HIV and AIDS 5

Men and boys during Sixteen Days of Activisim walk in Botswana. Photo: Gomolemo Rasesigo

KEY POINTS

- Southern Africa is the epicentre of the HIV and AIDS pandemic globally. This varies considerably across the region. Four countries have a prevalence rate of 20% and above; four 10% and above and seven below ten percent.
- In 2019, 54% of all new infections globally were among key populations - sex workers, people who use drugs, gay men, and men who have sex with men, transgender people and prisoners and their partners. In Southern Africa, where the pandemic is largely heterosexually driven, these categories accounted for 25% of the total.
- Women, and especially young women, comprise the highest proportion of those living with HIV and AIDS, except for the islands (Madagascar, Mauritius and Seychelles) where intravenous drug needles are the main means of transmission.
- Three SADC countries have achieved the UNAIDS 90-90-90 targets (percent people living with HIV who know their status; percent people who know their status who are on ART; and percent people on ART who achieve viral suppression). Seven countries have achieved two targets. Three countries have not met any of the three targets.
- Overall, the region has met 25 of the 45 targets (15 countries x three targets each). This means overall progress in achieving HIV and AIDS targets is 56%.
- A total of 26,247 people accessed Pre exposure Prophylaxis or PrEP in 2018. An important application of this prevention strategy is in cases of sexual violence.
- In 2018, ARVs averted 682,000 deaths in Southern Africa, 330,000 of these in South Africa.
- Evidence from South Africa suggests that drug resistance is a threat to the expanded treatment programme. This requires vigilance from all.
- The AU is calling for two million more community health workers and for governments to ensure that they receive training, psychosocial support, remuneration and materials.

Introduction

"We have the knowledge and tools to end AIDS. We cannot change the virus, but we can change inequalities, power imbalances, marginalization, taboos, stigma and discrimination. We can change behaviours and societies"

Gunilla Carlsson, UNAIDS Executive Director, Global Aids Update 2019

SADC is the epicentre of the HIV epidemic. It is the only region in the world where HIV prevalence rates are above 10%. The global average prevalence is only 0.8% and most regions of the world have prevalence below 1%. Four SADC nations (Eswatini, Lesotho, South Africa and Botswana) have prevalence above 20%; four more between 10 and 20% (Zimbabwe, Mozambique, Namibia and Zambia). Southern Africa is home to 54% of the world's people living with HIV.

Globally, there have been many twists and turns in the HIV saga over the last four decades. HIV flourishes in conditions of secrecy, prejudice, stigma, discrimination and shame. It is enhanced by poverty, migration, mismanagement of resources, weak health systems, insufficient political will and support. The latest UNAIDS report states that: "Gains continue to be made against HIV, especially in testing and treatment. Nearly four in five people living with HIV globally knew their serostatus in 2018; almost two thirds of all people living with HIV in 2018 were receiving life-saving antiretroviral therapy, and more than half had suppressed anti-viral loads."[1]

The report notes that in sub-Saharan Africa, condom use has increased, and countries are gradually adopting pre-exposure prophylaxis (PrEP) as an additional HIV prevention option. It also notes that there has been remarkable progress towards the 2020 target of voluntary medical male circumcision (VMMC). AIDS-related mortality in Southern Africa has declined by 44% from 2010 to 2018.[2]

The most marked gains in the last fifteen years are in relation to expanded access to treatment. South Africa's President Cyril Ramaphosa has committed to expanding HIV treatment to an additional two million people by 2020. With 4.5 million people on treatment South Africa is already treating 20% of the global total of people on HIV therapy. The Cheka Impilo programme was launched on World AIDS Day 2018 as a multi-disease national wellness campaign to screen and test for HIV, TB, sexually transmitted infections and non-communicable diseases, including hypertension and diabetes[3].

There are huge costs in maintaining such large treatment programmes. Much of the cost is subsidised by international donors. The ever present possibility of drug resistance means that investment is continuously required in developing new and more effective drugs. Furthermore, the UNAIDS report cautions against complacency, noting that many countries and regions (including Southern Africa) have not reached the targets in the UN General Assembly 2016 Political Declaration on Ending AIDS.[4]

1 "Communities at the Centre: Defending Rights, Breaking Barriers, Reaching People with HIV Services." UNAIDS Global Update 2019 p3
2 Ibid
3 https://www.unaids.org/en/resources/presscentre/featurestories/2018/december/south-africa-access-hiv-treatment
4 Ibid

In 2014 UNAIDS called on the global community to set ambitious targets for the post 2015 period that would lead to an end of AIDS by 2030. This resulted in the ambitious 90 - 90 - 90 targets which were endorsed by the 2016 high level meeting. 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.

South Africa has the largest HIV Treatment Programme in the world

The SDGs do not place as much emphasis on HIV as the MDGs did but do include target 3.3: "By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases." Ending AIDS as a Public health threat will contribute to good health (SDG 3); reduce inequalities (SDG 10); the achievement of gender equality (SDG 5); promotion of just and inclusive societies (SDG 16). Ending HIV and AIDS is closely linked to revitalised global partnerships (SDG 17), ending poverty (SDG 1) and ensuring quality education (SDG 4).

Table 5.1: Key HIV data 2019

INDICATORS	Angola	Botswana	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
HIV and AIDS Prevalence															
Overall prevalence (%)	2	20	0.8	27	23.6	0.3	9.2	1.3	12.6	11.8		20.4	4.6	11.3	12.7
Women who are HIV positive as a % of total	59	55	59	58	59	46	59	28	58	60	42	60	61	52	58
Women aged 15 to 49 HIV prevalence rate	2.7	24.6	1.1	34.8	28.8	0.2	11.1	0.9	15.1	14.1		25.8	5.7	13.8	15.4
Men aged 15 to 49 HIV prevalence rate	1.2	16.2	0.4	19.2	18.5	0.4	7.3	1.8	10	9.3		15	3.5	8.8	10
HIV prevalence among young women (15-24)	1.2	8.9	0.5	15.9	10.8	0.1	4.3	0.2	3	4.5		11.3	2.2	4.9	5.5
HIV prevalence among young men (15-24)	0.3	4.9	0.2	3.1	4.1	0.2	2	0.2	3	2.6		3.7	1.2	2.4	3.1
Sex workers															
HIV prevalence (%)	8	42.2	5.7	60.5	71.9	5.5	55	15		40.7	4.6	57.7	15.4	48.8	41.4
Condom use (%)	71.7	75.7	69	82.9	62.3	62.8	65	67.2			16	86.1	70	78.5	96.1
Men who have sex with men															
HIV prevalence (%)	2	14.8	3.3	12.6	32.9	14.9	7	17.2			13.2	18.1	8.4		31
Condom use (%)	59.1	77.5	77.4		46.4	57.2	44	53.1				97.9	13.9		
Prevention															
Proportion of people age 15+ who know their HIV status															
Women age 15+ who know their HIV status	47	95	64	93	89	21	94	19	80	95		93	82	88	94
Men age 15+ who know their HIV status	44	89	79	93	82	7	89	23	61	87		88	73	87	86
Condom use at last high risk sex															
Condom use at last high risk sex - women	32	N/A	23	54	76	5	50	N/A	42	66		61	30	41	67
Condom use at last high risk sex - men	63	N/A	32	67	77	13	76	N/A	47	80		73	47	56	85
Elimination of mother-to-child transmission															
Coverage of pregnant women who receive ARV for PMTCT (%)	38	95	44	79	77	25	95	95	95	95		87	93	95	94
Mother to child transmission rate	27.8	2.5	27	7.8	12.7	39.8	7.8	13.7	15	3.9		4.9	10.5	11.2	7.6
Knowledge															
Comprehensive knowledge of HIV and AIDS	32	47	20	50	36	24	42	32	31	58		46	43	44	46
Knowledge about HIV prevention among young women aged 15-24	32.5	47.4	18.6	49.1	37.6	22.9	41.1	4.4	30.8	61.6		46.1	40.1	41.5	46.3
Knowledge about HIV prevention among young men aged 15-24	31.6	47.1	24.9	50.9	30.9	25.5	44.3	30	30.2	51.1		45.6	46.7	46.7	46.6
Attitudes															
% of women who say a woman has the right to insist on a man using a condom	55%	26%	11%	53%	61%	67%	58%	36%	17%	18%	50%	50%	63%	60%	59%
Treatment - Antiretroviral therapy (ART)															
% of those living with AIDS who are on ARV treatment	27	83	57	86	61	9	78	22	56	92		62	71	78	88
Women aged 15 and over receiving ART	59	95	91	95	73	75	92	95	79	95		71	95	95	95
Men aged 15 and over receiving ART	32	80	93	85	66	95	76	95	69	88		63	77	79	95
Children aged 0 to 14 receiving ART	13	38	25	76	70	5	61	45	60	78		62	72	78	76

Source: UNAIDS Data 2019 except for Attitudes which comes from the GL Gender Progress Score (GPS).

Table 5.1 shows that:

- In Southern Africa HIV and AIDS is still predominantly a heterosexually driven pandemic, with women comprising the highest proportion of those living with HIV and AIDS, except for the islands (Madagascar, Mauritius and Seychelles) where intravenous drug needles are the main means of transmission.
- Women are much more likely than men to be aware of their HIV status.
- Prevention of Mother to Child Transmission (PMTCT) is high but still lacking in poor, post conflict countries such as Angola and DRC, and is not a priority in the islands, since this is not a primary means of transmission.

- The response among women to the question "a woman has the right to insist on a man using a condom" varies widely, from 11% in DRC to 67% in Madagascar.
- Coverage of adults and children receiving Antiretroviral Therapy has improved dramatically, but ranges from 9% in Madagascar to 92% in Namibia. In all SADC countries (except the islands) women are more likely than men to be on ART.

Table 5.2: Progress towards achieving the 90-90-90 in SADC

Country	Status first 90	Status second 90	Status third 90	Achieved all three 90s	Total	%
	% people living with HIV who know their status	% people who know their status on ART	% people on ART who achieve viral suppression			
Botswana	91	92	95	1	3	100%
Eswatini	92	93	95	1	3	100%
Namibia	91	95	95	1	3	100%
Lesotho	86	71	93		2	67%
Malawi	90	87	89		2	67%
South Africa	90	68	87		2	67%
Seychelles		90	90		2	67%
Tanzania	78	92	87		2	67%
Zambia	87	89	75		2	67%
Zimbabwe	90	95	0		2	67%
DRC	62	92	0		1	33%
Mauritius	22	95	73		1	33%
Angola	42	63	0		0	0%
Madagascar	11	84	0		0	0%
Mozambique	72	77	0		0	0%
	8		8	3	25	56%

Source: Gender Links, with data from UNAIDS Data 2019.

Table 5.2 shows that:

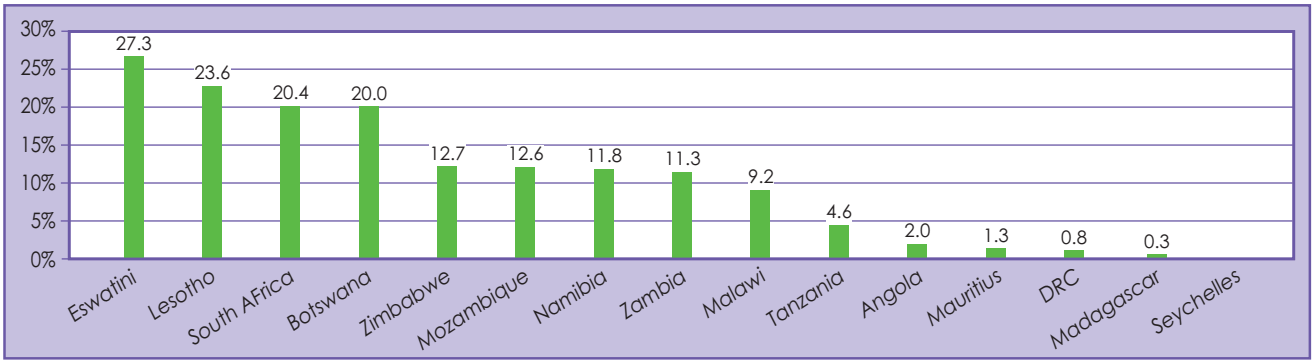
- Three SADC countries have achieved the UNAIDS 90-90-90 targets (percent people living with HIV who know their status; percent people who know their status who are on ART; and percent people on ART who achieve viral suppression). These three countries are Botswana, Eswatini and Namibia.
- Seven countries Lesotho, Malawi, South Africa, Seychelles, Tanzania, Zambia and Zimbabwe) have achieved two targets.
- Three countries (Angola, Madagascar and Mozambique) have not met any of the three targets.
- Overall, the region has met 25 of the 45 targets (15 countries x three targets each). This means overall progress in achieving HIV and AIDS targets is 56%.

There is renewed effort to map epidemics more effectively so that interventions are targeted at districts with the greatest need.[5] It is clear that the world cannot treat itself out of the HIV epidemic and there is renewed emphasis on primary prevention to reduce new infections. Areas of focus for prevention in SADC must be: adolescent girls, young women and their partners, including adolescent boys; key populations, including sex workers, prisoners, men that have sex with men, injecting drug users; expanded condom distribution; expanded voluntary medical male circumcision; access to PreP and continued development of prevention of mother to child transmission programmes. This chapter covers prevalence; policies; prevention; treatment and care of HIV in Southern Africa over the last year, with a particular focus on the gender dimensions of the pandemic, and its link to SRHR more broadly.

[5] See for instance Dwyer-Lindgren, L. et al. Mapping HIV prevalence in sub-Saharan Africa between 2000 and 2017. Nature. May 2019. doi: 10.1038/s41586-019-1200-9

Prevalence and drivers of the pandemic

Figure 5.1: Overall prevalence of HIV



Source: Gender Links, with data from UNAIDS Data 2019.

The highest rates of HIV and AIDS in Southern Africa are in South Africa and its neighbouring countries

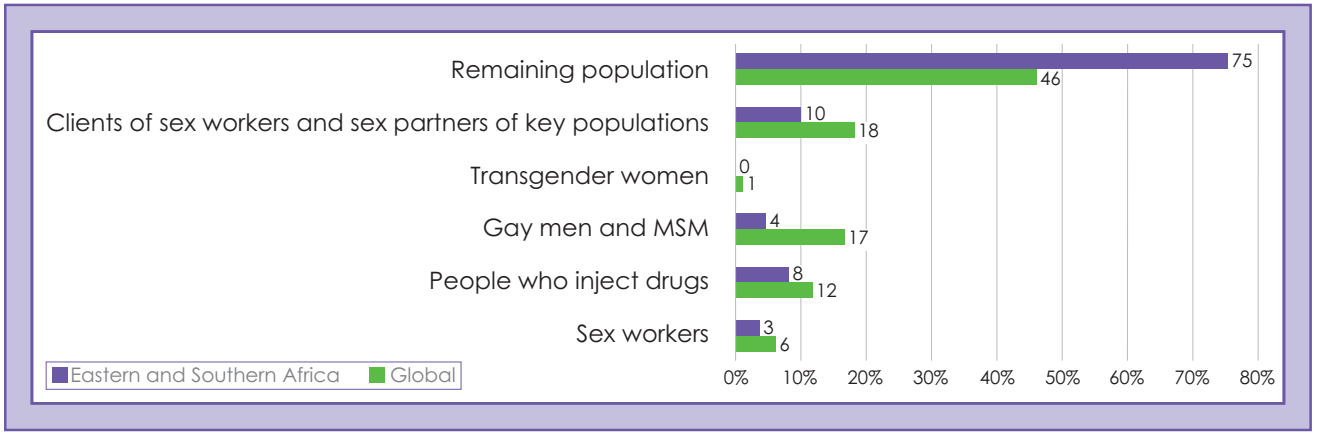
Southern Africa has a population of 277 million. Just over 16 million people are living with HIV and AIDS (7.5 million in South Africa), the highest in the world. However, as illustrated in figure 5.1, this varies considerably across the region. Four countries have a prevalence rate of 20% and above; four 10% and above and seven below 10%. Six SADC countries have a prevalence rate of less than 5%. Throughout this chapter it is important to note that Mauritius and Seychelles have quite small total populations (1.27 million and 98 000 respectively) and also very low HIV prevalence compared to other SADC member states. Thus, absolute numbers are often very low in these two nations and percentages not available.

The highest rates of HIV in Southern Africa are in South Africa and its neighbouring countries; the lowest in the three island countries (Mauritius, Madagascar and Seychelles) and the two countries furthest removed from South Africa (Angola and DRC). South Africa's history of race, gender and class inequality, as well as high levels of gender violence have been major contributory factors to the pandemic in Southern Africa's largest nation. South Africa is closely linked to its neighbouring countries through a long history of migrant labour to the mines, trade and trucking routes.

	Global	Eastern and Southern Africa
Sex workers	6%	3%
People who inject drugs	12%	8%
Gay men and MSM	17%	4%
Transgender women	1%	
Clients of sex workers and sex partners of key populations	18%	10%
Remaining population	46%	75%

Source: Gender Links.

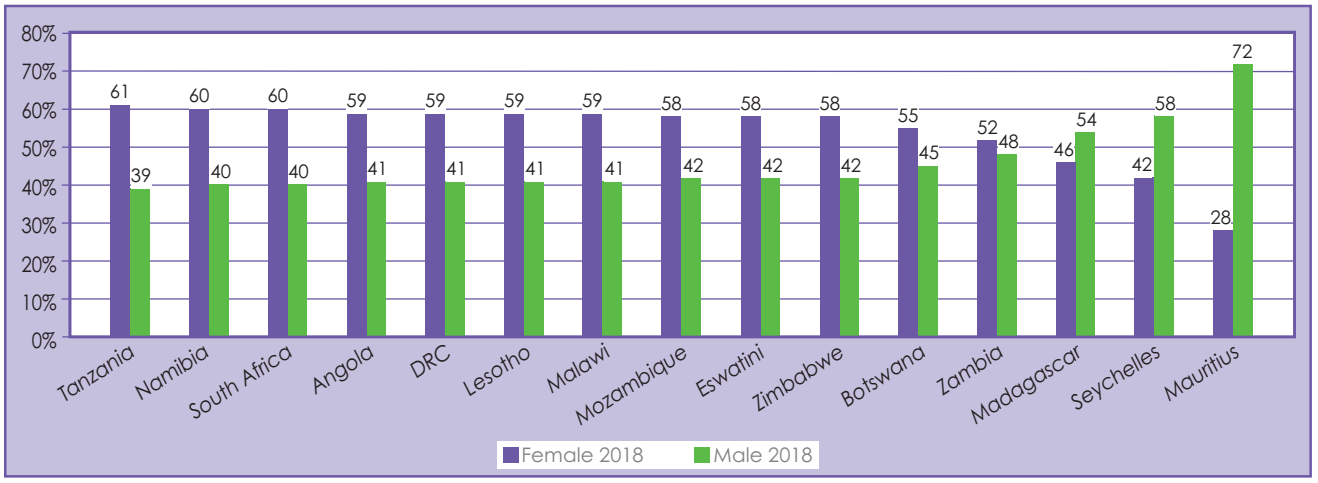
Figure 5.2: Distribution of new HIV infections - 15 to 49 years by population group



Source: Gender Links, with data from UNAIDS 2019.

As illustrated in Figure 5.2, globally "the pandemic is changing: in 2018, more than half of all new infections were among key populations - sex workers, people who use drugs, gay men, and men who have sex with men, transgender people and prisoners and their partners. New infections among young women (aged 15 to 24 years) were reduced by 25% between 2010 and 2018."[6] In Southern Africa, however, key populations account for only 25% of those living with HIV and AIDS, with "remaining population" accounting for 75%, in a region where HIV and AIDS is largely heterosexually driven.

Figure 5.3: Proportion of women and men living with HIV 2019

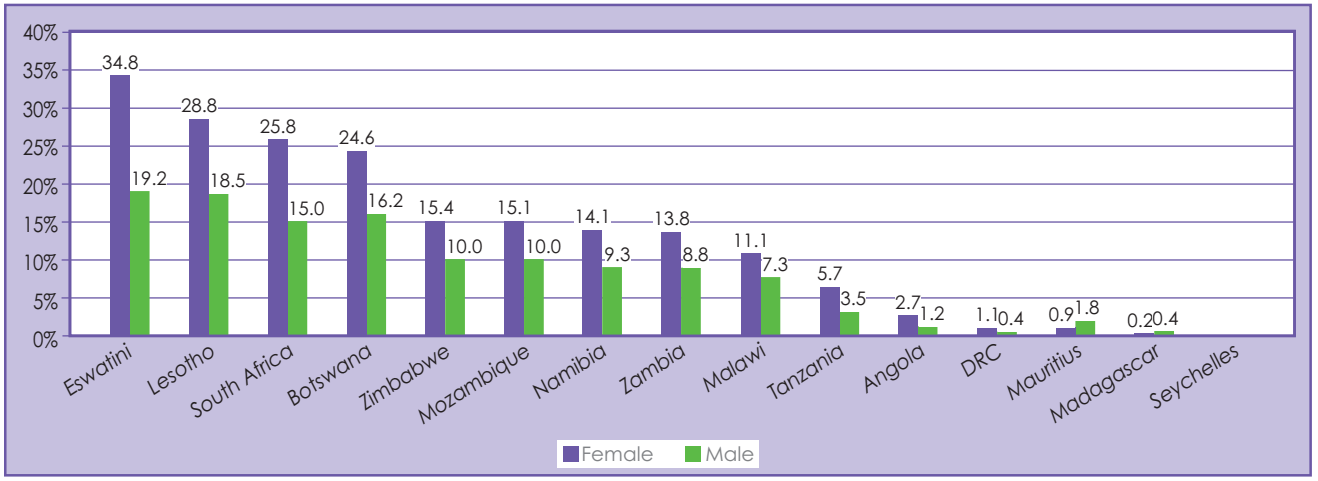


Source: UNAIDS Special analysis 2019.

As illustrated in Figure 5.3, with the exception of Madagascar, Seychelles and Mauritius where HIV is largely driven by drugs and the use of intravenous needles, there is a far higher proportion of women than men living with HIV in SADC. Globally, HIV infections among young women (age 15 to 24 are 60% higher than among men the same age.

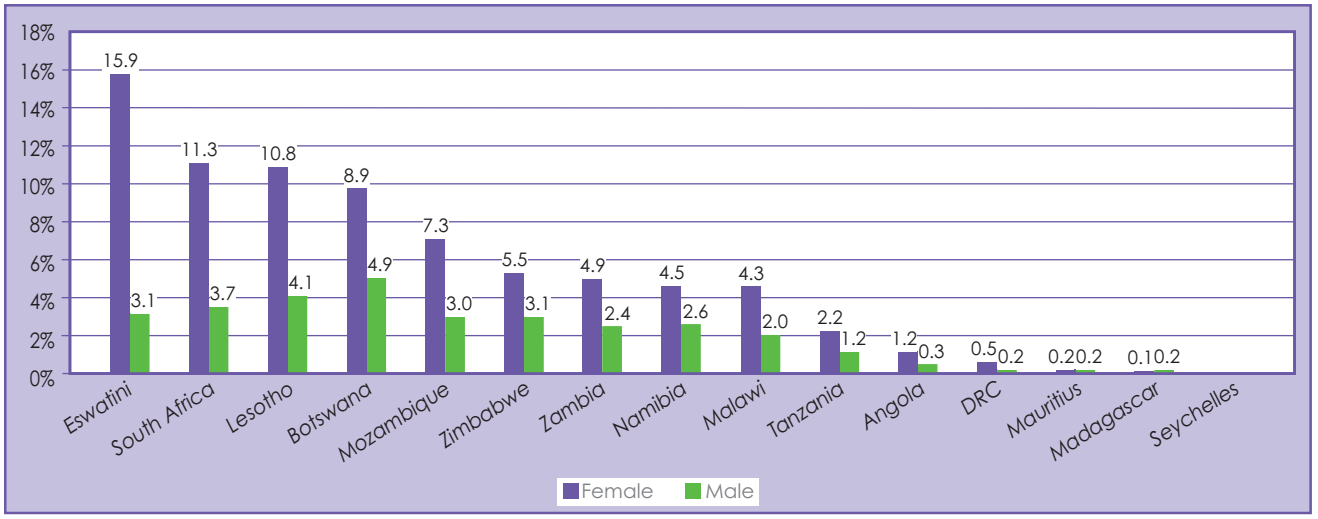
[6] "Communities at the Centre: Defending Rights, Breaking Barriers, Reaching People with HIV Services." UNAIDS Global Update 2019 p2

Figure 5.4: HIV prevalence rates in women and men - 15 to 49



Source: UNAIDS Special analysis 2019.

Figure 5.5: HIV prevalence rates in women and men - 15 to 24



Source: UNAIDS Special analysis 2019.

Figure 5.4 and 5.5 shows prevalence rates among women and men 15 to 49 and 15 to 24 in 15 countries of the region. The graphs show that (with the exception of the islands) women constitute a higher proportion of those living with HIV than men, and this is especially pronounced among the youth. According to the UNAIDS 2019 report: "HIV and intimate partner violence share common risk factors: poverty, economic stress, gender inequality, social norm and rigid construction of masculinity and femininity (which often condone male sexual infidelity, heavy alcohol use and violence within relationships."[7]

[7] "Communities at the Centre: Defending Rights, Breaking Barriers, Reaching People with HIV Services." UNAIDS Global Update 2019 p12.

Table 5.3: New HIV and AIDS infections in Southern Africa

Country	Women (15+)	% of total	Men (15+)	% of total	Young women (15-24)	% total	Young men (15-24)	% total	New infections all ages	Target 2020	Variance
Angola	14000	68%	6700	32%	6800	78%	1900	22%	28000	5000	-23000
Botswana	4500	55%	3700	45%	2000	67%	1000	33%	8500		-8500
DRC	8700	76%	2800	24%	4100	80%	1000	20%	19000	3000	-16000
Eswatini	4100	59%	2800	41%	2400	83%	500	17%	7000	3000	-4000
Lesotho	6600	62%	4000	38%	3200	71%	1300	29%	13000	5000	-8000
Madagascar	1700	30%	4000	70%	1000	38%	1600	62%	6100		-6100
Malawi	20000	57%	15000	43%	9900	70%	4200	30%	38000	11000	-27000
Mauritius	500	33%	1000	67%	100	50%	100	50%	1000		-1000
Mozambique	73000	57%	55000	43%	39000	66%	20000	34%	150000	30000	-120000
Namibia	3300	57%	2500	43%	1400	58%	1000	42%	6100	3000	-3100
Seychelles											0
South Africa	140000	62%	86000	38%	69000	73%	25000	27%	240000	88000	-152000
Tanzania	36000	57%	27000	43%	16000	68%	7600	32%	72000	14000	-58000
Zambia	25000	58%	18000	42%	13000	70%	5600	30%	48000	14000	-34000
Zimbabwe	19000	58%	14000	42%	9000	68%	4200	32%	38000	16000	-22000
TOTAL	**355900**	**60%**	**241500**	**40%**	**175800**	**71%**	**72400**	**29%**	**645700**	**192000**	**-453700**

Source: Gender Links with data from UNAIDS, 2019.

New infections are still three times greater than the 2020 target

Though most countries in SADC have experienced significant declines in the numbers of new infections, Table 5.3 shows that the rates are still very high. In countries with more mature heterosexual epidemics the gap between the rates of new infections in women and men is narrowing, while rates of new infections in children are decreasing significantly as PMTCT programmes bear results. Overall, new infections in women are 51% of the total, in men are 38% of the total and children 11%.

The total number of new infections in SADC in 2018 stood at 645,700 compared to a 2020 target of 192,000: more than three times higher than the desired target. Women over the age of 15 constitute 60% of the new infections. Young women (15 to 24) constitute 70% of the new infections. The new infections in all countries are still between 2 and 5 times as high as the target that has been set. There is thus huge need to focus on HIV prevention.

The **Zambia** PHIA report[8] released in 2019 presents discouraging evidence about HIV in adolescents. Among persons aged 15-24 years, nearly twice the proportion of males (17,1%) compared to females (9,5%) reported having sexual intercourse before the age of 15 years. Sexual debut before the age of 15 years among those aged 15-24 years was twice as high in rural areas (17,3%) as in urban (8,6%). Early sexual debut ranged from 7,4% in Copperbelt Province to 29,4% in North-Western Province. The percentage who reported early sexual debut was 17,9% among those with only primary education compared to 4,1% among those with more than a secondary education. HIV incidence among persons aged 15-24 years in Zambia was 0,57% (0,08% among males and 1,07% among females).

[8] Ministry of Health, Zambia. Zambia Population-based HIV Impact Assessment (ZAMPHIA) 2016: Final Report. Lusaka, Ministry of Health. February 2019. https://phia.icap.columbia.edu/wp-content/uploads/2019/03/ZAMPHIA-Final-Report__2.26.19.pdf accessed 5 June, 2019

Policies, laws and resources

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.

ICPD: 8.27 All countries, as a matter of some urgency, need to seek changes in high-risk sexual behaviour and devise strategies to ensure that men share responsibility for sexual and reproductive health, including family planning, and for preventing and controlling sexually transmitted diseases, HIV infection and AIDS.

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.

Table 5.4: Countries with a stand-alone HIV and AIDS policy or strategy

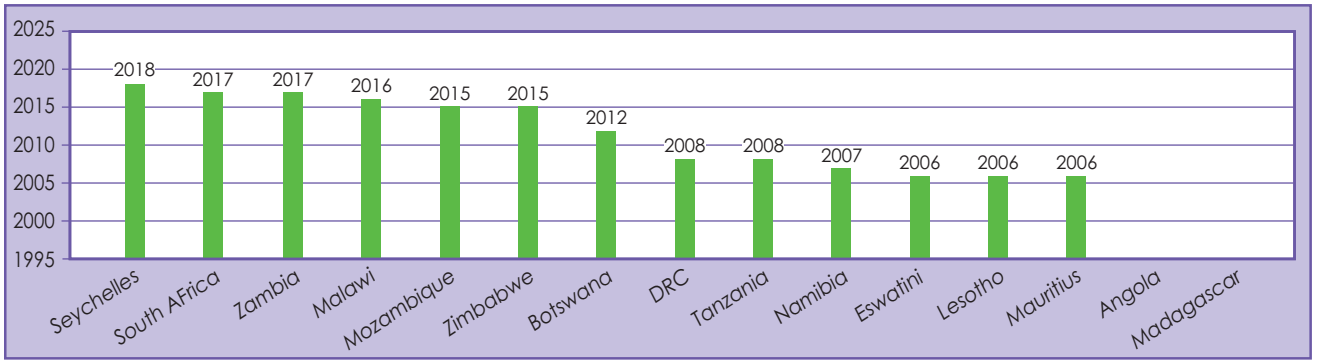
Country	Country has stand-alone HIV and AIDS policy or strategy	HIV and AIDS policy includes other STIs
Seychelles	Yes	Yes
Zambia	Yes	Yes
Malawi	Yes	Yes
Mozambique	Yes	Yes
Zimbabwe	Yes	Yes
Botswana	Yes	Yes
DRC	Yes	Yes
Tanzania	Yes	Yes
Namibia	Yes	Yes
Eswatini	Yes	Yes
Lesotho	Yes	Yes
Madagascar	Yes	Yes
Angola	Yes	Yes
South Africa	Yes	Yes
Mauritius	Yes	No

Source: Gender Links, with data from UNAIDS 2019.

Table 5.4 shows that all the SADC countries have a stand-alone HIV and AIDS policy. With the exception of Mauritius, the HIV and AIDS policies for all countries include other STIs. Stand-alone HIV policies are essential in a region where HIV overshadows so much other development. The HIV landscape is changing so rapidly that it is imperative that countries have up to date policies and strategic plans to guide them towards ending AIDS as a public health threat by 2030.

All SADC member states have a stand-alone HIV policy

Figure 5.6: When HIV and AIDS policies were adopted

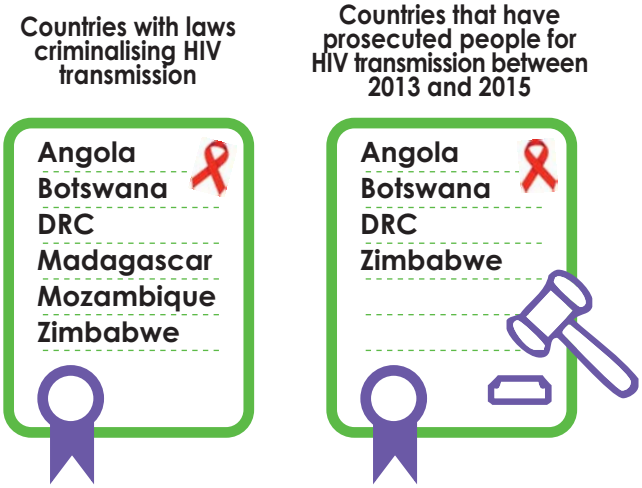


Source: GL Audit of SRHR Policies and Laws 2019.

Figure 5.6 shows that countries adopted stand-alone HIV and AIDS policies between 2000 and 2018. Seychelles (2018) is the latest country to adopt an HIV and AIDS policy. In at least seven Southern African countries for which data is available (DRC, Tanzania, Namibia, Eswatini, Lesotho, and Mauritius), HIV and AIDS policies are more than ten years old. Five countries (Seychelles, Botswana, the DRC, Namibia, and Angola) are currently updating their HIV and AIDS policies.

Figure 5.7 shows that six SADC countries (Angola, Botswana, DRC, Madagascar, Mozambique and Zimbabwe) currently criminalise HIV transmission and that four (Angola, Botswana, DRC and Zimbabwe) have prosecuted people for HIV transmission between 2013 and 2015.

Figure 5.7: Countries that criminalise/prosecute HIV transmission[9]



Source: HIV Justice Network.

[9] http://www.hivjustice.net/news/new-report-shows-hiv-criminalisation-is-growing-global-problem-but-advocates-are-fighting-back/

Criminalising people for having HIV is a violation of human rights that undermines public health efforts to control the epidemic. Prosecutions for HIV-specific crimes often flout core legal principles such as intent and causation. There is no evidence that applying the criminal law to HIV reduces its spread. Rather, such approaches promote fear and stigma about HIV, can adversely affect relationships between patients and healthcare providers, and can discourage people from seeking HIV testing and treatment.

HIV criminalisation has particularly profound effects on women. Because women are often the first in a household to learn their HIV status, they can become vulnerable to blame and violence. The threat of prosecution is a potential disincentive for women to leave abusive relationships, and some laws are so broad that they criminalise transmission of HIV during pregnancy and breastfeeding.[10]

Zimbabwe is set to decriminalise wilful transmission of HIV through the Marriages Bill which is now set to be tabled before Parliament for debate. Section 53 of the Marriages Bill will repeal Section 79 of the Criminal Law (Codification and Reform) Act which makes it an offence to transmit HIV to a partner. Justice Minister Ziyambi Ziyambi told Parliament that the global thinking was that the law stigmatised people living with HIV and Aids.[11] The thinking in Zimbabwe follows similar action in Malawi.

Per capita expenditure

Table 5.5: Spending on HIV and AIDS

Country	HIV	Health	HIV spending as proportion of health spending
Namibia	$90	$442	20%
Eswatini	$89	$265	34%
Botswana	$72	$389	19%
Lesotho	$51	$91	56%
Seychelles	$39	$490	8%
South Africa	$34	$510	7%
Zambia	$19	$69	28%
Zimbabwe	$19	$69	27%
Malawi	$13	$341	4%
Mozambique	$12	$28	43%
Tanzania	$7	$27	26%
Mauritius	$6	$367	2%
DRC	$3	$19	14%
Angola	$1	$122	1%
Madagascar	$1	$21	3%

Source: UNAIDS Special analysis 2019.

Table 5.5 shows that spending on HIV varies widely in the SADC region: from $90 per capita in Namibia to $1 per capita in Angola and Madagascar. This is to some extent driven by the extent of the pandemic in each SADC country (Angola and Madagascar have low prevalence rates), but also levels of poverty and health expenditure generally. HIV spending ranges from 56% of the health budget in Lesotho to just 1% of the health budget in Angola. The UNAIDS 2019 report comments that: "in Eastern and Southern Africa where expenditures per person living with HIV have reached the 2020 resource needs estimate, reductions in HIV infections and AIDS-related deaths are approaching the 2020 targets."[12]

[10] https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(18)30219-4/fulltext
[11] https://zoomzimbabwe.com/2019/07/22/government-to-decriminalise-wilful-transmission-of-hiv/, accessed on 31 July 2019.
[12] Communities at the Centre: Defending Rights, Breaking Barriers, Reaching People with HIV Services." UNAIDS Global Update 2019 p9.

Malawi passes progressive HIV legislation[13]

Activists and civil society organisations from Malawi and across southern Africa applaud the government of Malawi for showing leadership in its HIV response and upholding human rights standards, with the recent passing of a new HIV/AIDS (Prevention and Management) Act No. 12 of 2017, which came into force on 1 February 2018. The Act has been received with approval by various stakeholders including, women's groups, movements of people living with HIV, and national, regional and international human rights organisations fighting against human rights infringements in national responses to HIV, including the criminalisation of HIV.

The HIV and AIDS (Prevention and Management) Act has been a standing item on Parliament's agenda for almost a decade now. Previous versions of the Bill contained provisions that were inconsistent with international good practice and violated fundamental human rights. The Bill, which had its origins in a 2008 Law Commission Report, included provisions to make HIV testing and treatment mandatory for select populations on a discriminatory basis, and provisions that criminalise HIV exposure and transmission.

As a result of concerted advocacy from civil society organisations in Malawi and beyond, powerfully led by women living with HIV in Malawi, the HIV and AIDS (Prevention and Management) Act that recently passed into law is free of these punitive and rights-infringing provisions. Parliament's willingness to remove these provisions and to pass the law in its current form is evidence of Malawi's commitment to promoting a human rights based response to HIV based on the best available scientific evidence and represents a significant step in moving the country closer to realising the 90-90-90 targets set by UNAIDS of having 90% of all people tested for HIV, 90% of these initiated on antiretroviral treatment and 90% of these having a suppressed viral load.

"We are greatly indebted to the parliamentarians for passing the HIV and AIDS Prevention and Management Act that will ensure that all Malawians, especially women and girls living with HIV, have equal access to quality HIV and AIDS services that are provided in an environment free of stigma and discrimination and in which human rights are protected," said Edna Tembo, Executive Director of the Coalition of Women Living with HIV/AIDS in Malawi (COWLHA).

"This is a moment to celebrate the women of the Coalition of Women Living with HIV/AIDS (COWLHA) who, with assistance in legal empowerment from the Women Lawyers Association (WLA) and others, were able to engage with the parliamentarians and sit in the House when the bill was read out and amended line by line," said Sarai Chisala-Tempelhoff of the WLA.

Source: South African Litigation Centre, 2018

[13] http://www.southernafricalitigationcentre.org/2018/02/13/news-release-our-bodies-our-rights-activists-welcome-the-passing-of-the-malawi-hiv-and-aids-prevention-and-management-act/

Prevention

Article 27. 3: State Parties shall:
a) Develop gender sensitive strategies to prevent new infections.
BPFA +20 Africa Declaration: (h) Scale up combined preventive HIV/AIDS measures for young women and girls and expand programmes to eliminate mother-to-child transmission;
SADC SRHR Strategy: HIV and AIDS ended as a public health threat by 2030 (SDG 3.3.);
ICPD: 7.32 Information, education and counselling for responsible sexual behaviour and effective prevention of sexually transmitted diseases, including HIV, should become integral components of all reproductive and sexual health services.
UNAIDS 90/90/90: TARGET 1: By 2020, 90% of all people living with HIV will know their HIV status (90% diagnosed)
The SADC-sponsored UN Resolution on women, girls, HIV and AIDS

- 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.

It is impossible to reach the target of controlling HIV and ending AIDS by 2030 until the majority of those living with HIV know their status, access treatment and are virally supressed. Currently, the major gap in this process is testing so that all those living with HIV are aware of their status. The UNAIDS 2018 report, Knowledge is Power, details many barriers to testing including stigma, criminalization of key populations, distance and other physical barriers to accessing services, as well as costs (including loss of income) associated with accessing services. The report also details different approaches to ensuring that everyone

Renewed investment in testing is imperative to reach the first 90

is reached with testing. These include community testing, testing in places where men frequent (outside health centres) or at times that are convenient; self-testing, with or without support; following families of those that are known to be living with HIV (index case finding), and point of care testing for babies.

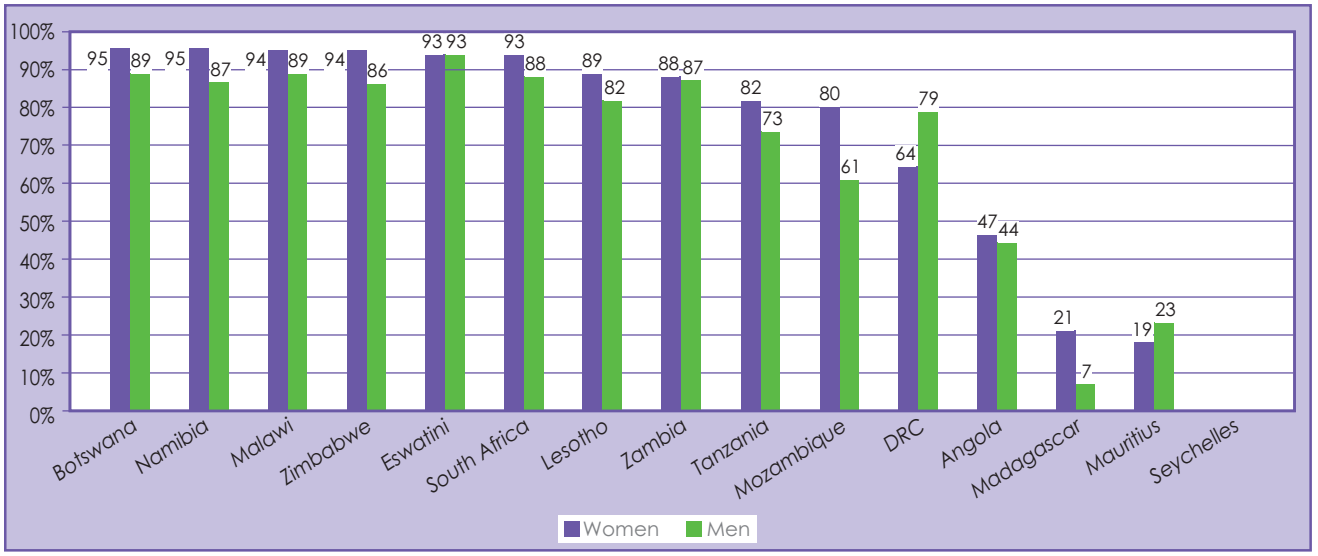
As progress to meeting prevention targets has not been fast enough, a Global Partnership on Prevention has developed the HIV Prevention 2020 road map.[14] Prevention is focused on 26 countries globally that are contributing the highest number of new infections, including ten countries in SADC - South Africa, Mozambique, Zambia, Tanzania, Zimbabwe, Malawi, Angola, Lesotho, Namibia and Eswatini.

The plan calls for significantly increased political will and leadership; addressing policy gaps that would enable members of key populations (including sex workers, those in same sex relationships, injecting drug users, and prisoners) and young women and their partners to access prevention services; increasing funding for primary prevention and improving coordination for implementation. Leaders of the partnership met in 2018 to review progress.[15] Some of the issues highlighted in the meeting were: the need for bold action to scale up prevention programmes; national and sub national accountability for prevention; addressing stigma, discrimination and criminalization of key populations; and increased access to condoms for all that need them.

Still marching: World Aids Day in Mazenod, Lesotho. Photo: Ntolo Lekau

Knowledge of HIV status

Figure 5.8: People living with HIV 15+ who know their status



Source: Source: UNAIDS Special analysis 2019.

[14] UNAIDS, 2017. HIV Prevention Road Map. Geneva. UNAIDS. https://www.unaids.org/en/resources/documents/2017/hiv-prevention-2020-road-map
[15] https://www.unaids.org/en/resources/presscentre/featurestories/2018/july/global-hiv-prevention-coalition

Figure 5.7 shows that six SADC countries (Botswana, Namibia, Malawi, Zimbabwe, Eswatini, and South Africa) have succeeded in expanding coverage of testing to at least 90% of those that are living with HIV, with Zambia, Tanzania and Mozambique not too far behind. This is a particularly noteworthy achievement in South Africa, which has the largest population of people living with HIV of any country in the world. Low coverage of testing in the islands is understandable, due to low prevalence, but is a concern, as testing is one of the most powerful prevention tools.

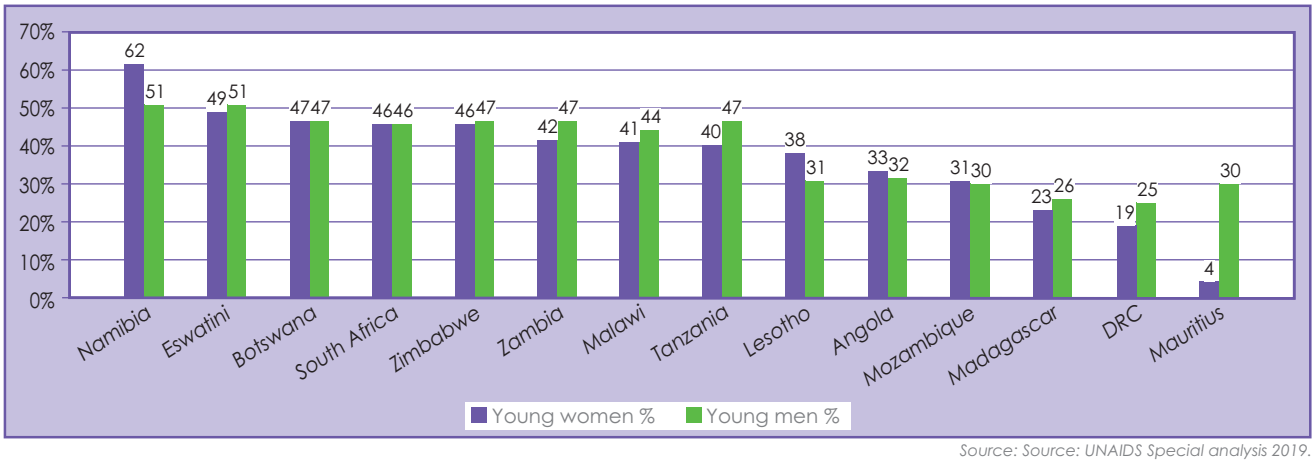
A self testing kit ready for operation in Mutare, Zimbabwe. Photo: Tapiwa Zvaraya

In all these countries (except Mauritius), knowledge of HIV status is higher among women than men. According to the UNAIDS 2019 report, globally uptake of the three 90s is much higher among women than men: "This is in line with numerous studies showing that men are less likely than women to take HIV tests and to initiate and adhere to HIV treatment, which results in poorer clinical outcomes and a greater likelihood that they will die of AIDS-related causes."[16]

Comprehensive, accurate knowledge of HIV and AIDS

In addition to knowledge of status, knowledge about the pandemic is essential to encourage safe sexual behaviour and promote HIV prevention. Available data suggests that knowledge is still low in both young women and men across SADC and therefore the target of reduction in new infections is unlikely to be reached.

Figure 5.9: Knowledge of HIV prevention 15 - 24



Source: Source: UNAIDS Special analysis 2019.

[16] "Communities at the Centre: Defending Rights, Breaking Barriers, Reaching People with HIV Services." UNAIDS Global Update 2019 p85

Zimbabwe: Men's attitudes to health stalling SRHR progress[17]

Moses Chamunorwa aged 24 complains about burning sensations in his urethra and continuous fever but he refuses to go for HIV testing. In spite of having Sexually Transmitted Infection(s) symptoms, Chamunorwa prefers traditional healers to the clinic. "I am not employed and survive on vending. I cannot afford user-fees charged at polyclinics plus drug costs prescribed after consultation and examination," said Chamunorwa revealing his wife's medical records from an Opportunistic Infection (OI) Clinic.

"She is the one that goes to clinic. At least, my wife got treated when she delivered our son," he added. Realising that Chamunorwa cannot grasp what is written on the medical records of his partner, I interviewed Musindo separately. "My husband does not want to go to clinic, despite telling him that nurses say that I should come with him for treatment citing exorbitant costs."

Chamunorwa does not believe that he is HIV positive nor his wife and has never seen Musindo taking ARVs. "She only took some metro and other pills I can't remember when, perhaps when we had an STI in 2013 after her delivery," he said. When asked why he does not take advantage of free HIV counselling and testing outreach programmes common these days Chamunorwa said, "I am fit and I do not look ill, neither my son nor wife, so why should I go for HIV testing?" he questioned confidently.

Men in Zimbabwe shy away from treatment. Photo: Tapiwa Zvaraya

Chamunorwa revealed that the problem he and wife were currently facing were sore warts around the genital areas. "The warts are painful and we have tried to take some herbs but it is not helping," he said. According to the Harare City Council 2017 Annual Health Report the total number of new Sexually Transmitted Infections (STI) cases recorded in its health department clinics was 32 582. "This represents a 6% decrease compared to the previous year when 34 707 cases were recorded.

"Even though there was a decrease, there is still a need for health education in the community and stress on the importance of correct and consistent condom usage," reads part of the city's health report. Of concern to note is that adolescents aged 10-24 years accounted for 11 242 of the 32 582 STI cases recorded last year while children under the age of 9 years accounted for 1 094 STI cases.

It costs $5 for an adult consultation at local clinics in Harare excluding medication and examination tests, while maternal fees are $25. Amounts that very few people in Zimbabwe are able to raise in the face of 94 percent unemployment rate.

By: Thabani Dube, Gender Links News Service, 2019

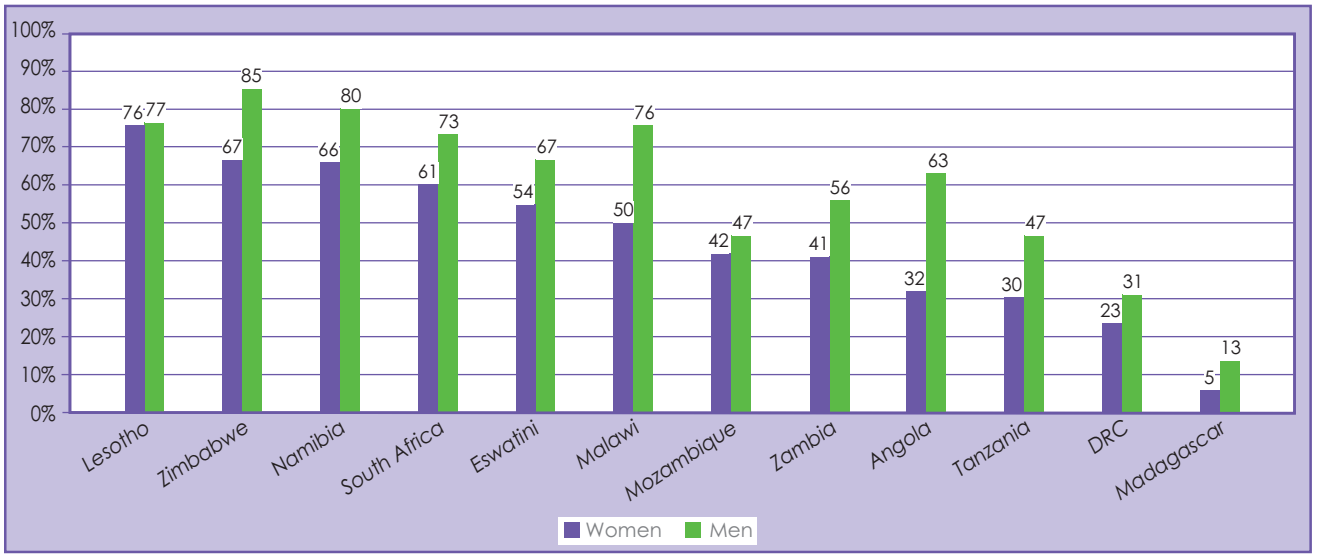
[17] Derived from http://genderlinks.org.za/news/zim-ignorance-stalling-srhr-progress/

Figures 5.9 shows that despite enormous effort the levels of knowledge of HIV are still generally low among young people. Knowledge about HIV is still less than 50% for both young women and young men in all but two countries (Eswatini and Namibia). Levels have not changed very much between 2008 and 2019. Poor knowledge is very likely to translate into low levels of risk awareness and poor prevention of HIV at a time when we need to redouble our efforts in prevention. With the exception of Namibia, knowledge is higher among young men than young women, despite the prevalence rate being much higher among young women than among young men.

The Malawi PHIA[18] report found that only 44.0% of females and 50.1% of males aged 15-24 years answered all five HIV knowledge questions correctly with a higher proportion of young men in urban areas (59.5%) responding correctly to all five questions, compared to those in rural areas (47.4%). Among those aged 15-24 years, 13.7% reported having sexual intercourse before the age of 15 years (19.0% among males and 8.8% among females). Sexual debut before the age of 15 years was especially high among those with no education. Among those aged 15-24 years living with HIV, 46% had not been diag-nosed, and among those diagnosed, 14% had not initiated ART. Among those on treatment, only 19% have not achieved viral load suppression.

Condom use at high risk sex

Figure 5.10: Condom use at high risk sex

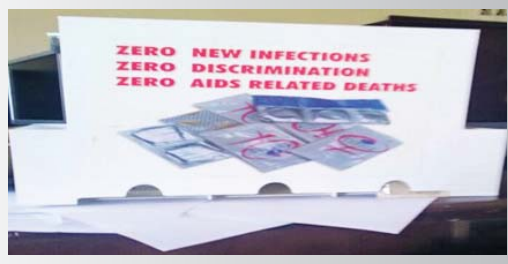


Source: Source: UNAIDS Special Analysis 2019.

Despite all the public education and awareness on condoms, the UNAIDS 2019 report notes that median condom use by men at last higher risk sex in 27 sub-Saharan countries stood at 58.6%.[19] Figure 5.8 shows that seven countries (Zimbabwe, Namibia, Lesotho, Malawi, South Africa, Eswatini and Angola) have condom at last high risk sex of over 50%. Other countries lag behind. The uptake among women in all countries is considerably lower than men.

[18] Ministry of Health, Malawi. Malawi Population-Based HIV Impact Assessment (MPHIA) 2015-2016: Final Report. Lilongwe, Ministry of Health. October 2018.
[19] http://phia.icap.columbia.edu accessed 26 April, 2019
Ibid p7

ECHO study on contraceptive options for women at risk of acquiring HIV[20]



The Evidence for Contraceptive Options and HIV Outcomes or ECHO Study in Eswatini, Kenya, South Africa and Zambia, which all have high HIV incidence, to test whether different methods of family planning may be related to increased risk of HIV acquisition. 7829 sexually active HIV-negative women aged 16 to 35 years who wanted to use a modern method of contraception were enrolled and randomly assigned to one of three contraceptive methods:

- DMPA - intramuscular (DMPA-IM), a three monthly, progestogen-only, reversible injectable contraceptive;
- Levonorgestrel implant, a progestogen-only implant inserted under the skin in the upper arm that can be used for up to five years;
- A copper-bearing IUD, a device inserted into the uterus that can be used for up to 10-12 years.All women received ongoing health services, including counselling on HIV prevention and care, screening and treatment for sexually transmitted infections.

The study found that all methods had high levels of safety and effectiveness in preventing pregnancy and were well-accepted by the women using them. 397 HIV infections occurred. 143 in women who used DMPA-IM, 116 in women who used a levonorgesterel implant and 138 in women who used an IUD. There was no statistical difference in the rate of acquisition of HIV among the different contraceptive methods. The study therefore supports continued access to all the methods studied by all women including those at high risk of HIV infection.

However, this was an incidence rate of 3.8% per year, which is alarming. Further, the rate of HIV infection was higher for women younger than 25 years irrespective of the method of contraception used. This reinforces the need to strengthen HIV prevention integration within contraceptive and other sexual and reproductive health services. These may include HIV testing and linkage to antiretroviral therapy for those testing HIV-positive, partner testing, condom promotion, and pre-exposure prophylaxis (PrEP). The reported HIV incidence is above the WHO suggested threshold for offering PrEP, which should be considered in countries where the incidence of HIV is above 3%.

WHO will issue updated recommendations concerning women's eligibility for using various contraceptive methods if they are at high risk of HIV by the end of August 2019.

Source: WHO, 2019

The rate of HIV infection was higher for women younger than 25 years irrespective of the method of contraception used

[20] Derived from https://www.who.int/news-room/detail/13-06-2019-new-study-finds-no-link-between-hiv-infection-and-contraceptive-methods accessed 20 June, 2019.

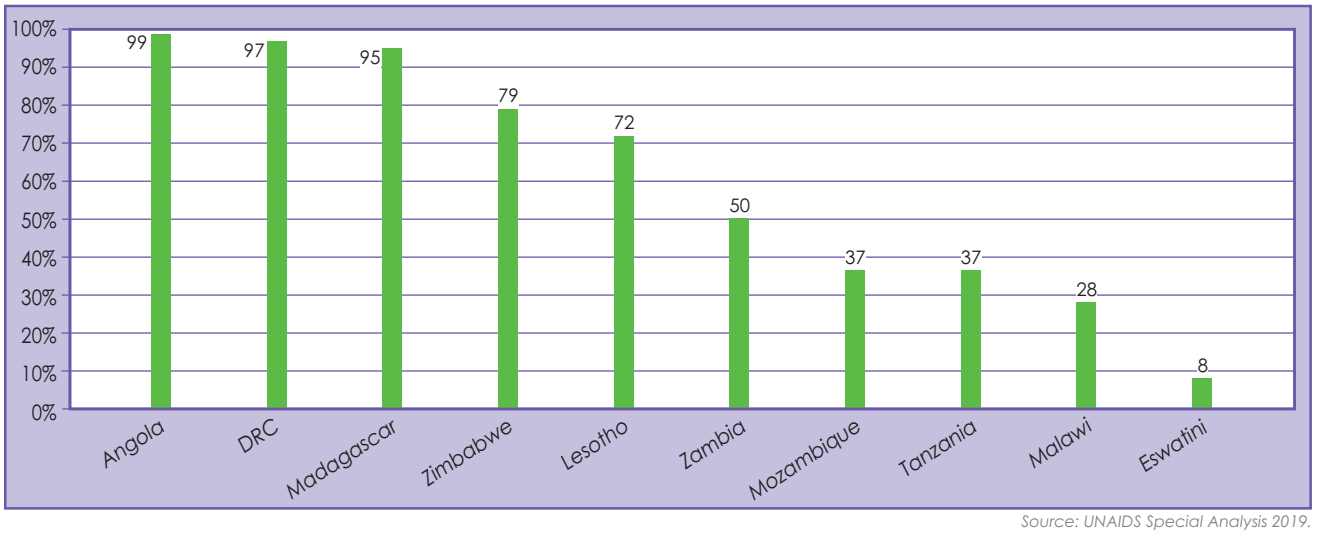
Voluntary Medical Male Circumcision (VMMC)

Voluntary male circumcision is taking off in Zambia.

Voluntary medical male circumcision (VMMC) is to date the only one-time intervention for reducing the risk of HIV infection. The procedure provides lifelong partial protection against female-to-male HIV transmission and should be used in combination with wider sexual and reproductive health service provision for boys and men. Together with condom promotion, STI management, pre-exposure prophylaxis, HIV testing and prompt initiation of antiretroviral therapy, VMMC can have a major impact on HIV epidemics in high-prevalence settings.

Ten of the 15 priority countries identified for intense effort to increase levels of VMMC are in SADC (Botswana, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe). The Prevention Partnership goal is to increase the number of men that access VMMC by an additional 25 million by 2020.

Table 5.11: Proportion of men who are circumcised



Source: UNAIDS Special Analysis 2019.

Figure 5.11 shows that there are wide variations in the proportion of men circumcised in SADC: from 99% in Angola to 8% is Eswatini. Male circumcision is practiced traditionally among certain ethnic groups in east and Southern Africa but not in others.

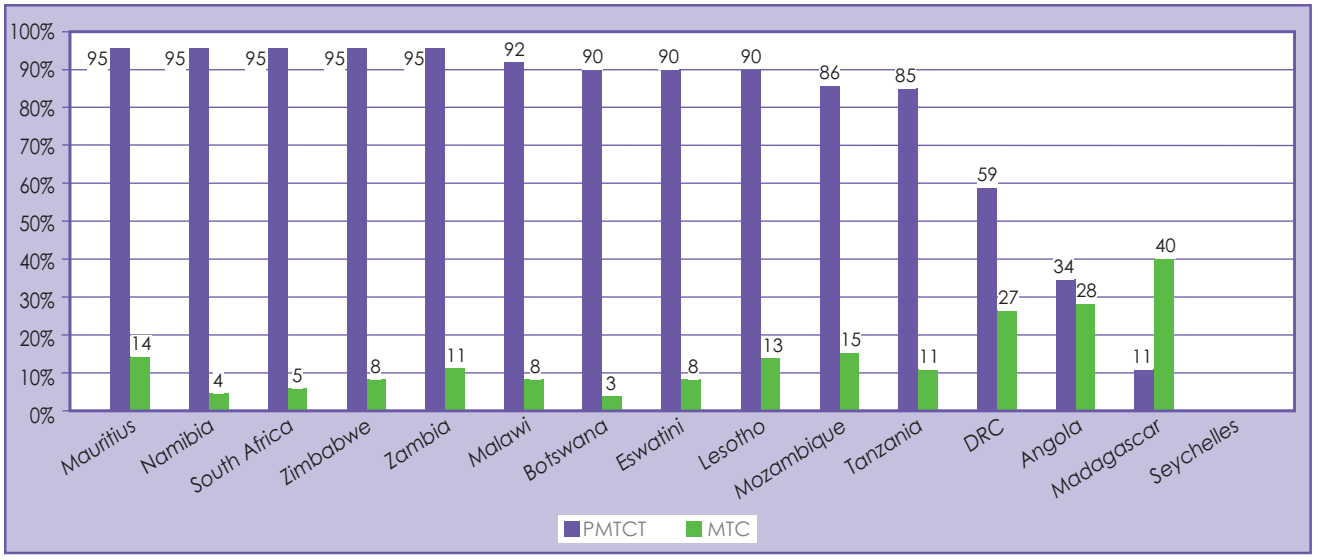
[21] https://www.unaids.org/en/resources/presscentre/featurestories/2019/may/20190529_VMMC_Malawi

In **Malawi**, more than 166,350 circumcisions were conducted in 2017, more than double the number conducted in 2014 and up from just 589 in 2008.[21] Among men ages 15-64 years, 9.2% reported undergoing medical circumcision and 16.1% reported having a non-medical circumcision. The percentage of males who reported being uncircumcised ranged from 65.8% among those ages 60-64 years to 73.2% among those ages 50-54 years. Among those who tested HIV positive in the survey, 8.8% reported having undergone medical circumcision, while 67.4% self-reported their status as uncircumcised. Of those who tested HIV negative, 71.7% self-reported not having undergone any form of circumcision, while 9.0% reported having undergone medical circumcision.

The proportion who reported medical circumcision was 10 times higher in men with more than secondary education (21.6%) than in men with no education (2.5%). Non-medical circumcision was approximately three times greater in men with no education (25.3%) than in men with more than secondary education (7.6%). The highest frequency of medical circumcision was reported among those in the highest wealth quintile (16.5%). The lowest frequency of uncircumcised men was among those who identified as Muslim (3%), with the majority (79.5%) having undergone non-medical circumcision.[22]

Preventing new HIV infections in children and keeping their mothers alive: The roll out of testing and enrolment on treatment for pregnant mothers is one of the success stories in the fight against HIV. The levels of access to ARVs by pregnant mothers have risen to excellent levels. But there are few countries that are near the target of eliminating all vertical transmission of HIV.

Figure 5.12: Coverage of ARVs in pregnant women and MTCT rates



Source: UNAIDS Special Analysis 2019.

Figure 5.12 compares coverage of ARVs among pregnant mothers to Mother to Child Transmission (MTC). Nine SADC countries (Mauritius, Namibia, South Africa, Zimbabwe, Zambia, Malawi, Botswana, Eswatini and Lesotho) have now achieved over 90% ARV coverage for pregnant women or Prevention of Mother to Child Transmission (PMTCT). These are the countries with the highest HIV prevalence. Countries lagging behind on PMTCT (DRC, Angola, Madagascar and Seychelles) also have the lower levels of HIV. Many SADC countries have considerably reduced MTC: at 2.5%, Botswana has the lowest MTC. However no country has eliminated vertical transmission altogether, and in Madagascar this stands at 39.8%.

[22] Ministry of Health, Malawi. Malawi Population-Based HIV Impact Assessment (MPHIA) 2015-2016: Final Report. Lilongwe, Ministry of Health. October 2018. http://phia.icap.columbia.edu

Even with high levels of access, few countries have eliminated all vertical transmission of HIV

The figures show that there are still high levels of transmission during breastfeeding and post-delivery. This calls for renewed efforts to ensure that all babies born to mothers that are HIV + are tested at least within two months of birth. Mothers need support to exclusively breastfeed and to continue taking their ART. With support from UNITAID and several other organizations, fifteen African countries (including DRC, Tanzania, Malawi, Zambia, Zimbabwe, Mozambique, Eswatini and Lesotho) are rolling out Point of Care infant diagnosis. Children who do not access treatment are likely to die before their second birthday. South African introduced testing at birth as early as 2015. Mozambique has recently also begun testing babies at birth, conducted by nurses. The results have found testing to be accurate and feasible.[23]

As more children are accessing treatment, the numbers that contracted HIV in utero, during delivery or through breast feeding that are now adolescents is increasing. In the Start Free, Stay Free, AIDS Free priority countries, almost two thirds of male adolescents aged 15 -19 that are living with HIV contracted it vertically, while almost two thirds of female adolescents living with HIV have contracted it through sexual transmission. Gender attitudes, such as those found through the Gender Links Attitude Survey contribute to high rates of sexual transmission in adolescent girls and young women as illustrated in figures 5.13 to 5.15.

Prevention among key populations

Key populations are sex workers, men who have sex with men, people who inject drugs, trans-gender persons, 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 HIV.[24] They face many hurdles which stop them from accessing services such as punitive laws and policies, police harass-ment and stigma and discrimination within health settings.

Table 5.6: Sex Workers: HIV Prevalence and prevention

Country	Population size	HIV prevalence %	Condom use %
Lesotho	7 500	72	62
Eswatini	4 000	61	83
South Africa	240 000	58	86
Malawi	36 000	55	65
Zambia	18 000	49	79
Botswana	6 700	42	76
Namibia	8 100	41	
Zimbabwe	45 000	41	96
Mauritius	6 200	15	67
Tanzania	160 000	15	70
Angola	54 000	8	72
DRC	350 000	6	69
Madagascar	190 000	6	63
Seychelles	<1 000	5	16
Mozambique	27 000		

Source: UNAIDS Special Analysis 2019.

[23] UNAIDS. 2018. Knowledge is Power. Geneva.
[24] https://www.usaid.gov/what-we-do/global-health/hiv-and-aids/technical-areas/key-populations

Table 5.6 shows much higher HIV prevalence rates in sex workers than in the general population, as well as very large populations of sex workers in DRC, Madagascar, Tanzania and South Africa. Prevalence ranges from 5% among sex workers in Seychelles, to 72% among sex workers in Lesotho. The table also shows much greater attention to issues of sex workers, as data on them is beginning to be collected. The data shows that use of condoms among sex workers in most countries is above 60% and goes as high as 96% in Zimbabwe. However, the table has many gaps, indicative that the data which is being collected is not sufficient. All countries need to take this issue much more seriously and to ensure that sex workers access testing, ARVs and are encouraged to adhere to ARVs.

Sex workers have much higher HIV prevalence than in the general population

Table 5.7: Provisions for sex work in SADC countries

Which statement best describes the provisions and their practice	Country
Sex work is outlawed and this is vigorously enforced	DRC, Madagascar, Malawi
Sex work is outlawed but this is not vigorously enforced	Botswana, Seychelles, Mozambique, Eswatini, Lesotho, Namibia, Mauritius, Tanzania, Zambia, Zimbabwe
Sex work is outlawed but recent court cases or other occurrences have opened the door to decriminalization	Angola, South Africa

Source: Audit of SRHR Laws and Policies in SADC.

Table 5.7 shows that all 15 SADC countries criminalise sex work but there are variations in the enforcement of the anti-sex work laws. The DRC, Madagascar, and Malawi vigorously enforce the law against sex work. Eight countries, (Botswana, Seychelles, Mozambique, Eswatini, Lesotho, Namibia, Mauritius, Tanzania, Zambia, and Zimbabwe) do not vigorously enforce the anti-sex work law. Court cases challenging the criminalisation of sex work may result in decriminalisation of sex work in Angola and South Africa. Criminalisation fuels stigma and discrimination and severely hampers access to all services. Thus, for those countries where there is information about sex workers, their knowledge of their HIV status is generally not good, except in Zimbabwe which has had NGO programmes targeting sex workers for a long time.

Sex workers at the Zimbabwe International Trade Fair. Photo: Google images

Supported by a network of peer educators, **the Sisters programme in Zimbabwe** provides female sex workers with free preventive and clinical services, including condoms and lubricants, management of STIs, contraceptive advice and options, HIV testing, and referral of anti- retroviral therapy. The programme, which began at five sites, has expanded to 36 clinics, most in urban areas or on transport routes. In 2017, the programme served 24,000 women and by 2018 had achieved 190,000 visits. A study of a representative sample showed that whereas only one third had tested for HIV in the past, almost all

those served by the programme have now gone for testing. Those living with HIV are receiving ARVs. Knowledge of HIV increased from 48% to 78%. Studies have found a decrease in police harassment as a result of the programme and general human rights awareness.[25]

Table 5.8: Men who have Sex with Men, Prevalence and Prevention

Country	Population size	HIV prevalence %	Condom use %
Lesotho	6 100	33	46
Zimbabwe	<1 000	31	
South Africa	300 000	18	98
Mauritius	5 500	17	53
Botswana	2 600	15	78
Madagascar	17 000	15	58
Eswatini	2 400	13	
Seychelles	<500	13	
Tanzania	50 000	8	14
Malawi	43 000	7	44
DRC	190 000	3	77
Angola	29 000	2	59
Mozambique	16 000		
Namibia	6 500		
Zambia	6 500		

Source: UNAIDS Special Analysis 2019.

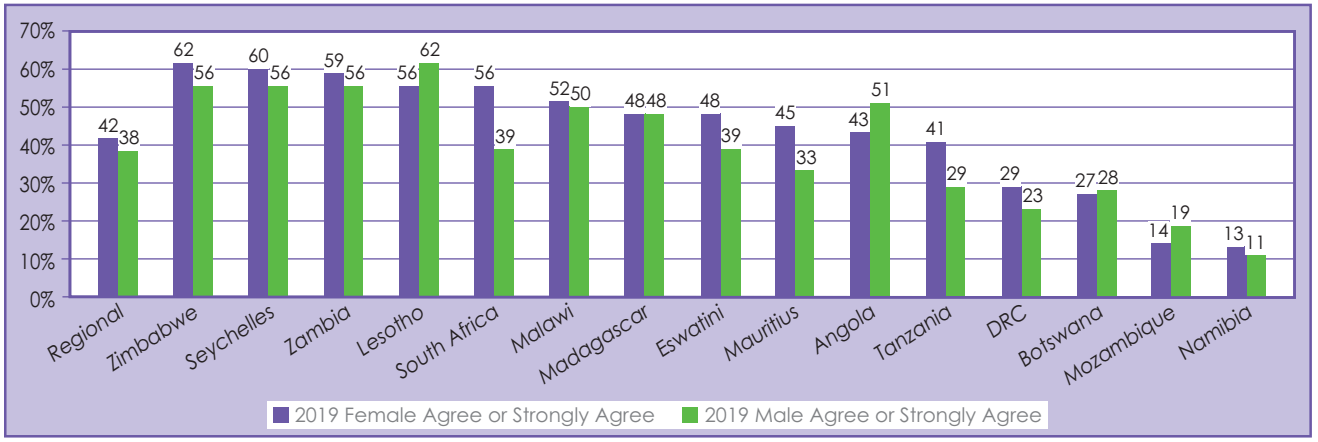
Table 5.8 shows that, as with sex workers, countries are beginning to collect data on men that have sex with men. Homosexual activity is still largely criminalised and highly stigmatised. Access to services is generally very poor, as shown by low levels of knowledge of HIV status. Where information is available it indicates much higher prevalence levels than in the general population and poor knowledge of HIV status in most countries. While condom use is encouraging in countries such as South Africa and Botswana, this is generally lower than what is needed to reach epidemic control. Table 5.8 also has many gaps which is indicative of the gaps in knowledge about men who have sex with men in SADC.

Attitudes

A critical test of HIV and AIDS prevention campaigns is the extent to which the attitudes that fuel this pandemic are changing. Each year Alliance partners administer the Gender Progress Score (GPS) that include several questions relevant to HIV and AIDS.

[25] Communities at the Centre: Defending Rights, Breaking Barriers, Reaching People with HIV Services." UNAIDS Global Update 2019 p50-51.

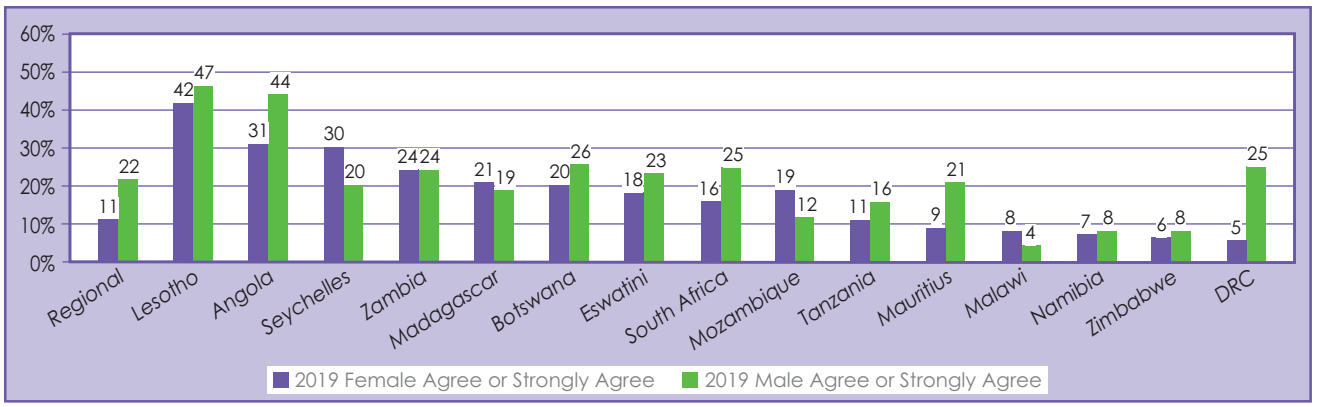
Figure 5.13: A woman can refuse to have sex with her husband



Source: Gender Links Attitude Survey, 2019.

The attitudes on whether a woman can refuse to have sex with her husband range quite widely with the highest rate of agreement to this statement of 62% of female respondents in Zimbabwe and the lowest rate of 11% of male respondents in Namibia. Overall male and female views are similar in every country. Over 50% of both females and males in Zimbabwe, Seychelles, Zambia, Lesotho and Malawi agree with the statement. South Africa and Angola have significant differences in attitudes between males and females with more females agreeing with the statement in South Africa and more males in Angola.

Figure 5.14: Nothing a woman can do if her husband wants to have girlfriends

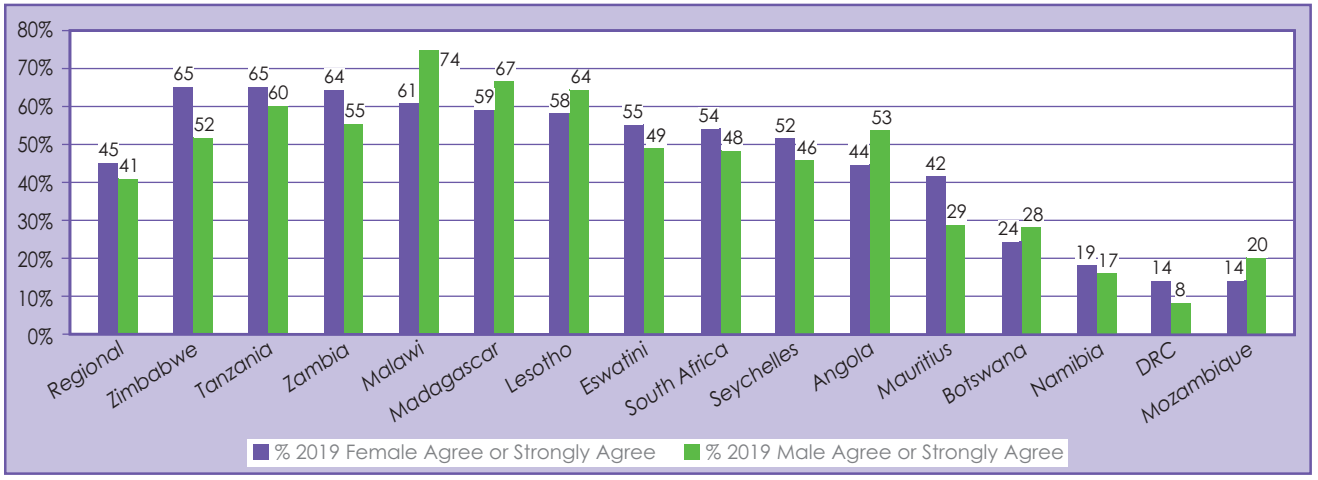


Source: Gender Links Attitude Survey, 2019.

Both males and females do not agree that there is nothing that a woman can do if her husband wants to have girlfriends. The highest rate of agreement in both females and males is in Lesotho (42% females and 47% males) and lowest for both is Zimbabwe (6% females and 8% males). Generally, the rates are quite similar for males and females in most countries, with higher rates for males in many countries.

Attitudes vary but do not yet promote HIV prevention

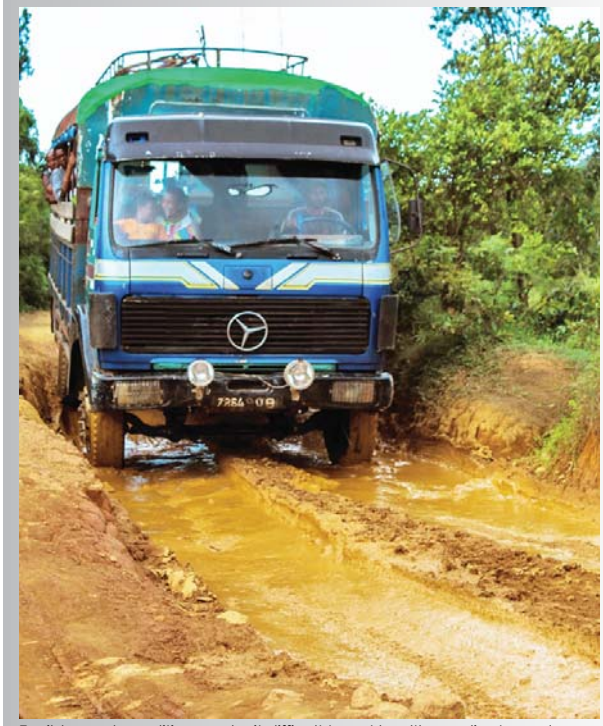
Figure 5.15: Women can insist and have right to insist on using a condom



Source: Gender Links Attitude Survey, 2019.

Over 50% of female respondents in Zimbabwe, Tanzania, Zambia, Malawi, Madagascar, Lesotho, Eswatini, South Africa and Seychelles believe that a woman can insist on using a condom. It is disturbing that rates of agreement drop to as low as 14% of female respondents in DRC and Mozambique. In some countries, such as Malawi, Angola and Mozambique more males than females agree that women have a right to insist on a man using condom. This reflects some change in attitude, especially at the local level.

Councils contribute to HIV prevention



Terrible road conditions make it difficult to get health supplies to rural communities in Madagascar. Photo: SEED Madagascar

In two very different settings, councils that have been part of the Gender Links programme have taken action to join schools and communities in fighting HIV and seeking to reduce the rate of new HIV infections.

The Urban Council of Mahajanga is located in the north-western part of **Madagascar**[26]: The population is estimated at 240 000 in an area of 53 square kilometres. Mahajanga is a tourist area and is classified as a red zone in terms of HIV prevalence, which means that prevalence in this area is higher than average.

The council sat with a range of stakeholders to develop an SRHR action plan which is funded by the council. One activity was SRHR training for key community members. After the training, the community members proceeded directly to the community sensitisation focusing on young people and reproductive health, HIV and AIDS, family planning and early pregnancy issues.

[26] https://genderlinks.org.za/casestudies/madagascar-mahajanga-fights-back-the-red-zone/

The programme was carried out in three public and private schools around the council by a team of the council staff, representatives of the health department and Population Services International (PSI) Madagascar during the 16 days of activism against Gender Based Violence in 2018.

Matzikama[27], is on the West Coast in the Western Cape Province of South Africa. Matzikama means "place of water" and boasts a wonderful destination where southern Namaqualand can be explored, with tourist attractions such as famous wines from the West Coast Winelands and beautiful flowers.

The council identified a number of problems, including HIV, poor use of condoms, commercial sex, CBOs facing funding challenges; patients not taking their medication correctly, or resorting to traditional medicines when they go to their rural homes and not adhering to their ARVs, failing to adhere over the weekends and turning to alcohol instead as well as the need for more support groups.

The municipality's main goal is a safe and healthy society. The municipality partnered with others such as local councillors, the police, department of Health, NGOs, home based care groups, local farmers, farm workers and mines. A committee was set up which is overseeing the programme. Monthly awareness and education sessions were instituted, which included awareness through the radio and social media. CBOs and Home Based Care organizations have been assisted to conduct door to door campaigns which has increased their visibility in communities. Each street now has an activist to monitor patients on their street and support them to adhere to their medication.

The committee also held a high profile awareness raising event in one area with high rates of substance abuse. This involved distribution of pamphlets and home visits. The campaign aims to change the mind set of people about HIV, GBV, substance abuse and address stigma. The campaign is also targeting TB which is very prevalent. The Municipality is planning a road show to every town to continue the awareness raising.

Source: Gender Links, 2019

PreExposure Prophylaxis (PrEP)

PreP is one of the five prevention pillars outlined in the Prevention Roadmap of the Global HIV Prevention Coalition. Prep means taking an ARV (currently Truvada - 1 pill per day) every day, before you have contracted HIV, to prevent HIV.

PrEP is recommended for discordant couples (where one is positive and the other negative), sex workers, or others at high risk of contracting HIV. If taken consistently and correctly the potential to prevent HIV is very high. Currently PrEp is not widely available but the prevention partnership aims to increase availability to 3 million by 2020.

Table 5.9: Number of people accessing PrEP

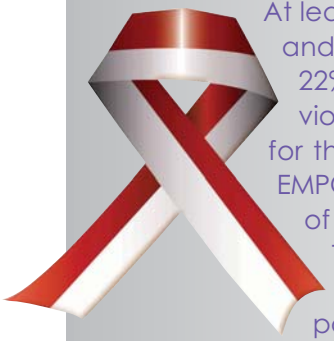
Country	Number of people that accessed PrEP in 2018
Angola	238
Botswana	7279
Mauritius	3
Namibia	190
Seychelles	4
South Africa	8184
Zambia	3823
Zimbabwe	4982

Source: UNAIDS Special Analysis 2019.

Table 5.9 indicates that PrEP is still in its infancy in Southern Africa. A total of 26,247 people accessed PrEP in 2018; the largest number in South Africa, Lesotho, Zimbabwe and Zambia. An important application of this prevention strategy is in cases of sexual violence.

[27] https://genderlinks.org.za/casestudies/south-africa-sexual-and-reproductive-health-hiv-aids/

GBV screening, counselling and PrEP



At least two studies have shown a clear link between intimate partner violence (IPV) and HIV. It is estimated from these studies that IPV accounts for between 12 and 22% of HIV. There are many pathways by which physical, sexual and emotional violence by a partner increases HIV risk for young women. One of the pathways for that linkage is in preventing a female partner from using HIV prevention. The EMPOWER study, conducted by Wits Reproductive Health Institute (RHI) at the University of the Witwatersrand in South Africa, in partnership with the Mwanza Intervention Trials Unit in Tanzania, the London School of Hygiene and Tropical Medicine in the UK, and the International Center for Research on Women, found that it is possible to deliver PrEP to Adolescent Girls and Young Women (AGYW) as part of a prevention package, within a framework of empowering them to manage and perhaps avoid unhealthy, controlling and violent relationships.[28]

The study found that integrating GBV screening into HIV counselling and testing for AGYW is acceptable and feasible when appropriate referral, staff debriefing and technical support are offered, and basic principles of empathetic listening and confidentiality are respected. It is essential that counselling for this group is adolescent-friendly and non-judgmental.[29] *Source: EMPOWER Study, 2018*

Treatment - access to ART

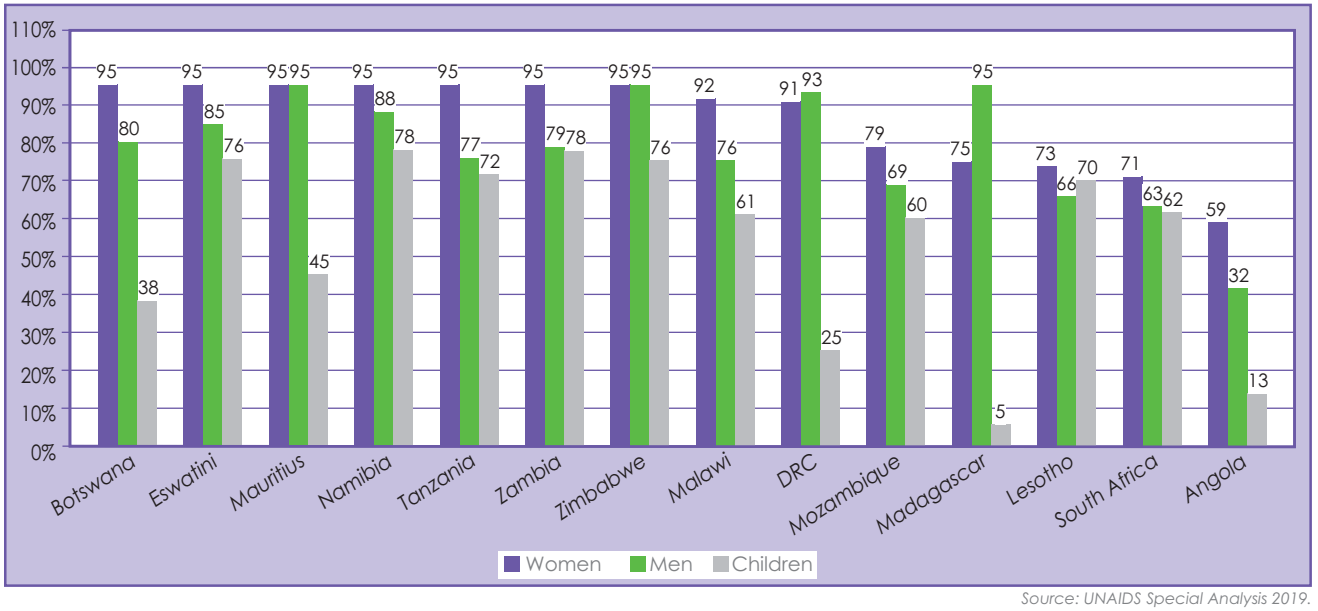
Article 27.3
b) Ensure universal access to HIV and AIDS treatment for infected women, men, girls and boys; and
UNAIDS 90/90/90: Target (2) By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; Target (3) By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.

By 2018, all countries had significantly improved their treatment coverage for both women and men compared to 2008. All countries have adopted a test and treat approach, which means providing ARVs for all people living with HIV as soon as they are tested and found to be living with HIV, and many have increased coverage significantly despite limited infrastructure for health and heavy HIV burdens. The region has made great gains in treatment and the attainment of the 90-90-90 targets.

Great gains in the 90-90-90 targets

[28] http://www.ehpsa.org/all-documents/general/554-empower-eb/file accessed 5 June, 2019
[29] M.B. Colombini 1 , L. Ramskin2 , N. Khoza2 , A. Stangl 3 , F. Scorgie2 , S. Harvey4 , C. Manyamba2 , C. Watts4 , S. Kapiga5 , S. Delany-Moretlwe2 , Integrating gender-based violence screening and support into HIV counselling and testing for adolescent girls and young women accessing PrEP in South Africa and Tanzania - experiences from the EMPOWER study. IAC 2018 presentation. http://www.ehpsa.org/all-documents/aids2018/530-empowerment-columbini-1/file

Figure 5.16: People who know their HIV status on ARVs



Source: UNAIDS Special Analysis 2019.

Figure 5.16 shows that there are wide gender variations in access to ART, with women having higher levels of access than men. Namibia, Botswana, Eswatini, Namibia, Seychelles, Tanzania, Zambia, Zimbabwe, DRC and Mauritius have achieved at least 90% access to ART for women. Though South Africa and Mozambique have the largest absolute numbers of women on treatment (2, 782, 420 and 751, 577) this is only 66 and 63% of the number that is living with HIV respectively in the two countries. A total of 6,543,160 women living with HIV had access to ART in SADC in 2017.

The percentage of men living with HIV who accessed ART was much lower - with the highest rate of 76 per cent being in Eswatini and Zimbabwe. The only countries in which the percentage of men living with HIV that access ART is higher than the percentage of women living with HIV that access ART, are the DRC and Angola. The absolute number of men who access ART is generally approximately half of the absolute number of women in every country, except Madagascar. A total of 3,313, 340 men were on ART in SADC in 2017. In all countries the percentage of children living with HIV that were on treatment in 2017 was lower than that of women. In most, the percentage was lower than that of men as well.

Tanzania: Living positive, Living healthy[30]

"My first thought was how people would treat us. I was also afraid that if my husband and I were to die, our children would have no one to care for them. But, I thank God that seven years later, we're still surviving and we're a happy family". Asha Ramadhan is 42 years old and lives in the Tanzanian capital, Dar es Salaam. When she and her husband were diagnosed with HIV, their first thought was that they would die.

[30] Derived from http://genderlinks.org.za/news/tanzania-living-positive-living-healthy/

Her first husband died in a motorcycle accident in 2011 and she later remarried. However, she never went for HIV testing with her second husband until she fell pregnant. It was during her check-up at a local health center that both she and her husband were diagnosed with HIV. The doctor advised the mother of three that it was possible for their baby to be born without HIV as long as they followed the health instructions they received. The family began to follow the doctor's recommendations such as nutritional diets and medicine. In 2012, Ramadhan gave birth to a healthy baby.

She says, the child lives healthily and that as a family, they adhere to all the health principles administered by medical personnel. Asha says that being diagnosed with HIV is not the end of one's life. Their son, whom they named Akram, is now six years old and is a standard one student at a government school.

Ramadhan and her husband say that a lot has changed over the last seven years but they are glad to have survived. They now have a vision to do business in order to get plots for building houses.

"It is true that treatment has improved over time and has increased the life expectancy for those who access the medication. We appreciate the effort of the Tanzanian government, scientists and other stakeholders who play a big role to make sure that those living with HIV are under good supervision and care," She added.

She also said that health centers, dispensaries and hospitals, are playing a big role in educating women about preventing mother to child transmission of the disease.There is still a long way to go to ensure maximum sensitization in the country. More than 60% of women and 71% of men aged 15-49 know that HIV can be prevented by using condoms and by limiting sexual intercourse to one uninfected partner. Men are slightly more likely than women to know about the different HIV prevention methods and knowledge of HIV prevention methods is highest among women and men in urban areas and in the highest wealth quintile.

Rural areas need to be sensitized on issue of mother to child transmission. About 85% of women and 79% of men know that HIV can be transmitted by breastfeeding, only about two-thirds of women and men know that the risk of mother to child transmission of HIV can be reduced by the mother taking special drugs during pregnancy.

Even with so much HIV and AIDS information readily available, stigma and discrimination related to HIV are still widespread among Tanzanian adults. Although, the majority of women and men say they are willing to care for a family member with AIDS in their home, only 41% of women and 57% of men say that they would not want to keep secret that a family member has HIV. Another challenge, despite the availability of information, is the reluctance of some people living with HIV to take antiretroviral drugs.

During the opening ceremony of the National Aids Day International Conference for 2018, Antony Peter Mavunde, Deputy Minister for State in the Prime Minister's Office Responsible for Policy, Parliamentary Affairs, Labour, Employment, Youth and the Disabled said it was important that those diagnosed with HIV continue to take antiretroviral drugs. "This is important because they will be able to live a healthier life, they need to know that we need them to build our nation," he continued.

UNAIDS Country Director in United Republic of Tanzania, Dr.Leo Zekeng said Tanzania has taken a major step towards fighting AIDS since the 1980s and with access to treatment since 2010. "Tanzania can achieve the goal of removing AIDS as a health threat to the community by the year 2030 as part of Millennium goals and Tanzania vision of 2025. However, stigma and discrimination still continue to prevent people from getting an HIV testing to know their status."

Source: Godfrey Ismaely, Gender Links News Service, 2019

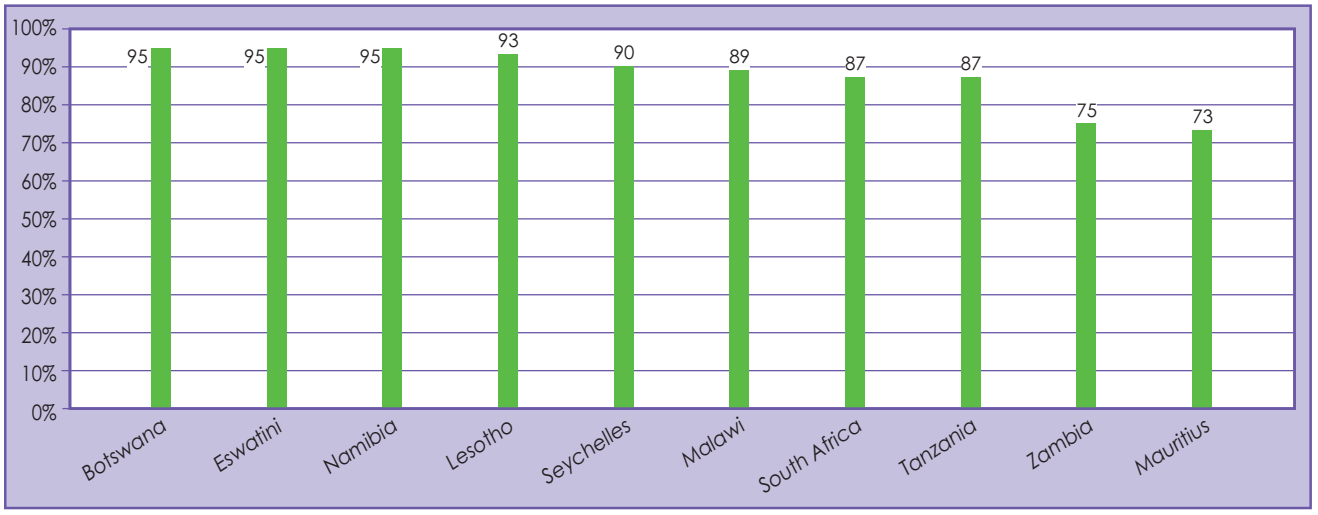
Drug resistance

Part of the Fifth South African National HIV Prevalence, Incidence and Behaviour Survey in 2017 was HIV drug resistance testing for the first time. The survey found that one in six people not on treatment already had drug-resistant HIV and more than half of those on treatment had resistance to at least one drug. The survey did not find any difference in the prevalence of drug resistance by age or sex.[31] The finding raises many concerns and researchers called for prioritisation of integrase inhibitors in first-line regimens and the stepping up of adherence support for people on antiretroviral treatment. Earlier switches from failing regimens are also needed to prevent the development of further drug resistance. South Africa plans to introduce dolutegravir-based first-line treatment during 2019. Dolutegravir (also known as DTG) has a higher barrier to resistance than other drugs but some South African clinicians think it should be preserved for use in third-line treatment.

Viral suppression

UNAIDS TARGET 3: 90% of all people receiving antiretroviral therapy will have viral suppression.

Figure 5.17: People on ART who achieve viral suppression



Source: UNAIDS Special Analysis 2019.

[31] Moyo S et al. HIV drug resistance in South Africa: results from a population-based household survey. Conference on Retroviruses and Opportunistic Infections, Seattle, abstract 152, 2019. http://www.aidsmap.com/page/3465700/

Figure 5.17 covering nine SADC countries has incomplete data, an indication that data on patients that have been retained in care or on viral suppression is not yet being routinely collected. It is anticipated that this data which will become more available in the coming years. Overall, the data which is available suggests that those that are being initiated on treatment are adhering. Thus, Botswana, Eswatini, Namibia, Lesotho and Seychelles are showing adherence levels of 90 per cent or higher. Malawi, South Africa and Tanzania show adherence levels between 80 and 90 per cent. However, there are differences, which are not seen in broad national data, between adherence in different sub groups of the population. This will need to be monitored closely and those on treatment will need continued encouragement to adhere to treatment.

Progress towards the third 90 is promising

The **Lesotho** PHIA study found that HIV prevalence in Lesotho peaks at 49,9% in women aged 35 - 39 and at 46,9% in men aged 40 to 44. At the age of 20 - 24 prevalence in females is 16,7% compared to prevalence in males of 4%. Viral load suppression (VLS) is highest at 45 to 59 years old at 80,3% for females and 81,4% for males. VLS in 20 to 24 years old is much lower - 50,9% in females and 46,1% in males.[32]

The **Namibia** PHIA study has shown that 86.0% of PLHIV aged 15-64 years were aware of their HIV status: 89.5% of HIV-positive females, and 79.6% of HIV-positive males. Among PLHIV aged 15-64 years who knew their HIV status, 96.4% were currently on ART: 97.1% of HIV-positive females and 94.9% of HIV-positive males. Among PLHIV aged 15-64 years who self-reported current use of ART and/or had a detectable ARV in their blood, 91.3% were virally suppressed: 92.2% of HIV-positive females and 89.5% of HIV-positive males.[33]

HIV and TB Coinfection

The World Health Organisation estimates that in 2017 there were about 10 million people (5·8 million men, 3·2 million women, and 1·0 million children) with TB, 9% of whom were coinfected with HIV. Of the 10 million, approximately 3.6 million, or 36%, are "missing", not diagnosed or properly treated. Among people living with HIV, the gap is 49%. People living with HIV with latent TB are 20 times more likely to develop active TB. Untreated TB is rapidly fatal among people living with HIV. TB is the leading infectious killer globally and the leading killer of people living with HIV, accounting for one in every three AIDS-related deaths. In 2017, 1.6 million people died of TB globally, including 300 000 people living with HIV.

The first ever United Nations High-Level Meeting on Tuberculosis held in September 2018, resulted in a "Political Declaration on Tuberculosis" to end the tuberculosis epidemic globally by 2030. The declaration included ambitious and bold targets for scale-up of tuberculosis care and prevention services, as well as commitments on research for new tools, principles of equity and human rights, and resource needs targets for both implementation and research. As current testing and treatment options are antiquated, achieving the end of TB will require at least double the current funding for both TB programming and research. This ambitious goal will also require action and accountability at all levels.

Seizing this opportunity would stop more than 6000 people dying every day from TB and HIV, prevent new infections and bring the world closer to achieving the Sustainable Development Goals.[34]

[32] Ministry of Health, Lesotho. 2018. Lesotho Population based HIV impact assessment. LePHIA 2016 -17. Summary sheet preliminary findings. http://phia.icap.columbia.edu
[33] MOHSS, Namibia. 2018. Namibia Population based HIV impact assessment. NamPHIA 2017. Summary sheet preliminary findings. http://phia.icap.columbia.edu.
[34] https://www.unaids.org/en/resources/presscentre/featurestories/2018/september/tb-and-hiv and Sahu, S, L. Ditiu & A. Zumla, " After the UNGA High Level Meeting on Tuberculosis - what next and how?", The Lancet Global Health, Vol 7, Issue 5. May 1, 2019.

Table 5.10: Aids related deaths

Country	AIDS related deaths	AIDS orphans (0-17)	Deaths averted due to ARVs
South Africa	71 000	1 200 000	330 000
Mozambique	54 000	1 100 000	73 000
Tanzania	24 000	850 000	57 000
Zimbabwe	22 000	630 000	51 000
Zambia	17 000	470 000	60 000
Angola	14 000	160 000	8 300
DRC	13 000	410 000	20 000
Malawi	13 000	500 000	37 000
Lesotho	6 100	110 000	16 000
Botswana	4 800	65 000	13 000
Namibia	2 700	37 000	8 000
Eswatini	2 400	45 000	7 700
Madagascar	1 700	24 000	500
Mauritius	1 000	3 600	500
Total	**246 700**	**5 604 600**	**682 000**

Source: UNAIDS Special Analysis 2019.

AIDS-related mortality in the SADC region declined by 54% between 2010 and 2018: from 540,000 to 246,700. The main reason for the decline in AIDS-related mortality in the region is the expansion of antiretroviral therapy[35] (ART) with 64 percent [58-72 per cent] of people living with HIV receiving ART, or about 10.4 million people. In 2018, ARVs averted 682,000 deaths, 330,000 of these in South Africa.

Care work

Article 27.3 a) 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.

SDG 5.4 Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.

SADC sponsored UN resolution on Women, Girls and HIV: 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.

BPFA +20 Africa declaration: Reduce, recognize and redistribute unpaid care work, which falls disproportionately on women and girls, by investing in infrastructure and time-saving technology and emphasizing shared responsibilities between women and men, girls and boys.

[35] Regional Strategy for Sexual and Reproductive Health and Rights (SRHR) 2019–2030

In 2018, the International Labour Organization released a report, Care Work and Care Jobs for the Future of Decent Work[36]. Some of the findings of the report are:

- Most unpaid care work consists of household work (81.8%), direct personal care (13.0%) and volunteer work (5.2%).
- Across the world, women perform three-quarters of unpaid care work, or 76.2% of the total of hours invested. There is no country in the world in which men and women contribute an equal share of unpaid care work.
- Globally, unpaid care work is most intensive for girls and women living in middle-income countries, those married and of adult age, with lower educational achievement, resident in rural areas, and with children under school age.
- Most care workers are employed in education (123 million) and in health and social work (92 million). This total of 215 million workers (143 million women and 72 million men) represents 6.5% of total global employment in 2018. Domestic workers amount to at least 2.1% of total global employment: there are 70 million domestic workers employed by households across the world; of these, 49 million are women and 21 million are men.
- Care workers are mostly women who require a range of skills which are seldom recognized nor remunerated to engage with care recipients. They are not often well trained to provide these skills. Care workers often engage with clients in sustained care relationships; and often experience tensions between those they care for and the conditions in which they have to provide care. Care workers are not a homogenous group: there are differences and hierarchies among them, including in terms of pay, conditions and status.
- Community health workers are frequently undertrained, under- resourced and either underpaid or unpaid, and are often engaged to make up for a shortage of professional health workers.
- Poor job quality for care workers leads to poor quality care work. This is detrimental to the well-being of those who receive care, those who provide care, and also for unpaid carers who have fewer options available.
- It is in everyone's best interests to ensure good conditions for care delivery in both unpaid and paid forms. Transformative policies and decent care work are crucial to ensuring a future of work founded on social justice and promoting gender equality for all.
- We should aim to double investment in the care economy, leading to a total of 475 million jobs by 2030, or 269 million new jobs.

The role of community caregivers is continuing to be redefined as the AIDS epidemic progresses. It is generally accepted that we will not be able to care for all that need prevention services, testing, access to treatment, resupply of treatment and adherence support through the formal health system, especially in high burden countries such as in SADC. Thus, it is essential that formal services are supplemented by informal caregivers. The theory is that people living with HIV will receive differentiated care which takes account of different needs and realities. This may mean that fewer and fewer will be attended by professional care givers, with greater emphasis being on care provision by lay workers, who may be on a stipend or complete volunteers.

Lets Grow in Orange Far, Johannesburg provides peer education, care and support. Photo: Colleen Lowe Morna

[36] Addati, I, U. Cattaneo, V. Esquivel and I. Valarino. 2018. "Care Work and Care Jobs for the future of decent work, Summary," Geneva. ILO.

CHWs "provide the world's most promising health workforce resource for accelerating progress"

The African Union is calling for an additional two million community health workers (CHWs) to be recruited, trained and deployed. The case for these community health workers is[37]:

- In 2013, there were 17.4 million fewer health workers worldwide than were needed for essential primary health care services, with the most serious health workforce shortfall in Africa. Additionally, according to surveys, substantial percentages of doctors and nurses in Africa migrate to northern countries - 16.5% in South Africa, 17% in Nigeria and 43% in Zimbabwe. CHWs would help alleviate the impact of the loss of trained health personnel to other countries.
- Many health services can be effectively delivered through CHWs in community settings. Leveraging CHWs to serve as a bridge to sustainable health systems requires the rational sharing of clinical responsibilities among diverse cadres of health workers.
- A comprehensive review of available evidence found that CHWs "provide the world's most promising health workforce resource for accelerating progress".
- A major advantage of CHWs is that they take services directly to individuals and communities, at a time and place that is convenient for the client.
- Delivery of HIV testing services by CHWs offers an efficient and effective way to increase testing uptake as part of a "testing revolution" to achieve the first 90. This includes awareness raising for testing, making self-testing available and promoting community testing events.
- In the push to reach the second 90 by increasing the number of people receiving antiretroviral therapy from 18 million in June 2016 to 30 million by December 2020, CHWs can deliver medicines, monitor patients and support treatment adherence, achieving outcomes that exceed those reported for health facilities. Community-delivered models, with support from a range of CHWs, have achieved extremely high retention rates that are superior to those achieved in health facilities.
- In the face of seemingly insurmountable challenges, CHWs have proven to be innovators. For example, they pioneered community distribution of antiretroviral medicines, increasing treatment uptake while achieving very high rates of treatment adherence.
- Low rates of retention in HIV care led to the creation of peer-led adherence clubs, peer-based adherence assessments and other successful innovations. These community-generated innovations in the HIV treatment field, which were initially regarded as unorthodox but ultimately validated by rigorous evaluations, are now widely being adopted as standard national policy in high-burden countries.
- Studies indicate that supportive supervision of CHWs contributes both to the satisfaction of these workers and to the quality of the services they provide. A systematic review of available evidence found that community- and home-based approaches to the management of antiretroviral therapy generate clinical outcomes that are at least as good as those produced by facility-based care management, with patients receiving community support reporting higher levels of satisfaction.
- CHWs have made substantial contributions towards universal health coverage by ensuring meaningful service access for the hardest-to-reach, especially those that would not access health care as a result of stigma or negative attitudes. These include adolescents and young people, sex workers, men that have sex with men and injecting drug users.

[37] African Union. 2017. Two Million African community health workers: Harnessing the demographic dividend, ending AIDS and ensuring sustainable health for all in Africa. Addis Ababa. https://www.unaids.org/sites/default/files/media_asset/African2mCHW_en.pdf. Accessed 6 June, 2019.

- Studies have consistently found that services delivered by CHWs are highly cost effective.

Trained CHWs who are paid a living wage and valued by their community, are not likely to move, as they live in the communities they serve and are often elected to fill this role by their fellow community members.

The AU suggests 10 key action steps towards this massive new initiative:

1. Make development of a robust community health workforce a key political priority.
2. Reform policy frameworks to enable and accelerate mobilization of a community health workforce.
3. Develop a time-bound national scale-up plan for community health workers.
4. Empower communities to drive the recruitment of community health workers.
5. Use and adapt existing tools to train community health workers.
6. Provide fair compensation to community health workers.
7. Ensure proper supervision, access to mobile technology and performance monitoring of community health workers.
8. Train other health care workers to address and overcome potential professional resistance.
9. Ensure that community health workers have an organizational voice.
10. Mobilize sufficient financing for implementation of each national plan.

Next steps

- ***Continue to focus on cost effective mechanisms to increase prevention***, especially for adolescents and young people (both girls and their male partners). Prejudice, stigma and discrimination in relation to sex workers, men who have sex with men, prisoners, injecting drug users and other key populations will continue to fuel the epidemic and must be addressed.
- ***Put renewed emphasis on testing*** and ensuring that all know their status. It is not possible to begin the treatment cascade without testing. It is important that all are encouraged to be tested, including those that are older and those that are younger.
- ***Encourage mothers who are living with HIV adhere properly to their own medication and to ensure that their babies are tested early.*** The rates of transmission to babies will not reach elimination through only mothers accessing treatment during pregnancy. There is need for vigilance throughout breast feeding.
- ***Continue to focus on adolescents and young people:*** and especially encourage them to stay in school.
- ***Renew the focus on co- infections with TB*** and ensure that all that test positive for HIV are also screened for TB and that those need it receive TB medication.
- ***Support the AU calls for two million more community health workers*** and ensure that they receive training, psychosocial support, remuneration and materials which they require to conduct their work.

Candlelight vigil in Mauritius. Photo: Gender Links