCT services in Mali (from four centers to 169 through use of mobile services) increased the number of individuals tested for HIV by 48 percent. Mobile services improve the accessibility to HIV testing, particularly for high-risk groups.
- The Red Card Initiative in Madagascar empowered adolescent girls to say "no" to risky sexual situations. The Initiative reached 900,000 girls ages 10 to 14. More than 78,300 at-risk youth received quality counseling and reproductive health services (a 122 percent increase from the previous year) through a franchised network of private sector service providers in seven high-risk cities. One positive impact of the program was an increase in youth ages 15 to 18 who had never had sexual intercourse from 65.6 percent in 2003 to 82 percent in 2006.
- USAID supported the Swaziland National AIDS Program in HIV testing and counseling. The Agency has been at the forefront of policy, technical guidance, service delivery, and training for national HIV testing and counseling scale-up. The USG has provided substantial assistance to the rollout of Swaziland's provider-initiated counseling and testing plan while maintaining an important focus on outreach and client-initiated counseling and testing.
- USAID supported Benin in the adoption of a national law that prohibits stigma and discrimination against PLWHA.
- In the DR Congo, USAID-supported community outreach to prevent HIV reached more than 148,000 individuals. USAID also supported the promotion of condom social marketing, with 8.1 million condoms distributed in 2007 in Bukavu, Lubumbashi, and Matadi, and palliative care for more than 3,200 PLWHA.

Important Links

USAID HIV/AIDS Web site 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 Web site: *http://www.usaid.gov/our_work/global_health/aids*

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