HIV/AIDS HEALTH PROFILE

Southern Africa Region

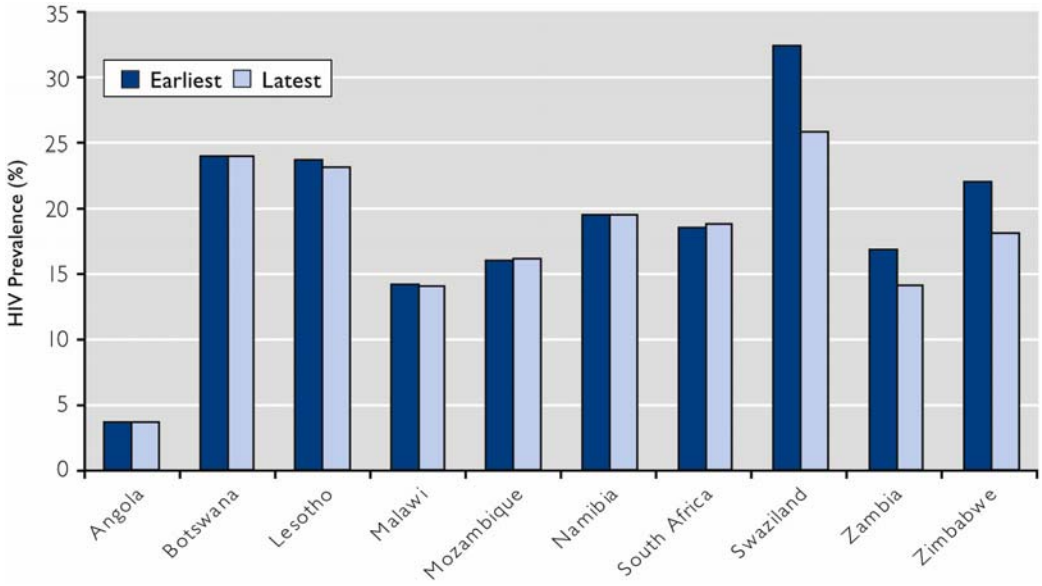
Overall HIV Trends

Southern Africa remains the global epicenter of the HIV/AIDS pandemic. The World Bank has stated that the "hyper" epidemic in the countries at the epicenter is a continental – and global – exception, unlikely to occur elsewhere. In 2007, the region accounted for 35 percent of all people living with HIV worldwide and 32 percent of the world's new HIV infections and AIDS deaths. According to UNAIDS, in 2005, eight countries in southern Africa (Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe) had a national adult HIV prevalence higher than 15 percent. Prevalence rates in the region have for the most part leveled off. Although Swaziland, Zambia, and Zimbabwe appear to have had significant declines in prevalence, UNAIDS cautions that the extent of these declines is not clear due to inconsistencies in the data.

In major urban areas of southern Africa, various studies over the past eight years have recorded HIV infection among female sex workers at levels as high as 68 percent in Zambia and 50 percent in South Africa. These data underscore the need for HIV prevention efforts to be scaled up among sex workers, even in countries with generalized epidemics.

Although data from low- and middle-income countries are relatively scarce, the available evidence confirms that the prevalence of HIV infection among prisoners is almost invariably higher than in the general population. In South Africa, estimates put the figure as high as 41 percent in the total prisoner population and higher yet among prisoners in individual prisons. A recent report from Zambia's prison headquarters stated that in 2004 alone, some 449 inmates had died of AIDS-related illnesses.

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



Sources: 2006 Report on the Global AIDS Epidemic and 2006/07 Demographic and Health Surveys

In Zimbabwe, data from national sentinel surveillance and national and local community-based surveys show a declining trend in HIV prevalence. National adult HIV prevalence is estimated at 18.1 percent, down from 22.1 percent in 2003. One study of pregnant women demonstrated a decline from 26 percent in 2002 to 18 percent in 2006 and another study over the same period indicated that prevalence declined from 21 to 13 percent. The declining trends are in part attributed to high mortality and also to declining incidence, which is related to behavior change. Evidence from eastern Zimbabwe has found that more women and men are avoiding sex with nonregular partners and that condom use increased among women with nonregular partners from 26 percent in 1998–2000 to 37 percent in 2001–2003. With 1.7 million people living with HIV, Zimbabwe needs to sustain the declining trend in HIV prevalence and dramatically improve the provision of antiretroviral therapy (ART) if it is to gradually bring its epidemic under control.

South Africa has the highest number of HIV infections in the world. Based on its extensive antenatal clinic surveillance system, national surveys, and HIV testing and mortality data from the civil registration system, an estimated 5.5 million people, and an estimated 18.8 percent of adults aged 15 to 49, were living with HIV in 2005. About 30 percent of pregnant women attending public antenatal clinics were living with HIV in 2006. Recent trends indicate infections may be leveling off, and a decrease in prevalence among pregnant women aged 15 to 24 suggests a possible decline in the annual number of new infections.

In Swaziland, data from the 2006–2007 Demographic and Health Survey (DHS) suggest a decline in HIV prevalence from 32.4 percent in 2003 to 25.9 in 2006–2007. UNAIDS, however, indicates that the extent of the decline, while still significant, is not clear due to inconsistencies in the data. High AIDS-related mortality is one reason for the decline. Population-based and antenatal clinic survey data show little difference in HIV prevalence between regions, but there is a significant difference in infection levels between men and women. Although many young women report delaying their sexual debut, once women do have unprotected sex, the odds of acquiring HIV are alarmingly high. An estimated 31 percent of women tested HIV positive in 2007, compared with approximately 20 percent of adult men. Sexual aggression appears to be widespread. In a study among high school students, almost 18 percent of sexually active female students said their first sexual experience had been coerced.

HIV Estimates in the Southern Africa Region	
Angola	
Total Population	16 million
Estimated Number of Adults and Children Living with HIV/AIDS	320,000
Adult HIV Prevalence	2.5%
HIV in Most-at-Risk Populations:	
Sex Workers (Luanda)	33%
Botswana	
Total Population	1.8 million
Estimated Number of Adults and Children Living with HIV/AIDS	270,000
Adult HIV Prevalence	24.1%
Lesotho	
Total Population	1.9 million
Estimated Number of Adults and Children Living with HIV/AIDS	268,000
Adult HIV Prevalence	23.2%
HIV in Most-at-Risk Populations:	
Returning Mine Workers	40%
Textile Workers	43%
Malawi	
Total Population	13.9 million
Estimated Number of Adults and Children Living with HIV/AIDS	940,000
Adult HIV Prevalence	14.1%
Mozambique	
Total Population	20.9 million
Estimated Number of Adults and Children Living with HIV/AIDS	1.8 million
Adult HIV Prevalence	16.1%
Namibia	
Total Population	2.1 million
Estimated Number of Adults and Children Living with HIV/AIDS	230,000
Adult HIV Prevalence	19.6%
South Africa	
Total Population	44 million
Estimated Number of Adults and Children Living with HIV/AIDS	5.5 million
Adult HIV Prevalence	18.8%
HIV in Most-at-Risk Populations:	
Urban Female Sex Workers	50%
Prisoners	41%
Swaziland	
Total Population	1.1 million
Estimated Number of Adults and Children Living with HIV/AIDS	220,000
Adult HIV Prevalence	25.9%
Zambia	
Total Population	11.5 million
Estimated Number of Adults and Children Living with HIV/AIDS	1.1 million
Adult HIV Prevalence	14.3%
HIV in Most-at-Risk Populations:	
Urban Female Sex Workers	68%
Zimbabwe	
Total Population	12.4 million
Estimated Number of Adults and Children Living with HIV/AIDS	1.7 million
Adult HIV Prevalence	18.1%

Sources: Angola National Statistics Institute; U.S. Census Bureau 2007; DHS 2006/2007; UNAIDS 2003, 2006, 2007; Lesotho Bureau of Statistics; Lesotho Ministry of Health and Social Welfare; Apparel Lesotho Alliance to Fight AIDS

Botswana's epidemic is very serious, with national adult HIV prevalence estimated at 24.1 percent in 2005. However, HIV prevalence among pregnant women attending antenatal clinics in recent years declined from 36 percent in 2001 to 32 percent in 2006. The declining trend is also seen among young pregnant women. Among pregnant teenagers 15 to 19 years of age,

HIV prevalence declined from 25 percent in 2001 to 18 percent in 2006 and from 39 to 29 percent among 20- to 24-year-olds over the same period.

Lesotho's epidemic also remains serious, with an estimated national adult HIV prevalence of 23.2 percent. However, women appear to be disproportionately affected, with approximately 57 percent of HIV infections occurring among women. Of particular concern are the high rates of infection among young women. Among the 25- to 29-year age group, 38 percent of antenatal clinic attendees were HIV positive. New surveillance data show a decline in infection levels among pregnant women aged 15 to 24; this may be due to the addition of new sentinel surveillance sites.

In Namibia, national HIV prevalence among adults is estimated at 19.6 percent. In antenatal clinic attendees, HIV prevalence has stabilized, with one in five women attending antenatal clinics testing HIV positive.

With an estimated 2.5 percent of the adult population HIV positive, Angola has the lowest HIV prevalence rate in continental southern Africa. According to UNAIDS, HIV prevalence among pregnant women remained fairly stable at 2.4 percent in 2004 and 2.5 percent in 2005. During the 1975–2002 Angolan civil war, cross-country travel was nearly impossible, thus impeding the spread of HIV/AIDS. In the years since the war, movement has become less restricted and the likelihood of HIV reaching once-isolated communities has increased. The large number of young people in Angola – nearly 70 percent of the population is under 24 – coupled with widespread high-risk sexual behaviors puts Angola in danger of a severe epidemic.

After a period of stabilization in the early 2000s, HIV prevalence among women attending antenatal clinics appears to be rising in Mozambique. HIV prevalence was lowest in the north, where it was approximately 9 percent in 2004, and much higher in the central and southern zones, which had prevalence rates of more than 20 percent. The prevalence rate in Sofala province reached 27 percent in 2004.

HIV prevalence rates have remained fairly stable in Malawi. Behavior changes that reduce the risk of HIV infection may account for prevalence among pregnant women remaining around 15 to 17 percent since 2000, as detected by sentinel surveillance.

According to the latest DHS, the national adult HIV prevalence rate for Zambia has declined, from 15.6 percent in 2001 to 14.3 percent in 2007. Women continue to have higher prevalence rates than men (16.1 and 12.3 percent, respectively). The epidemic continues to have a significant impact on urban areas, where HIV prevalence is twice as high as in rural areas (20 percent and 10 percent, respectively).

ART is increasing rapidly in southern Africa, but there is still a large percentage of the region's population in need of treatment who have yet to receive it. There is also great variation from country to country, as seen in the following ART coverage rates: Angola, 10 percent; Botswana, 79 percent; Lesotho, 31 percent; Malawi, 43 percent; Mozambique, 14 percent; Swaziland, 42 percent; Zambia, 35 percent; and Zimbabwe, 15 percent. ART coverage rates among HIV-infected children and pregnant women are significantly lower than in the general HIV-infected population. For example, Botswana has almost universal coverage in the general HIV-infected population, yet only 54 percent of HIV-infected pregnant women have access to treatment to prevent mother-to-child HIV transmission. In Zambia, 35 percent of all people needing treatment receive it; however, only 15 percent of HIV-infected children and pregnant women receive treatment.

HIV-tuberculosis (TB) co-infection, which poses a challenge to providing treatment and care for both diseases, is of increasing concern in southern Africa. In 2006, TB incidence rates per 100,000 population in the region were Angola, 127; Botswana, 218; Lesotho, 255; Malawi, 143; Mozambique, 186; Namibia, 316; South Africa, 382; Swaziland, 458; Zambia, 228; and Zimbabwe, 227. The southern Africa subregion has the highest rates of HIV prevalence in adult-incident TB cases in the world. In Angola, it is 6 percent; Botswana, 54 percent; Lesotho, 48 percent; Malawi, 70 percent; Mozambique, 30 percent; Namibia, 38 percent; South Africa, 44 percent; Swaziland, 54 percent; Zambia, 37 percent; and Zimbabwe, 43 percent.

Economic and Social Impact of HIV/AIDS in the Southern Africa Region

The consequences of high HIV prevalence are felt in virtually every area of life. After years of steadily improving life expectancy, AIDS is wiping out this gain and causing life expectancy to drop to levels not seen in decades. The U.S. Census Bureau predicts that by 2010, life expectancy in Botswana could be 27 years; in Swaziland, 33 years; and in Namibia and Zambia, 34 years – half of what they would have been without the effect of AIDS.

Part of the impact of AIDS on life expectancy in southern Africa is due to child mortality, either as a direct or indirect result of AIDS. In Botswana, under-5 mortality had been reduced to 62 deaths per 1,000 live births between 1990 and 1995; today, under-5 mortality is approximately 106 deaths per 1,000 live births. However, the biggest increase in mortality has been among adults aged 20 to 49, who accounted for only 20 percent of all deaths between 1985 and 1990. Today, this age group accounts for almost 60 percent. Although the usual pattern of disease-related mortality is concentrated among the very young and very old, AIDS causes deaths among adults in their most economically productive years, weakening the segment of the population that could best respond to the crisis.

In the hardest-hit countries, HIV/AIDS is depleting technical and administrative capacity through illness, death, and emigration. 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.

Most health systems in Africa already face labor shortages due to worker migration to other regions for better pay and working conditions. For example, more than 5,000 doctors have left South Africa in recent years, and 300 nurses leave every month. 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. HIV/AIDS is exacerbating these shortages by affecting large numbers of the remaining health care workers. Botswana, for example, lost 17 percent of its health care workforce to HIV/AIDS between 1999 and 2005. In Malawi, more than 1,400 health sector employees died during the 1990s. Zambia – which once had 1,600 doctors – now has 400, and 40 percent of the country's midwives were found to be HIV positive.

Agriculture is also neglected or abandoned by households affected by HIV/AIDS, adding to food insecurity in many areas. Millions of agricultural workers have died of AIDS in societies where up to four-fifths of the population depend on small-scale subsistence agriculture for family livelihoods. In Malawi, where the agricultural workforce is expected to shrink by 14 percent by 2020, HIV/AIDS is the source of the country's falling agricultural output. In Mozambique, Botswana, Namibia, and Zimbabwe, the International Labor Organization estimates that the agricultural workforce loss by 2020 could be as high as 20 percent.

Household and community impacts are also great. A recent study in northern Zambia explored the dynamics of the impact of HIV-related illness on families and communities and found that female-headed households taking care of people living with HIV supported an average of 3.6 orphans each – far more than male-headed households. They were also "food-insufficient" for an average of 3.4 months a year. Few households taking care of HIV-positive people were able to participate in cooperatives – the main source of loans for agriculture – due to financial or time constraints.

The impact of AIDS on children continues to mount. Currently, children under age 15 account for one in six AIDS-related deaths worldwide and one in seven new HIV infections – the vast majority through mother-to-child transmission. In southern Africa, approximately 9 percent of children under 15 have lost at least one parent to AIDS, and one in six households has children caring for at least one orphan. The orphan crisis is expected to worsen considerably in the coming years. Many of these children are raised by their grandparents. As more parents die, the effect of HIV/AIDS on the region's children cannot be overstated. Many children orphaned by AIDS lose their childhood and are forced by circumstances to become producers of income or food, or caregivers for sick family members. They suffer their own increased health problems related to inadequate nutrition, housing, clothing, and basic care.

Orphans are also less able than other children to attend school regularly. In Zimbabwe, a study found markedly low primary school completion rates among children who had lost their mothers. This is partly because of a lack of support from fathers (many of whom are absent for employment reasons) and the reluctance of stepmothers to care for stepchildren. School completion was higher among paternal orphans and double orphans, particularly girls. The World Food Program's recent *Literature Review on the Impact of Education Levels on HIV/AIDS Prevalence Rates* found that rising HIV rates were correlated with lower levels of education. A study in Zambia from the same source found that AIDS spreads twice as fast among uneducated girls.

National/Regional Responses

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

In recent years, Angola has tripled the budget allocated to the national response with major grants from the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria. In 2005, Angola received a two-year grant of $27.7 million from the Global Fund to prevent HIV transmission and reduce the socioeconomic impact of the epidemic through the implementation of an integrated multisectoral approach that reinforces and extends existing efforts in HIV prevention, treatment, and surveillance, while increasing institutional capacity, mobilizing and supporting people living with HIV/AIDS (PLWHA), coordinating partners, and monitoring the distribution and use of resources.

In Botswana, the National AIDS Council, with technical support from the National AIDS Coordinating Agency, has implemented a multisectoral response, with HIV/AIDS an integral part of the national development plan. The National Strategic Plan on

HIV/AIDS for 2003–2009 focuses on expanding the multisectoral response and incorporating civil society and the private sector, as well as national- and district-level stakeholders. In 2003, Botswana adopted routine HIV testing to increase the number of people who know their status, thus potentially increasing demand for ART. Additionally, Botswana is the first African country to offer free ART to its citizens and had 91,780 people on ART as of the end of 2007. This represents a coverage rate of 79 percent.

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 a national AIDS strategic plan, and the establishment of the Lesotho AIDS Program Coordinating Authority under the Prime Minister's Office. In 2005, the Government passed a bill establishing the semi-autonomous National

AIDS Commission (NAC) and National AIDS Secretariat to coordinate and support strategies. In 2006, Lesotho's Parliament enacted a bill providing married women, who up to then were considered minors, with status equal to their spouses. Another favorable development was the release of the Statement of Commitment by Lesotho's Church Leaders on AIDS.

The Government of **Malawi**'s response to the epidemic, in collaboration with the U.S. Government (USG) and other international partners, has been impressive. It is currently implementing its second National HIV/AIDS Action Framework for 2005–2009, building from the groundwork laid by the first National Strategic Framework for 2000–2004. The Ministry of Health is the leading provider of health services to the population, with facilities at the local, district, and national levels. The single biggest constraint on health services is the shortage of health professionals at all levels and locations in Malawi, with the greatest impact on peripheral services. Malawi has filled only 40 percent of established medical posts, with most of the unfilled posts located in rural areas.

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

Namibia has declared HIV/AIDS to be its top priority. With HIV prevalence among pregnant women reported at 22 percent by sentinel surveillance in 2002, prevention of mother-to-child HIV transmission (PMTCT) is a priority action area. Other priorities of the National HIV/AIDS Strategic Framework include condom distribution, information and behavior change communication, treatment of sexually transmitted infections, workplace programs, and care and support. In addition to national efforts, individual ministries have initiated sector-specific HIV/AIDS programs.

South Africa, which has more HIV-positive individuals than any country in the world, has shown high-level commitment to providing care and treatment for those living with HIV/AIDS and prevention interventions for those who are not. The country allocates 15 percent of government expenditures to health and has drafted a national strategic framework involving 16 key sectors and a wide range of partners. The Comprehensive HIV/AIDS Care, Management and Treatment Plan aims to provide ART to 1.4 million people by 2008. According to the South African Department of Health, by the end of October 2006, an estimated 224,895 patients were started on ART, of whom 22,411 were children.

Swaziland has actively responded to HIV since 1986. In 1999, King Mswati III declared AIDS a national disaster and established the Cabinet Committee on HIV and AIDS and the Crisis Management and Technical Committee, which developed the National Strategic Plan for 2000–2005. New strategic and action plans for 2006–2008 were developed by a broad group of national stakeholders. The six key areas of the plans are prevention; care and support; impact mitigation; communications; monitoring and evaluation; and management and coordination. In November 2007, the Swaziland National Country Coordinating Mechanism applied to the Global Fund for a third HIV/AIDS grant – a seventh-round proposal for a five-year, $81.9 million grant for HIV/AIDS. Swaziland is currently implementing a fourth-round grant approved in 2005 to scale up key components of the national HIV/AIDS response.

Zambia has made HIV/AIDS an integral part of its poverty reduction efforts. Its National Strategic Plan for HIV/AIDS consists of seven objectives: promotion of behavior change; PMTCT; safe blood transfusion; counseling and testing; care and support for PLWHA, including orphans and other affected children; an information system database; and multisectoral coordination at the district, provincial, and national levels. Integrating HIV/AIDS into all government sectors is a high priority, but implementation is hampered by a lack of available human resources.

Although **Zimbabwe** is in the mature stage of a generalized HIV and AIDS epidemic, there are important age, gender, and geographical differences in HIV prevalence. The new National Behavior Change Strategy, finalized in mid-2006, has received wide acclaim both for the research that was undertaken for its development and for its strategic focus. Under the direction of the National AIDS Council, it has received strong endorsement from the Ministry of Health and Child Welfare and is widely supported by the nongovernmental organization (NGO) and donor communities. Primary goals focus on safer sexual behavior, greater access to services, and a more enabling environment for change. A well-coordinated district-based approach is outlined. Zimbabwe's national ART program began providing antiretroviral (ARV) drug services on a relatively large scale in 2004. As of September 2006, approximately 40,000 people were on ARVs, with about 35,000 people receiving ARV services through the public sector.

Partnering for Success: USAID and the U.S. President's Emergency Plan for AIDS Relief

The U.S. President's Emergency Plan for AIDS Relief (Emergency Plan/PEPFAR) is the largest commitment ever by any nation for an international health initiative dedicated to a single disease. To date, the U.S. has committed $18.8 billion to the fight against the global HIV/AIDS pandemic, exceeding its original commitment of $15 billion over five years.

Reauthorized on July 30, 2008, the U.S. is continuing its commitment to global AIDS in the amount of $39 billion for HIV/AIDS bilateral programs and contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Working in partnership with

host nations, the initiative will support antiretroviral treatment for at least 3 million people, prevention of 12 million new HIV infections, and care and support for 12 million people, including 5 million orphans and vulnerable children.

The Emergency Plan encompasses all USG international HIV/AIDS activities, including those implemented by USAID. Under the Emergency Plan in Africa, USAID's staff of foreign service officers, trained physicians, epidemiologists, and public health advisors work with host governments, NGOs, and the private sector to provide training, technical assistance, and supplies – including pharmaceuticals – to prevent and reduce the transmission of HIV/AIDS and provide care and treatment to PLWHA. In fiscal year 2008, USAID continued efforts to prevent the spread of HIV/AIDS using several interventions:

- The ABC (Abstinence, Be faithful, correct and consistent use of Condoms) approach to preventing sexual transmission of HIV Research and interventions on the prevention of AIDS through male circumcision
- Prevention of further HIV transmission with PLWHA
- PMTCT services
- Voluntary counseling and testing (VCT)
- Injection safety and ensuring the safety of blood supplies
- Provision of therapy for concurrent illnesses and opportunistic infections, as well as palliative care
- Nutritional therapy
- Provision of ART for PLWHA
- Support for OVC

USAID is uniquely positioned to support multisectoral responses to HIV/AIDS that address the widespread impact of HIV/AIDS outside the health sector. In particular, USAID is supporting cross-sector programs in areas such as agriculture, education, democracy, and trade that link to HIV/AIDS and mutually support the objective of reducing the impact of the pandemic on nations, communities, families, and individuals. Under the Emergency Plan, USAID also supports a number of international partnerships; provides staff support to the Global Fund; and works with the Fund's local coordinating committees to improve implementation of Fund programs and their complement to USG programs. In addition, USAID supports targeted research on vaccines; the development and dissemination of new technologies; new packaging and distribution mechanisms for ARVs; training for improved local responses to the epidemic by NGOs and faith-based organizations; and infrastructure development for appropriate clinical design and laboratory facilities.

USAID Country Support in Southern Africa

In southern Africa, USAID-supported Emergency Plan initiatives are carried out in five focus countries: Botswana, Mozambique, Namibia, South Africa, and Zambia. In addition, HIV/AIDS programs are also implemented in many other countries, including Angola, Lesotho, Malawi, Swaziland, and Zimbabwe.

The USAID Regional HIV/AIDS Program (RHAP), based in Pretoria, South Africa, supports five PEPFAR focus countries, three bilateral programs, and three non-USAID presence countries (Botswana, Lesotho, and Swaziland). 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.

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

- In Angola, USAID supports the *Jango Juvenil* (Youth Centers) Project, run jointly with *Banco de Fomento Angola* to disseminate HIV/AIDS prevention messages to young people using interactive techniques. To date, the Project has reached about 160,000 youth. USAID recently opened a fifth *Jango Juvenil*, and there are plans to build more centers and integrate VCT services into existing recreational and HIV prevention activities. In areas where the *Jango Juvenil* Project is operating, youth aged 15 to 24 reported fewer sexual partners in one three-month period than youth in other areas.
- In Lesotho, USAID's support for an assessment of the national PMTCT program in 2004 resulted in a Ministry of Health and Social Welfare follow-on request for increased support to the national program. In response, USAID funded and organized a PMTCT partnership that includes the Elizabeth Glaser Pediatric AIDS Foundation, Columbia University, the Infant and Young Child Nutrition Project, and Baylor College of Medicine. Together, these organizations are responsible for coordinating PMTCT, PMTCT+, and postnatal care activities with government

counterparts. By the end of 2008, the partnership will provide PMTCT services in seven of 10 districts nationwide, including seven hospitals, three filter clinics, and 47 health centers.

- In **Swaziland**, USAID supported the "Reducing Gender-Based Violence as a Cause and Consequence of HIV/AIDS" campaign of the Swaziland Action Group Against Abuse. The campaign reached more than 5,900 people in 67 communities while also promoting men's involvement in preventing HIV and gender-based violence. USAID also supported the National AIDS Program in HIV testing and counseling and has been at the forefront of policy, technical guidance, service delivery, and training for national VCT scale-up. The USG has provided substantial assistance to the rollout of Swaziland's provider-initiated counseling and testing plan while maintaining an important focus on outreach and client-initiated counseling and testing.

- Through PEPFAR, USAID in **Botswana** has provided support to the Department of Social Services in the Ministry of Local Government in policy development, scaling up OVC programs, and an assessment of the child welfare situation in the country. The Department provided food basket services, education, and health care to 53,000 orphans and 67,900 vulnerable children.

- In **Malawi**, USG-funded programs supported counseling and testing services for 579,200 people in 2006.

- In **Mozambique**, USG-funded programs reached 1.35 million individuals with community outreach HIV/AIDS prevention programs. In 2007, nearly 265,000 individuals received palliative care services, and 135,100 OVC received much-needed support.

- In **South Africa**, the number of HIV-positive pregnant women having received ART increased from 76,000 at the end of 2004 to 251,400 at the end of 2006. An estimated 47,700 infant infections were averted.

- USAID in **Namibia** assisted with the development of the national policy on OVC, completed and endorsed by the Ministry of Women Affairs and Child Welfare. In 2006, an OVC program served 88,700 children.

- By providing significant technical assistance to countries in the region, RHAP helped to increase the quality of health programs throughout southern Africa through the provision of technical assistance, 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 and Contacts

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USAID 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/

September 2008