Lesotho

Operational Plan Report

FY 2013

Lesotho Operational Plan Report Fy 2013 Aids Relief

United States United States
Department of State

Lesotho Operational Plan Report Fy 2013 Aids Relief:

Yearbook of International Organizations 2014-2015, Volumes 1a & 1b (Set) Union of International Associations,2014-06-16 Volume 1 A and B covers international organizations throughout the world comprising their aims activities and events Lesotho Operational Plan Report Fy 2013 United States United States Department of State,2014-11-12 The Kingdom of Lesotho located in the eastern part of Southern Africa covers an area of 30 350 km2 and has a population of 1 876 633 million Largely mountainous 23% of the population lives in urban areas clustered along the flatter north western borders The remaining 77% live in rural and difficult to access areas Less than 20% of the population has salaried employment and 77% of households in Lesotho depend on subsistence agricultural as their main source of food Employment in Lesotho is limited 43% of the population lives on less than 1 25 per day and the Lesotho workforce depend on migration to the Republic of South Africa for work opportunities such as mining agriculture construction and domestic work Health indicators are poor maternal mortality has increased to 1 155 deaths per 100 000 live births and population growth declined to 0 08% The impact of the HIV epidemic has been identified as a major factor in the decline in population growth and is linked to broader health and development challenges for Lesotho **Angola Operational Plan Report Fy 2013** United States United States Department of State,2014-11-12 In 2011 Secretary Clinton called on the world to join in the fight for an AIDS Free generation and in 2012 the Secretary revealed a PEPFAR President s Emergency Plan for AIDS Relief Blueprint outlining the path to making this a reality Aligned with the Global Health Initiative GHI Strategy our Partnership Framework PF and the Blueprint s policy imperative Angola s PEPFAR initiatives are based on strategic scientifically sound investments to scale up core HIV prevention to maximize impact Based on a capacity building systems strengthening model PEPFAR Angola is working with partners to effectively mobilize coordinate and efficiently use resources to save more lives sooner The focus will be on key populations on women and girls to increase gender equality and ending stigma and discrimination against people living with HIV Cross Cutting Appendix A This will be measured by setting benchmarks that are regularly assessed with the long term goal of country ownership The Angola PEPFAR Team will continue to build upon successes of our past maintaining current programs like supporting the Government of Republic of Angola GRA INLS INSP CNS decentralization plan with technical assistance in health systems strengthening implementation of an enhanced Prevention of Mother To Child Transmission PMTCT services building GRA human resources by training local surveillance experts to sustain the country s capacity in strategic information and supporting the military to strengthen its HIV Prevention Program and promote organizational networking with other military partners at the regional level In addition to continuing programs in fiscal year 2014 Angola PEPFAR will expand PMTCT and HIV testing and counseling in Luanda province and coordinate HIV initiatives across borders to demonstrate collaboration with our neighbors in unity toward an AIDS Free generation The United States Government USG Appendix C utilizes a technical assistance approach in areas identified by the

Ministry of Health MoH Secretary Clinton stated in her remarks at the 2012 International AIDS conference that we should continue to be focused on supporting high impact interventions and make tough decisions driven by science This is the fundamental goal of the Angola PEPFAR program **Mozambique Operational Plan Report Fy 2013** United States United States Department of State,2014-11-12 As part of our two year Country Operational Plan COP the 2013 plan supports the global priorities set forth in the AIDS Free Generation AFG policy to provide antiretroviral treatment ART for 6 million people perform 4 7 million voluntary medical male circumcision VMMC procedures provide antiretroviral ARV prophylaxis to 1 5 million HIV infected pregnant women to prevent mother to child transmission PMTCT support the Government of Mozambique s GRM national HIV AIDS Acceleration Plan 2013 2015 Acceleration Plan to increase the percentage of eligible adults and children with advanced HIV infection who receive antiretroviral therapy to 80% increase the percentage of HIV positive pregnant women who receive ARVs to 90% and increase the percentage of adult males circumcised in target provinces to 75% by 2015 The Acceleration Plan developed in collaboration with the PEPFAR Mozambique team and closely coordinated with the development of the Ministry of Health s Global Fund Round 9 phase II application for HIV AIDS prioritizes high impact interventions and geographic areas and focuses on a continuum of response by addressing key populations This year s COP represents result driven and target based budget allocations through direct application of PEPFAR Expenditure Analysis and other unit cost data to PEPFAR s contribution to the national targets Our interventions target priority districts identified in the GRM s Acceleration Plan and ensure strong linkages between counseling and testing care treatment and PMTCT for a robust continuum of response Our overall budget is carefully aligned to the priorities of an AIDS Free Generation Prevention activities represent 24% of our overall budget with 8% allocated to PMTCT for ARV prophylaxis for 61 147 pregnant women 8% allocated to VMMC to circumcise 224 413 men 3% reserved for sexual prevention to reach most at risk populations MARPs 4% dedicated to test and counsel 2 2 million individuals 33% allocated for antiretroviral ART treatment for 380 680 adults and children including 16% for ARV drugs 19% dedicated to the care of almost one million HIV infected adults and children including 10% for orphans and vulnerable children and 13% budgeted for system strengthening activities to support prevention care and treatment goals HIV commodities including ARV drugs represent 23% of the budget USG management and operations represent 11% of PEPFAR resources Tanzania Operational Plan Report Fy 2013 United States United States Department of State,2014-11-12 Since 2004 PEPFAR Tanzania has been working closely with the United Republic of Tanzania and other donors including the Global Fund to Fight AIDS Tuberculosis and Malaria to respond to the HIV epidemic PEPFAR T the GFATM and the URT share a symbiotic relationship in Tanzania While PEPFAR T predominantly focuses on services and system strengthening GFATM is responsible for commodity procurement and some systems strengthening and the URT provides policy framework infrastructure systems and personnel Deficits in resources governance and health systems continue to complicate Tanzania s ability to adequately

respond to HIV AIDS As a result Tanzania s health programs especially for HIV are highly dependent upon donor funding Foreign funds account for 97% of the Mainland s HIV AIDS response of which 90% come from the combined efforts of PEPFAR T 74% and the GFATM 16% In addition the country grapples with weak health infrastructure shortages of health and social workers high levels of stigma cumbersome government procurement systems weak management and strategic planning and poor accountability According to the 2011 UNAIDS Report on the Global AIDS Epidemic adult HIV prevalence in the country is estimated at 5 8% and an estimated 1 6 million Tanzanians are living with HIV of which 1 3 million are OVC An estimated 84 000 AIDS related deaths occur in Tanzanian each year According to the 2007 08 Tanzania HIV and AIDS and Malaria Indicator Survey the impact of the epidemic varies significantly by region with the highest prevalence region Iringa estimated at 15 7% and the lowest estimated Zanzibar at 0 6% and with a significant difference in the prevalence between urban 9% and rural 5% areas The data also reveal significant sex differentials in HIV prevalence with male prevalence at 5% and female prevalence at 7% A new THMIS was conducted in 2011 2012 and is due to be released in late March 2013 Despite a generalized epidemic key populations play a critical role in HIV transmission dynamics Data indicate that injection drug use specifically heroin use is on the rise in urban Tanzania and Zanzibar Studies carried out in Dar es Salaam indicate that the HIV prevalence is 42% among people who inject drugs 2007 and 31 4% among sex workers 2010 while unpublished data for men who have sex with men in Dar es Salaam indicates prevalence over 30% 2012 PEPFAR support to Tanzania has enabled a dramatic increase in the number of adults and children accessing ART with 364 000 individuals receiving treatment in FY2012 Also during FY2012 a total of 3 370 000 individuals received HIV testing and counseling 1 100 000 pregnant women were tested and counseled through PMTCT services 526 000 OVC received support and 152 000 VMMC took place **Swaziland Operational Plan Report Fy 2013** United States United States Department of State,2014-11-12 Swaziland is a landlocked kingdom at the epicenter of the global HIV AIDS pandemic struggling to mitigate the world s highest prevalence rates of HIV and TB Economically Swaziland is closely tied to South Africa from which it receives 90 percent of its imports and a large proportion of its public sector financing through the Southern African Customs Union SACU Compounding the economic situation and exacerbating the strains on the health and social systems was a precipitous fall in revenue resulting from two thirds cut of SACU customs receipts in 2009 More than half of the population is under 20 and nearly half of the youth are at extremely high risk of HIV The 2010 Multiple Indicator Cluster Survey MICS reported that 45 1% of children and youth fit the definition of orphaned or vulnerable Traditional family structures have all but collapsed with only 22 percent of children raised in two parent households Gender based inequalities violence poverty and income disparities persist in the country and create significant barriers to effective HIV prevention interventions and the up take of care and treatment services Economic growth and development have been deeply impacted by the health crisis which literally threatens the future of the kingdom The 2010 MICS reported high rates of malnutrition with 40 9 percent of children

experiencing moderate to severe stunting Furthermore anecdotal reports show that food insecurity is one of the main reasons that eligible individuals will not initiate treatment they fear not having food to take with ARVs The Swaziland HIV Incidence Measurement Survey SHIMS published in late 2012 provides the best data available to date on the epidemic SHIMS identified a national HIV prevalence of 31 percent among adults 18 49 years of age A reanalysis of the 2007 Demographic Health Survey data determined prevalence of 31 percent in adults 18 49 indicating that the HIV prevalence in Swaziland has stabilized in the last five years Adult incidence is high at 2 4 percent with a significantly higher incidence for women of 3 1 per cent 1 7 per cent for men **Botswana Operational Plan Report Fy 2013** United States United States Department of State,2014-11-12 The U S Botswana health partnership remains strong and effective HIV associated mortality has been reduced by more than half since treatment became available and the rate of new infections has declined Botswana s HIV treatment and Prevention of Mother to Child Transmission PMTCT programs are models for their coverage and quality of services The rate of mother to child HIV transmission in Botswana has declined to **Uganda Operational Plan Report Fy 2013** United States United States Department of State,2014-11-12 In September 2012 the Ministry of Health MOH released the results of the Uganda AIDS Indicator Survey UAIS 2011 which indicated that Uganda continues to experience a severe HIV epidemic HIV prevalence in the general population 15 to 59 years old is estimated to be 7 3% in 2011 compared to 6 4% in 2004 5 HIV prevalence is higher among women 8 3% than among men 6 1% Compared to the 2004 5 UAIS survey the magnitude of change in HIV prevalence varied across regions Central Western Southwestern and Northern regions remain the worst affected while modest declines in prevalence were recorded in the East Central and Mid Eastern regions Of particular concern is the rise in HIV prevalence among young people aged 15 24 years generally and in all age groups specifically in the West Nile and North East regions that previously were least affected UNAIDS projects the number of new annual infections at 150 000 2011 an increase from 120 000 in 2004 AIDS mortality is estimated at 62 000 deaths in 2011 the lowest estimate in a long decline since 2000 reflecting the significant expansion of ART The UNAIDS most recent World AIDS Day Report warned of increasing unprotected sex both sexes and multiple partners women The estimated number of people infected with HIV has risen to 1 39 million 55% of whom are female and 14% are children under the age of 15 years HIV is predominantly heterosexually transmitted accounting for 75 80% of new infections However population subgroups show that the most affected and the risk factors and drivers of HIV infections have evolved in recent years Studies show an HIV prevalence of 1 2% in university students 15 40% in fishing communities 37% among sex workers 18% in the partners of sex workers and 13% in the group of men with a history of having sex with men Strikingly 35% of new infections occur amongst self reported monogamous individuals which raises concerns regarding rising multiple concurrent partnerships The remaining transmissions are largely due to mother to child HIV transmission In response to the 2011 UAIS results PEPFAR revised its programmatic and technical approaches and targets to better respond to Uganda s escalating epidemic The 2013

COP is based on scientific evidence prioritized proven interventions resources matched effectively across subpopulations and efforts directed towards sources of new infections to assist the HIV AIDS epidemic response in Uganda The 2013 COP is the product of a consultative process that involved the GOU PEPFAR implementing partners IP and bilateral and multilateral donors Ghana Operational Plan Report Fy 2013 United States United States Department of State,2014-11-12 HIV prevalence and incidence have been declining in the general population since prevalence peaked at 2 4% in 1998 and is presently estimated at 1 5% in the general population Nevertheless the numbers of persons living with HIV and AIDS continue to increase due to population growth and to the decline in AIDS deaths as more infected persons receive anti retroviral treatment ART HIV infection rates among young pregnant women attending antenatal clinics have been declining as measured by the national HIV sentinel surveillance system HIV prevalence among persons 15 24 years old is estimated to be 1 7% and is expected to decline HIV prevalence in key populations 11% in sex workers and 18% in MSM and in tuberculosis patients 15% continues to be much higher than that of the general population From a modes of transmission study MOT conducted in 2008 it is estimated that sexual transmission accounts for the majority of new adult infections and that almost 40% of new adult infections can be attributed to FSWs their clients and the partners of their clients and MSM Twenty nine percent of new infections are attributed to casual heterosexual sex and the partners of those who engage in casual heterosexual sex It is unclear if informal transactional sex by people who do not consider themselves sex workers e g university students represents another driver of the epidemic An estimated 9% of all new infections is attributed to MTCT of HIV **Zimbabwe Operational Plan Report Fy 2013** United States United States Department of State,2014-11-12 The country continues to experience a generalized HIV epidemic with an estimated 1 2 million HIV infected adults and children in 2011 and approximately 58 000 deaths each year Social cultural and economic factors contributing to HIV transmission include transactional sex multiple and concurrent partners alcohol abuse low awareness of HIV infection status lack of ART use in undiagnosed individuals poor treatment adherence and low levels of male circumcision MC While prevalence among youth has dropped significantly it is worth noting that prevalence among girls was twice that of boys of the same age HIV is the leading cause of death among adults and accounts for over 27% of all deaths among mothers and infants Maternal mortality rate nearly tripled between 1994 and 2010 Zimbabwe s TB case rate 603 per 100 000 is one of the highest in the world The TB epidemic in Zimbabwe is largely HIV driven with a very high TB HIV co infection rate at 80% with an increasing number of MDR and XDR cases TB is the second leading cause of adult morbidity and mortality in Zimbabwe National Response The National AIDS Council NAC and the Ministry of Health and Child Welfare MOHCW lead the national HIV AIDS response and have outlined their goals in Zimbabwe National Strategic Plan ZNASPII 2011 2015 While the level of institutional leadership within the MOHCW is high in terms of technical direction and policy setting the capacity for implementation continues to be limited For the MOHCW low capacity is largely an outcome of limited national resources for

programming which affects its capacity to deploy and adequately train sufficient experienced health professionals provide adequate commodities and provide a high level of monitoring and supervision to ensure high quality service delivery As such donor resources have been essential to national prevention care treatment and health systems strengthening HSS efforts The majority of HIV AIDS related activities are donor funded Nevertheless Zimbabwe has not received the magnitude of donor funding that countries with similar HIV burden have been fortunate to access Zimbabwe is facing potential critical shortages of key inputs to achieve ambitious goals particularly in the areas of treatment prevention of mother to child transmission PMTCT and MC **Cameroon Operational Plan Report Fy 2013** United States United States Department of State,2014-11-12 Cameroon is a lower middle income country with a population of 20 million representing over 275 ethnic groups Cameroon s epidemiological profile is dominated by communicable diseases such as malaria and HIV prevalence of 4 3% DHS 2011 and an increased prevalence in non communicable diseases such as diabetes and cardiovascular disease Maternal mortality is estimated at 782 per 100 000 live births while the under five mortality rate is estimated at 122 per 1 000 live births Funding for health is approximately 5% of the 2013 budget In 2010 private spending out of pocket accounted for 70 4% of total health expenditure including 94 5% in the form of direct payments 13 2% of the funding was provided by external resources while government funds covered 16 4% of total expenditures on health World Bank Report on Health and Health Systems in Cameroon 2012 The significant financial burden on households to finance health care consequently affects access to and use of health services in Cameroon Malawi Operational Plan Report Fy 2013 United States United States Department of State,2014-11-12 The Republic of Malawi has a population of nearly 16 million people living in an area of 118 484 square kilometers approximately the size of Ohio As one of the poorest countries in the world currently ranked 171 out of 187 on the Human Development Index Malawi has faced an uphill battle to achieve improvements in key health indicators Malawi is faced with double digit HIV prevalence one of the highest malaria prevalence rates in the world and a population that is expected to double by 2030 These challenges are putting increasing pressure on land natural resources and social services Malawi is well known in the region for its innovations in public health programming and maintains a well coordinated health donor environment under the leadership of the Sector Wide Approach SWAp Secretariat in the Ministry of Health MoH The strong national commitment and leadership to improved health outcomes with support from development partners has significant achievements to show for it Malawi is on track to meet MDG 4 reducing child mortality by two thirds by 2015 HIV prevalenceamongst 15 49 year olds has declined from 11 8 % in 2004 to 10 6% in 2010 per the Malawian Demographic and Health Survey MDHS Maternal mortality has decreased from 1 120 per 100 000 live births in 2000 to 675 in 2010 Fertility has declined from 6 3 births in 2000 to 5 7 births per woman in 2010 Modern contraceptive use has increased from 26% in 2000 to 42% in 2010 Modeling of 2010 ANC data and the 2010 MDHS data shows just under one million Malawians living with HIV 19% of whom are children under 15 and 47% of whom are adult women AIDS is the

leading cause of death with an estimated 44 000 deaths in 2011 and is a major contributing factor to Malawi s low life expectancy of 54 years TB continues to be a challenge and co morbidity with HIV is common The WHO estimated 29 000 new cases of all forms of TB in 2011 with approximately 62% in PLHIV While there has been a significant increase in TB treatment success rate of 87% up from 67% in 2001 the overall case detection rate remains about 66% Zambia Operational Plan Report Fy 2013 United States United States Department of State,2014-11-12 The recent 2012 UNAIDS World AIDS Day Report showed significant improvements in HIV and AIDS related results globally In general new HIV infections declined among children there were fewer AIDS related deaths and there were increased investments in the response to HIV and AIDS Zambia like many countries has recorded significant improvements in all three key areas According to the report between 2001 and 2011 Zambia reduced new HIV infections by 58% while the country also cut AIDS related deaths by more than 50% The 2007 Zambia Demographic and Health Survey 2007 ZDHS measured adult HIV prevalence at 14 3% With the population currently standing at 13 1 million people with 61% in rural areas and 39% in urban areas Zambia still has one of the world s most devastating HIV and AIDS epidemics with more than one in seven adults living with HIV Infection rates are twice as high in urban as in rural areas while life expectancy is estimated at 49 years in what is still a generalized epidemic UNAIDS Report on the Global AIDS Epidemic 2010 The HIV epidemic is geographically diverse with provincial prevalence levels ranging from 6 8% to 20 8% The Northern and Northwestern provinces have the lowest prevalence just below 7% Both provinces are predominantly rural with low population density and high levels of poverty In contrast Lusaka Central and Copperbelt Provinces are more densely populated with large urban areas and have prevalence levels of 17% and higher The most recent UNAIDS Report on the Global AIDS Epidemic 2012 UNAIDS estimated Zambia s HIV prevalence among 15 49 year olds to have declined to 12 5% The country is awaiting the results of the newly started DHS that will enable an update to the most recent HIV and AIDS statistics The six key drivers of the HIV and AIDS epidemic in Zambia are 1 high rates of multiple concurrent partnerships 2 low and inconsistent condom use 3 low rates of voluntary medical male circumcision VMMC 4 population mobility 5 vulnerable groups with high risk behaviors and 6 mother to child transmission MTCT In addition other factors such as gender inequality disparity socio cultural practices and stigma interact with these drivers to sustain high levels of risk and vulnerability Ethiopia Operational Plan Report Fy 2013 United States United States Department of State,2014-11-12 With 82 million people Ethiopia is the second most populous country in Sub Saharan Africa Despite impressive economic growth Ethiopia remains a low income country with a real per capita income of US 351 and 39% of the population living below the international poverty line of 1 25 day According to the UN Human Development Index 2012 Ethiopia ranks 174 out of 187 countries on both the overall index and the per capita GNI Gross National Income It is also one of the least urbanized countries with 82% of the population living in rural areas In 2010 Ethiopia launched a five year Growth and Transformation Plan GTP which envisages an annual Gross Domestic Product GDP

base growth case scenario of 11% and a high growth case scenario of 14 9% Improving the quality of social services and infrastructure ensuring macroeconomic stability and enhancing productivity in agriculture and manufacturing are major objectives of the plan The high growth rate has been offset by high inflation in recent years Year on year inflation peaked at 64% in July 2008 the second highest in Sub Saharan Africa after Zimbabwe In 2012 the situation had apparently improved as the inflation rate had dropped from 35 9% in January to 15 6% by December 2012 The Health Sector Development Plan IV HSDPIV and the Strategic Plan for Intensifying Multisectoral HIV and AIDS Response SPMII outline their contributions towards the GTP The death a few months back of Prime Minister Meles has led to a change in leadership The new Minister of Health leads a young team and is looking to develop his own legacy after the charismatic leadership of the former Minister Dr Tewodros Adhanom who became Foreign Minister in December 2012 The HIV AIDS situation in Ethiopia continues to be characterized by a mixed epidemic with significant heterogeneity across geographic areas urban vs rural and population groups The 2011 Ethiopia Demographic and Health Survey EDHS found HIV prevalence at 1 5% nationally compared to 2 4% according to the formerly accepted Single Point Estimate Comparison with 2005 EDHS data suggest stable low HIV prevalence of 0 6% in rural areas but substantial declines from 7 7% to 4 2% in urban areas Routine biannual antenatal surveillance confirms sustained declines in HIV prevalence in both urban and peri urban areas up through the most recent estimate published for 2009 There are contrasts in prevalence across regions ranging from 6 5% in Gambella and 5 2% in Addis Ababa to 0 9% in SNNP residence types 4 2% urban versus 0 6% rural and gender 1 9% for women vs 1 0% for men Prevalence among 15 24 years has also significantly declined from 12 4% in 2001 to 2 6% in 2009 SPECTRUM projections combining DHS and ANC data estimate a rapidly declining mixed epidemic where incidence has fallen to 0 03% a 60% reduction since the introduction of PEPFAR in Ethiopia in 2005 Only Gambella region in southwestern Ethiopia with less than 0 5 percent of Ethiopia s population of 82 million showed a net increase in HIV prevalence over the same period and a worrying 9% prevalence among women aged 15 24 years At the same time projected national incidence rates were substantially lower than previously estimated with just over 20 000 new cases in 2012 compared to over 134 000 according to the former Single Point Estimate although the country retains a substantial burden for secondary prevention and treatment with an estimated 734 000 people currently living with HIV in 2013 According to SPECTRUM 70% of projected new infections in 2013 will come from sexual transmission which is disproportionately low compared with other countries This may be attributable to the relative successes with prevention of sexual transmission and high treatment coverage compared with relative lack of success with prevention of vertical transmission **Nigeria Operational Plan Report Fy 2013** United States United States Department of State,2014-11-12 The Federal Republic of Nigeria consists of six geo political zones that include thirty six 36 states and the Federal Capital Territory FCT which in turn contain seven hundred and seventy four 774 local government areas LGAs Nigeria occupies an area more than twice the size of the State of

California In both geographic size and population many states are larger than various African countries The country has 3 46 million HIV positive individuals and constitutes the third greatest burden of HIV AIDS care and treatment worldwide Adding to this burden are the estimated 2 19million children orphaned by HIV AIDS 1 Nigeria also has one of the highest tuberculosis TB burdens in the world 311 100 000 population2 and the largest TB burden in Africa Many TB cases go undetected despite increasing TB detection rates and TB program coverage This situation results in significant challenges for the HIV AIDS response due to the high rates of TB HIV co infection Since reporting the first case of AIDS in Nigeria in 1986 the epidemic has become generalized This illness affects all population groups and spares no geographical area Generalized prevalence among 15 49 year olds is about 3 6 percent3 but significantly higher rates exist among key populations including commercial sex workers 30 2 37 4 percent injecting drug users 5 6 percent and men who have sex with men 13 5 percent 4 Heterosexual transmission accounts for up to 95 percent of HIV infections Women account for close to 60 percent of all adults living with HIV 5 **Rwanda Operational Plan Report Fy 2013** United States United States Department of State,2014-11-12 Rwanda has made remarkable progress since the tragedy of the 1994 genocide with growth in real per capita income averaging nearly 5% and accelerating to an average of over 8% in the period 2006 2010 NISR Statistical Yearbook 2011 However Rwanda remains one of the world s poorest countries and is ranked 166 out of 187 countries on UNDP s Human Development Index 2011 According to the 2011 household survey 45% of the population lives below the poverty line of 1 30 per day with 24% falling below an extreme poverty threshold of about 0 90 per day NISR 2012 Although Rwanda has made significant progress in improving the health status of its population much work remains Females have a life expectancy of 53 8 years while males have a life expectancy of 49 4 years NISR 2011 The burden of disease in Rwanda is similar to that of other developing countries Acute respiratory infections ARI accounted for 36% of all illnesses in 2011 followed by intestinal parasites 9% Rwanda MOH Annual Health Statistics Booklet 2011 Cases of malaria have dropped from 8% in 2010 to 3% in 2011 but account for 6% of total deaths in 2011 as compared to 13% in 2010 In 2011 HIV and associated opportunistic infections was the fourth leading cause of hospital mortality with 7% of deaths after premature birth 11% ARIs 9% and cardiac diseases 9% *Burundi Operational Plan Report Fy 2013* United States United States Department of State,2014-11-12 Burundi is a low income developing country with a population of 10 5 million July 2012 CIA World Fact book an annual population growth of 2 4 percent and more than 300 inhabitants per km2 This makes Burundi the country with the second highest population density in sub Saharan Africa Burundi remains one of the poorest countries in the world with a per capita gross national income GNI of 170 and it is considered one of the world s 40 Heavily Indebted Poor Countries Additionally it is worth noting that a civil war which lasted 13 years from 1993 killed more than 300 000 people severely weakened the health and social welfare systems and negatively affected donor support and private sector investment in Burundi Namibia Operational Plan Report Fy 2013 United States United States Department of

State,2014-11-12 Namibia is one of Africa s largest yet least densely populated nations With an estimated population of 2 1 million and a land mass slightly more than half the size of Alaska 825 400 sq km Namibia s people are distributed unevenly in urban centers and rural communities across enormous distances with a population density of 2 8 people sq km Namibia s projected population growth rate remains at 1 87% and the Government of the Republic of Namibia GRN anticipates continued growth in demand for health and social services through the current 30 year planning cycle 1 In 2010 nearly 60% of the population was under the age of 24 2 3 of whom were estimated to be under the age of 18 2 Based on Gross National Income per capita the World Bank WB has classified Namibia as an Upper Middle Income Economy 3 However substantial income inequalities exist Namibia s Gini coefficient ranks among the highest in the world 4 Current estimates suggest that up to 28 7% of Namibians live in poverty 5 Chronically high unemployment 34% in the formal sector according to recent IMF estimates is an important contributing factor to elevated rates of poverty 6 Namibia depends on revenues from the common South African Customs Union pool for approximately 30% of its budget the percentage varies from year to year and could be hard hit by a revision of the formula used to distribute these revenues In addition the economy is heavily dependent on fluctuating mineral prices with revenues from uranium and diamonds comprising 8% of the budget Mining fishing agriculture and tourism are expected to remain the pillars of the economy for the next decade According to recent visits from International Monetary Fund and WB teams Namibia s outlook for the next 1 to 3 years is stable However both institutions have urged caution given the expansionary budgets the GRN has adopted over the last two years **President's Emergency Plan for AIDS Relief: Efforts to Align Programs with Partner Countries' HIV/AIDS Strategies and Promote Partner Country Ownership** , **AIDS Operational Plan** Brian L. Gibson,Toronto (Ont.). Department of Public Health,Toronto (Ont.). Board of Health,1989

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