



# HIV/AIDS HEALTH PROFILE

## Sub-Saharan Africa



### Overall HIV Trends

Sub-Saharan Africa continues to bear an inordinate share of the global HIV burden: 23 million people living with HIV/AIDS (PLWHA) make their homes in the region. Though the number of new infections on the continent seems to have peaked in the mid-1990s, the epidemic continues to be a major challenge to the health and development of many African nations. The epidemics vary considerably from country to country across the continent, with prevalence estimates ranging from 0.1 percent in **Madagascar** to more than 15 percent in some of the

countries in the southern cone. Deaths from HIV/AIDS continue to decline as antiretroviral therapy (ART) coverage and prevention of mother-to-child transmission of HIV (PMTCT) coverage increase.

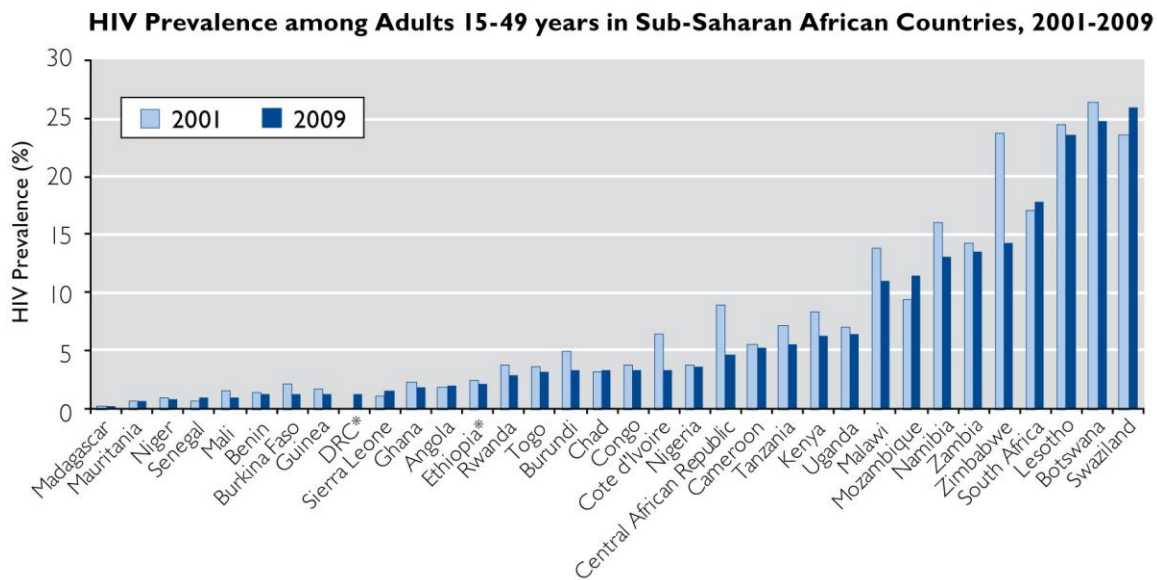
The impact of HIV/AIDS varies considerably in the countries of the region, depending on the size and duration of the outbreak. Most countries have generalized epidemics. Adult prevalence exceeds 20 percent in some countries, including **Botswana** (24.8 percent), **Lesotho** (23.6 percent), and **Swaziland** (25.9 percent), according to the Joint United Nations Program on HIV/AIDS (UNAIDS). Others have concentrated epidemics with disease hotspots, such as **Burundi**, where the prevalence of 38 percent among sex workers is 16 times higher than that of the general adult population. In West Africa, 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 epidemiology of the disease in individual countries and subregions.

Sub-Saharan Africa has a heterogeneous epidemic with differing patterns in the three regions. In Southern Africa, prevalence has stabilized at high levels in most countries, while prevalence in East Africa has declined since 2000 and stabilized at lower levels than in Southern Africa. In West Africa, prevalence rates are markedly lower than on the rest of the subcontinent, at under 2 percent across the region, except in **Cameroon** (5.3 percent), **Côte d'Ivoire** (3.4 percent), **Gabon** (5.2 percent), and **Nigeria** (3.6 percent). Within countries, the impact of HIV/AIDS also varies a great deal, with urban centers often being the most affected. Across all three regions, heterosexual sex is the primary form of transmission, though in countries with more concentrated epidemics, other forms of transmission can play a significant role, including sex work, migration, men having sex with men, and mother-to-child transmission.

**Southern Africa.** With 11.3 million PLWHA in 2009, Southern Africa continues to be the most severely affected region in the world, accounting for nearly one-half of all PLWHA on the subcontinent. UNAIDS estimates 40 percent of all HIV-positive women in the world live in the subregion. Globally, more than one in five PLWHA live in **Botswana**, **South Africa**, and **Zimbabwe**; 5.6 million PLWHA live in **South Africa** alone. **Swaziland** has the highest prevalence of any country in the world: Approximately one in every four citizens is HIV positive. Prevalence rates in most countries in the region have stabilized, though **Zimbabwe** experienced a recent surge in new infections – possibly related to its ongoing civil and political unrest. Further decreasing the number of new HIV infections in Southern Africa is a continuing challenge. Compared to other countries in the subregion, **Angola** has a remarkably low HIV prevalence (2 percent), in part due to the limited cross-country travel during its protracted civil war (1975–2002), which impeded the spread of the virus.

In this region, the epidemic affects individuals at all levels of society, education, income, and migration strata. Scale-up of prevention programs is necessary to generate continued declines in HIV prevalence and incidence.

Unfortunately, current programs often fail to address key drivers of national epidemics such as the paucity of prevention initiatives among people in stable relationships and adults over 25 years of age.



All data from UNAIDS 2010 Report on the Global HIV Epidemic  
 \*DRC and Ethiopia from UNAIDS 2008 Epidemic Update, data for 2001 and 2007.

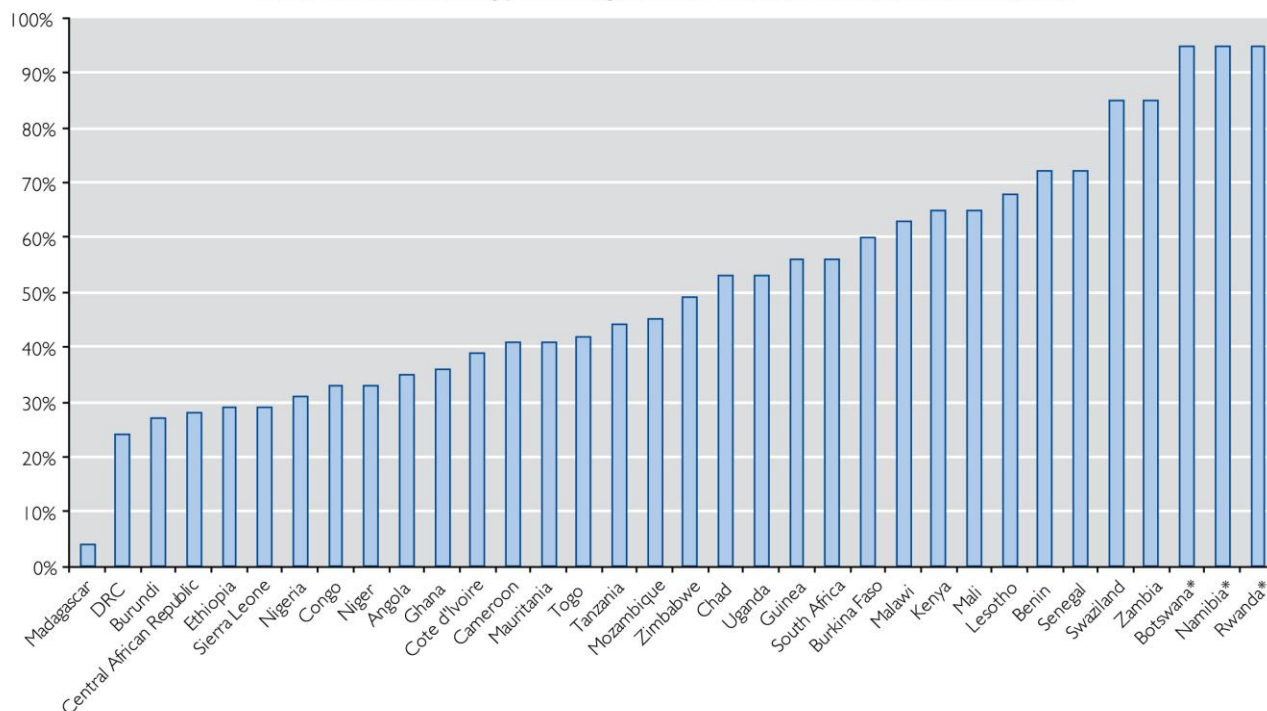
**East Africa.** In the countries of East Africa, HIV prevalence has either decreased or remained stable over the past several years. In this region, the intensity of national epidemics varies from country to country, and heterosexual sex is the primary form of transmission. Multiple and concurrent partnerships are a particular challenge, as they place normally low-risk individuals – those who are married or in committed relationships – at an elevated risk. Prevalence in **Kenya**, **Tanzania**, and **Uganda** exceeds five percent (6.3 percent, 6.2 percent, and 5.4 percent, respectively). Hotspots within countries are common, and prevalence varies as much as 15-fold across different provinces in **Kenya** and regions in **Tanzania**. **Rwanda** has had particular success reducing adult prevalence, now at 2.8 percent, though prevalence remains high among young, pregnant women (15 to 19 years of age) at 5.1 percent. Due to ongoing conflict in the **Democratic Republic of the Congo (DRC)** and a military coup in **Madagascar**, the future of the HIV/AIDS epidemic in those two nations is uncertain. **Madagascar** has been one of the lowest prevalence countries in East Africa, with an adult prevalence of 0.1 percent, while the **DRC** has been in an ongoing state of civil war for nearly two decades, limiting collection of HIV-related data and propagating the spread of the epidemic through widespread rape and violence.

**West Africa.** UNAIDS data indicate the countries of West Africa have the lowest HIV prevalence in sub-Saharan Africa. Adult prevalence exceeds 2 percent only in **Cameroon** (5.3 percent), **Côte d'Ivoire** (3.4 percent), **Gabon** (5.2 percent), and **Nigeria** (3.6 percent). UNAIDS has reported promising declines in HIV prevalence among pregnant women in **Mali**, **Niger**, **Burkina Faso**, **Côte d'Ivoire**, and **Togo**. In many countries, the epidemic appears to have stabilized, though concentrated epidemics persist in MARPs such as female sex workers and men who have sex with men (MSM). In **Senegal**, for example, national prevalence is less than 1 percent, yet it is as high as 30 percent among commercial sex workers in the urban center of Ziguinchor. Some countries have also seen declines in prevalence among young adults; in **Ghana**, prevalence among young adults (15 to 24 years of age) has significantly decreased from 3.2 percent in 2002 to 1.3 percent in 2009. Provision of antiretroviral drugs (ARVs) for the prevention of PMTCT services has improved but remains much lower in West and Central Africa (23 percent coverage) compared to East and Southern Africa (68 percent coverage). Due in part 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). As in other countries, concentrated epidemics in MARPs have been reported.

Gender inequalities, abuse, and physiological susceptibility to HIV make women more vulnerable to contracting the virus than men; additional social, legal, and economic disadvantages also increase risk. Prevalence among women is two to four times greater than among men of similar age cohorts throughout the region. 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. In **Uganda**, one in five young women (15 to 19 years of age) reported her first

sexual encounter was forced or coerced. Sexual violence further compounds the risk of infection for women, and it has been officially documented as a major factor in the epidemic in **Lesotho**. In the **DRC**, prevalence as high as 25.6 percent has been found among women who suffered sexual violence in areas of armed conflict, whereas prevalence for women overall is 1.8 percent.

**Antiretroviral Therapy Coverage in Sub-Saharan African Countries, 2009**



All data for coverage end 2009, according to the WHO 2006 standards for initiating ART (CD4 < 200 cells/mm<sup>3</sup>), from WHO/UNAIDS/UNICEF Towards Universal Access 2010, except DRC and Ethiopia for end 2007 from WHO/UNAIDS/UNICEF Towards Universal Access 2008.  
 \*Coverage estimated at greater than 95 percent.

Comprehensive knowledge of HIV/AIDS remains low in sub-Saharan Africa and is an obstacle to reducing incidence rates. For example, approximately 2 million PLWHA in **South Africa** do not know they are infected, believe they are not in danger of becoming infected, and are unaware they can transmit the virus to others. A review of Demographic and Health Surveys (DHS) from countries across West Africa from 2003–2008 estimated less than 50 percent of the population between the ages of 15 and 49 had adequate correct knowledge about HIV/AIDS (identified two major ways of preventing the sexual transmission of HIV, rejected the two most common local misconceptions about HIV transmission, and knew a healthy looking person could have HIV).

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. In Southern Africa, where HIV prevalence is highest, more than 50 percent of adults with TB are also HIV positive; this is also the case in **Uganda**. Though HIV testing for TB patients is increasing quickly throughout the 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. Approval by the World Health Organization (WHO) of new diagnostic and drug susceptibility test methods will change detection and treatment in the coming years. Combined with the use of effective infection control practices in HIV/AIDS care clinics, much can be done to improve case finding and prevent the spread of TB and HIV-TB co-infections.

Sustained progress in the response to AIDS will only be attained by intensifying HIV prevention and treatment simultaneously. As of 2010, WHO has revised its 2006 recommendations for when to initiate ART, advocating treatment for PLWHA whose CD4 count is equal to or below 350 cells/mm<sup>3</sup>, rather than under 200 cells/mm<sup>3</sup>. While this immediately increases the number of people in need of treatment, WHO anticipates it will reduce HIV-related morbidity, mortality, and hospitalization in the long term.

ART coverage has scaled up significantly over the past decade. From 2008 to 2009, sub-Saharan Africa had the greatest increase in the number of people receiving ART of any region. According to WHO, ART coverage rose from 2.95 million in December 2008 to 3.91 million one year later – an increase of approximately 33 percent. Despite this increase, WHO/UNAIDS/UNICEF's 2010 *Towards Universal Access* report indicates only 37 percent of PLWHA in sub-Saharan Africa who are eligible for treatment under the 2010 guidelines currently receive treatment. However, ART coverage varies greatly from country to country; current levels of ART coverage are displayed in Figure 2.

## Economic and Social Impact of HIV/AIDS in Africa

HIV/AIDS creates a twofold challenge, particularly for the countries throughout Africa that are most affected by the epidemic. First, HIV/AIDS is an immediate crisis requiring responsive health systems and programs to address the health of PLWHA. Over the coming years and decades, the virus will create a systemic condition exacerbating existing struggles with poverty, development, and economic opportunity that must be addressed, according to the Economic Commission for Africa's *Africa: the Socio-Economic Impact of HIV/AIDS* report. Over time, HIV/AIDS depletes savings, reduces labor supplies, increases household vulnerability to shocks, reduces productivity in the public and private sectors, and negatively affects public finances and economic growth (World Bank's *Commitment to HIV/AIDS in Africa* report, 2008).

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 are between the ages of 15 and 49, and millions of adults are dying young or in early middle age. AIDS-related mortality has increased among 20 to 49 year olds; thus, many adults are affected in their most economically productive years. According to the United Nations' 2010 *The World's Women* report, 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/AIDS epidemic. More recent data (2005–2010) have shown a slight increase (52 for women, 51 for men) as a result of efforts to prevent new infections and provide life-prolonging ART. In East and West Africa, where countries experienced less severe yet still alarming epidemics, earlier patterns of strong increases in life expectancy diminished over the past two decades to steady but marginal increases.

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 household; notably, in countries with larger epidemics, those in the highest wealth quintiles are often as or more likely to have HIV than those in the lowest. 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, in particular, 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 cause of the country's falling agricultural output. The United Nations Food and Agriculture Organization (FAO) estimates AIDS has killed around 7 million agricultural workers since 1985 in the 25 hardest-hit countries in sub-Saharan Africa. It further estimates an additional 16 million could die due to complications from HIV infection by 2020. This is of particular concern for many nations in Africa, 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 the agricultural workforce loss could be as high as 20 percent by 2020; the FAO estimates 25 percent of the agricultural labor force in sub-Saharan Africa could be lost by 2020. Therefore, businesses have a stake in responding to the epidemic, which affects their workforces and can reduce markets for their goods.

Other sectors, particularly health and education, are affected by loss of skilled labor to HIV/AIDS. According to The World Bank, before the introduction of ART programs, **Zambia** lost approximately half as many teachers as it trained each year due to HIV/AIDS. This depletion of trained human capital in the education sector made it difficult to train and educate future generations. 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 of 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.

Many families are devastated by HIV/AIDS, as they lose their primary income earners and the incomes of other 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, and research studies show the heaviest impact of HIV/AIDS tends to fall on widows and their family members.

Sub-Saharan Africa is experiencing an unparalleled orphan crisis as a result of the HIV/AIDS epidemic, home to approximately 90 percent of children orphaned by HIV/AIDS globally, according to UNAIDS. More than 10 percent of all children (0 to 17 years of age) have lost one or both parents to HIV in **Zimbabwe** (16 percent), **Lesotho** (13 percent), **Botswana** (12 percent), and **Swaziland** (12 percent). Many of these children are raised by their grandparents or live in households headed by other children. As more parents die, the effects of HIV/AIDS on the region's children cannot be overstated. Many children orphaned by HIV/AIDS lose their childhoods 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, and [their] lower school attendance reduces the potential to develop human capital in future generations. Though school attendance among children orphaned by HIV/AIDS has been increasing in recent years due to scale up in basic health and social service programs for orphans, they are still less able than other children to attend school regularly.

Finally, HIV-related stigma and discrimination in sub-Saharan Africa create major barriers to preventing infections, 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 compounded for individuals who identify with otherwise stigmatized groups or behaviors, including sex workers and MSM. Accepting attitudes toward PLWHA are rare in some countries; in **Zambia**, for example, the 2007 DHS found less than one-third of men and women had accepting attitudes<sup>1</sup> toward PLWHA. In **Ghana**, less than one-fifth of the population demonstrates accepting attitudes. PLWHA 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 Response

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. Strong commitment to achieving universal access to prevention and treatment is constant throughout the region.

**Southern Africa.** Countries throughout Southern Africa either have comprehensive national plans or sets of policies and laws guiding the response to the HIV/AIDS 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, due to the scale of the epidemic in multiple countries in the subregion. 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/AIDS activities, which increased the domestic spending on HIV/AIDS sixfold from 2001 to 2005.

**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. In **DRC**, **Madagascar**, and **Sudan**, ongoing civil and political unrest have created particular challenges to the sustainability of HIV/AIDS responses; however, all three countries have plans or frameworks for responding to their respective epidemics.

**West Africa.** Across this subregion, countries coordinate efforts to combat HIV/AIDS through the Economic Community of West African States and its affiliate, the West Africa Health Organization (WAHO). In addition, most countries have their own national-level multisectoral AIDS councils to steer country HIV/AIDS programs. National strategic plans are complemented by WAHO's fiscal year (FY) 2009–2013 Strategic Plan for the area, which

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

focuses on strengthening health systems, improving delivery of health services, and development of a sustainable financing plan for provision of HIV/AIDS and other health services throughout the region.

Success of clinical trials evaluating the use of male circumcision (MC) to reduce HIV transmission has prompted multiple countries to enact policies to scale up and encourage MC as a prevention strategy. Though scale-up of MC, as a surgical procedure, requires considerable funding and investment in capacity building, there could be long-term cost savings. **Botswana, Namibia, Swaziland, and Zimbabwe** have scaled up MC services nationwide and included MC as a specific target in national prevention and HIV/AIDS control plans. In **Kenya**, the MC Policy and Strategic Plan specifically targets communities in districts where MC is not traditionally practiced and incidence of HIV infection is high.

Governments have also formed many public-private partnerships as part of their HIV/AIDS responses. In **Botswana**, a public-private partnership with the Bill & Melinda Gates Foundation and Merck supported increased ART supply through a \$106.7 million financial commitment and donation of ARVs through 2010. The number of workplace programs at private companies that provide HIV prevention information, voluntary counseling and testing (VCT), referrals to health facilities, and other services has also increased significantly as employers recognize how the loss of productive laborers to HIV/AIDS could impact their businesses. In **Madagascar**, for example, free condom distribution, peer education, and promotion of VCT are available for employees of the leading electricity distributor and a major agricultural enterprise. The company that owns the world's largest bauxite mine will fund and maintain two HIV counseling and testing centers, providing free HIV testing to mine workers and their families in **Guinea**.

The Global Fund to Fight AIDS, Tuberculosis and Malaria also plays a key role in the response to the HIV/AIDS epidemic. In East Africa alone, the Global Fund has disbursed more than \$1.7 billion in grants for HIV/AIDS programming; in addition, approximately \$1.3 billion in Southern Africa and \$858 million in West and Central Africa bring total disbursements for HIV/AIDS close to \$4 billion from the Global Fund's inception in 2003 through January 2011. The range of programs supported by the Global Fund includes prevention with MARPs, treatment, and care for orphans and vulnerable children. Recently, the U.S. Agency for International Development (USAID)/West Africa was awarded a Senior Global Fund Liaison position to provide critical leadership and technical assistance to Global Fund recipients, who will play an important role in the region by supporting countries accessing funding and implementing grants in accordance with Global Fund policies.

The Global Fund has played a key role providing ART throughout sub-Saharan Africa, and programs supported by the Global Fund currently provide 1.9 million PLWHA in the region with ART, according to the 2010 Global Fund *Innovation and Impact* report. In 2009 alone, 325.6 million condoms were distributed throughout Africa under Global Fund grants. The U.S. Government (USG) provides nearly 30 percent of the Global Fund's total contributions worldwide.

## USAID Regional Support

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 USG initiative to support partner nations around the world in responding to HIV/AIDS. Through PEPFAR, the USG has committed approximately \$32 billion to bilateral HIV/AIDS programs and the Global Fund through FY 2010. PEPFAR is the cornerstone of the President'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.

USAID implements programs through the East, West, and Southern Africa Regional Health Offices. The USG has signed Partnership Frameworks with a number of countries throughout the subcontinent, including **Angola, Botswana, DRC, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, Tanzania, and Zambia**. Each of these Partnership Frameworks is designed to provide a five-year joint strategic framework for cooperation among the USG, the partner government, and other partners to combat HIV/AIDS in the host country through service delivery, policy reform, and coordinated financial commitments. The emphasis on health systems strengthening and program integration in current HIV/AIDS programming promotes a more sustainable, country-led response to the epidemic. For example, in **Mozambique**, HIV/AIDS services have been incorporated into malaria, maternal and child health, family planning, reproductive health, and TB programs in policy and through service delivery.

The USG is also working with the private sector in HIV prevention efforts throughout Africa. These efforts include collaborations through initiatives in **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/AIDS treatment and care for approximately 60,000 people, including 16,000 workers, their families, and other community residents.

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

#### *Southern Africa*

- In **Malawi**, USAID programs provided counseling and testing for nearly 400,500 individuals in 2009, including approximately 103,600 pregnant women; the country's PMTCT program has been scaled up to reach 90 percent of pregnant women nationwide and provided 9,000 HIV-positive pregnant women with ARV prophylaxis in 2009.
- Home-based care programs in **Namibia** adopted orphans and vulnerable children tools and processes to establish standards of care and improve programming, and 518,000 individuals were reached with community outreach HIV/AIDS prevention activities that promoted correct and consistent use of condoms and related interventions.
- USAID provided support to the **Swaziland** Action Group Against Abuse's program to reduce gender-based violence related to HIV, which reached approximately 6,000 in 67 communities and promoted men's involvement in the prevention of both HIV transmission and gender-based violence.

#### *East Africa*

- In the **DRC**, USAID provided HIV-related technical assistance to 105 indigenous organizations, building local capacity and engaging with civil society to encourage sustainability in the response to the epidemic.
- PMTCT programs in **Ethiopia** provided 8,300 HIV-positive pregnant women with ARVs for PMTCT.
- Despite the suspension of new funding in **Madagascar**, the Top Reseau network of private, youth-friendly clinics was able to expand from seven to eight cities, with a total of 130 clinics and 170 private providers.
- In **Tanzania**, USAID-supported PMTCT programs provided more than 1 million pregnant women with HIV counseling and testing services and delivered ARV prophylaxis for PMTCT to 39,200 of them.

#### *West Africa*

- In **Mali**, expansion of USAID-sponsored counseling and testing centers from four to 169 increased the number of individuals tested for HIV by 48 percent, leveraging mobile VCT technology that improves access for MARPs.
- Continued scale-up of ART coverage led to significant improvements from 2003 to 2009 in **Côte d'Ivoire** (from 4 to 39 percent) and **Nigeria** (from 2 to 31 percent).
- In order to integrate different health services and improve case finding of TB in **Côte d'Ivoire**, USG partners worked with the Ministry of Health to incorporate a TB screening tool into the national HIV patient encounter form.

## **Important Links**

USAID's HIV/AIDS Web site for Africa:

[http://www.usaid.gov/our\\_work/global\\_health/aids/Countries/africa/hiv\\_summary\\_africa.pdf](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](http://www.usaid.gov/our_work/global_health/aids)

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