



CHAPTER 7

HIV and AIDS

Article 27



Blood testing for HIV in Antananarivo, Madagascar.
Photo: Zotonantenaina Razanatratafa

KEY POINTS

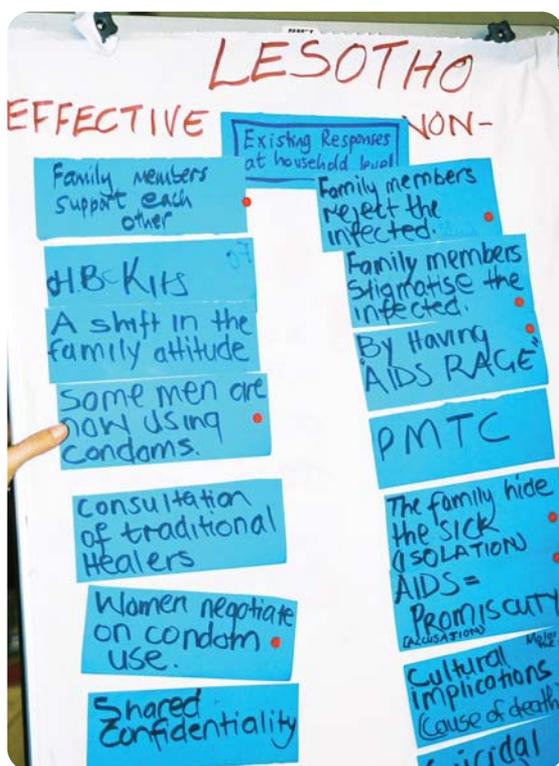
- Southern Africa Development Community (SADC) is still the epicentre of the HIV epidemic, accounting for 38% of new infections globally in 2017. South Africa accounts for 39% of new infections in SADC, Mozambique 15% and Tanzania 10%.
- Though rates of new infections are declining, at the current rate of decline the region will still have at least 570, 000 new infections annually in 2020, more than double the target of 230,000.
- Gender inequality is still a strong driver of the pandemic: 59% of new infections in Southern Africa are women, but 53% of AIDS related deaths are men.
- Young women 15 to 24 years old are only 10% of the total population but 26% of new HIV infections.
- Considerable effort is being invested in prevention including Comprehensive Sexuality Education (CSE), Voluntary Medical Male Circumcision (VMMC), services for key populations such as harm reduction, condoms, Pre-Exposure Prophylaxis (PrEP) and continued Prevention of Mother-to-Child Transmission (PMTCT). South Africa is set to become the first country in Southern Africa to decriminalise sex work.
- Progress is being made towards 90-90-90, the UNAIDS programme to diagnose 90% of all HIV-positive persons; provide Anti-Retroviral Therapy (ART) for 90% of those diagnosed and achieve viral suppression for 90% of those treated by 2020. Madagascar, Angola and DRC still require support and resources.
- All countries have made significant progress in PMCTC. Ten countries (Seychelles, Mauritius, Zimbabwe, Namibia, South Africa, Zambia, Malawi, Botswana, eSwatini and Lesotho) now have coverage of 90% or higher.
- Most countries in SADC have adopted Test and Treat which is rapidly increasing the number of people that are on ART.
- The rising number of people on treatment requires a much greater focus on differentiated care within the community, from community caregivers who need training, support, supplies, remuneration and recognition.

SADC is still the epicentre of the HIV epidemic

Table 7.1: Trends in HIV and AIDS since 2009

	Target 2030	Baseline 2009	Progress 2018	Variance (progress minus 2030 target)
SHARE OF HIV INFECTION				
Highest percentage of women	50%	Namibia (68%)	Tanzania (61%)	11
Lowest percentage of women	50%	Mauritius (15%)	Mauritius (28%)	-32
HIV POSITIVE PREGNANT WOMEN RECEIVING PMTCT				
Country with highest coverage	100 %	Seychelles (99%)	Seychelles (100%)	0
Country with lowest coverage	100 %	Madagascar (3%)	Madagascar (11%)	-89
PERCENTAGE OF THOSE ELIGIBLE RECEIVING ARVS				
Country with the highest proportion	100 %	Namibia (68%)	eSwatini (85%)	-15
Country with lowest proportion	100%	Madagascar (3%)	Madagascar (7%)	-93
EXTENT OF COMPREHENSIVE KNOWLEDGE OF HIV AND AIDS				
Highest percentage of women	100 %	South Africa (95%)	Seychelles (100%)	0
Lowest percentage of women	100 %	Angola (7%)	DRC (17%)	-83

Source: Gender Links, 2018.



The trends table shows wide variations between SADC countries between the highest and lowest achievements. The most significant change has occurred in prevention of Prevention of Mother-

to-child Transmission of HIV (PMTCT) where there are now at least ten countries (Seychelles, Mauritius, Zimbabwe, Namibia, South Africa, Zambia, Malawi, Botswana, eSwatini and Lesotho) that have achieved over 90% coverage. This is a major achievement for a country such as South Africa which has a large population that must be reached. The Post 2015 SADC Protocol on Gender and Development is set to support SADC's huge efforts to end AIDS by 2030. In East and Southern Africa (ESA), the populations requiring continued focus are: adolescent girls and young women and their partners; sex workers, older people, men who have sex with men, prisoners, migrants, injecting drug users and intimate partners.

Background

There has been remarkable progress on HIV and AIDS over the last decade with regard to increased access to treatment; much lower mother to child transmission; much reduced illness and death. However, SADC remains the epicentre of the epidemic. It is still home to at least 40% of all people that are living with HIV globally, though it accounts for less than 4% of the world's total population. Total number of AIDS-related deaths in SADC increased from 82,300 in 1990 (28% of the global total of 290,000), to 758,400 in 2003 (40% of the global total of 1.9 million). This figure has declined to 313,800 in 2017 or 33% of the global total of 940,000.¹

¹ Derived from UNAIDS: AIDS Info. AIDS Related Deaths. <http://aidsinfo.unaids.org/> accessed 20 July, 2018.

The Post
2015
SADC
Protocol
supports
huge
efforts to
end
AIDS by
2030

Table 7.2: HIV Prevalence in Adults 15 - 49: 1990, 2008 and 2017

Country	1990	2008	2017	Variance (2017 minus 2008)
eSwatini	1.9	27.2	27.4	0.2
Lesotho	1.3	22.8	23.8	1
Botswana	7.0	23.4	22.8	-0.6
South Africa	0.7	18.0	18.8	0.8
Zimbabwe	14.9	16.5	13.3	-3.2
Mozambique	1.8	14.1	12.5	-1.6
Namibia	1.6	14.3	12.1	-2.2
Zambia	8.1	12.7	11.5	-1.2
Malawi	9.1	11.5	9.6	-1.9
Tanzania	5.4	6.1	4.5	-1.6
Angola	0.2	1.6	1.9	0.3
DRC	1.7	1.4	0.7	-0.7
Madagascar	<0.1	0.2	0.3	0.1
Global	0.3	0.8	0.8	0

Source: UNAIDS: AIDS Info. HIV Prevalence. Adults 15 - 49. <http://aidsinfo.unaids.org/> accessed 19 July, 2018.

Some improvement: Table 7.2 shows the adult HIV prevalence rates in SADC for 1990, 2008 (when the first Barometer was produced) and 2017. Data for Mauritius and Seychelles (which have very low prevalence rates) is not available. The table shows that the prevalence has stabilised in many countries and is beginning to decline in some such as Botswana, Zimbabwe, Mozambique, Namibia, Zambia, Tanzania, DRC and Malawi.

But SADC is home to three countries (eSwatini, Botswana and Lesotho) with the highest prevalence of HIV and AIDS in the world. All three have adult prevalence rates higher than 20%. South Africa, Zimbabwe, Namibia, Zambia and Mozambique have prevalence rates ranging from 10 to 19%². Only DRC, Madagascar, Mauritius and Seychelles have HIV prevalence rates that are lower than the global average of 0.8%.

The pandemic is still distinctly gendered with a greater toll on young women and women than on men. However, this chapter underscores the fact that progress can only be made when women move with men. As we seek to “leave no one behind” governments must pay more attention to the most marginalised and ensure that appropriate services are available to all.

Southern Africa has for decades been a region of high mobility which increases the risk of HIV infection. The Lesotho Population-Based HIV

Impact Assessment (LePHIA) found that HIV prevalence is 39.1% for women who have lived outside in comparison to 28.5% for women who have not lived outside and 27.5% for men who have lived outside compared to 17.8% for men who have not lived outside of Lesotho.³ Female sex work is high along many of the transport routes in the region and the HIV prevalence rates are very high among female sex workers. Men who have sex with men, prisoners, other lesbian, gay, bisexual, and transgender and intersex (LGBTI) populations, people living with disabilities and people affected by displacement and emergencies are all people at higher risk.

People who inject drugs remain vulnerable to HIV infection: Although the overall proportion of the SADC population that injects drugs is low, some countries with large numbers of drug users have high HIV prevalence in this group. For example, 44.3% of injecting drug users in Mauritius; 11.3% in DRC; 3.8% in Seychelles; 8% in Madagascar and 15.5% in Tanzania are HIV positive⁴. There is also evidence to suggest that women who inject drugs face violence from intimate partners, police and sex trade clients, which increases their vulnerability to HIV infection. Women who inject drugs remain less likely to access services, so if those living with HIV and AIDS become pregnant they are much less likely to access Prevention of Mother to Child Transmission (PMTCT) services.

² Prevalence of HIV, in Table 1 <https://data.unicef.org/topic/hivaids/global-regional-trends/> Accessed 2 July, 2017.

³ Lesotho Population Based HIV Impact Assessment. 2017. Summary Sheet Preliminary Results.

⁴ Derived from People who inject drugs - HIV prevalence <http://aidsinfo.unaids.org/#>, last accessed July 20, 2016.

SADC is home to 3 countries with the highest prevalence of HIV and AIDS in the world

Policies



Article 27.1: State Parties shall take every step necessary to adopt and implement gender sensitive policies and programmes, and enact legislation that will address prevention, treatment, care and support in accordance with, but not limited to, the Maseru Declaration on HIV and AIDS and the SADC Sponsored United Nations Commission on the Status of Women Resolution on Women, the Girl Child and HIV and AIDS and the Political Declaration on HIV and AIDS.

Article 27.2: State parties shall ensure that the policies and programmes referred to in sub-Article take account of the unequal status of women, the particular vulnerability of the girl child as well as harmful practices and biological factors that result in women constituting the majority of those infected and affected by HIV and AIDS.

Achieving the 90-90-90: The June 2016 high level meeting on HIV and AIDS adopted the Political Declaration on HIV and AIDS which endorses the UNAIDS strategy for 2016 to 2021: *On the Fast Track to End AIDS*⁵. Though the SDGs do not have specific targets for HIV and AIDS as the MDGs did, this strategy has specific targets that are linked to achievement of a number of SDGs. The **2016-2021 Strategic Agenda** is organised around five SDGs most relevant to the AIDS response: good health (SDG 3), reduce inequalities (SDG 10), achieve gender equality (SDG 5), promote just and inclusive societies (SDG 16) and revitalize global partnerships (SDG 17), while recognizing that other SDGs such as end poverty (1) and ensure quality education (4) are also important. It emphasises that all regions

must analyse their own situations to ensure that no one is being left behind. In East and Southern Africa this requires much greater emphasis on adolescent girls and young women with focus also on sex workers, older people, men who have sex with men, prisoners, migrants, injecting drug users and intimate partners.

The vision of the strategy is **Zero new HIV infections, Zero discrimination and Zero AIDS-related deaths**. The strategy has three overall strategic directions:

- HIV prevention.
- Treatment, care and support.
- Human rights and gender equality for the HIV and AIDS response.

The ten targets of the five-year plan include:

1. 90% of people (children, adolescents and adults) living with HIV know their status, 90% of people living with HIV who know their status are receiving treatment and 90% of people on treatment have suppressed viral loads;
2. Zero new HIV infections among children, and mothers are alive and well;
3. 90% of young people are empowered with the skills, knowledge and capability to protect themselves from HIV;
4. 90% of women and men, especially young people and those in high-prevalence settings, have access to HIV combination prevention and sexual and reproductive health services;
5. 27 million additional men in high-prevalence settings are voluntarily medically circumcised, as part of integrated sexual and reproductive health services for men;
6. 90% of key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants, have access to HIV combination prevention services;
7. 90% of women and girls live free from gender inequality and gender-based violence to mitigate the risk and impact of HIV;
8. 90% of people living with, at risk of and affected by HIV report no discrimination, especially in health, education and workplace settings;
9. Overall financial investments for the AIDS response in low- and middle-income countries reach at least US\$ 30 billion, with continued increase from the current levels of domestic public sources;
10. 75% of people living with, at risk of and affected by HIV, who are in need, benefit from HIV-sensitive social protection.



⁵ UNAIDS Strategy, 2016 - 2021. On the Fast Track to end AIDS <http://www.unaids.org/en/resources/documents/2016/GlobalPlan2016> accessed 10 May, 2016.

All SADC member states have redoubled their efforts and designed new policies and programmes that are in line with the global call to halt the HIV epidemic by ensuring that 90% of all people living with HIV have been tested and know their status; that 90% of those that know that they are living with HIV are on antiretroviral treatment (ART) and that 90% of those that are on ART have reached viral suppression; coupled with a greater focus on primary prevention.

Some of the policies and plans are:

- Botswana National Policy on HIV and AIDS, Revised 2012.
- DRC National Strategic Plan 2015-2018.
- eSwatini National HIV Prevention Policy, 2012.
- Malawi National HIV and AIDS Strategic Plan, 2011- 2016.
- Mauritius National Strategic Framework on HIV and AIDS 2013 - 16.
- National Strategic Framework for HIV and AIDS Response in Namibia 2011- 16.
- Seychelles National AIDS Council ACT, 2013.
- South Africa National Strategic Plan for HIV, TB & STIs, 2017 - 2021.

- Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS (2013/14 - 2017/18)
- Zambia National HIV & AIDS Strategic Framework, 2017-2021.
- Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III 2015-2018).



Seychelles is preparing to develop a new HIV Strategic Plan. Some of the priorities that will be addressed in the plan

include: injecting drug users, the LGBTIQI community, sex workers and training of health workers.⁶ The strategy will reflect advances in HIV care and knowledge to reach the whole nation and will acknowledge the role of NGOs in HIV care.

Botswana is implementing an HIV Testing Services Strategy, including self-testing, to increase testing yields. The HIV positive yield for HIV testing is around 5%. The strategy includes HIV testing in TB clinics, hospitals and Index testing.⁷



Table 7.3: Progress in achieving 90-90-90 in SADC 2015 and 2017

	2015			2017		
	Percent of people living with HIV who know their status	Percent of people who know their status who are on ART	Percent of people on ART who achieve viral suppression	Percent of people living with HIV who know their status	Percent of people who know their status who are on ART	Percent of people on ART who achieve viral suppression
Angola	39	64		na	na	na
Botswana	76	>95		86	>95	>95
DRC	34	89	57	59	93	na
Eswatini				90	94	87
Lesotho	67	57	80	80	92	92
Madagascar	6	69	90	8	81	na
Malawi	65	90	>95	90	79	87
Mauritius				na	na	na
Mozambique	49	81	>95	59	92	na
Namibia	91	83	na	90	94	87
Seychelles			89			83
South Africa	86	60	78	90	68	78
Tanzania	62	85	na	na	na	73
Zambia	72	>95		na	na	na
Zimbabwe	70	>95	82	85	>95	na
Global	67	73	78	75	79	81

Source: UN AIDS: AIDSInfo. Progress towards 90 - 90 - 90. <http://aidsinfo.unaids.org/> accessed 19 July, 2018.

⁶ Government of Botswana. 2018. Country Progress Report - Botswana. http://www.unaids.org/sites/default/files/country/documents/BWA_2018_countryreport.pdf accessed 10 July, 2018.

⁷ <http://www.nation.sc/article.html?id=256774> accessed 1 July, 2018.

Botswana
HIV
Testing
Services
Strategy,
including
self-
testing

SADC



initiating
those
that test



on
treatment

Protocol@Work

Table 7.3 summarises available data on progress, between 2015 and 2017 in achieving the 90- 90- 90 goals that have been set for 2020. It shows that:

- **Percent of people living with HIV who know their status:** eSwatini, Malawi, Namibia and South Africa have achieved, or are very close to the 90% goal. Botswana and Zimbabwe made good progress between 2015 and 2017. Madagascar is still very low and a number of countries do not have data.
- **Percent of people who know their status who are on ART:** Overall SADC member states are doing well in initiating those that test positive on treatment. Botswana, DRC, eSwatini, Lesotho, Mozambique, Namibia and Zimbabwe have achieved over 90% coverage. South Africa is increasing coverage but was only at 68% which is below the global average, but represents a huge number of people on treatment.



- **Percent of people on ART who achieve viral suppression:** Botswana and Lesotho have levels of viral suppression over 90% with other countries at least over 73%.
- **SADC Sponsored UN Resolution on Women, the Girl Child and HIV and AIDS:** In 2016 the CSW passed a SADC-sponsored resolution, put forward on behalf of SADC by Botswana: The SADC Sponsored United Nations Commission on the Status of Women Resolution on Women, the Girl Child and HIV and AIDS. Among others, the resolution calls on governments, the private sector and development partners to: give full attention to the high levels of new HIV infections among young women and adolescent girls and their root causes; attain gender equality and the empowerment of women and girls; eliminate all gender-based violence and discrimination against women and girls and harmful practices, such as child, early and forced marriage and female genital mutilation and trafficking in persons, and ensure the full engagement of men and boys to reduce women and girls' vulnerability to HIV.

In July 2017 women parliamentarians from SADC issued the Mahe Declaration committing to work for the domestication of the provisions of resolution CSW 60/2 and calling on their governments to accelerate implementation. The declaration makes specific mention of the much higher HIV prevalence in female sex workers.⁸

Women MPs back the SADC Gender and HIV Resolution

Women Members of Parliament from the Southern African Development Community (SADC) attending a two day conference organised by SADC Parliamentary Forum (PF) and other partners in Mahé, Seychelles from 5 to 6 July 2017, have made strong recommendations for greater parliamentary involvement in the ratification and domestication of relevant international and continental instruments relating to women, girls, HIV and Sexual and Reproductive Health Rights.

In a bold declaration dubbed the Mahé Declaration, the Parliamentarians resolved to implement and to advocate for the implementation of United Nations Commission on the Status of women (UNCSW) Resolution 60/2 entitled: "Women, the Girl Child and HIV and AIDS". This international instrument calls for attention to be paid to the high levels of new HIV infections among young women and adolescent girls and its root causes.

The Mahé Declaration was developed in the context of continued high prevalence of HIV, particularly among women and girls in the SADC Region, a situation which raises great public health and developmental concern. The Parliamentarians noted that HIV had the potential to undermine the SADC Region's attainment of Sustainable Development Goals (SDGs) whose end date is 2030.

As indicated in the declaration, Eastern and Southern Africa has less than 7% of the global population but it contributes close to 50% of new adult infections globally and it is home to more than 19 million people living with HIV, of which more than half are women. The prevalence of the epidemic continues to cause morbidity and mortality, as well as induce poverty and inequality both of which are an antithesis for sustainable development according to the Parliamentarians.

⁸ <http://www.safaids.net/22-news/109-declaration-set-to-address-hiv-and-srhr-in-sadc> Accessed 2 July, 2018.



SADC Parliamentarians step it up for gendered responses to HIV.
Photo courtesy of Seychelles News

The Mahé Declaration therefore contains extensive recommendations to address the root causes of HIV prevalence among women and girls. These include taking rapid actions to reduce poverty, ensuring access to quality integrated and adolescents and youth friendly health services, information and education opportunities with a special focus on comprehensive sexuality education for in- and out-of-school youth while eradicating child marriage as defined in the SADC Model law on Eradicating Child Marriage and Protecting those already in marriage.

Going forward, the Parliamentarians committed to acquainting themselves with the legal and policy environment in their respective countries with regards to HIV and sexual and reproductive health rights. They said enhanced knowledge of the legal and policy environment would be critical in making informed assessments of the effectiveness thereof and where necessary, enactment of laws aiming at protecting the sexual and reproductive health rights of all, with a specific focus on the most vulnerable.

A solid commitment was also made by the Parliamentarians to review, revise, amend or repeal all laws, regulations and policies including cultural and religious practises and customs that have a discriminatory impact on youths, especially girls and young women.

Economic inequality and unequal power relations; discrimination in society and in the workplace; all forms of violence; inhumane and degrading treatment; sexual exploitation; women and child trafficking and harmful practises and norms including some cultural practices, disempower women and girls and further expose them to substantial risks of contracting HIV, the lawmakers noted.

The Parliamentarians further noted that existing inequalities among certain key populations such as sex workers, people living with disabilities, migrants, girls living in poverty and transgender persons are disproportionately affected by HIV and AIDS.

Among the concerns highlighted in the Mahé Declaration, HIV among female sex workers in SADC is significantly higher than it is among the general adult population. This same population group also faces violence, stigma and discrimination at the hands of family members, in communities, at the workplace and in health-care settings. Often their rights to dignity, health and education are denied.

The Parliamentarians therefore lament that these persistent structural barriers as well as male chauvinism and patriarchy often work to reinforce women's unequal status in society and fuel HIV vulnerability among women and girls. Harmful social and cultural norms and practices also continually deny women and girls the opportunity to attend schools, further reinforce their vulnerability to violence and HIV while also denying them opportunities to economic independence.

The Mahé Declaration states that the prohibition of such practices and customs, can aptly be resolved by ensuring that provisions of domestic legislation conform more to international human rights laws and include protection from all harmful practices.

Additionally, the Parliamentarians pledged to enact laws aimed at improving inclusive access to education at all levels and provide for viable alternatives for the many young people. This would include paying particular attention to the participation of adolescent girls, who drop out of the formal education system, by facilitating re-entry, revamping informal education and training through standardized certification within and between African countries.

Various activities including the dissemination of information, training, sensitisation workshops and the development of Model Laws relating to the various issues of HIV and Sexual and Reproductive Health Rights are some of the ways through which SADC PF can come on board to assist parliaments enact national laws based on international and regional instruments.

SADC PF was supported in hosting of this conference by Sweden and Norway. It got additional financial and technical support from development partners that include UN Agencies, the United Nations Development Programme, UNFPA and UN Women as well as from regionally based Civil Society Partners, ARASA and SAFAIDS.

Source: Moses Magadza, SAFAIDS News Service



Prevention



Article 27. 3: State Parties shall:

a) Develop gender sensitive strategies to prevent new infections.

The Post 2015 SADC Gender Protocol places a strong emphasis on gendered responses to prevention. The SADC-sponsored UN Resolution on women, girls, HIV and AIDS strengthens this through the following specific provisions:

- Achieve universal access to comprehensive HIV prevention, programmes, treatment, care and support to all women and girls and achieve universal health coverage.
- Enhance the capacity of low- and middle-income countries to provide affordable and effective HIV prevention and treatment products, diagnostics, medicines and commodities and other pharmaceutical products, as well as treatment for opportunistic infections and co-infections, and reduce costs of lifelong chronic care,
- Eliminate mother-to-child transmission and keep mothers alive.
- Provide combination prevention for women and girls for the prevention of new infections, to reverse the spread of HIV and reduce maternal mortality.
- Avail comprehensive data disaggregated by age and sex to inform a targeted response to the gender dimensions of HIV and AIDS.
- Build up national competence and capacity to provide an assessment of the drivers and impact of the epidemic.

- Support action-oriented research on gender and HIV and AIDS, including on female-controlled prevention commodities.

A Global HIV Partnership for Prevention: The June 2016 high level meeting on HIV and AIDS laid out an ambitious plan to reach epidemic control by 2030. The five elements of the prevention plan are:

1. Combination prevention, including comprehensive sexuality education, economic empowerment and access to sexual and reproductive health services for young women and adolescent girls and their male partners in high-prevalence locations.
2. Evidence-informed and human rights-based prevention programmes for key populations, including dedicated services and community mobilisation and empowerment.
3. Strengthened national condom programmes, including procurement, distribution, social marketing, private-sector sales and demand creation.
4. Voluntary medical male circumcision in priority countries that have high levels of HIV prevalence and low levels of male circumcision, as part of wider sexual and reproductive health service provision for boys and men.
5. Pre-exposure prophylaxis for population groups at higher risk of HIV infection.



Men's involvement is key: Men's sector in Botswana discussing HIV with former Minister of Labour and Home Affairs, Edwin Jenamiso Batshu. Photo: Keletso Metsieng

In October 2017 the Global Partnership launched a specific campaign focused on 26 countries - including Angola, DRC, eSwatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe. Countries in the partnership will report quarterly on progress and challenges.

Table 7.4: New infections 2017 compared to maximum since 1990

Country	Number of new infections, 2017	Maximum number of new infections in 1 year	Year in which maximum occurred	New infections 2017 as percent of the maximum number
Zimbabwe	41 000	230 000	1993	18
DRC	15 000	67 000	1996	22
Malawi	39 000	110 000	1992	35
Namibia	7 400	20 000	1996	37
Botswana	14 000	37 000	1995	38
Tanzania	65 000	170 000	1993	38
Eswatini	7 000	18 000	1995	39
Zambia	48 000	110 000	1992	44
Lesotho	15 000	32 000	1997	47
South Africa	270 000	530 000	1998	51
Mozambique	130 000	170 000	2001	76
Angola	27 000	28 000	2012	96
Madagascar	5 300			100
SADC Total	683 700			
Global	1 800 000			

Source: Derived from UNAIDS. AIDS Info. Number of new HIV Infections. <http://aidsinfo.unaids.org/> accessed on 19 July, 2018.

Table 7.4 shows that:

- SADC is still a major source of new infections globally, accounting for 683,700 or 38% of new infections globally in 2017, compared to 35% in 1997 when the total number of new infections was at the highest level it has ever been, at 3.4 million with SADC accounting for 1,186,900 of these.
- South Africa accounts for 39% of new infections in SADC, Mozambique 15% and Tanzania 10%.
- Major progress in prevention has been achieved since as early as 1992 when some countries began to show decline in new infections. This is particularly true in countries such as Zimbabwe, DRC, Malawi, Namibia, Botswana, Tanzania and eSwatini where number of new infections are now less than 40% of the maximum number.

A Joint United Nations Programme on HIV/AIDS (UNAIDS) panel of experts has determined that an HIV incidence: prevalence ratio, which is the ratio of the number of new HIV infections to the number of people living with HIV within a population, of 0.03 is the level at which the epidemic will transition. The progress in reducing AIDS-related deaths and preventing new HIV infections has resulted in an incidence: prevalence ratio for eastern and southern Africa of 0.04. This is close to the transition level.⁹

Though rates of new infections are declining, at the current rate of decline the East and Southern



HIV and AIDS Test Kit in Zimbabwe.

Photo: Tapiwa Zvaraya

African region will still have at least 570,000 new infections in 2020, compared to a target of 230,000. There is urgent need for continued focus on prevention in all member states. Countries have been categorised according to:

- Those that need slight acceleration (up to 1.6 times the current rate of decline) which are Mozambique, Zimbabwe and eSwatini.
- Those that need moderate acceleration (up to 2, 5 times the current rate of decline) which are Malawi, Botswana, South Africa and Tanzania.
- Those that need acceleration up to 4 times the current rate of decline which include Zambia, Namibia, Lesotho, Angola.
- Not on track - including Madagascar, where currently the prevalence rate is increasing and will need to be reversed and then rapidly decline.¹⁰

⁹ UNAIDS. Global AIDS Update, 2018. Miles to Go. Geneva, Switzerland.

¹⁰ UNAIDS. RSA ESA. 2017. Reinvigorating Prevention: Are we on Track? Presentation to the SADC meeting on Prevention, October, 2017. Johannesburg.

SADC
accounted
for
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Prevalence
in
YOUNG



is almost

3

times
higher

than in

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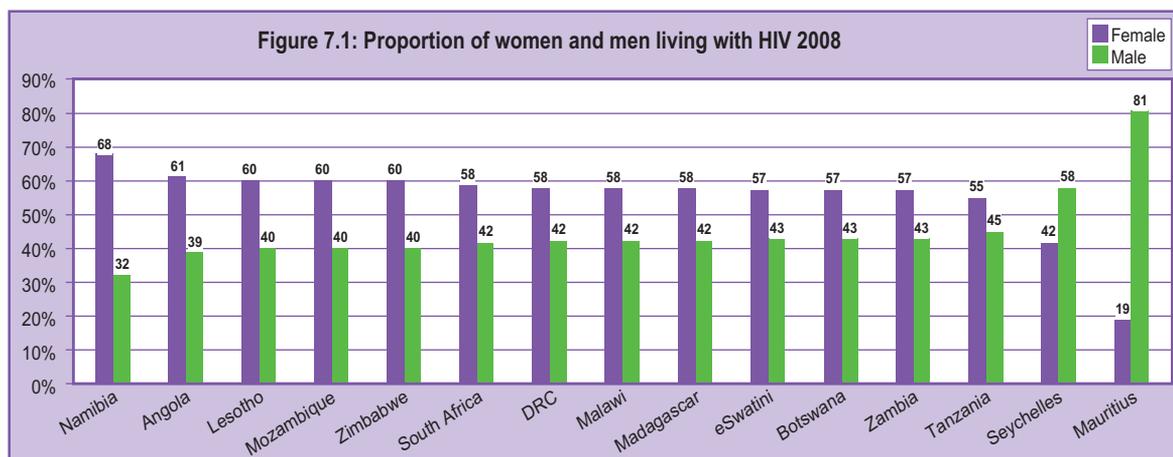
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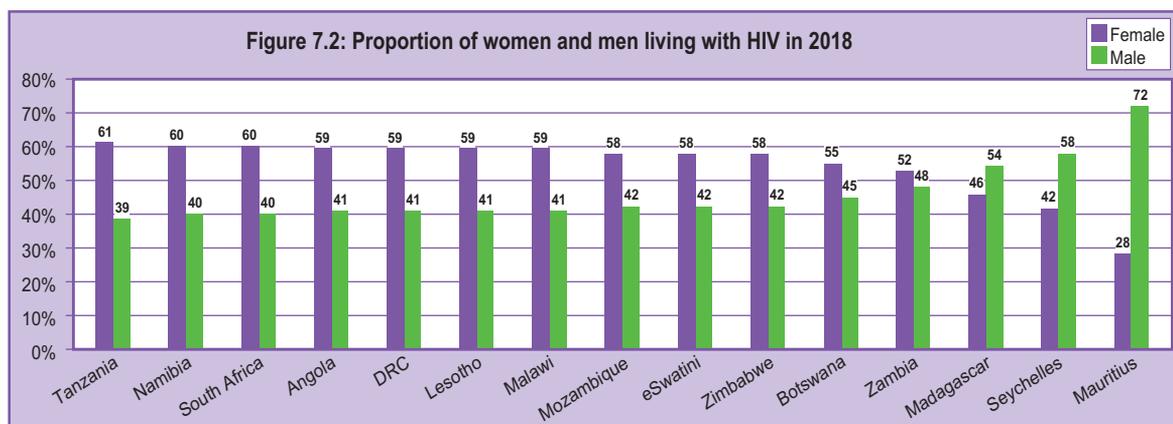
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age

range



Source: Gender Links 2018 and 2008, compiled from UNAIDS data.



Source: Gender Links 2018 and 2008, compiled from UNAIDS data.

Figure 7.1 compares the proportion of women and men living with HIV in 2008, while figure 7.2 compares the proportion of women and men living with HIV in 2018. The proportions have not changed much. Most of SADC has a generalised epidemic that is largely driven by heterosexual sex. Key facts emerging are that:

- In general, prevalence in women is almost three times higher than in men in the 15 to 24 age range and prevalence in men begins to increase in the 30 to 40 age range.
- In these countries there are generally more women living with HIV than men, although maturing epidemics in Namibia, for instance, have resulted in a lower proportion of women (down from 68% in 2008 to 60% in 2018).
- At baseline in 2008, and in the 2018 statistics, Madagascar, Seychelles and Mauritius have much higher proportions of men, which is consistent with much smaller epidemics that are largely concentrated in two populations - injecting drug

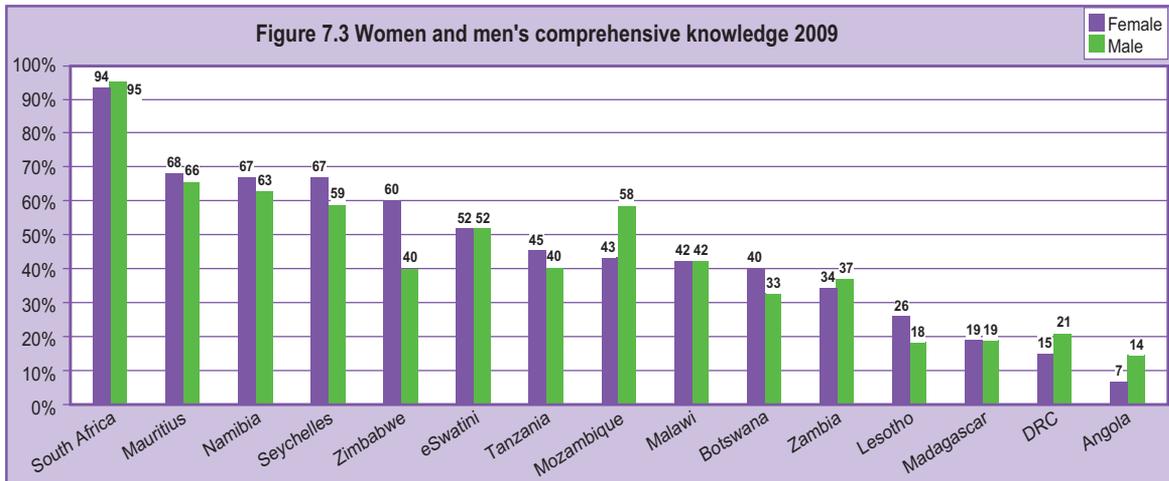
users who tend to be more male, and men who have sex with men.

While impressive gains are being made in the fight against HIV, the rates of new infections as well as mortality in young people are still cause for grave concern. In 2015, 300,000 of the 790,000 new infections in East and Southern Africa (ESA) were in young people 15 to 24 years old. Young women 15 to 24 years old are only 10% of the total population but constituted 26% of new HIV infections in 2017. The number and age of a young woman's sexual partners have a significant impact on her HIV status. While mortality is beginning to stabilise and decline, the rates are still high and are still increasing in adolescent boys and young men. Thus, while more adolescent girls are acquiring HIV more adolescent boys are dying of AIDS.¹¹ Globally, AIDS is one of the top ten causes of adolescent death.

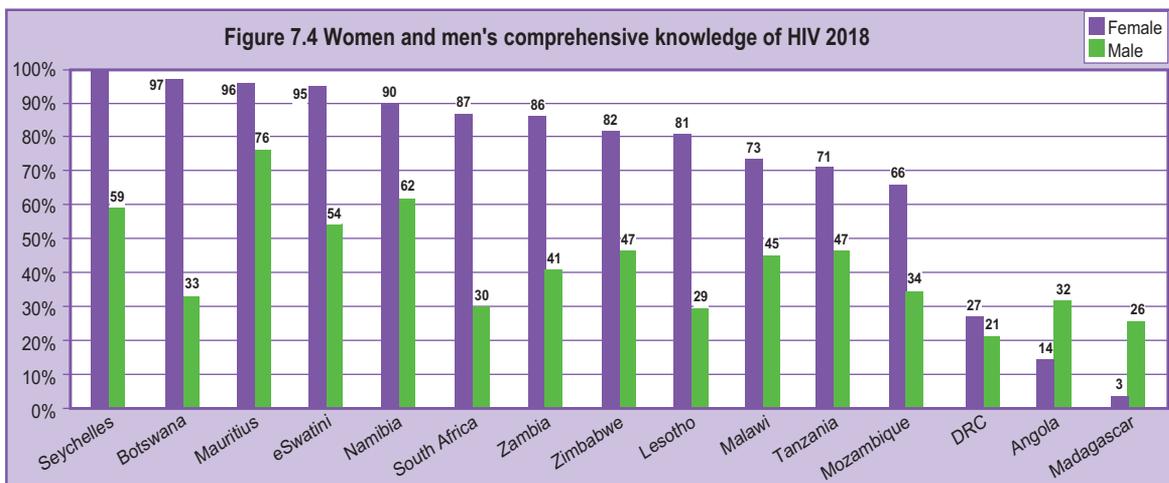
¹¹ Govender, K et al. HIV Prevention in Adolescents and Young People in the Eastern and Southern African Region: A Review of Key Challenges Impeding Actions for an Effective Response. The Open AIDS Journal, 2018, 12, 3-00.

Gender inequality is still a strong driver of the pandemic: 59% of new infections in ESA are in women. The largest numbers of new infections are in young women. This occurs in 15 to 19 year olds in South Africa, Zambia, eSwatini, Madagascar; and in 20 - 24 year olds in Tanzania, Mozambique, Zimbabwe, Malawi, Lesotho, Angola, Namibia and Botswana. However, levels of knowledge of one's status are very low among young people.

Comprehensive, accurate knowledge of HIV and AIDS is fundamental to ensuring citizens use HIV services and engage in safe sexual behaviours. Yet, knowledge remains low among young women and men (aged 15-24) in SADC, with significant gaps in even basic knowledge about HIV and its transmission.



Source: 2009 Barometer.



Source: Unicef | Statistical Update | 2017 TABLE 4: Knowledge, sexual behaviour, HIV testing, and HIV treatment among adolescents% of adolescents (aged 15-19) who have comprehensive knowledge of HIV, 2011-2016* <https://data.unicef.org/topic/hiv/aids/adolescents-young-people/> accessed 27 June, 2018.

Little change in levels of knowledge: Figure 7.3 and Figure 7.4 compare levels of HIV knowledge in young women and men in 2008 and 2018. The general picture is one of little change. Botswana, Mauritius and Seychelles, which all have relatively smaller populations have made the most progress in relation to women's knowledge, but there are no corresponding increases in men's knowledge. South Africa has shown a marked reduction as

have Mozambique and eSwatini. Only Mauritius, Madagascar, Lesotho and Angola show modest increases in knowledge in young men. Overall the levels of knowledge are too low for a region which needs such active engagement in prevention, testing, treatment and adherence. Ten countries still have knowledge levels of lower than 50% for both women and men.

59%
of new
infections
in East
and
Southern
Africa
are





In general, there are very low rates of testing in both young men and women: Table 7.5 presents data from six of the Population-Based HIV and AIDS Impact Assessment surveys that have been conducted in the last three years on HIV

prevalence, self-reported awareness of HIV status, self-reported access to ART amongst those that know that they are HIV+, viral load suppression in those that report to be on ART and overall viral load suppression.

Table 7.5: HIV prevalence, knowledge of HIV status, ART access and VL Suppression in adolescent girls and young women

	Years survey conducted	HIV prevalence	Aware of HIV-positive status, %	Self-reported ART, %	Viral load suppression among those self-reported on ART, %	Viral load suppression among all HIV-positive, %
eSwatini	2016-2017	13.9	70.2	79.9	79.9	55.5
Lesotho	2016-2017	11.1	61.4	89.7	76.4	50.9
Zimbabwe	2015-2016	5.9	48.2	86.2	89.0	47.9
Zambia	2016	5.7	40.1	77.9	78.1	33.6
Malawi	2015-2016	3.4	55.3	84.8	79.6	49.7
Tanzania	2016-2017	2.1	46.3	88.2	90.6	47.1

Source: Derived from Brown, K. et al. Status of HIV Epidemic Control Among Adolescent Girls and Young Women Aged 15-24 Years - Seven African Countries, 2015-2017. *MMWR* / January 12, 2018 / Vol. 67 / No. 1.

Table 7.5 shows that:

- Prevalence in women aged 15 to 24 varies from a low of 2.1% in Tanzania to a high of 13.9% in eSwatini.
- Awareness of HIV status varies from a low of 40% in Zambia to a high of 70% in eSwatini, which is far short of the 90% target.
- The percentage of those that know their HIV status that are on ART is good, ranging from 78% in Zambia to 90% in Lesotho.
- There are relatively good levels of viral load suppression in those that are on ART of between 76% (Lesotho) to 91% (Tanzania), the overall viral load suppression is still very low (ranging from 34% in Zambia to 56% in eSwatini).



South Africa recognised the extreme vulnerabilities faced by adolescent girls and young women aged 15 to 24. In 2015, 1975 young women were being infected by HIV every week. This is now down to 1500 or 29% of all new

infections. South Africa had 70,000 pregnancies in girls under 18 every year; one third of adolescent girls and young women experienced gender based violence and high dropout rate from school with 60% of young people failing to complete their matric (or secondary school) and high unemployment with few opportunities for economic activity. In 2016 South Africa launched the She Conquers national campaign, on behalf of the South African National AIDS Council, to focus on adolescent girls. The campaign is led by the Departments of Health, Social Development and Education, in collaboration with the police. A district level coordinator spearheads activities to share knowledge and skills and access services to avoid HIV and other STIs; avoid unwanted pregnancy; stay in school; stand against sexual and gender based violence and access educational and economic opportunities. Impact of the campaign is already being seen in reduced teen pregnancies in some schools which used to have very high rates of HIV and AIDS.¹²

¹² <http://sheconquerssa.co.za/> and <http://www.kznhealth.gov.za/mediarelease/2018/KZN-health-MEC-excited-about-the-impact-of%20%E2%80%93she-conquers-campaign-at-umgungundlovu27022018.htm> accessed July 15, 2018.

Promoting HIV Education in schools in Chegutu, Zimbabwe



Sex education begins at an early age at Kaguvi Primary School in Chegutu. Photo: Joseph Denga

Kaguvi Primary School in Chegutu, in the Mashonaland West province of Zimbabwe has begun promoting health education through teaching grade 3 pupils in a once-a-week, after school club, about HIV and AIDS.

The club has sub groups: Girl Education Movement and Boy Education Movement. These are complementary and have a long term goal of equipping the learners with skills to help them become responsible citizens. The provision of information is facilitated through discussions, peer teaching, debate, simulation, drama, brainstorming and quizzes. The club aims to promote positive values, behaviour and attitudes that prevent the spread of HIV, STIs and other health concerns. The programme was inspired by the National AIDS Policy, which noted that the HIV pandemic requires a multi-sectoral approach, and the school is playing its part through education from a young age.

The broad goal of this is the promotion of responsible behaviour and positive values of Unhu/ Ubuntu. Other short term goals are:

- Appreciating the importance of good personal hygiene.
- Identifying or describing STIs and symptoms, prevention and treatment of STIs.
- Establishing the link between HIV and STIs.

- Distinguishing between useful and harmful effects of the Internet and social media.
- Understanding exploitation and victimisation.
- Understanding rights and responsibilities.
- Identifying ways in which communities deal with substance abuse, sexual abuse and sexual relationships.
- Challenging stigma and discrimination.
- Describing the economic, social, emotional challenges of living with HIV.
- Appreciating the importance of abstinence in HIV prevention.

The programme focuses on making sure the children know about freedom from gender based violence and access to comprehensive sexuality education, including about HIV, AIDS and STIs. Delivery methods include - peer teaching, drama, group discussions, brainstorming. In addition, written tests and quizzes were facilitated.

The project has worked and created synergies with the local schools, the local authority (Chegutu Municipality), the Ministry of Education, the police and clinic. The local National AIDS Council is also involved and the project sends them monthly reports.

So far the project has been allocated US\$500 by the council to conduct their activities, resulting in 30 direct beneficiaries, and a total of 800 indirect beneficiaries. Time to meet all the club members remains a struggle, though the solution to this has been suggested as meeting on Friday afternoons, to allow members who cannot make previous sessions to catch up with others. The programme is monitored through feedback, which guides subsequent plans and sessions. The programme seems to benefit more girls as they note that most of the participants in the National AIDS Quiz are girls. The school team won a bronze medal at the National AIDS Quiz and their prize was a water tank. When community members come to fetch water from the tank, the children are very proud. Through this initiative, more and more parents are encouraging their children to join the AIDS Club.

Source: Joseph Denga, Chegutu. SADCProtocol@Work,2018

Adolescents more likely to drop out of care than children or adults



Growing evidence is pointing to the protective value of social protection combined with parental care, education and caring health services for reducing the rate of new HIV infections in young women. These same interventions improve testing, access to treatment and adherence. In general, adolescents aged 15 to 19 are more likely to drop out of care than those 10 to 14 or adults, pointing to the need for different approaches for this age group. The evidence suggests that pregnant adolescents find it particularly difficult to stay in care.¹³

The US Government through President's Emergency Plan For AIDS Relief (PEPFAR) has supported the **DREAMS** (Determined, Resilient, Empowered, AIDS Free, Motivated and Supported) in ten countries that account for more than half of all infections in adolescent girls and young women globally, including Lesotho, Malawi, Mozambique, South Africa, eSwatini, Tanzania, Zambia, and Zimbabwe which are in SADC. In the 2018 report to Congress, PEPFAR reported that 41 of the 63 districts implementing the DREAMS programme achieved a decline of new HIV diagnoses of over 25% from 2015 to 2017. The decline was over 40% in 14 of the districts. In 2017 PEPFAR extended funding for programmes with adolescent girls, with a focus on reducing sexual violence amongst 9 to 14 year olds to five countries, including Botswana and Namibia in SADC.¹⁴



In **South Africa**, only 18% adolescents aged 10-19 years who received food support, parental or caregivers support and participated in an HIV support group failed to adhere to anti-retroviral therapy, compared to 54% among adolescents who had none of these.

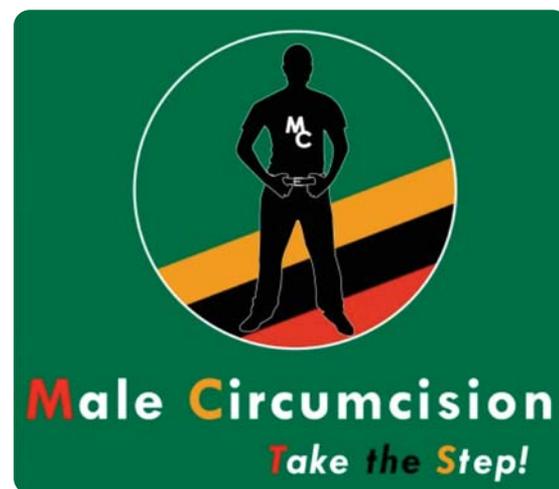
In **Zambia**, HIV testing uptake increased from 62% to 73% for girls and from 47% to 57% for their male peers when social cash transfers were provided with enhanced HIV treatment and prevention services for young people (aged 15-19 years). When health staff were trained and supported to provide adolescent-friendly services, and support through peer educators, theatre groups and youth-friendly gathering spaces, levels of condom use at last sex increased from 50% to 72% for girls and 48% to 61% for boys.¹⁵



Voluntary Medical Male Circumcision (VMMC)

is a cost-effective, once off intervention that provides lifelong partial protection for males. VMMC reduces female-to-male sexual transmission of HIV by 60%. WHO and UNAIDS recommend implementation of VMMC programmes in countries with a high HIV prevalence among the general population together with behavioural and structural strategies, as part of a comprehensive HIV prevention plan. It is important to note that VMMC alone does not provide complete protection for men. Men must also use condoms and desist from risky sexual behaviour. Available evidence suggests that circumcised men are not reducing condom usage or increasing other risky behaviour.

15 priority countries in eastern and southern Africa with high levels of HIV prevalence and low levels of male circumcision have been identified for intense effort to increase levels of VMMC. Ten of these are in SADC (Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, eSwatini, Tanzania, Zambia and Zimbabwe). The new stra-



Voluntary male circumcision is taking off in Zambia .
Photo courtesy of Zambia VMMC

¹³ UNAIDS. Global AIDS Update, 2018. Miles to Go. Geneva, Switzerland.
¹⁴ PEPFAR. 2018. PEPFAR 2018 Report to Congress. Washington, DC. <https://www.pepfar.gov/documents/organization/279889.pdf> Accessed 9 July, 2018.
¹⁵ UNAIDS. Global AIDS Update 2018. Miles to go. Geneva, Switzerland.

tegic plan aims to increase voluntary medical male circumcision (VMMC) in 10 to 29-year-old males in these priority countries to 90% by 2021.

One study used mathematical modelling to assess the likelihood of this target being achieved in eSwatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Uganda, and Zimbabwe, taking into account their historical VMMC progress and current implementation¹⁶. This study found that only Tanzania was likely to reach the target. The study concluded that it is necessary to rapidly increase the number of circumcisions conducted for 10 to 14 year olds and 15 to 29 year olds.

To do this requires a deeper understanding of the factors which motivate or discourage adolescent boys at different ages to be circumcised. Some evidence suggests that younger boys are influenced by others while older adolescents (15 to 19) are aware of the benefits in terms of reducing HIV risk. All adolescents are concerned about pain¹⁷. Further evidence suggests that support from female adolescent partners before and after the procedure is an important motivating factor¹⁸ and that it is important to involve parents¹⁹. However, parents also need accurate information and motivation.

There is need for more awareness creation around other benefits of circumcision, including reduction of other sexually transmitted infections (STIs), penile cancer, and protection for women and girls from cervical cancer.



Lesotho: The VMMC programme which was launched in 2012 aims to circumcise 80 % of male adolescents aged 15 to 29 in five districts. The programme is integrating testing for HIV. 18 hospitals and over 100 health centres are providing VMMC and testing. In 2014 85,000 young men accessed VMMC, of whom 56% were also tested for HIV. Lesotho is also offering Early Infant Medical Circumcision (EIMC) but uptake has been slow as culturally boys are circumcised during initiation into adolescence.²⁰

eSwatini VMMC was found to be highest in 15 to 19 year olds at 38,2% and decreases with age to a low coverage of 7,5% in men over 65.²¹



Preventing new HIV infections in children and keeping their mothers alive: UNAIDS developed a Global Plan for the elimination of new HIV infections among children by 2015 and keeping their mothers alive which focused on 22 high prevalence countries; 21 of which are in Africa and 12 in SADC (Angola, Botswana, DRC, Lesotho, Malawi, Mozambique, Namibia, South Africa, eSwatini, Tanzania, Zambia and Zimbabwe).

The Global Plan had four prongs:

- Preventing new HIV infections among women of childbearing age.
- Preventing unintended pregnancies among women living with HIV.
- Preventing HIV transmission from a woman living with HIV to her baby.
- Providing appropriate treatment, care and support to mothers living with HIV and their children and families.

All SADC member states have followed Malawi's introduction of Option B+ where all pregnant mothers living with HIV are immediately introduced to lifelong ART irrespective of CD4 count. This has led to rapid increase in the number of pregnant women on ART. In 2008 when the first barometer was developed, the guidelines indicated that women with a CD4 count lower than 200 should receive full ARVs. The majority were tested and given a single dose of nevirapine to take during delivery. South Africa added a short course of AZT in 2008. Figure 7.5 shows rapid expansion of PMTCT in many countries such as Zimbabwe, Namibia, South Africa, Zambia, Malawi, ESwatini, Lesotho, Mozambique, Tanzania (where the increase is from 10% coverage to 85%), DRC and Angola. In 2018, women are being initiated on to full ART immediately, with increased demands on the health system. Expanded coverage is accompanied by increased services.

¹⁶ Njeuhmeli, E. et al. Scaling Up Voluntary Medical Male Circumcision for Human Immunodeficiency Virus Prevention for Adolescents and Young Adult Men: A Modeling Analysis of Implementation and Impact in Selected Countries. <https://www.hivsharespace.net/resource/scaling-voluntary-medical-male-circumcision-human-immunodeficiency-virus-prevention> accessed July 5, 2018.

¹⁷ Motivations for Voluntary Medical Male Circumcision Among Adolescents in South Africa, Tanzania, and Zimbabwe. <https://www.hivsharespace.net/resource/age-differences-perceptions-and-motivations-voluntary-medical-male-circumcision-among> accessed July 5, 2018

¹⁸ <https://www.hivsharespace.net/resource/females-peer-influence-and-support-adolescent-males-receiving-voluntary-medical-male> accessed July 5, 2018

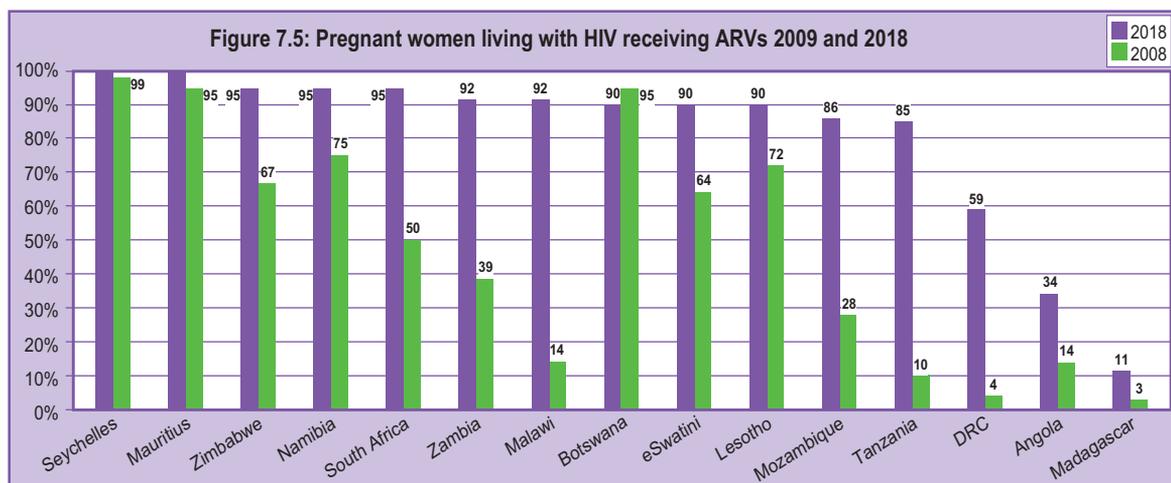
¹⁹ <https://www.hivsharespace.net/resource/parental-communication-engagement-and-support-during-adolescent-voluntary-medical-male> accessed July 5, 2018.

²⁰ <https://www.avert.org/professionals/hiv-programming/prevention/voluntary-male-medical-circumcision> Last accessed 3 July, 2018.

²¹ SHIMS2. 2017. Swaziland HIV incidence measurement survey2. A population based HIV Impact Assessment. Summary sheet.

VMMC
reduces
HIV
by
60%

Pregnant women have up to **3** times higher risk of acquiring **HIV**



Source: PMTCT Coverage, <http://laidinfo.unaids.org/#>, last accessed July 19, 2018 and Gender Links 2008.

Figure 7.5 shows that:

- All countries have made significant progress in increasing the coverage of pregnant women living with HIV receiving ARVs. Ten countries (Seychelles, Mauritius, Zimbabwe, Namibia, South Africa, Zambia, Malawi, Botswana, eSwatini and Lesotho) now have coverage of 90% or higher.
- This progress is especially significant in the case of Zimbabwe (75% to 95%); South Africa (50% to 95%); Zambia (39% to 92%); Malawi (14% to 92%); Mozambique (28% to 86%); Tanzania (10% to 85%); DRC (4% to 59%) and Angola (14% to 34%).
- DRC and Angola, with coverage of lower than 60%, remain a concern. Madagascar, at 11%, is of particular concern.

Despite the impressive progress there is little room for complacency.

Many other targets have not been met and new knowledge raises fresh challenges. The Global Plan aimed to reduce the MTCT rate to less than 5% in breastfeeding women, and less than 2% in non-breastfeeding women. Overall, the 21 Global Plan countries reduced MTCT among breastfeeding women from 22.4% to 8.9% between 2009 and 2015. Four countries (South Africa, Uganda, eSwatini and Namibia), achieved the 5% or less. Botswana, the only non-breastfeeding Global Plan priority country, achieved an MTCT rate of 2.6% - just above the 2% target.²²

The Global Plan aimed to reduce the number of new infections among women of reproductive age by 50%, but they only declined by 5% between 2009 and 2015.

Lesotho and Malawi were amongst the five countries which reduced unintended pregnancies by more than 10% between 2000-2004 and 2010-2014. New evidence suggests that pregnant women have up

to 3 times higher risk of acquiring HIV than other HIV- women. Women need to be encouraged to take more precautions to prevent infection during pregnancy and to be retested.

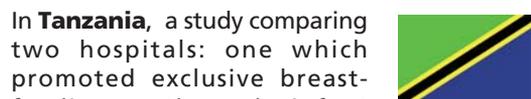
Factors influencing participation in continued access to PMTCT:

Many women adhere to treatment during pregnancy but are lost to follow-up after the birth of their babies. Pregnant adolescents particularly struggle with adhering to lifelong treatment and need special attention.

1. **Feeding options:** WHO recommends that women in resource poor settings who are on ART should be encouraged to exclusively breast-feed.



Malawi: A study reported that though the majority of mothers followed the advice to breastfeed, many reported mixed feeding in the first six months. Some of the reasons given for this were traditional feeding practices as well as a poor understanding of what exclusive breastfeeding involves or why women should exclusively breastfeed.



In Tanzania, a study comparing two hospitals: one which promoted exclusive breastfeeding as the only infant feeding option; and the other following Tanzanian PMTCT infant feeding guidelines which promote patient choice, found that women in the first were confident in exclusive breastfeeding while those in the second were unsure of what they should do.²³

²² <https://www.avert.org/professionals/hiv-programming/prevention/preventionmothertochildtransmission> Last accessed 3 July, 2018.
²³ *ibid.*

2. **Stigma and discrimination:** A body of emerging evidence is showing the impact of stigma on access and adherence to ART for PMTCT. An HIV positive diagnosis often elicits shock, denial of disease, depression, or fear of handling side effects and a lifelong commitment to treatment. Pregnant women are often afraid of disclosing their status to their partners and other family members. Women often experience violence and desertion from partners. Women also experience stigma from health care providers, which reduces access to the very services which they need.



Malawi: Stigma and fear of a partner's reaction has been found to inhibit women from accessing immediate treatment available under option B+.

3. **Limited health resources:** Patient overcrowding, poor treatment, limited availability of commodities all hinder uptake.
4. **Male involvement** has been found to have positive impact on PMTCT. Factors which reduce male involvement include fear of knowing their HIV status, unwelcoming health services. Men who already know their HIV status are more likely to participate in PMTCT. Being made to feel important in the process also encourages male involvement.

Key populations are people who inject drugs, men who have sex with men, transgender persons, sex workers and prisoners. Around the world, key populations face much higher rates of HIV and AIDS than the general population and are most at risk for contracting HIV²⁴. They face many hurdles which stop them from accessing services such as punitive laws and policies, police harassment and stigma and discrimination within health settings. Adolescent boys and young men who belong to key populations face heightened risks of HIV infection, but also demonstrate low knowledge, awareness and uptake of HIV services.

Female sex workers: There is increasing availability of data on sex workers - including prevalence which ranges from 4.6% in Seychelles to 71.9% in Lesotho; condom use with last partner (ranging from over 40% in the DRC to over 90% in Seychelles) and testing (ranging from about 20% in Seychelles to over 90% in Zimbabwe). Sex work is criminalised in almost all countries which hinders the provision of services.



South Africa is set to become the first Southern African country to decriminalise sex work:

The ruling African National Congress (ANC) party in South Africa resolved in December 2017 that sex work should be decriminalised. Parliament is debating decriminalisation. In March, 2018, the Commission for Gender Equality told parliament that the commission's position is that sex work should not be treated as a criminal activity. The Commission argued that decriminalisation would reduce the violence experienced by sex workers and increase access to services, including HIV prevention and treatment. Countries such as New Zealand which have fully decriminalised sex work have found that the numbers engaged in sex work have not changed significantly five years later.

Pre Exposure Prophylaxis (PrEP) is a daily course of Anti-RetroViral (ARV) drugs taken by HIV negative people who are at high risk of contracting HIV, such as sex workers, partners in sero-discordant couples and men who have sex with men. A number of studies in different settings have shown that if PrEP is taken correctly it can reduce the risk of HIV infection to almost zero. It has reduced infection rates from unprotected sex by 90% and from injecting drug use by 70%. However, for it to be effective there must be high levels of adherence. The 2016 declaration included a commitment to provide PrEP to three million people by 2020. Progress towards achieving this target is slow. PrEP at particular times of a person's life to prevent infection is more cost effective than long term ART to manage infection. There is demand for PrEP especially from men who have sex with men²⁵.

South Africa became the first African country to issue full regulatory approval for PrEP and to include it in the national HIV programme in December, 2015. The DREAMS programme, supported by PEPFAR, is supporting access to PrEP by adolescent girls and young women in Lesotho, Malawi, Mozambique, South Africa, eSwatini, Tanzania, Zambia and Zimbabwe who are at high risk of HIV.



The SAPPHERE project in **Zimbabwe** is trialling testing of sex workers with provision of ART for those that are positive and PrEP for those that are negative. Each woman belongs to a group which meets every month for support. She attends the group meetings with a "sister"

Sex work is criminalised in ALL countries

²⁴ <https://www.usaid.gov/what-we-do/global-health/hiv-and-aids/technical-areas/key-populations>
²⁵ <https://www.avert.org/professionals/hiv-programming/prevention/pre-exposure-prophylaxis> accessed 10 July, 2018.

Vaccine for HIV still a challenge

and the pair supports each other to adhere to their treatment. Group members are reminded about meetings through sms. During the group sessions sex workers also receive legal advice and are encouraged to access their rights.



In **Mauritius**, where the spread of HIV I has been largely due to injecting drug use, the focus is on **harm reduction**. From the beginning of the epidemic in 1987, to 2014, a total of 6090 cases of HIV were detected in Mauritius. The number of new cases rose very gradually to 98 in 2002 and then quite exponentially to 921 in 2005 and fell to 260 in 2013. 66.7% of all Mauritian HIV cases since 1987 have been people who inject drugs. This percentage increased from 7% in 2001 to 92% in 2005. Following the introduction of the Needle Exchange Programme and the Methadone Substi-

tution Therapy in 2006, it began to decrease to 34.7% in 2015 and 31.1% in the first six months of 2016²⁶.

An HIV Vaccine: Developing any new vaccine takes time as it must be tested rigorously. Developing a vaccine for HIV, which is found in a number of variants and which mutates, is very difficult. The 35-year quest for a vaccine is continuing and promising developments were reported in July 2018. A new 'mosaic' vaccine that is made from pieces of different HIV viruses which are combined to elicit responses against a number of HIV strains was tested in a phase 1/2a clinical trial with positive results. This same vaccine will now be tested for safety and efficacy in a phase 2b trial in Southern Africa with 2600 women. This is only the fifth HIV vaccine that has gone as far as efficacy trials in humans.

Treatment

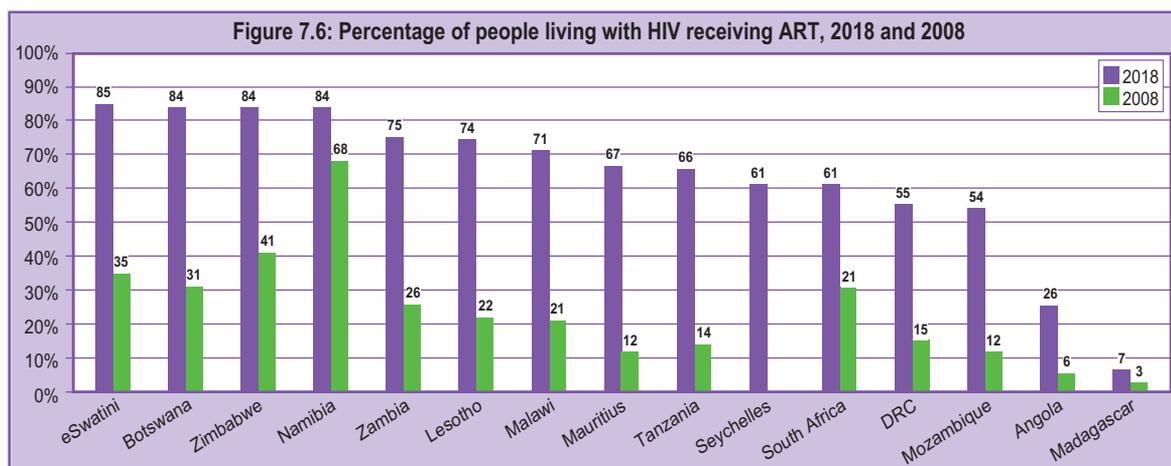


Article 27.3:

b) Ensure universal access to HIV and AIDS treatment for infected women, men, girls and boys; and

Major gains have been made: Most countries in SADC have now adopted the Test and Treat or Treat All approach, which is increasing the numbers of people on ART very quickly. In Botswana, for example, where Treat All was adopted in June 2016, the number of people on ART has increased by 37% since 2015.²⁷ In Zambia, which has also adopted the Treat All approach the number of

people living with HIV who have accessed ART increased from 530,702 in 2013 to 855,070 in 2017²⁸. When it is considered that in 2008 those who were eligible for ART were only those with CD4 counts that were lower than 200 whereas in 2018 it is all people living with HIV, to be able to increase rates of coverage is a remarkable achievement.



Source: Treatment coverage <http://aidsinfo.unaids.org/#>, last accessed July 19, 2018 and Gender Links.

²⁶ Republic of Mauritius Statistics on HIV/AIDS (as at end of June 2016).

²⁷ Government of Botswana. 2018. Country Progress Report - Botswana. http://www.unaids.org/sites/default/files/country/documents/BWA_2018_countryreport.pdf accessed 10 July, 2018.

²⁸ Government of Zambia. 2018. Country Progress Report - Zambia. http://www.unaids.org/sites/default/files/country/documents/ZMB_2018_countryreport.pdf accessed 10 July, 2018.

Figure 7.6 compares the situation with regard to treatment in 2008 with 2018. The graph shows that:

- By 2018, all countries had significantly improved their coverage compared to 2008.
- All countries have adopted a test and treat approach, which means providing ARVs for all people living with HIV, and increased their ART coverage and many have increased coverage significantly despite poor infrastructure for health and heavy HIV burdens.
- Four countries have achieved a reach of 80% or more. These are Namibia, Zimbabwe, Botswana and eSwatini.
- With coverage of only 26% and 7%, Angola and Madagascar remain a major concern.
- With its large population, South Africa has the largest number of people on ARV, but this only covers 61% of those needing to access.



South Africa has the largest HIV treatment programme in the world with over 4 million people on treatment by the end of 2017. It is estimated that by the end of 2014, 2.7 million South African adults had died from AIDS. The number of deaths per year peaked in 2006, at about 231,000 adult AIDS deaths, which dropped to about 95,000 by 2014. This is approximately 75% lower than what would have been expected in the absence of ART. The ART programme was introduced in 2004 and rapidly expanded after 2008. It is estimated that the programme resulted in 1.72 million fewer adult deaths by the end of 2014, which corresponds to 6.15 million years of life saved²⁹.

Differentiated care: Health services across the region cannot give monthly care to such large numbers of people that are on ART. There is therefore a move to provide more care at community level for those that are stable and do not need to see a health professional every month. This is done through treatment clubs, community workers and various other methods. It is being suggested that treatment may be initiated at community level, especially for groups such as men, who are hesitant to access health facilities.

Adherence to treatment is enhanced when services are confidential and non-stigmatising; decentralised to minimise travel and waiting times; when there is a trusting relationship between clients and service provider and when clients

recognize the value of treatment to their own lives and ability to care for and contribute to their families.

Drug Resistance: There are worrying reports of up to one in ten patients developing resistance to the most common first line ARVs³⁰. This is particularly the case for those that have been exposed to ARVs before - either in previous PMTCT programmes with single dose nevirapine, or who discontinued treatment for other reasons. Detecting treatment failure requires interaction with health centres and viral load testing. Any patient who is failing on first line treatment should be rapidly considered for second line drugs, which are much more expensive.

HIV and cervical cancer: Cervical cancer is considered to be an AIDS Defining Cancer. Women living with HIV have increased risk for persistent HPV (Human Papilloma Virus) infection which is associated with progression to cervical cancer, and are at least 5 times more likely to develop cervical cancer as women who are HIV negative. Studies in Botswana have found that the survival rates for women who are living with HIV with cervical cancer are poor, even when the women are on ART.³¹ There is great hope that expansion of HPV vaccination for girls before they reach sexual debut will provide greater protection for the next generation of women.³²

Zimbabwe became the 8th African country to introduce HPV vaccination into its routine vaccination programme in May, 2018.



HPV vaccination will be available to school girls aged 10 - 14. Zimbabwe has the fifth highest cervical cancer burden in the world³³. Other countries in the region that are already offering HPV vaccination include Botswana, Namibia and South Africa.

Focus on Men: The UN AIDS December 2017 report, "Blind Spot"³⁴, brought attention to the need to engage with and plan for men's health. Even though there are consistently more women in SADC that are living with HIV than men, all over the world, men are less likely to access health care than women, to access testing, or treatment or to adhere. This behaviour is not peculiar to men that are living with HIV as many studies have shown that men generally visit health facilities less frequently than women, have fewer health check-

SA
largest
HIV
treatment
programme
in the
world

²⁹ Leigh Johnson, 17 December, 2017. South Africa's HIV treatment programme: a phoenix rising from the ashes? <https://www.groundup.org.za/article/south-africas-hiv-treatment-programme-phoenix-rising-ashes/> Accessed 5 July, 2018.

³⁰ UNAIDS. Global AIDS Update 2018. Miles to go. Geneva, Switzerland.

³¹ IAS Webinar, 25 Jan 2017. The Double Burden; HIV and Cervical Cancer.

³² Melton, CL. How HIV affects cervical cancer risks and outcomes. <https://www.infectiousdiseasadvisor.com/hiv/and-cervical-cancer-risk-outcomes/article/713414/> accessed 2 July, 2018.

³³ UNICEF Zimbabwe Media Centre. Cervical Cancer Vaccine Introduced in Zimbabwe. https://www.unicef.org/zimbabwe/media_21520.html accessed 5 July, 2018.

³⁴ UNAIDS. 2017. Blind Spot. Geneva, Switzerland.

SA data:



25%

more likely than



to

die

from AIDS-related causes

ups, ask fewer questions and are diagnosed for life threatening conditions at later stages than women.

Men are exposed to a number of risk factors such as higher rates of alcohol and smoking.

There is evidence to suggest that higher alcohol use may be associated with risky sexual activity and acquisition of HIV. Alcohol use is also associated with progress of HIV infection to AIDS illness and is likely to influence poor adherence to treatment. Men are therefore more likely to die of AIDS related causes. In Sub Saharan Africa in 2016 41% of people living with HIV were men, but 53% of AIDS related deaths were in men.



Botswana reported that adult males lag behind on all three 90-90-90 targets - 74% of men know their status compared to an overall 86%; 72% of men who knew their status accessed treatment compared to 84% overall and 70% of those on treatment were virally suppressed compared to 81% overall.³⁵

In **South Africa** clinic data shows that men were 25% more likely than women to die from AIDS-related causes, even though women were more likely to be living with HIV. 70% of the men who died from AIDS-related causes had never sought health care for HIV.



Youth activists from Lets Grow in Orange Farm, South Africa, offer care, support and public education on preventing new HIV infections. Photo: Colleen Lowe Morna



A UNAIDS and WHO review of national policies on health, HIV, sexual and reproductive health and mental health in 14 eastern and southern Africa countries found that only **eSwatini** had a policy which addresses the health of men and boys. eSwatini has a specific strategy to provide a male-tailored comprehensive service package that includes health risk reduction, regular screening for non-communicable diseases and a range of sexual and reproductive health and HIV services.³⁶

Blind Spot recommends that more effort needs to be made by leaders at national and community level to engage with men,

both to enhance their own health as well as to be positive factors in the health of women, recognising that men's and women's health are closely interlinked. Men should be encouraged to take more responsibility for their own health, to challenge negative notions of masculinity which prevent them from seeking care and to adopt more protective sexual behaviours that will benefit themselves and their partners. Providers of health and HIV services need to find innovative ways to reach men. Reaching men requires an understanding both of their work lives and their leisure and arranging services to fit with these. Sport offers a unique avenue for increasing engagement with men.

Review of the impact of the HPTN071 (PoPART) prevention package on HIV incidence in 21 communities across Zambia found



that only 77% of men in **Zambia** knew their HIV status compared to 90% of women. The study team held focus group discussions with men to discuss alternative approaches to reaching men. These were the basis for a new campaign "Man up Now" which included weekend health events with a range of services including blood pressure readings, eye and dental check-ups, diabetes screening, voluntary medical male circumcision services and tests for tuberculosis, HIV and other sexually transmitted infections. Home visits were also conducted at times where men were more likely to be at home and workplace testing services were introduced. Later, self-testing was introduced, especially targeted to reach younger men.³⁷

³⁵ Government of Botswana. 2018. Country Progress Report - Botswana.

http://www.unaids.org/sites/default/files/country/documents/BWA_2018_countryreport.pdf accessed 10 July, 2018.

³⁶ Pascoe P. Addressing the Health Needs of Men and Boys: An Analysis of 14 Eastern & Southern African Countries' National Policies on Health, HIV, Sexual & Reproductive Health, & Mental Health. Commission by UNAIDS and WHO, 2017 (unpublished).

³⁷ UNAIDS. 2017. Blind Spot. Geneva, Switzerland. See also <https://www.hptn.org/research/studies/hptn071>

Care work



Article 27.3

c) Develop and implement policies and programmes to ensure appropriate recognition of the work carried out by care givers, the majority of whom are women, the allocation of resources and the psychological support for care givers as well as support for care givers as well as support of people for people living with AIDS.

From the outset, the SADC Gender Protocol has been unique in its recognition of care work. This is reinforced in the SADC sponsored UN resolution on Women, Girls and HIV, which calls on governments to: "Recognise women's contribution to the economy and their active participation in caring for people living with HIV and AIDS and recognize, reduce, redistribute and value women's unpaid care and domestic work through the provision of public services, infrastructure."

The face of care work has changed dramatically in the decade since the Barometer began. In 2008, most care workers were older women, driven by passion for their communities, neighbours and orphaned children around them, to give tirelessly of their time and care to ill and often dying people that the health care system was unable to help. A decade later it is accepted that community-based HIV service delivery is critical to reach the numerous targets, and especially to be sure that no one is left behind. But the face of the community care worker has changed quite significantly.

In 2018 community care workers are mobilising communities for testing, treatment and adherence, and also:

- Reaching adolescent girls and boys and their families for improved access to services, including VMMC where prospective clients appreciate being able to ask questions in private;
- Reach men and promote positive masculinity, especially as men do not want to travel to health centres and prefer services which are closer to home and at times which are more convenient for them;
- Reaching key populations, including sex workers, men who have sex with men, injecting drug users;
- Supporting differentiated care models for different groups - adolescents, mothers on PMTCT, men and others, to reduce congestion

in the health system and supporting patients to adhere to treatment.

Many community outreach supporters are expert clients or patients who provide peer support. This ranges from young men who have been circumcised who encourage others to do the same and answer questions about the procedure, to mothers that have been through PMTCT, to adolescents living with HIV and adhering to their treatment who support other adolescents, to men who reach out to other men. In numerous settings, collaboration between the health system and communities has been found to reduce stigma and discrimination and help to deliver services to those in greatest need. However, the scale of the task of eliminating AIDS requires that such collaboration be institutionalized, rather than limited to a few pilot projects and dependent on volunteerism. This is especially true as more and more work related to even initiation of treatment is being shifted from health centres to community level. The lived experience alone of expert clients is not sufficient and there is need for continued investment in training, support and supervision of these new care workers. Policies which were developed to support care workers a decade ago are still relevant in the new era.



In **Tanzania** early circumcision adopters who became voluntary community advocates contributed to a 500% increase in the number of circumcisions which were conducted.

In **Zambia**, the Government recognises the importance of investment in community care. Thus, the government of Zambia reports that it plans to double resources for community mobilization from 2016 to 2020. Further, spending on social enablers (including advocacy, political mobilization, law and policy reform and human rights) is expected to reach 8% of total AIDS expenditure by 2020³⁸.



Care workers mobilising for testing, treatment and adherence

³⁸ Government of the Republic of Zambia. 2018. Country Progress Report -Zambia. http://www.unaids.org/sites/default/files/country/documents/ZMB_2018_countryreport.pdf accessed 10 July, 2018.

Home based care offers solace in eSwatini

Umtfunti organisation is a home-based care project aimed at changing the lives of people living with HIV and AIDS. It was established due to the high AIDS mortality rate in the Lubombo region. Members were first trained as Lihlombe Lekukhalela (caregivers), under Siteki Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAAL) and this is where the community work began.

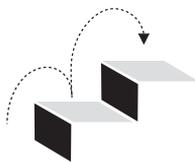
Training included GBV, child care, PMTCT and women empowerment. Members do door-to-door visits in the communities, teaching households about PMTCT, HIV, AIDS, home based care and GBV, and in addition train community members and school pupils on the same topics.

The organisation was formed to assist family caregivers in providing AIDS-related care, as public health services could not cope with the increasing demand for treatment and care. Some home-based care services focus on providing social and psychological support, with some nutritional support and basic nursing care, others also dispense ARVs and treat opportunistic infections. These services, whether provided through NGOs, government health clinics, or community groups, are essential in supporting people living with HIV, as well as people who provide care and support within families.

Umtfunti Foundation teaches people about health and wellness, takes care of the people who are terminally ill in their homes and educates and empowers women to sustain themselves economically, and to improve their lives through teaching them about micro-business. There is always hope for donor funding as, at the current time, there has been no funding at all, nor any partnerships - there are 20 beneficiaries of the programme. Lack of transportation poses problems for both the volunteers and the trained staff, local clinics and hospitals do not have vehicles that can be assigned to the care givers to do their work. Consequently, patients who live in remote areas cannot be easily reached and caregivers find patients living under very bad conditions but there are not enough resources to help them. There is no formal monitoring or evaluation of this home based care programme - nurses use outpatient cards to document care.

As a next step, the foundation intends to conduct community education with men living with HIV, young men, community leaders and male opinion leaders on the importance of male involvement, providing concrete information to encourage them to assume caregiving roles.

Source: Gillian Zwane, Umtfunti Foundation. SADC Gender Protocol@Work 2018



Next steps

- **Focus more on prevention:** Although treatment has played an enormous role in reducing the impact of HIV and AIDS, experts agree that it is not possible to treat the epidemic away. Long term there must be much more emphasis on prevention, including prevention of gender based violence and access to services for the most marginalised including men who have sex with men, sex workers, those who inject drugs and prisoners. Criminalisation of sex work, homosexuality and injecting drugs as well as stigma and discrimination are major barriers to accessing services and therefore will continue to fuel the epidemic.
- **Invest more on prevention:** Currently only 20% of global funding for HIV is being focused on prevention.
- **Focus on adolescents and young people:** For prevention, treatment, care and support. One of the best vaccines for young people is to make sure that they are in schools which are safe, supportive and where they are learning skills that they can use in life. The epidemic in young girls and women must be tackled with specific approaches tailored to this age group and must also include boys and young men.
- **Renew the focus on co-infections,** especially TB and cervical cancer. Expand vaccination for HPV and strengthen screening for cervical cancer in women living with HIV.
- **Recognise the role of a range of community based caregivers:** Such caregivers need the same support as they have throughout the pandemic - training, remuneration, materials and psychosocial support. Increasingly tasks are being shifted from health care professionals to community cadres who require input in training, supervision and support to be able to work effectively.
- **Increase investment** in systems for health, including linkages between clinical facilities and community based services. This must include increased domestic funding.