

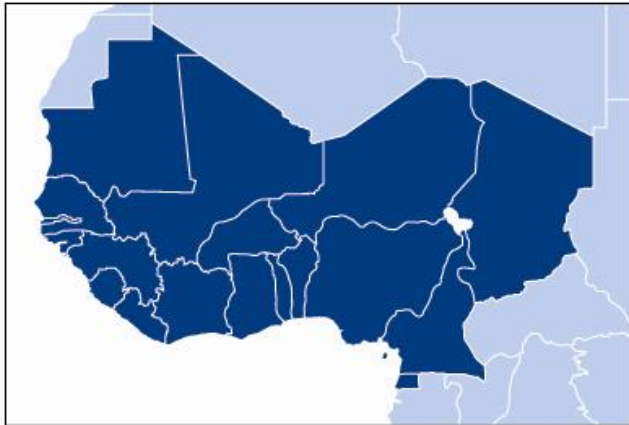


USAID
FROM THE AMERICAN PEOPLE



HIV/AIDS HEALTH PROFILE

West Africa



Overall HIV Trends

The HIV/AIDS epidemic in West Africa has remained relatively stable, with HIV prevalence markedly lower than in East and Southern Africa. Adult HIV prevalence is estimated at 2 percent or under in **Benin, Burkina Faso, Gambia, Ghana, Guinea, Liberia, Mali, Mauritania, Niger, Senegal, and Sierra Leone**. The highest HIV prevalence rates are found in **Cameroon** (5.3 percent), **Côte d'Ivoire** (3.4 percent), **Gabon** (5.2 percent), and **Nigeria** (3.6 percent), according to the 2010 Joint United Nations Program on HIV/AIDS (UNAIDS) *Report on the Global AIDS Epidemic*. Based on 2005 data, close to 6 million people in countries supported by the U.S. Agency for International Development (USAID) in West Africa are living with HIV/AIDS. The number of people living with

HIV/AIDS (PLWHA) in **Nigeria** is second only to South Africa, though the epidemic has stabilized recently. Heterosexual sex is the primary form of transmission.

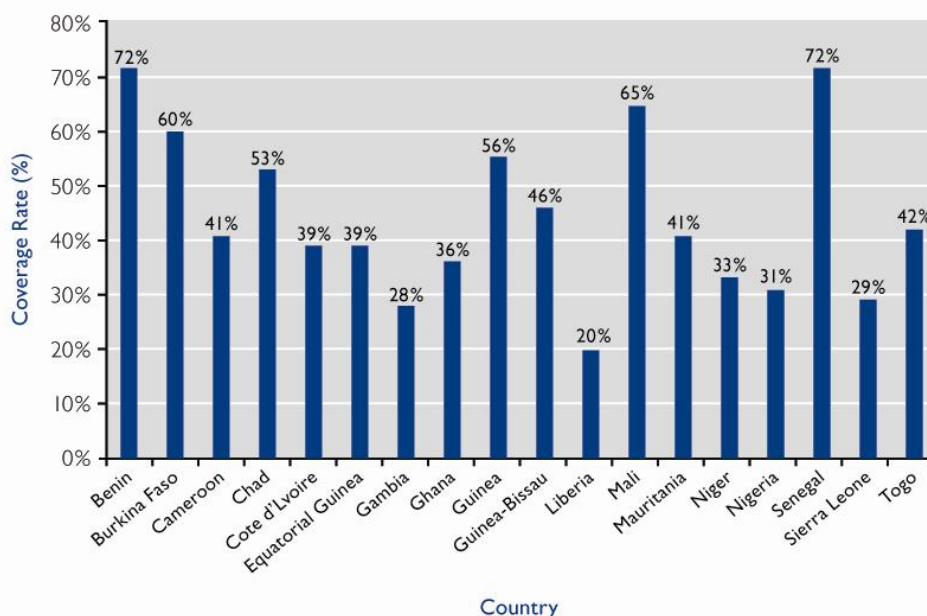
Within countries, adult prevalence varies widely by geographic regions and vulnerable populations. The 2005 **Côte d'Ivoire** AIDS Indicator Survey found marked regional variation in adult HIV prevalence, from 1.7 percent in the northwest region to 6.1 percent in Abidjan. In some regions of **Cameroon**, prevalence rates have reached above 8 percent compared with the national prevalence of 5.3 percent. **Nigeria** has an overall estimated national adult prevalence of 3.6 percent, but statewide HIV prevalence among pregnant women ranges from as low as 1.6 percent in Ekiti in the west to 10 percent in Benue in the southeast. In **Chad**, the epidemic appears to be concentrated mainly in urban areas, where the HIV prevalence was estimated at 7 percent, nearly three times higher than in rural areas.

Women and girls continue to be affected disproportionately by HIV/AIDS in the region, as in many other parts of sub-Saharan Africa. Their vulnerability to HIV stems both from greater physiological susceptibility to heterosexual transmission and from the severe social, legal, and economic disadvantages facing them. Throughout some West African countries, prevalence among women is markedly higher than men of the same age. In **Côte d'Ivoire**, for example, prevalence among adult women is more than double that in adult men.

Multiple countries have shown recent declines in HIV prevalence, including **Mali, Niger, Burkina Faso, Côte d'Ivoire, and Togo**. In **Togo**, prevalence among pregnant women tested for HIV at antenatal clinics in 2006 was 4.2 percent, down from 4.8 percent in 2003 and 4.6 percent in 2004, indicating a decline in national infection levels. Based on antenatal surveillance data, the adult prevalence in **Nigeria** seems to have stabilized at approximately 3.6 percent. In other countries, declines have been noted among key populations for curbing the epidemic, as evident in **Ghana**, where overall HIV prevalence has remained stable, though prevalence among young adults (15 to 24 years old) has decreased from 3.2 percent in 2002 to 1.3 percent in 2009.

Prevention of mother-to-child transmission of HIV (PMTCT) coverage has increased in recent years but remains much lower in West and Central Africa (23 percent), compared with East and Southern Africa (68 percent), according to the 2010 World Health Organization (WHO)/UNAIDS/UNICEF *Towards Universal Access* report. While less than a third of HIV-positive pregnant women in **Ghana** receive antiretroviral drugs for PMTCT, coverage more than doubled, from 12.6 percent in 2007 to 27 percent in 2008. The same trend is observed in **Côte d'Ivoire**, with an increased coverage from 17.2 percent to 43.7 percent. As a result, children continue to be affected by HIV through

HIV-Infected People Receiving Treatment in West Africa, 2001-2009



Source: WHO/UNAIDS/UNICEF, *Towards Universal Access*, 2010. Data for end 2009, according to 2006 WHO Standard

mother-to-child transmission, as well as through the loss of one or both parents to AIDS. At the end of 2009, UNAIDS estimated 360,000 children in **Nigeria** were living with HIV, and nearly 2.5 million had been orphaned by AIDS.

Most-at-risk populations (MARPs) include sex workers and men who have sex with men (MSM). Paid sex accounts for 30 percent of new infections in **Ghana** and plays a significant role in other countries' epidemics. More than one in four female sex workers (FSWs) in the capital cities of **Cameroon**, **Ghana**, **Côte d'Ivoire**, **Guinea**, **Mali**, **Nigeria**, and **Togo** are HIV positive. When comparing prevalence among sex workers with prevalence in the general population, the disparities are staggering: In **Senegal**, a country with an adult prevalence of approximately 0.9 percent, prevalence rates close to 30 percent have been found among FSWs in Ziguinchor. In **Guinea-Bissau**, HIV prevalence as high as 39.6 percent was found among sex workers in 2009, compared with 2.5 percent prevalence in the general population.

Transmission by MSM and prevalence rates in this MARP have been poorly documented; recent surveys have shown the MSM population plays a significant role in some national epidemics, though. The 2008 World Bank *West Africa HIV/AIDS Epidemiology Report* estimates the HIV prevalence among MSM varies from 13.5 percent to 25.3 percent in different countries throughout the region. In **Ghana**, MSM showed the highest HIV prevalence of any sub-population in the country at 9.6 percent and accounted for 7.2 percent of new infections (Bosu et. al, 2009). In **Senegal**, four-fifths of MSM said they also have sex with women, and it is not uncommon for MSM to have a wife and family; this increases the risk of transmission to the general population.

Comprehensive knowledge of HIV remains low in West Africa and is an obstacle to reducing new infections. For example, according to a review of Demographic Health Surveys (DHS) conducted across West African countries from 2003 to 2008, less than 50 percent of the population between the ages of 15 and 49 had comprehensive correct knowledge about HIV/AIDS¹. There is also a need for intensified efforts to increase HIV prevention among young people in order to stem the spread of the virus.

The number of PLWHA receiving treatment is having profound effects on HIV-related mortality in many countries due to prolonged life and reduced annual HIV-related deaths. Antiretroviral therapy (ART) programs have been rapidly scaled up in many countries across West Africa in an effort to achieve the United Nations' goal of universal access by 2015, and ART coverage in West and Central Africa has increased from 2 percent in 2002 to 25 percent in 2009, according to the 2010 UNAIDS *Report on the Global AIDS Epidemic*. According to ART coverage rates reported in

¹ The percentage of respondents who correctly identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission, and who know a healthy-looking person can have HIV

the 2010 WHO/UNAIDS/UNICEF *Towards Universal Access* report, both **Senegal** and **Benin** have made significant progress toward universal access, with an estimated ART coverage in excess of 70 percent as of December 2009; **Burkina Faso** and **Mali** both have rates equal to or above 60 percent. ART coverage in 2009 for other West African countries is shown in the figure on the previous page. Treatment adherence – the percentage of clients who remain on treatment for more than one year – has increased significantly as well; in **Cameroon**, more than 90 percent of ART clients stay on treatment for more than a year, and in **Ghana**, the figure is more than 80 percent.

In 2009, WHO issued revised recommendations on when adults and adolescents, including pregnant women, should start ART. WHO now recommends ART be initiated when the CD4 white blood cell count reaches or drops below 350 cells/mm³, rather than when it reaches or drops below 200 cells/mm³. While this change immediately increased 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.

PLWHA are particularly vulnerable to developing drug-resistant tuberculosis (TB) because of their increased susceptibility to infection and progression to active TB. In West Africa, TB co-infection with HIV constitutes a serious public health threat. According to the 2009 *Global Tuberculosis Control* report, HIV prevalence in new TB cases is very high in some West African countries, such as **Côte d'Ivoire** (39 percent), **Togo** (28 percent), **Chad** (27 percent), **Nigeria** (27 percent), and **Cameroon** (43 percent). **Nigeria** is one of the West African countries among the WHO 22 high-burden countries for TB. Three countries in the region are USAID TB priority countries: **Nigeria**, **Ghana**, and **Senegal**. Although HIV testing for TB patients is increasing quickly, HIV-infected persons are not routinely screened for TB, even though this is a relatively efficient method of case finding. There is an urgent need to improve access to TB culture and drug sensitivity testing and to introduce effective infection control practices in HIV clinics to prevent the spread of TB.

HIV Estimates in West Africa		
Benin		
	Total Population	9.1 million
	Estimated Number of Adults and Children Living with HIV/AIDS	60,000
	Adult HIV Prevalence	1.2%
	HIV Prevalence in FSWs (Porto Novo) (2009)	24.7%
	HIV Prevalence in Injecting Drug Users (Porto Novo) (2009)	4.2%
Cameroon		
	Total Population	19.3 million
	Estimated Number of Adults and Children Living with HIV/AIDS	610,000
	Adult HIV Prevalence	5.3%
	HIV Prevalence in FSWs (Yaoundé) (2009)	35.5%
Chad		
	Total Population	10.5 million
	Estimated Number of Adults and Children Living with HIV/AIDS	210,000
	Adult HIV Prevalence	3.4%
	HIV Prevalence in FSWs (N'Djamena) (2009)	20%
Côte d'Ivoire		
	Total Population	21 million
	Estimated Number of Adults and Children Living with HIV/AIDS	450,000
	Adult HIV Prevalence	3.4%
	HIV Prevalence in Commercial Sex Workers (Abidjan) (2000)	28%
Ghana		
	Total Population	24.3 million
	Estimated Number of Adults and Children Living with HIV/AIDS	260,000
	Adult HIV Prevalence	1.8%
	HIV Prevalence in FSWs (Accra) (2009)	25%
	HIV Prevalence in MSM (Accra) (2006)	25%
Guinea		
	Total Population	10.3 million
	Estimated Number of Adults and Children Living with HIV/AIDS	79,000
	Adult HIV Prevalence	1.3%
	HIV Prevalence in FSWs (Conakry) (2008)	32.7%
Mali		
	Total Population	13.8 million
	Estimated Number of Adults and Children Living with HIV/AIDS	76,000
	Adult HIV Prevalence	1.0%
	HIV Prevalence in FSWs (Bamako) (2006)	35.3%
Nigeria		
	Total Population	149.2 million
	Estimated Number of Adults and Children Living with HIV/AIDS	3.3 million
	Adult HIV Prevalence	3.6%
	HIV in Most-at-Risk Populations	
	HIV Prevalence in Injecting Drug Users (Abuja) (2007)	5.6%
	HIV Prevalence in FSWs (Abuja) (2007)	32.7%
	HIV Prevalence in MSM (Abuja) (2007)	13.5%
Senegal		
	Total Population	14.1 million
	Estimated Number of Adults and Children Living with HIV/AIDS	59,000
	Adult HIV Prevalence	0.9%
	HIV Prevalence in FSWs (Dakar) (2006)	19.8%
	HIV Prevalence in FSWs (Ziguinchor) (2006)	29.0%
	HIV Prevalence in MSM (Dakar) (2007)	21.8%
Togo		
	Total Population	6 million
	Estimated Number of Adults and Children Living with HIV/AIDS	130,000
	Adult HIV Prevalence	3.2%
	HIV Prevalence in FSWs (Lomé) (2005)	44.5%

*Sources: Population: U.S. Census Bureau; Adult prevalence and people living with HIV/AIDS: UNAIDS Epidemic Update, 2010; Most-at-Risk Population Prevalence: UNGASS *Country Progress Reports*, 2010 and UNAIDS Epidemic Update 2010

Economic and Social Impact of HIV/AIDS in West Africa

The HIV/AIDS epidemic is erasing decades of progress which had previously increased the life expectancy of the people of West Africa. The vast majority of people in West 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. The U.S. Census Bureau now reports that life expectancy in many West African countries has decreased by nearly 10 years compared to previous estimates as a result of HIV/AIDS. In **Côte d'Ivoire**, life expectancy is anticipated to decline from 57 to 46 years as a result of AIDS, while in **Burkina Faso**, the expected decline is from 55 to 46.

Analyses from UNAIDS indicate wealthier populations are more likely to be infected than poor populations; for those living in poverty who are infected though, HIV further strains limited resources. As such, the epidemic has been reversing progress in poverty reduction throughout the region. A study in **Burkina Faso** 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. Economic activity and social progress are slowing as more of the labor force becomes ill or dies. The International Labor Organization estimates the workforce in many West African nations will decline significantly in the coming years as a result of HIV/AIDS. In **Côte d'Ivoire**, HIV/AIDS has caused the deaths of a significant number of teachers, and it is anticipated that 11.4 percent of agricultural laborers will have died from HIV-related causes by 2020. Businesses have recognized they have a stake in responding to the epidemic, which can affect both their workforce and consumer base for their goods.

The effect of HIV/AIDS on West Africa's health sector is particularly challenging, as the epidemic simultaneously places additional strains on already overburdened health staff while depleting human resources. Research in **Nigeria** has found increases in health sector staff will be needed to meet the counseling, testing, and treatment targets set by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). In addition to the increased patient burden, many health workers are at risk of contracting HIV. According to Tawfik and Kinoti (2001) in *The Impact of HIV/AIDS on the Health Sector in Sub-Saharan Africa: The Issue of Human Resources*, an assessment in **Senegal** demonstrated that although 91 percent of surveyed health workers recognize that handling body fluids contaminated with HIV or hepatitis increases the risk of transmission, only 25 percent take appropriate precautions. Therefore, health personnel may encounter additional risk of contracting HIV depending on their adherence to proper procedures.

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 AIDS in sub-Saharan Africa can take up as much as one-third of a family's monthly income. As more family members fall ill and die due to causes attributable to the virus, the dependency ratio increases. Grandparents can no longer rely on their children for support; instead, they become responsible for their grandchildren and the burden of support this situation imposes. Among West African countries, the projected increase (by 2010) in economic dependency ratios due to HIV/AIDS deaths and illness was 2.8 percent in **Togo**, 3.5 percent in **Nigeria**, and nearly 4 percent in **Liberia**.

Millions of children are becoming orphans as a result of HIV/AIDS. The magnitude of the situation is particularly serious in **Nigeria**, where almost 2.5 million children have lost one or more parents to the virus. According to the 2010 UNAIDS *Report on the Global AIDS Epidemic*, 440,000 children in **Côte d'Ivoire** and 330,000 children in **Cameroon** have lost one or both parents to HIV. Depending on their status, many of these children are raised by their grandparents or live in child-headed households. Many children who lose parents are forced into adult roles early in their lives, generating income or food for their families or serving as 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. The 2006 *Literature Review on the Impact of Education Levels on HIV/AIDS Prevalence Rates* by the World Food Program found rising HIV rates were correlated with lower levels of education, contrary to earlier data indicating those with higher educational attainment had higher levels of infection compared to less-educated populations, emphasizing the important role of education in stemming the epidemic.

Stigma and discrimination have long been identified as major obstacles that keep people living with HIV from accessing prevention, treatment, and care services. According to the 2008 **Ghana** DHS, only 18.8 percent of men and 11.4 percent of women were found to have accepting attitudes toward people with HIV.² In **Guinea**, **Nigeria**,

² Respondents in a general population survey are asked the following series of questions about people with HIV: If a member of your family became sick with the AIDS virus, would you be willing to care for him or her in your household? If you knew that a shopkeeper or food seller had the AIDS virus, would you buy fresh vegetables from them? If a female teacher has the AIDS virus but is not sick, should she be allowed to continue teaching in school? If a member of your family became infected with the AIDS virus, would you want it to remain a secret? Only a respondent who reports an accepting or supportive attitude on all four of these questions enters the numerator. The denominator is all people surveyed.

and **Senegal**, accepting attitudes toward people with HIV were even lower, with less than 10 percent of men and less than 5 percent of women expressing accepting attitudes toward PLWHA. Stigma often leads to discrimination and other violations of human rights that affect the well-being of PLWHA.

National/Regional Response

Most countries in the region have established national-level multisectoral AIDS councils, which reside in the offices of the President or Prime Minister. Across the region, West African countries coordinate approaches to HIV/AIDS through the Economic Community of West African States and its affiliate, the West Africa Health Organization (WAHO), which receives significant support from USAID's West Africa Regional Program. Building on lessons learned from its first strategic plan that concluded in 2007, WAHO's fiscal year (FY) 2009–2013 Strategic Plan aims to support quality improvement of health systems, health services improvement, and development of sustainable financing of health in the region. WAHO is uniquely placed to aid in the coordination of health training, policies, standards, and improve the quality of care available in the region.

The following are examples of country-level responses to the epidemic in West Africa:

- In **Benin**, the National AIDS Control Committee coordinates the national AIDS response. In 2006, the Committee developed a 2007–2011 strategic framework focused on universal access, interventions for at-risk groups, and increased involvement of young people, with a greater emphasis on orphans and vulnerable children (OVC). The plan also focuses on the implementation of the “Three Ones” through a single system of evaluation and improved coordination among stakeholders.
- In **Cameroon**, the country has a National AIDS Control Committee and a wide representation of stakeholders, including the head of state. The Government's Poverty Reduction Strategy Paper declared HIV a health emergency and priority program. The 2006–2010 National Strategic Plan was launched in March 2006 with universal access objectives. The Government has demonstrated financial commitment to the fight against AIDS by increasing funding for the program. A new five-year National Strategic Plan (2011–2015) was adopted in August 2010.
- In **Chad**, sociopolitical insecurity and nearly 400,000 displaced persons and refugees have weakened the country's capacity to respond to the epidemic. Funding was suspended due to political instability and a new strategic framework (2007–2011) had to be developed and budgeted. A new operational plan (2008–2011) was also developed. The United Nations has mainstreamed HIV into the humanitarian response.
- **Côte d' Ivoire** was in the throes of a political and military crisis from 2002 to March 2007, when the Ouagadougou Peace Agreement was signed. The 2006–2010 National Strategic Plan contains targets for scaling up HIV prevention, treatment, and care and support toward universal access; a new 2010–2013 National Strategic Plan is currently being designed. Since 2007, major achievements have included the creation of 32 committees representing different sectors, from health to transport, and the integration of life skills and HIV units into the curricula at 15 regional offices for the Ministry of Education.
- In **Ghana**, the Ghana AIDS Commission is the coordinating body for all HIV/AIDS-related activities. The most recent National Strategic Plan (2006–2010) builds upon previous successes in HIV/AIDS prevention and treatment programs. Ministry of Education life skills education programs are currently in place, as are workplace programs through the Ministry of Employment and Social Welfare. The Government also inaugurated a new Commission in 2009 to support policy formation and direct the national response.
- In **Mali**, the Ministry of Health's National Committee for AIDS Prevention provides support to various initiatives and programs, including clinical and vaccine trials. Mali has a National Strategic Plan for 2006–2010. The Plan has strong support from civil society and the public and private sectors. A second National Strategic Plan (2011–2015) is under review.
- In **Nigeria**, the National Action Committee on AIDS was legally transformed into the Agency for the Control of AIDS by Parliament in 2007. The second National Strategic Framework (2010–2015) prioritizes improving program uptake, behavioral change, gender-sensitive health services, and non-health responses. Nigeria developed a plan for scaling up for universal access to HIV prevention, treatment, care, and support in February 2006.

Throughout West Africa, public-private partnerships (PPPs) combat the epidemic by leveraging business expertise and resources to promote HIV prevention, distribute information, and provide opportunities for PLWHA. The number of businesses engaging in group efforts to combat the epidemic has also increased in many

countries, especially as private sector actors recognize the long-reaching effects of HIV-related morbidity and mortality on their workforce. Multiple countries in West Africa have National Business Coalitions on HIV/AIDS, Malaria, and TB, including **Benin, Cameroon, Côte d'Ivoire, Ghana, and Senegal**. In **Mali**, PPPs are being sought through the Private Sector Coalition in the Fight against AIDS, created in 2005. Many coalitions have grown significantly in recent years; for example, the Coalition in **Côte d'Ivoire** grew from 12 enterprises originally to more than 300 in 2010.

The Global Fund to Fight AIDS, Tuberculosis and Malaria has approved grants to support HIV/AIDS activities for the many countries in West Africa. It has also played an integral role in funding programs to combat the HIV epidemic. Global Fund grants in West Africa total approximately \$2.2 billion; only \$803 million have been disbursed to the countries of West and Central Africa since 2002, though, due to bottlenecks and the failure of recipients to fulfill strict Global Fund requirements. Disbursed funds have supported the enrollment of more than 300,000 PLWHA in ART and other achievements. The U.S. Government (USG) provides nearly 30 percent of the Global Fund's total contributions worldwide.

USAID Regional Support

USAID implements its HIV/AIDS programs in West Africa as part of 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.

As of February 2011, two West African countries – **Ghana and Nigeria** – had signed Partnership Frameworks with the USG. Partnership Frameworks are designed as five-year joint strategic frameworks for cooperation among the USG, the partner government, and other partners to combat HIV/AIDS through service delivery, policy reform, and coordinated financial commitments. Partnership Frameworks also support and strengthen national HIV/AIDS strategies; focus on building strategic partnerships with host nations to secure long-term sustainability for HIV/AIDS programs; and are transparent and accountable in execution, with the active participation of other key partners from civil society, the private sector, bilateral and multilateral partners, and other international organizations.

In FY 2009, USAID/West Africa greatly increased coordination and collaboration with the Global Fund by being the first Mission to be awarded a Senior Global Fund Liaison position to provide critical leadership and technical assistance to Global Fund recipients. The liaison assists West African countries in accessing funding and successfully implementing their grants. It also plays an important role in the region due to the high number of countries failing to fulfill Global Fund requirements.

In West Africa, USAID initiatives are carried out in **Cameroon, Côte d'Ivoire, Nigeria, Benin, Ghana, Guinea, Mali, and Senegal**. Examples of recent USAID successes have included the following activities and interventions:

- USG partners worked with the **Côte d'Ivoire** Ministry of Health to incorporate a TB screening tool into the national HIV patient encounter form.
- The continued scale-up of ART led to significant improvements in coverage rates from 2003 to 2009 in **Côte d'Ivoire** (from 4 to 39 percent) and **Nigeria** (from 2 to 31 percent).
- In **Cameroon**, the regional Mission facilitated the design and the implementation of a new HIV/AIDS project targeting MARPs with state-of-the-art prevention strategies associated with an integrated biological behavior surveillance for MSM, as well as a program to advocate for greater resources for HIV/AIDS prevention, care, and treatment.
- In support of the **Benin** National AIDS Control Committee, USAID has funded a five-year program called the Integrated Project to Promote Family Health and Prevent HIV/AIDS since October 2006. Mass media have been employed as an important tool in the fight against HIV, with nearly 300 nongovernmental organization staff, community members, theater groups, and students trained to promote HIV/AIDS prevention.
- In **Mali**, USAID provided technical assistance for 3,000 people to receive training in AIDS IMPACT Modeling, an advocacy tool to create a supportive environment for HIV/AIDS programs; by 2009, the trainers had reached 22,000 people from a number of towns and villages throughout Mali.

- In **Guinea**, 30,279 women received counseling and testing for HIV through a diverse set of programs, including HIV prevention training for 53 female health workers, education sessions and radio programming to promote women's HIV/AIDS awareness, and provision of HIV testing for women receiving pre-natal care.
- In **Ghana**, USAID provided HIV counseling and testing to 35,000 individuals in 2010.

Important Links

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

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

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

February 2011