

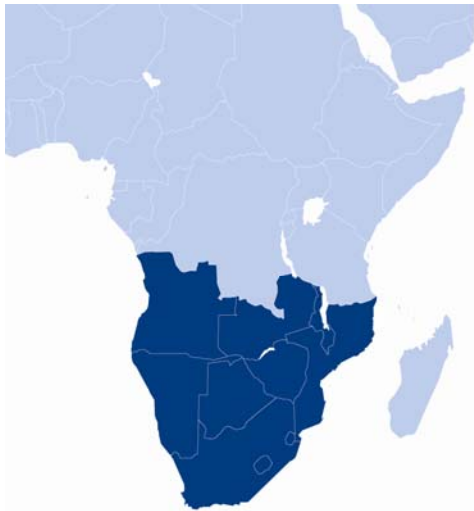


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HIV/AIDS HEALTH PROFILE

Southern Africa



Overall HIV Trends

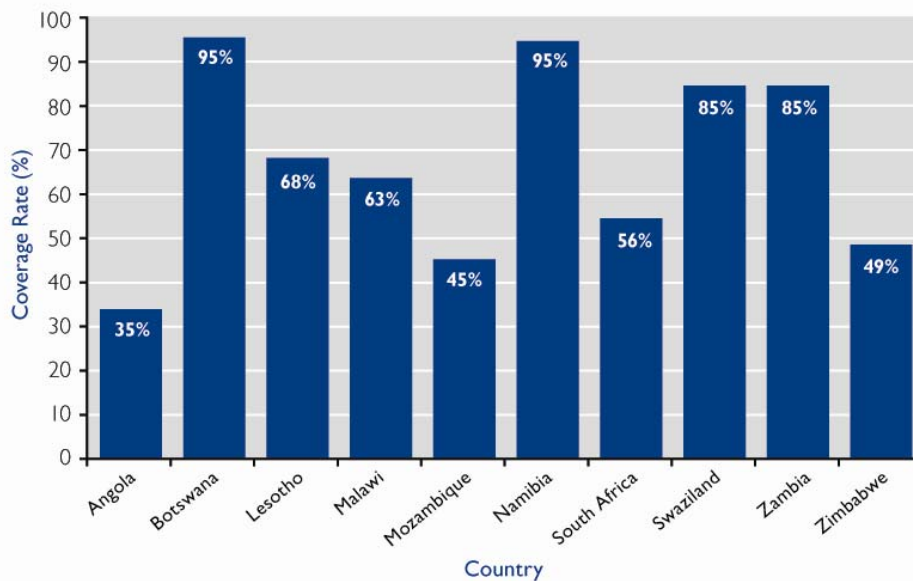
The countries of Southern Africa have some of the highest HIV prevalence rates in the world, and the region remains the global epicenter of the epidemic. The World Bank has stated that the “hyper” epidemic in the countries within the region is a continental – and global – exception, unlikely to occur elsewhere. According to the Joint United Nations Program on HIV/AIDS (UNAIDS), nine countries in Southern Africa continue to bear a disproportionate share of the global AIDS burden: All except **Angola** have an HIV prevalence greater than 10 percent and have some of the highest HIV prevalence rates in the world. The region is home to 11.3 million people living with HIV/AIDS (PLWHA), an increase of nearly one-third (31 percent) compared to the 8.6 million PLWHA in the region one decade earlier. Approximately 5.6 million of PLWHA currently living in Southern Africa reside in the country of South Africa. In 2009, the region accounted for 34 percent of all PLWHA worldwide and 34 percent of AIDS deaths. Prevalence rates in the region have stabilized in most countries in the region, although a recent surge in new infections has happened in **Zimbabwe**, linked to ongoing civil and political instability. Heterosexual sex continues to be the dominant mode of transmission.

In these countries with exceptionally high prevalence of HIV, the epidemic affects all levels of society. In **Lesotho**, prevalence of more than 15 percent has been found across all education, income, and migration strata. Despite promising declines in prevalence in many Southern African countries, curbing the epidemic will require continued scale-up of prevention programs, matching program components to countries’ needs. In **Swaziland**, the country with the highest HIV prevalence in the world, only 17 percent of total expenditures in 2008 supported prevention programs. Prevention strategies often fail to address key drivers of national epidemics, including people in stable relationships and adults over 25 years of age. A promising change across Southern Africa is the trend toward safer sexual behavior among young men and women (15 to 24 years of age), according to UNAIDS data from 2000 to 2007, and similar trends in the adult populations of select countries. In **South Africa**, for example, the proportion of adults (15 to 49 years old) reporting condom use during their most recent sexual encounter more than doubled, from 31.3 percent in 2002 to 64.8 percent in 2008; data from 2010 also indicate a declining prevalence among youth 15 to 24 years of age.

Women continue to be affected disproportionately by HIV in most Southern African countries, and 40 percent of all adult women with HIV in the world reside in this region. Their vulnerability to HIV stems both from greater physiological susceptibility through heterosexual transmission and from the severe social, legal, and economic disadvantages facing them. While selection bias may affect data on HIV prevalence by gender, as pregnant women are routinely tested for HIV as part of PMTCT programs, there remains a marked gap in many countries between prevalence among men and women.

According to UNAIDS, less than 10 percent of 18- and 19-year-old women are HIV positive in **Lesotho**, but by the time they turn 22, 30 percent will be infected. There is evidence that significant investment in girls’ education would substantially reduce HIV risk and vulnerability for women and girls, according to UNAIDS, but educational opportunities for young women are often compromised when a girl’s parent or parents are HIV positive. Prevalence among young women is often much greater than among young men. In **Malawi**, prevalence among young women 15 to 24 years of age (6.8 percent) is more than double the prevalence among young men (3.1 percent). In **Namibia**, the data tell a similar story, with 68 percent of new infections among young people occurring in young women, although antenatal care surveillance sites have reported a decline in prevalence among young women, from 15.2

HIV-Infected People Receiving Treatment in Southern Africa, 2009



Source: WHO/UNAIDS/UNICEF *Towards Universal Access 2010* based on WHO 2006 guidelines (CD4 < 200)

percent in 2004 to 10.6 percent in 2008. A 2009 review of data from **Lesotho** found sexual and physical violence against women to be a major factor in the country's epidemic.

There has been a massive scale-up effort in many Southern African countries to improve coverage of antiretroviral drugs (ARVs) for prevention of mother-to-child transmission (PMTCT). **Botswana, Namibia, South Africa, and Swaziland** have all achieved more than 80 percent coverage of antiretroviral prophylaxis for PMTCT. In **Mozambique**, 70 percent of HIV-positive pregnant women received ARVs for PMTCT in 2009, compared with 4.5 percent in 2005. As of 2009, UNAIDS has reported decreases in the number of new infections attributed to mother-to-child transmission, due to the scale-up of PMTCT. In 2009, there were 130,000 children (0 to 14 years old) newly infected with HIV in Southern Africa, compared with 190,000 in 2004 – a 32 percent decrease. AIDS-related deaths among children also declined in the same period, from 120,000 in 2004 to 90,000 in 2009.

In the major urban centers of Southern Africa, various studies over the past eight years have recorded HIV infection among female sex workers (FSWs) at levels as high as 65.4 percent in **Zambia** and 70.7 percent in some parts of **Malawi**. These data underscore the need for HIV prevention efforts to be scaled up among sex workers, even in countries with generalized epidemics. Sex workers are members of a priority population who can also act as a bridge to the general population.

Men who have sex with men (MSM) are an additional most-at-risk population (MARP), with HIV prevalence (based on limited data) varying markedly throughout Southern African countries. In Johannesburg and Durban, **South Africa**, a study found an overall prevalence of 38.3 percent among MSM. A recent cross-sectional survey indicated prevalence rates of 21.4 percent, 12.4 percent, and 19.7 percent in MSM populations in **Malawi, Namibia, and Botswana**, respectively. More than 42 percent of MSM in these three countries reported experiencing at least one human rights abuse, such as blackmail or denial of housing or health care.

Scaling up antiretroviral therapy (ART) coverage has been a major priority throughout Southern Africa in recent years, and many countries have successfully reached the universal access targets (at least 80 percent of PLWHA who are eligible for treatment receiving ART). According to the 2010 World Health Organization (WHO)/UNAIDS/UNICEF *Towards Universal Access* report, **Botswana, Namibia, Swaziland, and Zambia** have ART coverage rates exceeding the 80 percent threshold, as indicated in the figure above. Increases in the number of PLWHA who are receiving treatment are having profound effects on HIV-related mortality in many countries. In Southern Africa, deaths from AIDS-related causes have declined 18 percent from 2004 to 2009, according to UNAIDS.

Notably, in 2009, WHO issued revised guidelines and recommendations on when adults and adolescents, including pregnant women, should initiate ART. WHO now recommends ART be initiated when the CD4 – a form of white blood cell – count reaches or drops below 350 cells per cubic millimeter, rather than at or below 200 cells. While this change immediately increases the number of PLWHA eligible for and in need of treatment, WHO anticipates it

will reduce HIV-related morbidity, mortality, and hospitalization in the long term. Increases in the number of PLWHA who are receiving treatment are having profound effects on HIV-related mortality in many countries, prolonging life and reducing the number of fatalities annually resulting from HIV/AIDS.

Southern Africa has the highest rates of HIV prevalence in adult-incident tuberculosis (TB) cases in the world. According to the WHO 2010 *Global Tuberculosis Control* report, in **Angola**, 15 percent of adult TB cases are also HIV positive; **Botswana**, 66 percent; **Lesotho**, 77 percent; **Malawi**, 64 percent; **Mozambique**, 66 percent; **Namibia**, 58 percent; **South Africa**, 58 percent; **Swaziland**, 84 percent; **Zambia**, 67 percent; and **Zimbabwe**, 78 percent. HIV-TB co-infection poses a challenge to providing treatment and care for both diseases and is of increasing concern in Southern Africa. In 2008, TB incidence rates per 100,000 population in the region were **Angola**, 298; **Botswana**, 694; **Lesotho**, 634; **Malawi**, 304; **Mozambique**, 409; **Namibia**, 727; **South Africa**, 971; **Swaziland**, 1,257; **Zambia**, 433; and **Zimbabwe**, 742.

Epidemics across Southern African countries have many similarities, but they also have unique attributes and challenges. With an estimated 2 percent of the adult population living with HIV, **Angola** has the lowest HIV prevalence rate in continental Southern Africa. During the 1975–2002 civil war, cross-country travel was near impossible, impeding the spread of the virus. However, the country is at risk of a greater epidemic, with nearly 63 percent of the country's population under age 25 and evidence of widespread high-risk sexual behaviors. The possibility of cross-border infection from the Democratic Republic of the Congo and Namibia, which have much higher prevalence rates, also puts the country at risk. Knowledge of HIV is also low, with only 23 percent of youth surveyed in 2005–2006 aware of at least two means of preventing the spread of HIV.

Adult HIV prevalence in **Botswana** is estimated at 24.8 percent, higher than nearly any other country in the world, although prevalence has been decreasing since 2001. Prevalence among 20- to 24-year-old ANC attendees fell from 38.7

HIV Estimates in Southern Africa Region		
Angola		
Total Population		18.5 million
Estimated Number of Adults and Children Living with HIV/AIDS		200,000
Adult HIV Prevalence		2.0%
Sex Workers (Luanda, 2007)		23.1%
Botswana		
Total Population		2 million
Estimated Number of Adults and Children Living with HIV/AIDS		320,000
Adult HIV Prevalence		24.8%
HIV Prevalence in MSM (National, 2009)		19.7%
Lesotho		
Total Population		1.9 million
Estimated Number of Adults and Children Living with HIV/AIDS		290,000
Adult HIV Prevalence		23.6%
Returning Mine Workers		40%
Textile Workers		43%
Malawi		
Total Population		15.4 million
Estimated Number of Adults and Children Living with HIV/AIDS		920,000
Adult HIV Prevalence		11.0%
HIV Prevalence in FSWs (2006)		70.7%
HIV Prevalence in MSM (National, 2009)		21.4%
Mozambique		
Total Population		22.1 million
Estimated Number of Adults and Children Living with HIV/AIDS		1.4 million
Adult HIV Prevalence		11.5%
HIV Prevalence in Urban Sex Workers (2009)		28%
Namibia		
Total Population		2.1 million
Estimated Number of Adults and Children Living with HIV/AIDS		180,000
Adult HIV Prevalence		13.1%
HIV Prevalence in MSM (National, 2007)		12.4%
South Africa		
Total Population		49.1 million
Estimated Number of Adults and Children Living with HIV/AIDS		5.6 million
Adult HIV Prevalence		17.8%
HIV Prevalence in MSM (National, 2008)		10%
Swaziland		
Total Population		1.4 million
Estimated Number of Adults and Children Living with HIV/AIDS		180,000
Adult HIV Prevalence		25.9%
Zambia		
Total Population		13.5 million
Estimated Number of Adults and Children Living with HIV/AIDS		980,000
Adult HIV Prevalence		13.5%
HIV Prevalence in Urban FSWs (2004)		65.4%
Zimbabwe		
Total Population		11.7 million
Estimated Number of Adults and Children Living with HIV/AIDS		1.2 million
Adult HIV Prevalence		14.3%

*Sources: U.S. Census Bureau; UNAIDS Epidemic Update, 2010; Country UNGASS reports, 2010

percent in 2001 to 27.9 percent in 2007. As PMTCT services have been brought to scale, the annual number of new HIV infections among children has declined fivefold, from 4,600 in 1999 to 890 in 2007. Multiple concurrent partnerships and intergenerational sex are of particular concern, especially in efforts to reduce transmission to adolescent girls.

The epidemic in **Lesotho** appears to have stabilized, with an estimated adult prevalence of 23.6 percent. HIV infections in normally “low-risk” partnerships are high. In 2008, between 35 and 62 percent of infections among people who had only a single sexual partner and among individuals in stable relationships accounted for up to 62 percent of new infections. Taking additional partners, outside of one’s primary relationship, is a relatively common practice in the country due to labor migration that separates couples for long periods of time. As such, multiple concurrent partnerships and intergenerational sex, are key drivers in the epidemic.

HIV prevalence rates have been declining in **Malawi** since the epidemic peaked in 1998, with an estimated adult prevalence of 26 percent. According to the most recent data, approximately 11 percent of adults were HIV positive at the end of 2009. Prevalence in urban areas has been declining, but the epidemic remains a major concern in the rural areas, where 80 percent of Malawians live. The 2010 United Nations General Assembly Special Session (UNGASS) report indicated 17.1 percent prevalence in urban populations, compared with 10.8 percent in rural populations. Approximately one-half of all new HIV infections occur among youth 15 to 24 years of age; with 44 percent of Malawians under 15 years of age, the disproportionate number of new cases in younger men and women is of particular concern.

HIV prevalence among women attending antenatal clinics appears to have stabilized in **Mozambique**, although there are marked regional differences. In the southern region, prevalence rose from 16 percent in 2002 to 21 percent in 2009, compared with a 2009 prevalence of 9 percent in the northern region. Approximately 11.5 percent of adults were HIV positive in the country in 2009. ART delivery has been decentralized and integrated into the health network system, resulting in an exponential coverage increase for adults and children in a relatively short time. PMTCT was introduced in 2002 and rapidly scaled up, from eight facilities in 2002 to 832 in 2009; 70 percent of HIV-positive pregnant women received ARVs for PMTCT in 2009, according to WHO.

In **Namibia**, the HIV/AIDS epidemic grew rapidly from 1986 to 2002, when antenatal clinic sentinel surveillance showed signs the epidemic was slowing; current adult prevalence is estimated at 13.1 percent, still one of the five highest in the world. It is estimated there are 16 new infections each day. The estimated population of 2.1 million is highly dispersed, creating challenges in accessing services and reaching remote populations. While condom use is growing, HIV testing is low. In the past year, 74.4 percent of men and 65.7 percent of women who have had more than one sexual partner reported use of a condom at last sexual encounter.

HIV prevalence in **South Africa** has stabilized over the last three years, with antenatal clinic surveillance finding an HIV prevalence of approximately 29 percent among ANC attendees 15 to 49 years of age from 2006 to 2009. Women continue to be affected disproportionately, especially among youth. Condom use among youth is the highest of any subgroup in South Africa, which bodes well for future prevention of HIV and continued decreases in the number of new cases among young people. At their last sexual encounter in 2008, 73.1 percent of young women and 87.4 percent of young men used a condom. Condom use has been on the rise in the general population since 2002, supported by the Government’s free condom distribution program.

Swaziland has the world’s most severe HIV/AIDS epidemic, with an estimated prevalence of 25.9 percent in the adult population. From 1992 to 2004, prevalence among pregnant women attending antenatal clinics rose from 3.9 percent to 42.6 percent; UNAIDS data for antenatal clinic attendees indicated prevalence remained at 42 percent in 2008. One in six heterosexual Swazi couples is serodiscordant, and between 50 percent and 65 percent of new infections occur among steady, long-term partners. Major achievements in Swaziland have included a decline in new cases of HIV in young adults under 25 years of age and high levels of awareness and knowledge of HIV among adults. In addition, according to UNAIDS, the country has one of the highest rates of HIV testing (139 per 1,000 population).

According to the 2007 Demographic and Health Survey (DHS), the national adult HIV prevalence rate for **Zambia** stabilized at 13.5 percent in 2007. The epidemic peaked in the mid-1990s, with a prevalence rate of about 16 percent, and has stabilized at around 15 percent for the past 15 years. There are marked differences in prevalence across age, sex, and geographic groups. Young women ages 15 to 24 years are at particularly high risk, with HIV prevalence (8.9 percent) more than double that of young men of the same age (4.3 percent). Urban adult HIV prevalence, at 19.7 percent, is nearly double that of rural areas, at 10.3 percent, according to the 2007 Zambia DHS.

In **Zimbabwe**, HIV prevalence has been on the decline among the general population and specifically among youth (15 to 24 years of age). The country’s PMTCT program has been one of the strongest pillars of the HIV/AIDS

response, and PMTCT coverage increased from 22 percent in 2007 to 56 percent in 2009. There is a continued need for intensified prevention services to accompany “know your status” initiatives. According to the 2005–2006 DHS, only 5.9 percent of men and women were tested and received their results in the 12 months prior to the survey. In rural areas, women who tested HIV negative reported an overall increase in risky sexual behaviors, while women who tested positive reported increased consistent condom use with primary partners.

Economic and Social Impact of HIV/AIDS in Southern Africa

The consequences of high HIV prevalence are felt in virtually every area of life, and the epidemic continues to have an enormous impact on households, communities, businesses, public services, and national economies throughout Southern Africa. However, as HIV infection has expanded and its impact deepened over the past decade, many high-prevalence countries, such as **Zimbabwe** and **South Africa**, have undergone other major social and economic changes that make it difficult to disentangle the epidemic’s direct effects. After years of steadily improving life expectancy, AIDS is wiping out this gain and causing life expectancy to drop to levels not seen in decades. Between 1990 and 2007, the average life expectancy in **Swaziland** fell by half to 37 years. Previous gains in child survival also have been reversed by the AIDS epidemic. In the most heavily affected countries, such as **Botswana** and **Zimbabwe**, HIV is the underlying reason for more than one-third of all deaths among children under age 5. In **Swaziland**, the country with the highest prevalence of HIV, HIV/AIDS is responsible for 47 percent of under-5 mortality.

Although the usual pattern of disease-related mortality is concentrated among the very young and very old, AIDS does cause deaths among adults in their most economically productive years, weakening the segment of the population that could respond best to the crisis. A 2004 World Bank report estimated HIV/AIDS will reduce the gross domestic product in **Lesotho** by almost one-third by 2015. There have been particularly drastic declines in the economic situation in **Zimbabwe** in recent years, which are exacerbated by the challenge of HIV; the current economic recovery plan (2010–2012) specifically looks at ways to revitalize the health sector.

The effects of HIV are felt across all sectors, from agriculture to education. 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. In one **Malawi** study, one-third of teachers were found to be HIV positive. Households affected by HIV/AIDS often abandon their own agricultural enterprises, leading to food insecurity complicated by global financial shocks and rising prices. According to a recent study, when women in **Botswana** and **Swaziland** lack sufficient food, they are 50 percent more likely to engage in intergenerational sex and 70 percent more likely to have unprotected sex, increasing their risk of contracting the virus themselves.

Acute shortages of health care professionals impede treatment scale-up in the high-prevalence countries throughout Southern Africa. According to UNAIDS, Southern Africa’s doctors and nurses are emigrating to Australia, Europe, Persian Gulf countries, Japan, and the United States, further weakening already inadequate health systems. Limited numbers of health workers are a constant challenge for nations in Southern Africa, and HIV/AIDS is exacerbating these shortages by affecting large numbers of the remaining health care workers, prompting some countries to introduce special HIV prevention and treatment services for health workers. In **Malawi**, more than 1,000 health care workers were receiving ARVs in 2006; the Government of Malawi estimates improved ART access has saved the lives of at least 250 health care workers who can continue to serve other Malawians. To expedite treatment scale-up and increase available human resources, several countries have increased systematically the number of non-physicians trained to provide care. In **Mozambique**, medical officers in 85 percent of the country’s clinical sites were trained to prescribe ARVs. After this training, the number of sites administering the drugs increased threefold in eight months, and treatment coverage increased from 9.4 percent to 16.4 percent.

The impact of HIV is felt throughout households and communities caring for PLWHA. An analysis of data from **Botswana** found HIV results in a 10 percent decline in per capita household income, with average income losses almost twice as high for households in the lowest income level, according to a 2005 study. Women, who are disproportionately infected with HIV and affected by the epidemic, serve as primary caregivers throughout Southern Africa. Their household and community burdens grow as a result of HIV, compromising their own health, ability to generate income, and other markers of well-being. Women who are widowed by HIV are likely to become destitute due to a lack of legal protection for their assets and ability to inherit property. In **Zambia**, one study found the amount of land owned by a widow-headed household fell by more than one-third within three years of the death of the husband. Microfinance initiatives and programs operate throughout the region, working to empower women affected by the disease.

The orphan crisis is expected to worsen considerably in the coming years. Nearly 90 percent of the 16.6 million children orphaned by AIDS globally live in sub-Saharan Africa, many in Southern Africa. More than 10 percent of all children (0 to 17 years) in **Zimbabwe** (16 percent), **Lesotho** (13 percent), **Botswana** (12 percent), and **Swaziland**

(12 percent) have lost one or both parents to HIV. In **South Africa**, AIDS also accounts for more than one-third (35 percent) of deaths in children under 5, according to UNAIDS.

Many of the children orphaned by AIDS are raised by their grandparents; in **Namibia** and **Zimbabwe**, 40 to 60 percent of orphaned children are cared for by grandmothers, according to UNAIDS. The effect of HIV/AIDS on the region's children cannot be overstated. Many children orphaned by HIV lose their childhood and are forced by circumstances to become producers of income or food, or caregivers for sick family members. Due to limited resources, children often suffer their own increased health problems related to inadequate nutrition, housing, clothing, and basic care.

Social protection programs have developed into powerful tools to provide support to families caring for orphans and vulnerable children (OVC) by providing cash transfers and other material support. OVC programs in **Malawi** and **South Africa** include cash transfers or grant programs to support poor families caring for OVC. Children who are infected with HIV themselves face lifelong health challenges. High incidence of pediatric infection contributes directly to infant and young child mortality, complicates child malnutrition, and requires lifelong and expensive treatment.

National/Regional Response

The countries of Southern Africa have 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. Many countries are taking into account new approaches to prevention and treatment, and all have adopted multisectoral approaches to prevention and care. The challenge now is to translate carefully designed strategies into effective activities and programs.

The success of clinical trials of male circumcision to reduce transmission of HIV has prompted multiple governments to introduce policies to scale up male circumcision and to examine strategies for increasing neonatal circumcision. Several countries, including **Botswana**, **Namibia**, **Swaziland**, and **Zimbabwe**, have taken steps to scale up medical male circumcision specifically for HIV prevention. **Botswana** is integrating male circumcision into its national surgery framework, with the aim of reaching 80 percent of males from birth through 49 years of age by 2013. In **Zimbabwe**, a male circumcision policy was launched as part of a new overall HIV/AIDS prevention strategy. **Swaziland** has adopted a formal male circumcision policy, and an acceleration of male circumcision services is currently under way, in response to promising results from recent clinical trials evaluating male circumcision as a method of preventing the spread of HIV.

- In **Angola**, the National Strategic Plan on HIV/AIDS for 2011–2014 guides prevention and treatment activities. The Plan's priorities include providing HIV/AIDS education and teaching safe sex practices. The Government's commitment to combating the epidemic is clear, and 82 percent of total expenditures for HIV are funded by the Government of Angola. In recent years, the Government has tripled the budget allocated to the national response, in addition to receiving major grants from the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria.
- In **Botswana**, the response to the HIV/AIDS epidemic is currently guided by the National Strategic Framework II (2010–2016). New policies, including National HIV Treatment Guidelines (2008) and new National Guidelines for Testing and Counseling (2009), support prevention and treatment for all citizens. The country was the first to offer free ART to its citizens; the national ART program rolled out in 2002. As of 2009, more than 95 percent of PLWHA in need (according to WHO 2006 recommendations) were receiving ART.
- The Government of **Lesotho** has taken concrete actions to address the epidemic through the declaration of HIV/AIDS as a national disaster; the development of the National AIDS Strategic Plan for 2006–2011; and the establishment of the Lesotho AIDS Program Coordinating Authority. A partnership with Bristol-Myers Squibb, Baylor University, and the Government established the Children's Clinical Center of Excellence to provide treatment to HIV-positive infants and children; the Center opened on World AIDS Day in 2009.
- Even though initial efforts to combat AIDS in **Malawi** faced financial and organizational challenges, the Government has enacted legislation requiring all ministries to spend at least 2 percent of their budgets on HIV activities; from 2001 to 2005, the country increased its domestic spending on HIV sixfold, to \$18.3 million. The response to the epidemic is guided by the Extended National Action Framework for 2009–2013. Policies and guidelines for voluntary counseling and testing (VCT), PMTCT, equitable distribution of ARV drugs, and treatment of sexually transmitted diseases have also been implemented. ART has been free in the public sector since 2004, and Malawi has had particular success in rapidly scaling up ART availability.

- Since 2000, **Mozambique** has implemented strategic plans in response to the epidemic. The National Strategic Plan III (2010–2014) and the Response to HIV and AIDS Strategy within the Civil Service 2009–2013 guide HIV/AIDS prevention and treatment activities. Additional new policies address the urgency of the HIV response, including a new National Strategy for the Acceleration of Prevention and a 2009 law protecting the rights of PLWHA. Public funding is concentrated on prevention, treatment, care, and program management.
- **Namibia's** Vision 2030 regards HIV as one of the most serious threats facing the country and highlights the need to mainstream HIV programs to meet development challenges in the country. The response to the epidemic was governed recently by the third National Strategic Plan for HIV/AIDS (2004–2009), emphasizing prevention of the spread of HIV through behavior change and stigma reduction. A new national strategic framework for 2010–2015 was created and focuses on the gender and human rights aspects of HIV/AIDS. Due to Namibia's classification by the World Bank as an upper-middle-income country, donor support is more limited than in other parts of sub-Saharan Africa.
- The response to the HIV epidemic in **South Africa** is guided currently by the National Strategic Plan for 2007–2011 and supported by a number of policies for PMTCT, nutrition, youth and adolescent health, and OVC. In 2009, President Jacob Zuma heralded the beginning of a new movement to accelerate South Africa's universal access to HIV prevention, treatment, care, and support, a landmark commitment in a country with a tumultuous history of combating the epidemic. A new HIV counseling and testing policy, stigma mitigation framework, and medical male circumcision document will guide particular components of the Government's response to the epidemic.
- In 1999, the king of **Swaziland** declared AIDS a national disaster and championed the Government response to the epidemic. The second National HIV/AIDS Strategic Plan (2006–2008) focused on prevention, care and support, impact mitigation, communications, monitoring and evaluation, and management and coordination. In 2003, the Ministry of Health and Social Welfare launched the Emergency Care and Treatment Implementation Plan to provide free ART to PLWHA. By the end of 2009, 85 percent of HIV-positive individuals were receiving treatment.
- **Zambia's** current strategy to combat HIV focuses on six key drivers of the epidemic: multiple and concurrent sexual partnerships; low and inconsistent condom use; low rates of male circumcision in some provinces; mobility and labor migration; vulnerable and marginalized groups (commercial sex workers [CSWs], prisoners, and migrants); and vertical mother-to-child transmission. While the Government speaks out in support of efforts to combat the HIV/AIDS epidemic, low thresholds of public funding for programs as well as issues with the enforcement of laws protecting the rights of PLWHA – specifically MARPs – continue to be challenges.
- **Zimbabwe** has continued to demonstrate commitment to combating the epidemic, following recommendations from the National AIDS Council (NAC). The NAC board was restructured in 2008 to include representation from labor, the business sector, PLWHA and to increase representation of women. The country is actively reviewing and revising its HIV strategy in light of ongoing economic and political challenges. The country introduced a plan for national provision of ART in 2004 and continues to work toward universal access for its citizens. Government subsidies to local producers of the ART drugs have helped minimize stock-outs in 2009.

Public-private partnerships have evolved into powerful tools in the fight against HIV. In **Botswana**, a public-private partnership with the Gates Foundation and Merck has supported ART distribution through both a financial commitment of \$106.7 million and the donation of Merck's ARVs through 2010. The Global Fund to Fight AIDS, Tuberculosis, and Malaria has also made significant contributions to the scale up of ART, promotion of HIV prevention, health system strengthening, and other related activities. As of January 2011, over 1.1 million people were receiving ART supported by Global Fund grants, and nearly \$1.3 billion in grants had been disbursed to Southern Africa. The USG provides nearly 30 percent of the Global Fund's total contributions worldwide.

USAID Regional Support

USAID's HIV/AIDS programs in Southern 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 (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.

The USAID Regional HIV/AIDS Program (RHAP), based in Pretoria, South Africa, supports HIV programs in **Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe**. RHAP responds to regional priorities on HIV/AIDS, focusing on prevention, human capacity development and capacity building, and partnering with African institutions; promoting knowledge management and the sharing of best practices; and ensuring donor coordination and harmonization. In addition, RHAP provides quality technical assistance through five regional advisors and coordinates additional technical assistance for regional programs as needed.

Malawi was the first country to sign a Partnership Framework with the USG to coordinate the response to the epidemic, signing the agreement in May 2009; as of September 2010, **Swaziland** and **Lesotho** also had signed their own agreements. A Partnership Framework provides 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.

Examples of recent USAID successes include the following activities and interventions:

- In **Angola**, the Essential Health Services Program worked closely with provincial directorates of health to support the establishment of 30 new PMTCT units in antenatal clinics and 38 new VCT centers. In the same year, behavior change communications reached more than 100,000 individuals throughout the community.
- By the end of 2008, a PMTCT partnership provided additional PMTCT services in seven districts in **Lesotho** at seven hospitals, three filter clinics, and 47 health centers. The country also developed a Partnership Framework with the USG to support implementation of the national HIV/AIDS response and continue to combat the epidemic.
- USAID provided support to the **Swaziland** Action Group Against Abuse's Reducing Gender-based Violence as a Cause and Consequence of HIV/AIDS program, which reached approximately 6,000 people in 67 communities, while also promoting men's involvement in the prevention of HIV and gender-based violence.
- In **Botswana**, the USG supported provider-initiated and mobile VCT through "moonlight" and door-to-door counseling and testing programs that targeted farm workers in Ghanzi and an at-risk group of CSWs in the Kasane border area.
- USAID programs in **Malawi** provided counseling and testing for nearly 400,500 individuals in 2009, including approximately 103,600 pregnant women. As part of the PMTCT program, which now reaches 90 percent of pregnant women countrywide, 9,000 HIV-positive pregnant women received ARVs for PMTCT. Training of 425 providers in caring for PLWHA and 5,100 individuals in the promotion of prevention and awareness messages helped build local capacity.
- **Mozambique's** HIV programs have taken an innovative integrated approach, incorporating HIV/AIDS activities into malaria, maternal and child health, family planning and reproductive health, and TB programs in policy, health service delivery, and community-based interventions. New programs aim to strengthen the country's capacity to fight widespread gender-based violence.
- In **South Africa**, the link between TB screening and HIV testing was strengthened in 2009. About 75 percent of TB cases in 212 supported facilities were tested for HIV, and 77 percent of HIV clients were screened for TB.
- Home-based care programs in **Namibia** adopted OVC tools and processes to establish standards of care and improve programming, and 518,100 individuals were reached with community outreach HIV/AIDS prevention activities that promoted correct and consistent use of condoms and related interventions in 2009.
- By providing significant technical assistance to countries in the region, RHAP helped increase the quality of health programs throughout Southern Africa through the provision of training, strategic planning, and sharing of best practices.

With USAID support through RHAP, human resource managers and senior ministry officials in 12 countries implemented a model process to address their respective human resource crises; 20 organizations integrated nutritional care for HIV/AIDS; and staff from 808 small and medium enterprises received training in managing the impact of HIV/AIDS.

Important Links

USAID Regional HIV/AIDS Program

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USAID's HIV/AIDS Web site for Southern Africa:

http://www.usaid.gov/our_work/global_health/aids/Countries/africa/saregional.html.

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

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