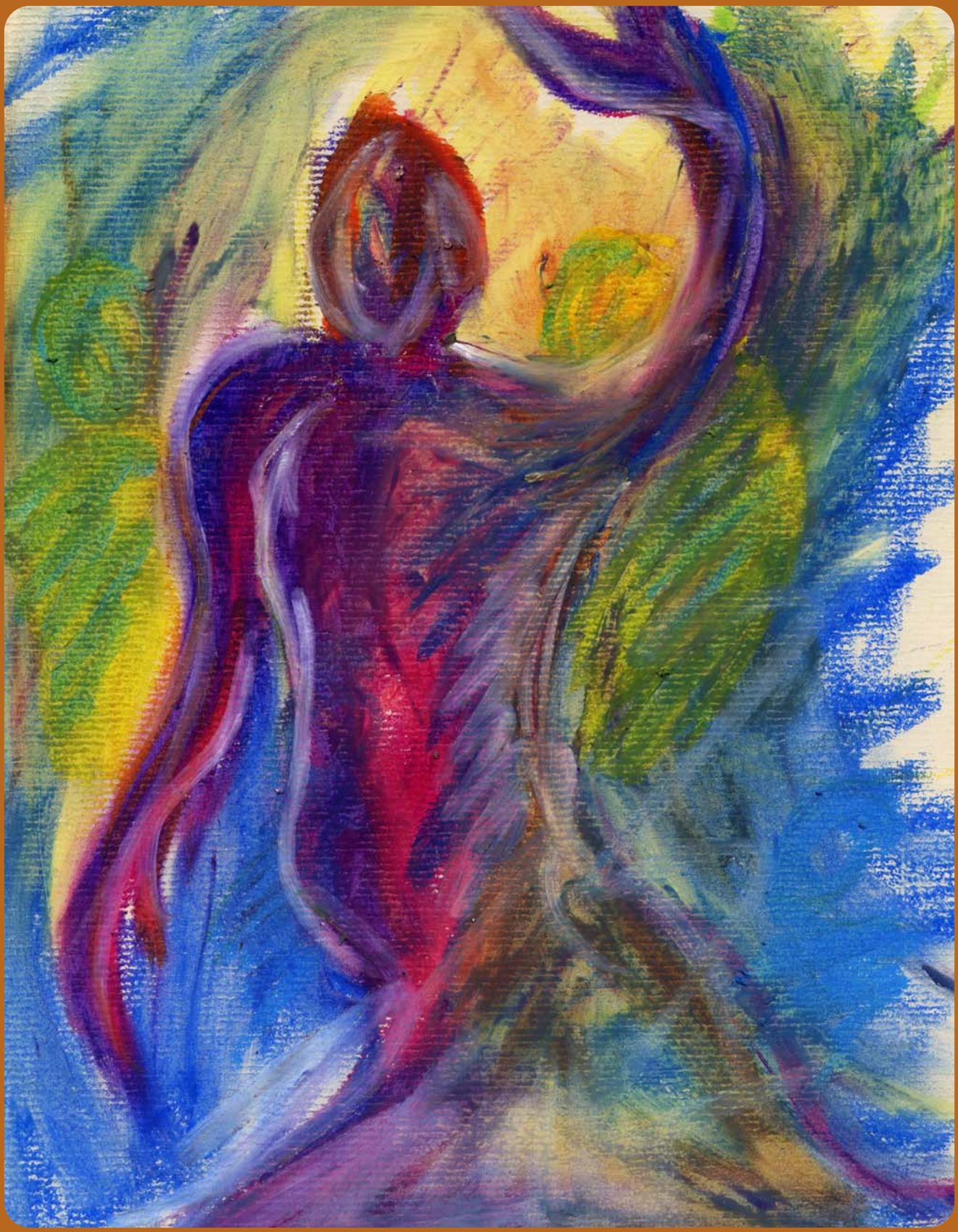


"Anita"

Anushka Virahsawmy

CHAPTER 7
HIV and AIDS

Article 27

Photo courtesy of Malawi Voice

KEY POINTS

- UNAIDS is leading the world in a campaign to end AIDS by 2030. This will require increased investment and political will.
- HIV and AIDS incidence has decreased consistently over the past decade as fewer people are becoming infected.
- Botswana, Lesotho, Malawi, Namibia, Mozambique, Swaziland, South Africa, Zambia and Zimbabwe still have adult prevalence rates of over 10%. Swaziland and Botswana still have prevalence rates above 20%. Lower mortality and more people living longer with HIV is contributing to this.
- Provision of antiretroviral therapy (ARVs) is expanding rapidly.
- Prevention of Mother to Child Transmission (PMTCT) coverage is expanding in all countries. Botswana and South Africa are close to the target of 0 new infections for unborn babies. No country is using Option A any longer and many are moving to option B+ which was pioneered by Malawi.
- Despite this progress, Sub- Saharan Africa continues to be the most affected area in the world. SADC accounts for 55% of all people living with HIV in Sub-Saharan Africa and 38% of the total number in the whole world. SADC also accounts for 50% of the children living with HIV in Sub-Saharan Africa and 45% of the total global number.
- Gender disparities continue to be a major driver of the pandemic. Women account for 58% of those living with HIV in the sub-Saharan region. Women bear the greatest burden of care.
- Reaching the UNAIDS 90 - 90 - 90 targets in SADC will require massive community mobilisation. Community caregivers will be needed in new roles.

HIV - Progress against targets trends table				
Parameter	**Target 2015**	**Baseline 2009**	**Progress 2015**	**Variance (Progress minus target)**
SHARE OF HIV INFECTION				
Highest percentage of women	50%	Namibia (68%)	Tanzania (61%)	11%
Lowest percentage of women	50%	Mauritius (15%)	Mauritius (28%)	-22%
HIV POSITIVE PREGNANT WOMEN RECEIVING PMTCT				
Country with highest coverage	100	Mauritius (100%)	Mauritius (100%)	0
Country with lowest coverage	100	DRC (4%)	Madagascar (3%)	-97%
PERCENTAGE OF THOSE ELIGIBLE RECEIVING ARVS				
Country with the highest proportion	100	Namibia (67%)	Seychelles (97%)	-3%
Country with the lowest proportion	100	Madagascar (3%)	Madagascar (3%)	- 97%
EXTENT OF COMPREHENSIVE KNOWLEDGE OF HIV AND AIDS				
Highest percentage of women	100	Mauritius (68%)	Mauritius (80%)	-20%
Lowest percentage of women	100	Angola (7%)	DRC (15%)	-85%
SCORES				
SGDI	100	47%	54%	-46%
CSC	100	63%	70%	-30%

According to UNAIDS 35 million people around the world are living with HIV and AIDS. While there have been 39 million deaths globally, the rate of mortality has been reduced by 35% (down to 1.5 million in 2013 from a peak of 2.4 million in 2005). The rate of new infections has also reduced by 38% (to 2.1 million from a high of 3.4 million in 2001), with a 58% reduction of new infections in children as a result of rapid increase in PMTCT coverage (down to 240 000 from 580 000 in 2001). As of June 2014, 13.6 million people had access to ART with the goal being to reach 15 million by 2015.[1]

The reduction of new HIV infections has required a massive injection of government and international donor funds. Global Fund, the US President's Emergency Plan for AIDS Relief (PEPFAR) and others have all contributed to this. UNAIDS is adamant that the world cannot afford to retreat from this massive investment but must continue and even expand. Failure to do so is likely to cause the number of new HIV infections to rise to 2 million (from 1.5 million in 2013), and the number of AIDS-related deaths to increase to 1.7 million (from 1.1 million in 2013). Drug-resistant strains may develop, generating an epidemic which will require much more costly second and third -line HIV treatment regimens.[2]

UNAIDS estimates that by 2020 low income countries will need to invest a total of $9.7 billion per year of which $1.1 billion will be domestic and $8.6 billion will be international; low middle income countries will need to invest $8.7 billion - $3.9 billion domestic and $4.8 billion international and upper middle income countries $17.2 billion - $16.3 billion domestic and $0.9 billion international.[3]

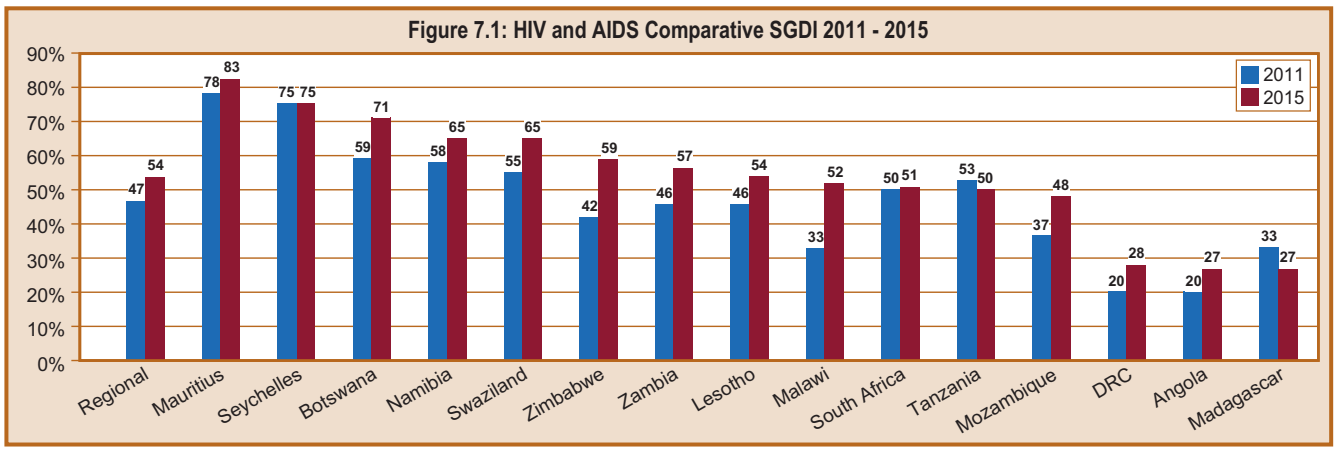
Recently the UN Innovative Financing Mechanism (UNITAID) announced a $23 million grant to Population Services International with several research partners and the WHO to pilot the use of self-testing technology in Malawi, Zambia and Zimbabwe.[4] WHO will use the lessons from this pilot to develop new guidance on self-testing which is perceived as critical to achieving the first 90% of those that are living with HIV knowing their status.

SADC continues to be the epicentre of the epidemic. There are 14.7 million people living with HIV in SADC which is 59% of the total population of people living with HIV in Sub- Saharan Africa and 42% of the total number in the whole world. Of this number, 7.7 million are women, which is 60% of the total women living with HIV in Sub-Saharan Africa and 48% of the number of women living with HIV in the whole world. SADC also has 1.48 million children living with HIV which is 51% of the children living with HIV in Sub-Saharan Africa and 46% of the total global number.[5]

1 UNAIDS. Fact Sheet 2014. http://www.unaids.org/sites/default/files/documents/20141118_FS_WADreport_en.pdf Last accessed 12 July, 2015.
2 UNAIDS, Issue Brief. 2014. HIV Treatment in Africa: A looming crisis.
3 UNAIDS, 2015. Implications of the Start Study Data. Questions and Answers.
4 WHO and partners obtain US$23 million UNITAID grant to catalyse access to HIV self-testing in Africa. http://www.who.int/hiv/mediacentre/news/unitaid_hiv-self-testing/en/
5 Derived from UNICEF. State of the World's Children 2015, Statistical Tables. Table 4. http://www.data.unicef.org/resources/the-state-of-the-world-s-children-report-2015-statistical-tables last accessed 12 July, 2015.

SADC constitutes just one third of the Sub-Saharan African population but is home to the countries with the highest prevalence of HIV (three countries still have adult prevalence rates which are higher than 20% and six have prevalence rates that are between 10 and 19%).[6] HIV in SADC is still a greater challenge for women than it is for men. The pandemic varies across SADC with widespread, generalised heterosexual epidemics across broad areas of the region, where prevalence rates have been declining, and more concentrated epidemics in Mauritius, Seychelles and Madagascar in key populations. These include sex workers, Men who have Sex with Men (MSM), people who inject drugs, prisoners and seafarers.

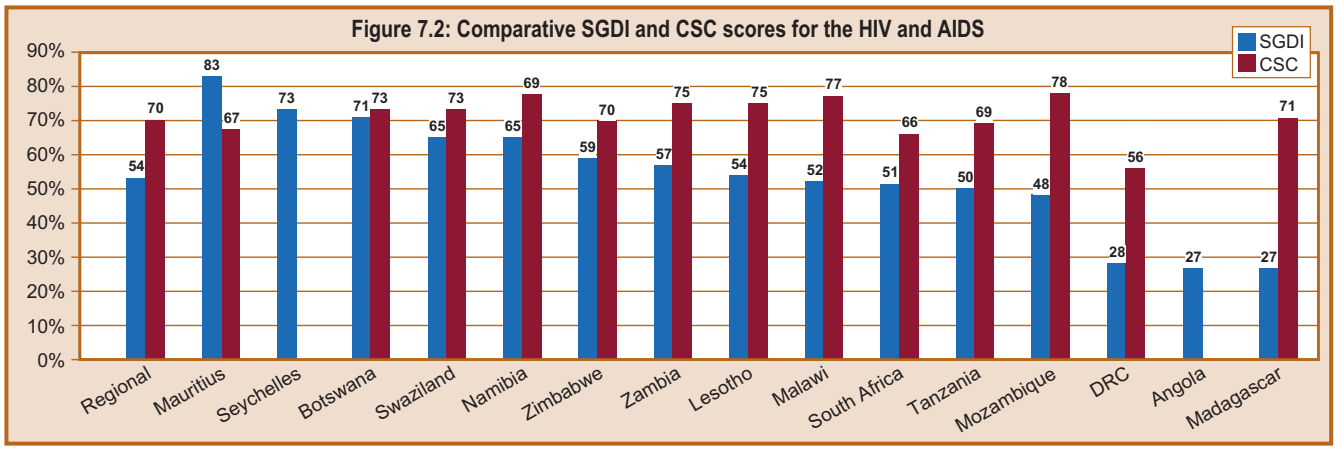
The Southern African Gender and Development Index (SGDI) is a composite basket of indicators that, for HIV and AIDS, includes sex-disaggregated data on HIV and AIDS prevalence; and HIV positive pregnant women receiving PMCTC treatment.



Source: Gender Links 2015.

Figure 7.1 presents comparative SGDI scores for 2011 and 2015. The average SGDI score has improved from 47% to 54%, but the improvement has not been constant over the years. There has been improvement in all countries with the exception of only Tanzania which shows a decline (from 53% to 50%). Malawi has shown the most significant increase (from 33% to 52%), but the rate of increase has slowed in the last year. Mauritius, Seychelles and Botswana have consistently recorded the highest SGDI scores with Angola, Madagascar and DRC recording the lowest. Despite the progress, the SGDI is still far from the target of 100 (with only five countries above 60%) and the crisis that HIV poses to SADC clearly demands continuing and expanding effort and investment.

The Citizen Score Card (CSC) is a measure of citizens' perceptions of the quality of services that they receive from their governments.



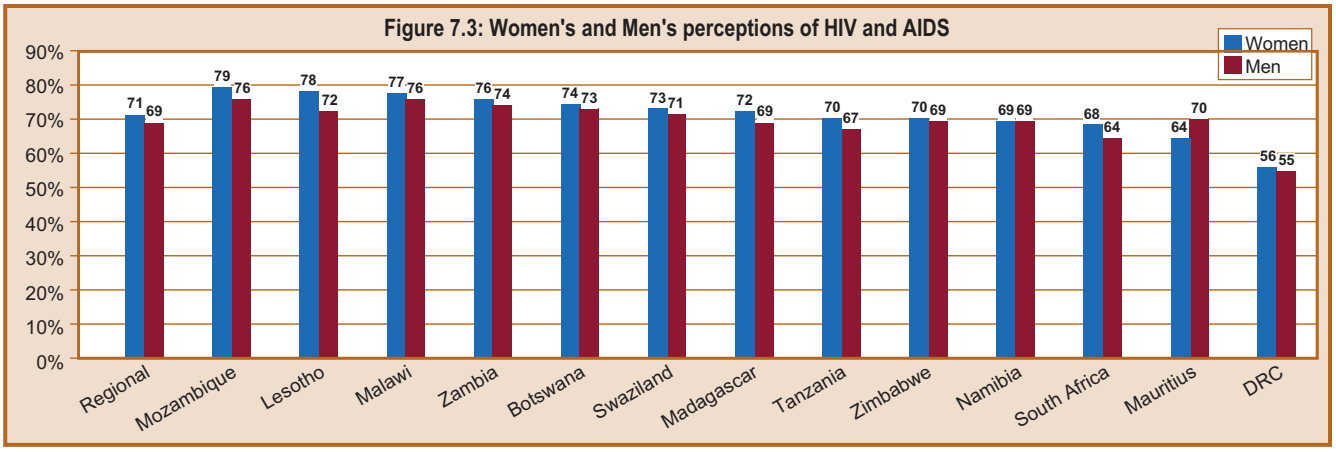
Source: Gender Links 2015.

[6] http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf accessed 18 July, 2015

Figure 7.2 presents a comparison between the SGDI and the CSC scores. This indicates that in general, citizens are more satisfied with the efforts of their governments than the empirical indicators suggest that they should be. This may be an indication of the appreciation that communities have for the relief from extreme morbidity and mortality with virtual helplessness in the health sector that once characterised the AIDS response. This is similar to the trend in previous years.

The average CSC score has decreased slightly between 2014 and 2015, from 72% to 70%. This represents a levelling of this score. CSC scores are quite similar across the region (with the highest score of 78% in Mozambique and lowest of 56% in the DRC). However, there have been some marked changes in countries with some, such as Namibia, falling from 78% to 69% which is much closer to the SGDI.

Others, such as Mozambique, have risen quite dramatically from 71% to 78% which is significantly higher than the SGDI of only 48%. The difference between the highest CSC score in Mozambique (78%) and the lowest in DRC (56%) is much less than the difference between the highest and lowest SGDI scores of 83% in Mauritius and 27% in both Madagascar and Angola.



Source: Gender Links 2015.

Figure 7.3 shows that men and women have quite similar perceptions of their governments regarding the provision of HIV and AIDS services. This suggests that services are provided in a gender-sensitive way, although the statistics suggest that a lower proportion of men that require HIV services access these than women. The regional average is 71% for women and 69% for men. The only country with a higher CSC score for men than women is Mauritius. This may be a reflection of the larger number of men living with HIV in Mauritius and that these are accessing services.

Know your status campaign gains momentum in Oshakati, Namibia.
Photo: Gender Links

Background

The AIDS pandemic has shaped the development agenda in SADC for over three decades. Though SADC is still far from total eradication of HIV, a high level of commitment and investment from governments, communities, donors and civil society is slowly beginning to turn the tide of the epidemic. The massive roll out of treatment and prevention of mother to child transmission across the region in the last decade has changed the HIV landscape dramatically from a situation of despair as large numbers of people experienced illness and death to one of hope as increasing numbers are able to live with HIV.

Bold global goals and targets are being pursued with the aim of eliminating AIDS by 2030. These are abbreviated as 90 - 90 - 90 by 2020 and 95 - 95 - 95 by 2030, standing for:

- 90% (rising to 95%) of all people living with HIV know their status.
- 90% (rising to 95%) of all who know that they are HIV positive access treatment.
- 90% (rising to 95%) of those that access treatment have their viral load suppressed to non-detectable levels so that they remain healthy.

Adult prevalence of HIV fell quite sharply between 2001 and 2008 but has stabilised as more people are on treatment and living with HIV. While new infections are slowing, the rate is still high. Nine of the 30 countries which account for 89% of new infections globally are in SADC (Angola, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe).[7] These countries are targeted for intensive support.

Factors in continued high rates of HIV transmission in SADC

- Low and inconsistent condom use - as reported in Swaziland, Botswana, Tanzania, Seychelles and Namibia.
- Cultural values and norms which disable women's decision-making power in matters of: sexuality, negotiating safe sex, reproduction and gender based violence - as reported in Swaziland, Botswana.
- Early exposure to sexual activity - as reported in Swaziland.
- Multiple Sexual partners - as reported in Swaziland, Botswana, Namibia and Seychelles.
- Men who have sex with men and women who have sex with women - as reported in Swaziland, Botswana, Seychelles and Tanzania.
- Sex work - as reported in Swaziland, Botswana, Tanzania, South Africa, Zimbabwe and Malawi.
- Higher incidence of young women entering relationships with older men (whether for cultural or financial reasons) - as reported in Botswana.
- Limited number of female controlled HIV prevention devices - as reported in Botswana
- High levels of stigma and discrimination, impacting on women's ability to access HIV counselling and testing and to adhere to treatment - as reported in Botswana and Swaziland.
- High rates of alcohol and drug abuse - as reported in Namibia, Botswana and Tanzania.

Improved data is essential for a sustained and successful campaign against HIV. Thus, **Botswana** embarked on the Botswana AIDS Impact Survey (BAIS) which showed that just over 200,000 of the country's one million people are living with HIV and AIDS. The survey also showed:

- HIV prevalence was indirectly proportional to education in women;
- By 2013, 52.9% of children aged 0-17 years had lost at least one parent (unknown whether to the epidemic or not);
- The prevalence of HIV is higher in urban areas than in rural areas.

Women are more vulnerable to HIV infection than men: Women account for 58% of those living with HIV in the sub-Saharan region and women bear the greatest burden of care. Women - young women in particular - remain disproportionately more vulnerable to HIV infection than their male counterparts. In this region, women acquire HIV infection at least five to seven years earlier than men. If young women and adolescent girls had the power and means to protect themselves, the picture of the pandemic in the region would look different. This is beginning to happen. The rate of new HIV infections among young women in 26 countries is declining. However, these gains are fragile and must be sustained.[8]

Some of the factors that exacerbate women's risk to HIV include:

- High incidence of age-disparate sexual relationships (young women in sexual relationships with older men means a heighted risk of contracting HIV);
- Limited female-controlled HIV prevention devices and methods;

[7] UNAIDS, 2015. Fast Track. Ending the AIDS Epidemic by 2030.
[8] http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf accessed 18 July, 2014

- Continuing high levels of stigma and discrimination, impacting on women's ability to access HIV counselling and testing and to adhere to treatment;
- Intimate partner violence or fear of violence, leading to women's lowered ability to initiate discussions about safer sex, even when the partner is known to have other sexual partners;
- High rates of multiple concurrent partnerships;
- High rates of alcohol and drug abuse, and inconsistent condom use;
- High incidence of rape and sexual violence perpetrated against women;
- Harmful cultural practices, supported by patriarchy - such as polygamy, widow cleansing, widow inheritance, marrying girl-children to older men - limit women's ability to make choices which can protect them from HIV.
- Gender inequality renders women less able to negotiate and define sexual relations.

Zimbabwe: "Failing" women and girls

UNAIDS Executive Director Michel Sidibé visited the Mbare City Health Clinic in Harare, Zimbabwe, on 11 June 2015. The public clinic runs an antiretroviral treatment programme that also provides services for victims of rape.

During the visit to the clinic, which is supported by the City of Harare and Médecins sans Frontières, he met people living with HIV, including 19-year-old Thandiwe. Mr Sidibé heard the harrowing story of how she contracted HIV through rape and described her tears as, "A sign of our collective failures. We must do better for her and all women and girls."

Speaking at the clinic, traditional leader Chief Chiveso denounced violence against women and called on men to be activists against gender-based violence. Mr Sidibé hailed the Chief as a champion for gender equality and for ending gender-based violence and the AIDS epidemic.

Earlier, Mr Sidibé engaged in a dialogue with community leaders, who told him of the challenges that marginalization and unemployment bring. Mr Sidibé said that adolescent girls are affected by the poor economic situation, which has resulted in more girls being infected with HIV compared to their male peers.

Two thirds of the population in Zimbabwe is under 25 years and HIV prevalence is almost two times higher among women aged 15-24 than among men of the same age. Zimbabwe has the sixth highest number of annual adolescent AIDS-related deaths in the world.

UNAIDS Executive Director Michel Sidibé visiting Mbare City Health Clinic. *Photo courtesy of http://www.unaids.org*

Mr Sidibé lauded the combined efforts of Zimbabwe's civil society and government, which have resulted in a drop in HIV prevalence and the number of AIDS deaths, but warned that the country needs to do more to Fast-Track the response to HIV in order to end the AIDS epidemic in Zimbabwe by 2030. "If we are not careful, after 2015 people will forget about AIDS, complacency will creep in and people will look at other crisis," he said.

Source: http://www.unaids.org/en/resources/presscentre/featurestories/2015/june/20150612_zimbabwe accessed 12 July, 2015

Gender norms also increase men's vulnerability to HIV infection: Men are often encouraged to engage in high risk behaviour and discouraged from seeking health services. As a result fewer men than women get tested for HIV; men have lower levels of access to treatment than women, which means they have lower CD4 cell count levels by the time they seek treatment and have poorer adherence to treatment.[9]

Women sex workers remain among the most vulnerable to HIV infection: A 2012 review of available data from 50 countries, which estimated the global HIV prevalence among female sex workers at 12%, found that female sex workers are 13.5 times more likely to be living with HIV than other women.[10] Even in countries with a high prevalence, the HIV prevalence among sex workers is higher than in the general population. In

[9] UNAIDS Global Report, 2012.
[10] Baral S et al. Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis. Lancet Infectious Diseases, 2012, 12:538-549.

2014 the prevalence rate among sex workers in Swaziland was 64% compared to 27% in the general adult population. Other countries in SADC for which data is available are Angola - 7% in sex workers, 2.4% in general adult population; DRC - 5% and 1.1%; Mauritius 11% and 1.1%; and Zimbabwe 25% and 15%.[11]

Women Sex Workers. *Photo courtesy of Google Images*

Botswana documents sex workers' experiences

Botswana's Ministry of Labour and Home Affairs has launched a booklet and DVD called *Documenting the Voices of Female Sex Workers in Botswana*. The project combines print and video to capture the experiences of sex workers in areas such as motivation for entry into sex work and access to health and HIV prevention material. The Labour and Home Affairs Ministry Permanent Secretary, Ikwatlhaeng Bagopi, said in a statement that due to the sensitive nature of the industry, the documentary used blurred images to protect the identity of sex workers involved. The DVD comes at a time when former President Festus Mogae has called for the decriminalisation of sex work as another way of fighting the HIV scourge.

Source: The Star Africa: 21 August 2014

Mobility and proximity to transport routes increases risk of contracting HIV: Southern Africa has long exhibited a trend of higher HIV prevalence along transport routes and in border towns, partly due to high incidence of transactional sex. Sexual abuse of women and girls is also common in border towns. Mauritius and Mozambique have two of the most localised epidemics, with HIV prevalence more concentrated in some areas than others. In Mauritius, HIV is more prevalent in the port cities of Port Louis and Black River, which are characterised by constant movement of people from the inland region and tourism.[12] In Mozambique, while prevalence is stabilising in some areas, the southern region has been characterised by increasing prevalence, from 16% in 2002 to 21% in 2009.[13] Prevalence in Mozambique is also higher in border areas and along the three main transport corridors of Beira, Maputo and Nacala.

HIV prevalence is especially high among MSM: Although homosexuality is criminalised in a number of SADC countries, available data suggests that prevalence is much higher among Men who have Sex with Men (MSM). Globally, MSM are 19 times more likely to be living with HIV than the general population of men. In Madagascar the prevalence is 14% among MSM compared to 3% in the general population; in Mauritius it is 8% and 1.1%; Tanzania 18% and 5% and in the DRC 6% and 1.1%.[14]

MSM suffer stigma and discrimination: Although as prevalent in sub-Saharan Africa as elsewhere in the world, same-sex relations are highly stigmatised in the region. This stigma and homophobia, along with frequent violence perpetrated against homosexuals means MSM and transgender people have a higher risk of contracting HIV, because they are less likely to get tested and less able to access treatment. More than 42% of MSM surveyed in Botswana, Malawi and Namibia reported experiencing at least one human rights abuse, such as blackmail and denial of housing or health care.[15] Stigma and discrimination result in it being very difficult for MSM to access prevention, treatment or care services.

There is a shortage of targeted prevention and mitigation interventions for women who have sex with women: Women who have sex with women can also be vulnerable to contracting HIV infection, yet this group is rarely targeted with HIV interventions for a variety of reasons. This is mostly due to a lack of understanding of the specific sexual practices of women who have sex with women, as well as lack of knowledge of their sexual and reproductive health needs. According to a 2011 pilot study of the health experiences and

[11] Derived from UNICEF. State of the World's Children 2015, Statistical Tables. Table 4. http://www.data.unicef.org/resources/the-state-of-the-world-s-children-report-2015-statistical-tables last accessed 12 July, 2015 and HIV and AIDS: Complete global database 2015. http://data.unicef.org/hiv-aids/global-trends accessed 11 July, 2015.
[12] Government of Mauritius 2010
[13] USAID 2010
[14] UNAIDS, 2012. Global Report . and HIV and AIDS: Complete global database 2015. http://data.unicef.org/hiv-aids/global-trends accessed 11 July, 2015
[15] Ibid.

needs of lesbian and bisexual women in four Southern African countries, including South Africa, 30% of these women did not believe they risked contracting HIV if they had unprotected sex.[16] Women who have sex with women are also subject to homophobia, violent crime and rape, and discrimination at the hands of health providers. This limits their access to healthcare, preventative measures and treatment.

People who inject drugs remain vulnerable to HIV infection: Although the overall proportion of the SADC population that injects drugs is low, some countries with large numbers of drug users have high HIV prevalence in this group. For example, more than 50% of injecting drug users in Mauritius and 8% in Madagascar are HIV positive. There is also evidence to suggest that women who inject drugs face violence from intimate partners, police and sex trade clients, which increases their vulnerability to HIV infection. Women who inject drugs remain less likely to access services, so if those living with HIV and AIDS become pregnant they are much less likely to access Prevention of Mother to Child Transmission (PMTCT) services.[17]

While a SADC Declaration on HIV and AIDS already exists, the SADC Gender Protocol specifies the gender dimensions and adds specific timeframes and targets. The Protocol states that:

1. State parties shall take every step to adopt and implement gender - sensitive policies and programmes, and enact legislation that will address prevention, treatment, care and support in accordance, but not limited to the Maseru Declaration on HIV and AIDS.
2. State parties shall ensure that the policies and programmes referred to in sub-Article 1 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.
3. State Parties shall, by 2015:
   a. Develop gender sensitive strategies to prevent new infections;
   b. Ensure universal access to HIV and AIDS treatment for infected women, men, girls and boys;
   c. Develop and implement policies and programmes to ensure the appropriate recognition of the work carried out by caregivers, the majority of whom are women, to allocate resources and psychological support for caregivers as well as promote the involvement of men in the care and support of people living with HIV and AIDS;

The Barometer tracks the indicators in Table 7.3 annually as an indication of progress towards achieving these targets.

Table 7.1: Key gender, HIV and AIDS indicators

Faculty	Angola		Botswana		DRC		Lesotho		Madagascar		Malawi		Mauritius		Mozambique		Namibia		Seychelles		South Africa		Swaziland		Tanzania		Zambia		Zimbabwe	
%	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M
1. Extent of comprehensive knowledge on HIV AND AIDS (15-24)	25	32	40	33	15	21	39	29	23	26	42	45	80	76	36	34	65	62	67	59	27	30	58	54	40	47	38	41	52	47
2. Estimated adult (15 - 49) HIV prevalence %	2.4		21.9		1.1		22.9		0.4		10.3		1.1		10.8		14.3		2.5		19.1		27.4		5		12.5		15	
3. Share of HIV Infection by sex	59	41	55	45	59	41	59	41	46	54	59	41	28	72	58	42	60	40	42	58	60	40	58	42	61	39	52	48	58	42
4. % On ARV Treatment (total)	6		90		15		51		3		21		93		12		84		95.2		56		35		65		68		56	
5. % HIV Positive Pregnant Women Receiving PMTCT	14		97		27		81		3		73		96		66		90		100		87		95		71		86		82	

Source: UNGASS 2012 - 2014 Country progress reports; IAS 2012 Fact sheet on HIV and AIDS in sub-Saharan Africa and South Africa.
Sources: http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/#M accessed 18 June 2015.
http://mdgs.un.org/unsd/mdg/data.aspx accessed 18 June 2015.
Source: http://unstats.un.org/unsd/mdg/SeriesDetail.aspx?srid=742 accessed 18 June 2015.
http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf accessed 18 June, 2015.

[16] OSISA and HSRC, 2011.
[17] UNAIDS, 2012.

Policies

1. *State parties shall take every step to adopt and implement gender-sensitive policies and programmes, and enact legislation that will address prevention, treatment, care and support in accordance, but not limited to, the Maseru Declaration on HIV and AIDS.*
2. *State parties shall ensure that the policies and programmes referred to in sub-Article 1 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.*

There is no time-bound target for these provisions but they are at the heart of informing HIV interventions. Policies provide a framework for addressing the pandemic with an emphasis on prevention.

Lesotho, with a 24% prevalence rate (down from approximately 30% in 2004) has committed in its latest budget to try to bring this down to 15%, a clear sign of commitment. The government has also adopted the following national policies (mostly regarding prevention) to curb HIV and AIDS: National Action Plan on Women, Girls and HIV and AIDS (2012-2017); The Prevention of Mother-to-Child Transmission Strategy; the National HIV Prevention Strategy for a Multi-Sectoral Response; and the Operational Guidelines for Comprehensive HIV prevention interventions within the Health Sector.

The **Malawi** National HIV and AIDS Strategic Plan (NSP) for 2011 - 2016 is aligned with the Malawi Growth and Development Strategy (MGDS). It is consistent with the Malawi Growth and Development Strategy (MGDS) II, the Health Sector Strategic Plan (HSSP) 2011-2016; and the National HIV Prevention Strategy 2009-2013 and developments in medical and scientific knowledge. The NSP has nine key thematic areas that comprehensively address the HIV and AIDS pandemic. It has mainstreamed gender into priority areas to be sure that interventions benefit the specific needs of women, girls, men and boys.

The overall goal of the 2012-2016 NSP is to prevent the further spread of HIV infection, promote access to treatment for people living with HIV (PLHIV) and mitigate the health, social-economic and psychosocial impact of HIV and AIDS on individuals, families, communities and the nation. It aims to reduce new infections by 20% and AIDS deaths by 8%, including a 50% reduction in children's deaths.

The national HIV and AIDS Strategic Plan recognises the importance of mobilising traditional leaders and communities against harmful cultural practices that fuel the spread of HIV and AIDS, such as widow inheritance and child marriages. The plan also addresses stigma and discrimination, adherence and uptake of PMTCT and provision of care for the sick.

Mauritius has an HIV and AIDS Act as well as an HIV and AIDS Policy. Two of the guiding principles of the National HIV and AIDS policy developed and validated in 2011 are:

- People with HIV and AIDS shall have the same rights as all other citizens, and shall not be discriminated against on the basis of their HIV status, gender, socio-economic status, sexual orientation or HIV-risk factors.
- Gender norms and relations are a key factor in determining who acquires HIV in Mauritius, and in determining treatment, care and support outcomes. The national programme acknowledges this and all programmes and services shall devise and implement strategies that address gender norms and relations. Addressing the prevention and care needs of women and girls shall be a particular focus, combined with attention to male behaviour and cultural norms that increase the likelihood of women contracting HIV.

Other gender considerations are:

- Wherever possible, HIV and AIDS information, and prevention and care initiatives shall be integrated into existing programmes and services. In health, this shall mean integration into sexual and reproductive health services, maternal and child health, services for sexually transmitted infections, family health and other mainstream services.
- Treatment, care and support efforts shall focus on connecting all individuals and families (mostly women and children) affected by HIV and AIDS with health care and social support, and on focusing resources on geographical areas most affected by HIV and AIDS.

In **Zimbabwe** the Criminal Law (Codification and Reform Act) protects women from sexual abuse

and criminalises marital rape and the wilful transmission of HIV and AIDS. The country has also put in place the Zimbabwe Operational Framework on Women, Girls, Gender Equality and HIV (2011-2015) to complement the Zimbabwe National AIDS Strategic Plan II (2011-2015) and to provide direction in making HIV programming more responsive to the needs of women and girls, especially marginalised women - sex workers, migrant and internally displaced women, women living in informal settlements, cross-border traders, women and girls with disability and adolescent girls.

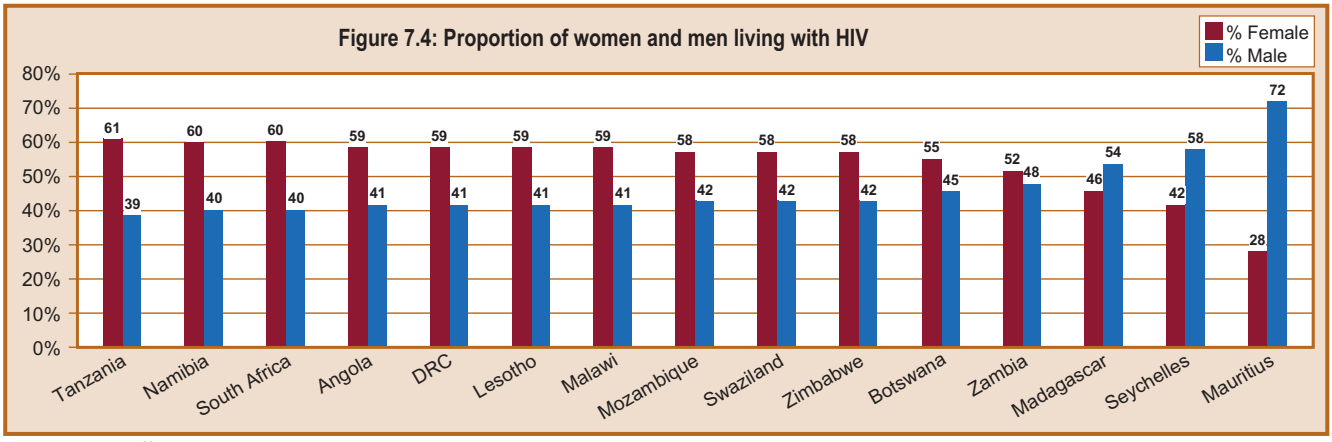
This framework, known as the Zimbabwe Agenda for Accelerated Country Action for Women, Girls, Gender Equality and AIDS (ZAACA), has five outcomes:

- Access to comprehensive HIV prevention, treatment, care and support services for women and girls.
- HIV integrated into sexual and reproductive health and other health and social services.
- Women and girls empowered to drive the transformation of social norms and power dynamics with the engagement of men and boys working for gender equality in the context of HIV.
- Developing a research agenda to gather evidence for better planning, programming and implementation of programmes.
- Resource mobilisation for the implementation of ZAACA.

Manicaland HIV AND AIDS Prevention Project.
Photo courtesy of ©Peter Strauli for the Manicaland HIV Prevention Project

Prevention

The Protocol requires that by 2015, state parties shall develop gender-sensitive strategies to prevent new infections, taking account of the unequal status of women, and in particular the 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.



Source: http://kff.org/global-indicator/women-living-with-hivaids/ - accessed 18 June 2015.

Figure 7.4 shows that women remain more affected by HIV than men. In 12 of the 15 countries in SADC there is a higher proportion of women living with HIV than there are men. Madagascar, Seychelles and Mauritius, which have a higher proportion of men living with HIV than women, have concentrated HIV epidemics in key populations such as injecting drug users and MSM.

According to UNAIDS women constitute approximately 58% of the estimated 35.5 million people living with HIV globally. It is further estimated that a total of 37, 000 women die every year from HIV and pregnancy complications in low and medium income countries, compared to almost none in high-income countries.[18] In all countries, as epidemics are maturing, the gap in the percentage of men and women living with HIV is narrowing.

Table 7.2: Proportion of Women and Men Living with HIV

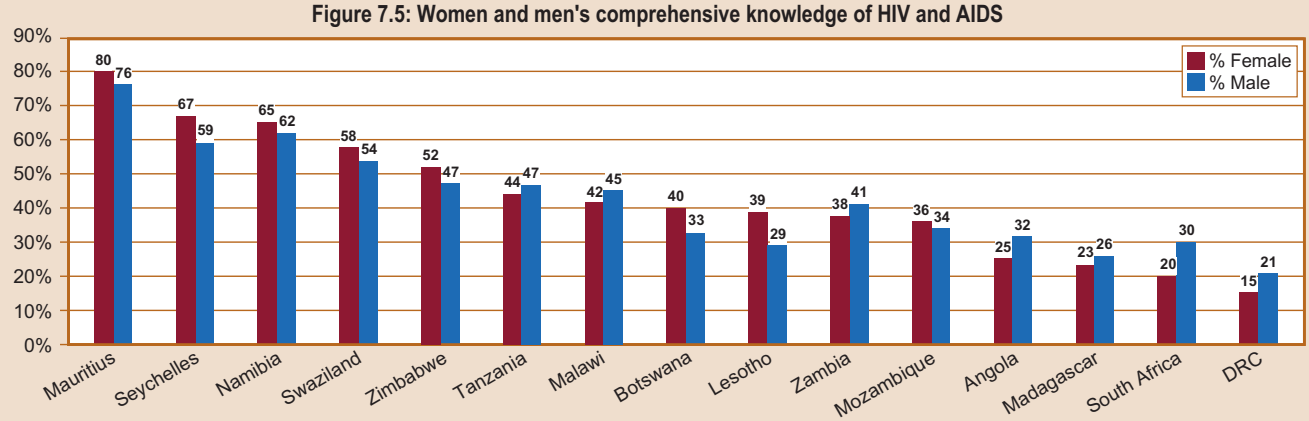
Country	Percentage of Women		Percentage of Men	
	2009	2015	2009	2015
Angola	61	59	39	41
Botswana	57	55	43	45
DRC	58	59	42	41
Lesotho	60	59	40	41
Madagascar	58	46	42	54
Malawi	58	59	42	41
Mauritius	18	28	82	72
Mozambique	60	58	40	42
Namibia	68	60	32	40
Seychelles	42	42	58	58
South Africa	58	60	42	40
Swaziland	57	58	43	42
Tanzania	55	61	45	39
Zambia	57	52	43	48
Zimbabwe	60	58	40	42

Source: Gender Links 2009 and 2015.

Table 7.2 compares the proportion of women and men living with HIV in 2009 with 2015. The proportions have not changed dramatically in any countries: in all but two countries (Mauritius, and Seychelles) women still constitute the majority of those living with HIV and AIDS. Madagascar has seen the greatest change from predominantly female (58%) to predominantly male (54%). Mauritius has also registered a shift from 18% women to 28%.

Comprehensive, accurate knowledge of HIV and AIDS i*s* fundamental to ensuring citizens use HIV services and engage in safe sexual behaviours. Yet, knowledge remains low among young women and men (aged 15-24) in SADC, with significant gaps in even basic knowledge about HIV and its transmission. Thus age-appropriate sexuality education must be mainstreamed into education.

Figure 7.5: Women and men's comprehensive knowledge of HIV and AIDS



Source: http://unstats.un.org/unsd/mdg/SeriesDetail.aspx?srid=742 http://mdgs.un.org/unsd/mdg/data.aspx accessed 18 June 2015.

[18] UNAIDS 2014.

There are great variations in knowledge of HIV and AIDS between countries: Figure 7.5 illustrates that the most comprehensive knowledge on HIV and AIDS is in Mauritius - 80% for women and 76% for men. There are only four countries - Mauritius, Seychelles, Namibia and Swaziland (all with relatively small populations) - where more than 50% of both men and women have comprehensive HIV and AIDS knowledge. Eight countries do not even have 40% of both men and women with comprehensive knowledge (Botswana, Lesotho, Zambia, Mozambique, Angola, Madagascar South Africa and DRC). This depressing picture is further exacerbated by wide disparities in knowledge between rural and urban young people (36% of females and 46% of males in urban areas; 23% of females and 32% of males), between higher and lower socio-economic groups (17% of females and 25% of males in the lowest quintile compared to 35% of females and 48% of males in the highest quintile),[19] and between those with more and less education.

The knowledge gap between women and men is relatively small: Women and men's comprehensive knowledge of HIV remains similar through all the countries with the highest disparity being in South Africa where women fall 10 percentage points behind men and in Lesotho where men fall 10 percentage points behind women.

Successful HIV prevention means investing in communities: A number of social and medical factors have contributed to a reduction in new infections in the region. A 2013 study conducted on behalf of the World Bank,[20] Investing in Communities Achieves Results, indicates that increasing knowledge on HIV through community activities and sensitisation contributes to increased uptake of counselling and testing, anti-retroviral treatment (ARV) and reduction in prevalence rate. It is recognisd that more investment in community mobilisation is critical to achieve the end of AIDS.[21]

South Africa has made enough progress in increasing access to testing that it is believed that the country could reach the target of 90% of those living with HIV aware of their status by 2018. This is an increase from 20% of those that are living with HIV aware of their status in the early 2000s. To achieve it will require that testing programmes continue to reach 10 million people per year. Current HIV testing programmes are not reaching enough men, adolescents and the elderly.[22]

Women are more likely to be aware of their HIV status: HIV testing, counselling and prevention services in ante-natal settings offer an excellent opportunity not only to prevent new-borns from becoming infected, but also to protect and enhance the health of HIV-infected women. In numerous countries in which testing data has been reported, women are significantly more likely than men to know their HIV serostatus, mainly due to the availability of testing. Opportunities for programmes which encourage joint testing of an HIV positive woman and her husband as part of a PMTCT programme also exist, so that treatment and care services can be afforded to both. Men's participation in PMTCT services is still limited in many countries and men often perceive pregnancy and childbearing as the sole responsibility of women.

Spotlight on youth

Adolescence is the period when young people transition from childhood to adulthood with rapid physical growth and change as well as psychosocial development. Global attention is being focused on adolescents, and particularly adolescent girls, as it emerges that this important group is not benefitting from enhanced prevention and treatment. As mortality rates are declining in all other age groups, they are still increasing in adolescents. AIDS is the leading cause of death in adolescents in Africa and the second highest cause globally.[23] Some 35% of the 1.9 million adults aged 15 and over infected with HIV globally in 2013 were young people aged between 15 and 24 and 13% (250,000) were adolescents aged 15-19. Adolescent girls are two to three times more likely to be infected than boys of the same age group.[24] There are a total of 958 700 adolescents living with HIV in SADC, which is 53% of the total number in Sub Saharan Africa and 46% of the global number of adolescents living with HIV.[25] Adolescents have a different concept of risk than adults.

Youth raise awareness of HIV and AIDS in Bongatsara, Madagascar.
Photo by Zotonantenaina Razanandrateta

[19] UNICEF, 2015. Progress for Children, Number 11: Beyond the averages, learning from the MDGs.
[20] Rosalía Rodriguez-García, René Bonnel, David Wilson and N'Della N'Jie (2013) Investing in Communities Achieves Results. Geneva: World Bank.
[21] UNAIDS, Issue Brief. 2014. HIV Treatment in Africa: A looming crisis.
[22] http://www.bdlive.co.za/national/health/2015/07/03/sa-has-uns-hiv-testing-goal-in-sight
[23] All in: #End Adolescent AIDS. 2015. Brochure. http://allintoendadolescentaids.org
[24] UNICEF, 2015. Progress for Children, Number 11: Beyond the averages, learning from the MDGs.
[25] HIV and AIDS: Complete global database 2015. http://data.unicef.org/hiv-aids/global-trends accessed 11 July, 2015.

Raising HIV awareness in young people in Madagascar

The Gender Committee of the rural council of Tsiafahy created the Association AMIS *(Friend)* in 2012 to achieve the 28 targets of the gender protocol on gender and development.

As young people constitute more than 50% of the council's population, the Association has decided to concentrate on education, information and sensitization of young people on gender, gender violence, sexual and reproductive health. Led by a young teacher, Rakotozafy Francia, the Association gathers young people from the council and members of the gender committee. With the support of local health centres, AMIS visited the 15 hamlets of the council doing free HIV testing and medical consultation.

During the Sixteen Days of Activism, the Association organised a march for the fight against GBV and football tournament where they shared booklets and leaflets on sexual and reproductive health. The members of the association are also organising periodical sensitisation campaigns in schools to inform young people on gender, the different kinds of sexually transmitted diseases including HIV and AIDS.

In 2014, the Association worked closely with the Ministry of Health and UN agencies for the popularisation of a project called *"Allo Fanantenana"*, free phoning, in which young people can get free counselling, information if they have problems. The advantage of this project is the fact that it is free, easy to access and confidential. Besides, as most of the members of the association are young people, peer learning is facilitated.

Rakotozafy Francia, President of the Association AMIS.
Photo by Gender Links

Apart from awareness-raising activities, the Association is also collaborating with the media. As radio is the most commonly accessed type of media, the group broadcasts radio dramas dedicated to young people. The drama conveys messages concerning gender equality, gender violence, sexual and reproductive health. In addition, as speaking about sexual and reproductive health is still a taboo in the Malagasy community, radio drama is the most appropriate communication tool.

Thanks to the Association's activities, the council has recognised the importance of sensitisation on Sexual and Reproductive Health and has included strategies for young people in the Development Action Plan of the council.

Table 7.3: Adolescent Prevention and HIV Testing

	HIV prevalence among young people (%) 2009 - 2013			Comprehensive knowledge of HIV % 2009 - 2013		Condom use among young people with multiple partners (%) 2009 - 2013		Young people who were tested for HIV in the last 12 months & received results % 2009 - 2013	
Country	**Total**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Angola	0.9	0.6	1.2	32	25	-	-	-	-
Botswana	4.7	3.5	6.0	-	-	-	-	-	-
DRC	0.4	0.3	0.5		15	22	11		7
Lesotho	8.1	5.8	10.5	29	39	60	45	17	40
Madagascar	0.2	0.2	0.2	26	23	7	9	2	3
Malawi	3.1	2.4	3.8	45	42	41	31	28	64
Mauritius	0.2	0.2	0.2	-	-	-	-	-	-
Mozambique	4.4	2.7	6.1	52	30	41	38	11	26
Namibia	3.7	2.7	4.8	62	65	79	68	26	43
Seychelles	-	-	-	-	-	-	-	-	-
South Africa	8.6	4.0	13.1	23	25	-	-	-	-
Swaziland	9.8	7.1	12.4	54	58	85	69	23	37
Tanzania	1.8	1.4	2.2	47	40	41	34	21	29
Zambia	4.0	3.4	4.5	41	38	43	42	13	28
Zimbabwe	5.3	4.1	6.6	47	52	51	39	14	30

Source: Derived from UNICEF. State of the World's Children 2015, Statistical Tables. Table 4. http://www.data.unicef.org/resources/the-state-of-the-world-s-children-report-2015-statistical-tables last accessed 12 July, 2015.

Table 7.3 reflects the gendered dimensions of HIV prevalence, knowledge, condom use and testing among young people. The table shows that:

- Lesotho and Swaziland have the highest proportion of young women and men living with HIV and AIDS - just under 10% in each case.
- In all countries except Mauritius and Madagascar where the proportions of young women and men are the same, there is a considerably higher proportion of young women than men living with HIV.
- The highest differential in prevalence is South Africa where young females (13.1%) are almost 3.3 times as likely to be infected with HIV as young males.
- In all countries except Namibia (62% young men and 65% young women) the rate of knowledge on HIV and AIDS is less than half.
- Swaziland, followed by Namibia, has the highest rate of condom use.
- In all countries for which data could be obtained, young women were much more likely than young men to be aware of their HIV status. The gap is largest in Malawi, (64% young women and 28% young men). Malawi also has the overall highest rate of awareness of HIV status among young people, and Madagascar the lowest. As reflected in the previous case study, youth groups in Madagascar are seeking to change this.

Preventing new HIV infections in children and keeping their mothers alive

Discussion on PMTCT in Ezulwini, Swaziland.
Photo by Thandokuhle Dlamini

Following a 2011 political declaration, UNAIDS developed a Global Plan for the elimination of new HIV infections among children by 2015 and keeping their mothers alive. The plan focuses on 22 high prevalence countries; 21 of which are in Africa and 12 in SADC (Angola, Botswana, DRC, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe).

An important aspect of the plan involves rapid expansion of PMTCT programmes. This included two options (known as Option A and Option B) that provide anti-retroviral medication for infants. However, both options could only be applied for women whose CD4 cell count is lower than 350. Inadequate laboratory facilities to test CD4 count limit the number of women that access either of these options. Thus Malawi introduced an Option B+ where all pregnant or breast feeding mothers living with HIV were immediately introduced to lifelong ART. In 2013 the WHO issued new guidelines on PMTCT, recommending that countries should introduce Option B+ and Option B where this was not possible. Option A is no longer used.

The total number of newly infected children dropped below 200 000 in the 21 priority countries under the Global Plan towards the elimination of new HIV infections among children and keeping their mothers alive. Malawi has had the largest decline in the rate of children acquiring HIV infection-by 67%. New HIV infections among children declined by 50% or more in Botswana, Malawi, Mozambique, Namibia, South Africa and Zimbabwe. In 2013, the priority countries had an overall six-week mother-to-child transmission rate of 7%; which rose to 16% after breastfeeding ended, indicating the importance of continued treatment for the mother during this period of risk for mother-to-child transmission and the need for programmes to provide effective post-natal follow up and antiretroviral medicines.[26]

In 2013, globally, 240 000 children were newly infected with HIV. This is 58% lower than in 2002, the year with the highest number, when 580 000 children became infected with HIV. Providing access to antiretroviral medicines for pregnant women living with HIV has averted more than 900 000 new HIV infections among children since 2009.

The proportion of pregnant women living with HIV who did not receive antiretroviral medicines has halved over the past five years, from 67% to 32%. Less than 10% of pregnant women living with HIV are not receiving antiretroviral therapy in 2013 in four countries: Botswana, Namibia, South Africa and Swaziland. However, there is concern about the almost static number of HIV-positive pregnant women receiving antiretroviral therapy. Only about 37 000 additional pregnant women living with HIV were reached in 2013, compared to nearly 97 000 more in the previous year which is an indication of how fragile progress is. Among pregnant women living with HIV, an estimated 61% were receiving lifelong antiretroviral therapy or prophylaxis during the breastfeeding period to reduce

[26] UNAIDS, 2014. 2014 Progress Report on the Global Plan towards elimination of new HIV infections among children by 2015 and keeping their mothers alive.

HIV transmission. This is a remarkable improvement from less than 20% in 2009.[27]

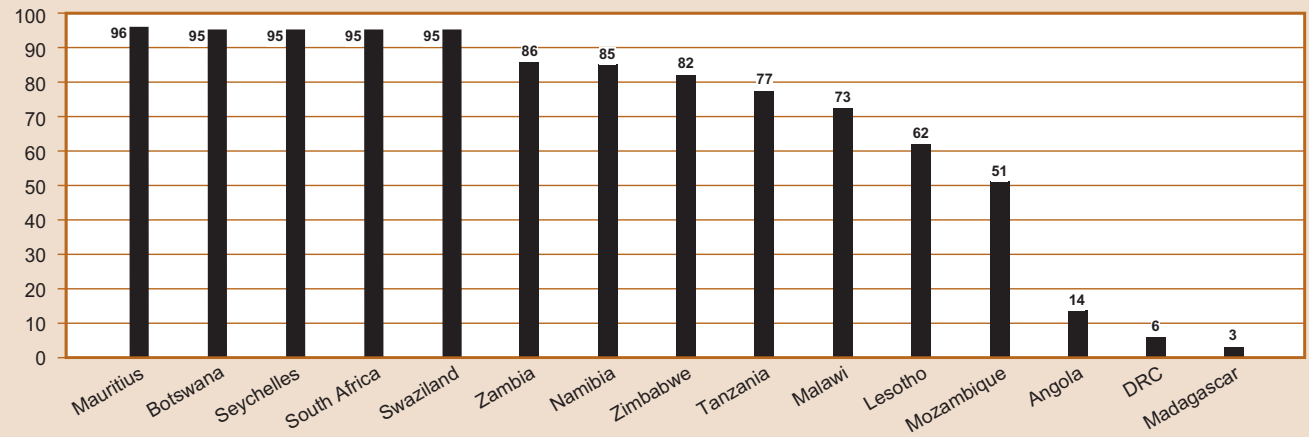
In 2015 Cuba became the first country in the world to achieve elimination, signalling that this can be achieved with political will and investment. Botswana is very close to the target of eliminating transmission of HIV and South Africa is also within reach. Namibia, Swaziland, Mozambique, Malawi, Zimbabwe. Zambia and Tanzania have all achieved transmission rates of less than 15% while Lesotho is still higher than 20%.

The elimination of HIV in children will require more than the provision of antiretroviral therapy (ART) for mothers. Another pillar of the programme is reduction in new infections in mothers by 50%. Progress in this pillar has been much slower, with new infections so far declining by only 17%.

A third pillar is provision of contraception to allow mothers living with HIV to plan the births of their children more effectively. Overall, the unmet need for contraception is 25%. While there is scant data about the unmet need of contraception for women living with HIV, it is safe to assume that they are not very different from the general population.

PMTCT programmes are also keeping mothers alive. There has been a 29% reduction in mortality of mothers as a result of HIV.

Figure 7.6: Percentage pregnant women living with HIV on PMTC



Sources: http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/#M
http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/MWI_narrative_report_2015.pdf
http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/TZA_narrative_report_2015.pdf
http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/MDG_narrative_report_2015.pdf - accessed 16 June 2015.

PMTCT uptake is improving dramatically but still remains uneven in the region: Figure 7.6 illustrates that five countries have PMTCT coverage of 95%, while four more have achieved over 80% coverage. These countries have already reached the World Health target of 80% coverage and may soon reach 100% coverage.

Social and structural factors impede scaling up of PMTCT. Programmes for mentoring of mothers, disclosure support, greater involvement of males and families and reduction of stigma might help address this. Further, there is a need for greater efforts to reach marginalised groups such as women prisoners, sex workers, drug users, migrants and people with disabilities. The rate of mother to child transmission in such groups is much higher than in the general population.

[27] http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf accessed 18 July, 2014

Table 7.4: Comparison of PMTCT Coverage 2009 - 2015					
	Mothers receiving PMTC				
Country	2009	2015	% change	Target	Variance
Seychelles	99	100	1	100	0
Botswana	95	97	2	100	3
Mauritius	95	96	1	100	4
Swaziland	64	95	31	100	5
Namibia	75	90	15	100	10
South Africa	50	87	37	100	13
Zambia	39	86	47	100	14
Zimbabwe	67	82	15	100	18
Lesotho	72	81	9	100	19
Malawi	14	73	59	100	27
Tanzania	10	71	61	100	29
Mozambique	28	66	38	100	34
DRC	4	27	23	100	73
Angola	14	14	0	100	86
Madagascar		3	-97	100	97

Source: Gender Links 2009 and 2015.

Table 7.4 compares PMTCT between 2009 and 2015. The table shows that:

- Seychelles, Botswana and Mauritius have the highest PMTCT coverage, at almost 100%, with Swaziland, Mauritius and South Africa not too far behind.
- Angola and Madagascar need to do much more. As noted above, such widespread access to PMTCT for the mother only translates into equivalent reduction in transmission to the infant if mothers continue to receive ARVs and care at least as long as they are breast feeding.
- Swaziland, South Africa, Zambia, Malawi, Tanzania and Mozambique have all made very remarkable progress in a very few years. Tanzania made the most dramatic improvement - from 10% to 71%.
- There are clear signs of progress in the DRC which must be maintained. This indicates that with political will and sufficient support it is possible to make rapid changes to the trajectory of the HIV epidemic.
- In Malawi, PMTCT coverage increased by 59 percentage points to 73% (similar to Tanzania); this puts the country just 27 percentage points below the 100% target.

Mauritius initiated PMTCT in 1999 and in 2009 it intro-duced new PMTCT protocols to improve management of HIV-positive pregnant mothers. All pregnant women attending hospitals are offered HIV testing, counselling, treatment, care and support. HIV-positive pregnant woman have access to ARV and free caesareans. All HIV-positive pregnant women receive ART by 12 to 14 weeks of gestation. Milk formula is supplied to all babies born to HIV-positive mothers, up to two years. The Polymerase Chain Reaction (PCR) tests are performed on babies at three and six month intervals for early detection of HIV infection. PMTCT coverage at the end of 2013 is high at 95%.

Mozambique PMTCT programme coverage is improving. Approximately 86% of ante-natal care facilities offer PMTCT services and HIV testing among pregnant women increased from 12% in 2005 to 87% in 2010. In 2011, 51% of pregnant women living with HIV (PWLHIV) received more effective ARVs for PMTCT - up from 38% in 2009. In 2010, 42% of children born to PWLHIV received ARVs for PMTCT.[28] Mozambique has developed a national scale-up plan towards elimination of mother to child transmission of HIV (2010-2015), and has adopted WHO Option B+ regimen.

South Africa has achieved the target of reducing transmission by more than 50% and transmission rates between mothers and babies have fallen to less than 5%. According to a study conducted by the Institute for Health Metrics and Evaluation at the University of Washington, new HIV infections in South African children under five years old have dropped by more than three quarters between 2003 and 2013. The study also found that the number of children who died due to Aids has decreased tenfold over the past 10 years.[29] However, a recent study has found that transmission of HIV to

[28] Early Infant Diagnosis of HIV in Mozambique: Progress Report January 2009 - December 2011.
[29] Institute for Health Metrics and Evaluation (IHME), 2014. http://mg.co.za/article/2014-07-21-hiv-infections-in-children-under-five-down-by-over-three-quarters.

infants is much higher in adolescent mothers than in older women.[30] Adolescents were much less likely to use contraception or dual contraception.

Tanzania is scaling up its PMTCT programme, mainly through integrating PMTCT services into Maternal Newborn and Child Health (MNCH) services. By 2010, the majority (90%) of ante-natal care facilities had integrated PMTCT services. HIV testing among pregnant women increased from 14% in 2005 to 86% in 2010, and 74% of pregnant women living with HIV received ARVs for PMTCT in 2011. The transmission rate has been halved but it is still 15%, with high levels of transmission during breastfeeding. Tanzania has implemented a costed national PMTCT scale-up plan (2011-2015).[31]

Malawi: HIV Prevention and treatment through PMTCT

Umunthu Foundation through networking has managed to build coalitions between public institutions working on HIV AND AIDS such as the Blantyre City Council AIDS Committee, the Blantyre District Health Office (DHO) and the people living with HIV AND AIDS (PLHIV) .The project has connected the people living with HIV and AIDS with voluntary community care givers.

The project is integrated with antenatal services which are provided in government health facilities of Bangwe and Limbe in Blantyre. Working hand in hand with public officials such as ART Nurses, Clinical Officers, Pharmacists and Auxiliary Nurses contributes to success of the project.

Count Testing Centre Bangwe and Limbe at Umunthu Foundation.
Photo courtesy of www.avert.org

The private institutions such as members of the business community have also contributed to the achievement of the project, for example the project has received material support for the women who are on PMTCT programme such as nutritious tinned food, nuts and other food items.

The HIV prevention treatment through PMTCT services and disbursement of soft loans to women who are affected and infected by HIV AND AIDS has improved timely access to the much needed services and most importantly reduced poverty among the project beneficiaries in Bangwe and Limbe. The coalition has been effective through beneficial networking. HIV test kits and accessories are supplied by the coalition members. There has also been tremendous technical support from senior officials from the HIV and AIDS Unit and ART Department of the Ministry of Health and Population. This has created effective Quality Assurance, Quality Control (QC) and standardisation in HIV and AIDS service delivery in the project clinics.

The capacity of project staff members has been strengthened through the training workshops that in turn result in project staff effectively providing quality services to the public. Awareness campaigns on HIV and AIDS, the rights of PLHIV and stigma and discrimination (S&D) against PLHIV especially, during World AIDS Day and International AIDS Candlelight Memorial, have aided the growth of the programme.

Among the many objectives of the project is the enhancing of equitable access to HIV Counselling, Testing and CD4, Count Testing services at Bangwe and Limbe. Through the counselling, testing and treatment services, pregnant women and girls who test HIV positive are placed on Prevention from Mother to Child Transmission (PMTCT) treatment. Secondly, as the project aims to strengthen equitable access to Treatment, Care and Support services to People Living with HIV AND AIDS [PLHIV] and economic empowerment among the vulnerable women living with HIV AND AIDS (WLHIV). The projects sets to re-enforce the Zero HIV related death by reducing the deaths in their immediate community.

Source: SADC Protocol @ Work Summit, Malawi, 2015

Protocol @ work

[30] http://www.aidsmap.com/South-Africa-Lower-coverage-of-maternal-HIV-testing-among-adolescents-leading-to-higher-mother-to-child-transmission/page/2981306/
[31] UNICEF, 2012, Factsheets on the status of national PMTCT responses in the most affected countries.

In Zambia, it is mandatory for every pregnant woman to undergo HIV testing so that if she is positive, she can quickly start treatment to reduce the chance of infecting the baby. Between 2009 and 2011, Zambia saw a 55% decline in the number of new paediatric HIV infections - from 21 000 to 9500. Meanwhile, 86% of pregnant women living with HIV received efficacious ARVs for PMTCT in 2011, up from 58% in 2009. Zambia has also adopted WHO Option B+.

Medical male circumcision

Several SADC countries have taken steps to scale-up Voluntary Medical Male Circumcision (VMMC) for HIV prevention. This has the potential to prevent an estimated one in five new HIV infections in Southern Africa by 2025. Though the unit cost is low and it is a once off rather than a recurring expense, substantial initial investment is required in human resource development. However, member states have generally allocated fewer resources toward the service and progress to date has been slow. While evidence suggests VMMC provides 60% protection from HIV infection for men, there is need for more awareness creation around other benefits of circumcision, including reduction of other sexually transmitted infections (STIs), penile cancer, and protection for women and girls from cervical cancer. There is also need for clear messaging to dispel the notion of VMMC as a once off solution or prevention measure. Men still need to use condoms and abstain from risky sexual behaviour.

The **Tanzania** National Strategy on Voluntary Medical Male Circumcision had targeted to circumcise 2,800,000 adult males in 12 priority regions by 2015, but the program has managed to circumcise only 415,398 (15 %) up to December 2012. This intervention will now aim at targeting sexually active men in the non-circumcising and high HIV prevalence regions for short term impact and targeting younger males for long term impact. The regions in target include Rukwa, Mbeya, Iringa, Kagera, Mwanza, Tabora, Shinyanga, Njombe, Geita, Simiyu, Katavi and Rorya district in Mara region.

Continued research into new prevention approaches

There is continued research into new and more effective mechanisms to prevent the transmission of HIV. These include the continued search for a vaccine, with a new trial launched in **South Africa** in 2015.[34] Another method that is being pursued is the search for a microbicide which is a mechanism that would be controlled by women. A current study, in South Africa, Zimbabwe, Malawi and Uganda, is using a vaginal ring which is a soft silicone-rubber ring infused with an anti-HIV drug that is inserted into a woman's vagina once a month and sits on the cervix. The idea of a long-lasting device like the ring is to get round the problem of daily adherence to PrEP (Pre-exposure prophylaxis) pills and microbicide gels that is the main reason for the failure to show efficacy of three out of four large studies of these prevention methods conducted in younger women in southern Africa.[35]

Harm Reduction

In **Mauritius**, where the spread of HIV is primarily due to injecting drug use, the focus is on harm reduction. Specific programmes undertaken since the implementation of harm reduction services on prevention and support for HIV and AIDS has made the following progress:

- Some 5 834 people who are injecting drug-users are under the Methadone Substitution Therapy (MST) programme. Some 17 dispensing units operate throughout the country with three drop centres.
- The Needle Exchange Programme (NEP) has reached more than 5 000 as at June 2013.
- A Biological and Behavioural Surveillance (BBS) survey was carried out among people who inject drugs (PWIDs). Its findings were disseminated to all stakeholders in August 2010. The number of injecting drug users (IDUs) has been revised to around 10 000 in the BBS survey, compared to 17 000 IDUs in a survey carried out in 2004.
- The BBS survey on female sex workers and men having sex with men (MSM) was conducted from July to September 2010.
- A fully-fledged Harm Reduction Unit was set up in January 2010 to prevent the spread of HIV Infection among PWIDs. The unit aims at harmonising the Methadone Substitution Therapy programme and the Needle Exchange Programme to ensure effective coordination and monitoring.

[32] Ibid.
[33] Ibid.
[34] http://www.niaid.nih.gov/news/newsreleases/2015/Pages/HVTN100.aspx
[35] http://www.aidsmap.com/Vaginal-microbicide-ring-study-releases-first-data-on-participants/page/2977742/

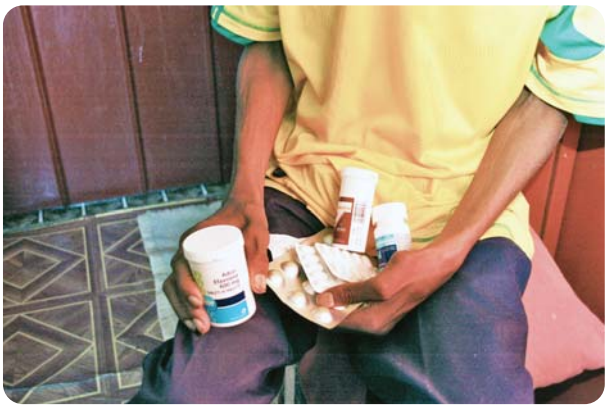
Treatment

The Protocol requires state parties to ensure universal access to HIV and AIDS treatment for infected women, men, boys and girls.

Access to ARVs

Major gains have been made: Some 86% of people living with HIV who know their status in Sub-Saharan Africa are receiving ART, and nearly 76% of them have achieved viral suppression. Six countries in SADC account for 56% of the global population that is on ARVs. These are: 33% South Africa; 5% Zimbabwe; 5% Mozambique; 5% Tanzania; 4% Zambia; and 4% Malawi.[36] South Africa has the highest number of people on HIV treatment - nearly 2.6 million - and has committed to nearly doubling that number in the next few years with a target of 3 million by 2015.

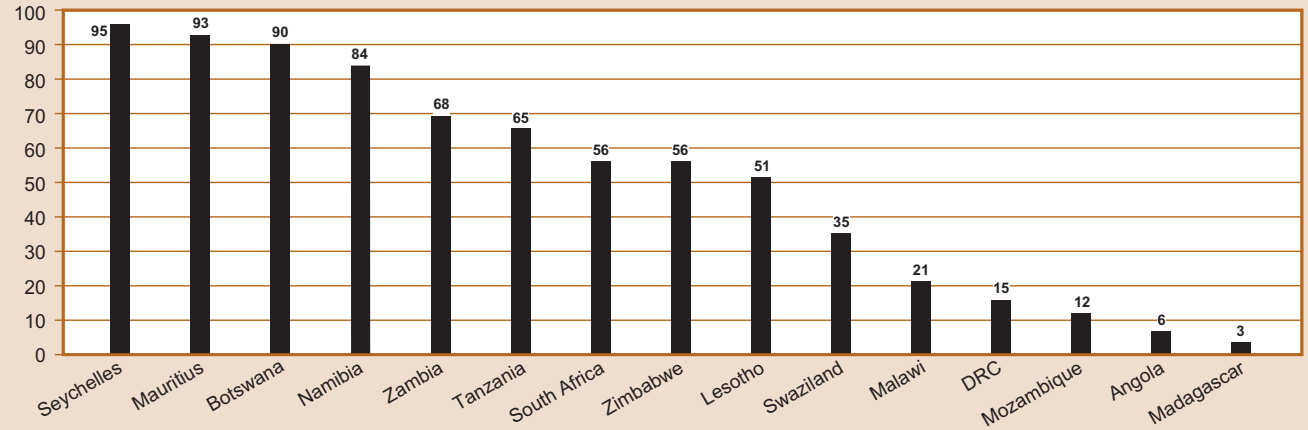
The numbers should be interpreted with care: It is important to recognise that the total number of people living with HIV has increased in this time and also that guidelines for treatment have raised the CD4 level at which treatment should be initiated which has increased the number that are eligible for treatment. Thus, increased percentages reflect very large increases in absolute numbers. Further, slow reporting of data also means that many figures are out of date and the real picture is much better than what is reflected.



An HIV patient holding the life-prolonging ARVs.

Photo by Trevor Davies

Figure 7.7: Percentage of those eligible receiving ARVs



Source: UNAIDS 2012.

There are still major differences between countries: Figure 7.7 illustrates that while there have been vast improvements in access to ARVs, there is still a long way to go. This is especially true in Angola and Madagascar, which respectively only provide ARVs to 6% and 3% of HIV positive citizens. Meanwhile, Seychelles and Mauritius have done much better at 95% and 93% respectively.

[36] http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf accessed 18 July, 2014.

Table 7.5: Comparison of ARV access 2009 to 2015					
Country	2009	2015	% change	Target	Variance
Seychelles		95		100	5
Mauritius	12	93	81	100	7
Botswana	31	90	59	100	10
Namibia	68	84	16	100	16
Zambia	25	68	43	100	32
Tanzania	14	65	51	100	35
South Africa	21	56	35	100	44
Zimbabwe	41	56	15	100	44
Lesotho	22	51	29	100	49
Swaziland	35	35	0	100	65
Malawi	21	21	0	100	79
DRC	15	15	0	100	85
Mozambique	12	12	0	100	88
Angola	5	6	1	100	94
Madagascar	3	3	0	100	97

Source: Gender Links 2009 and 2015.

Table 7.5 shows how much progress has been achieved between 2007 and 2015. Seychelles, Mauritius and Botswana have made the most rapid strides in achieving the target of full coverage, and are all within ten percentage points of achieving it. Angola and Madagascar have made the least progress, and are the only SADC countries where ARV coverage is less than 10%. Eight countries have now achieved over 50% of the target. There is little sex-disaggregated data on the uptake of ART but it is clear that gaps and challenges remain across the SADC region, with women more likely than men to avail themselves of treatment as they generally have much greater interaction with health services than men.

The Ministry of Social Integration in **Angola** is helping orphans and street kids access medication. Research in 2003 showed that 15% of all orphans in the country had lost their parents to HIV and AIDS. In partnership with UNICEF and other NGOs the government is raising awareness of orphans living with HIV and AIDS. In 2004 a law to protect people living with AIDS gives them the right to work, access to free medication and confidential assistance whenever they need it. The government is responsible for providing treatment but it still needs to implement monitoring and evaluation measures for the abuse of these rights especially when it comes to housing. In rural areas most of the women are illiterate, don't have access to transport and have to attend to other matters such as house hold chores and looking after children therefore they don't have time to go to hospitals for their medicine. More efforts must be made by the government to improve the situation and make it easier for women to have access to medication as they are more socially and psychologically vulnerable than men.

In 2002, **Botswana** became the first country in the region to offer free antiretroviral drugs to citizens who needed them. Until recently, neither refugees nor immigrants had access to free ART. However, the Red Cross now provides communities in refugee camps with ART.

In **Mauritius** all HIV-positive people can receive ART for free. In addition, all HIV-positive pregnant women can receive PMTCT to prevent HIV transmission to their unborn children.

The ART programme in **Malawi** has become one of the most important priorities of the national response with an increasing number of people receiving ARVs annually. In December 2013, the total number of patients alive on ART stood at 472 865, with 102 586 initiated in the year 2013 alone. Using the CD4 cell count of ≤350 as a threshold for determining eligibility to ART, researchers estimate that, by the end of December 2013, ART coverage in Malawi stood at 83%, up from 65% in 2012. Statistics indicate that more women access ARVs than men do: 61% and 39% respectively. There has been evidence of some improvements in mortality and morbidity rates of HIV infected people. The survival outcomes are around 80%, however, this is still below the 85% WHO target.

High Court orders Botswana to provide foreign inmates with ARVs
By Godfrey Ganetsang

High Court Judge Bengbame Sechele on Friday ordered the government of Botswana to provide non-citizen inmates with Highly Active Anti-Retroviral Treatment (HAART). Delivering judgment in a case in which two Zimbabwean inmates, Dickson Tapela and Mbuso Piye, together with Botswana Network on Ethics Law and HIV-AIDS (BONELA) had brought a constitutional challenge against a decision by the government of Botswana not to provide them with ARV treatment, Justice Sechele said: "Such a decision was a violation of the applicants' constitutional right to life as guaranteed by sections 3, 4, 7 and 15 of the Constitution of Botswana." The Judge added that:

- AIDS on its own is not an ailment but a conglomeration of opportunistic infections that descend on an HIV-infected person, whose immunity has been compromised, adding that the savingram only excludes foreign inmates whose condition has deteriorated to the clinical stages known as AIDS and not necessarily those who are HIV positive.
- The state's savingram of 26 March 2004, which sought to exclude non-citizen inmates from HAART, was irrational and invalid.
- Withholding HAART from non-citizen inmates would enable their HIV to replicate and thereby relegate them to the terminal stage known as AIDS.
- HAART is not only a medical necessity, but a lifesaving therapy, the withholding of which will take away a constitutionally guaranteed right to life.
- Constitutional challenges are matters of high importance, and the court will be less inclined in matters such as this to lay emphasis on technical inelegance. A party who seeks shelter under the sanctuary of the Constitution should not be turned away lightly.

Photo by Zotonantenaina Razanandrateta

- The state failed to provide evidence of a report from a medical officer from the prisons department detailing his findings on the circumstances connected with treatment of the applicants or any information that could support their argument that provision of HAART to non-citizen inmates will place an undue strain on the state's budget.
- The state failed to provide information on the number of non-citizen inmates who require HAART enrolment and the costs associated with such enrolment as well as information that could juxtapose the costs of providing HAART to that of treating recurrent opportunistic infections on non-citizen inmates.
- The moral argument raised by the state to the effect that the foreign inmates were convicted criminals who should not benefit from their crimes by enjoying free HAART treatment at the expense of those they have wronged had no basis as incarceration and deprivation of liberty is all that was subtracted from the Constitutional rights of these people.
- The presidential directive on which the decision to exclude foreign inmates from HAART was based was never put before him. The state attorneys produced a savingram from government confirming approval of the provision of free treatment to non-citizen inmates suffering from ailments other than AIDS.
- Punishment in the form of imprisonment equaliss all inmates regardless of their status and place of origin. It is impermissible for the state to indirectly extend the limits of punishment by withholding certain services to which inmates are lawfully entitled on account of their status as convicted non-citizen inmates.
- The assertion that they should not be granted treatment because they are convicted criminals also casts aspersions on the state's position that treatment was withheld because of lack of resources.
- The deprivation of HAART treatment to non-citizen inmates runs counter to the letter and spirit of section 4 of the constitution and is unlawful. It would be wrong for Botswana's courts to interpret legislation in a manner that conflicts with the international obligations that the country has undertaken.
- The non-treatment of foreign inmates poses a danger to the very citizen inmates that the state is trying so hard to protect because upon contracting opportunistic infections the costs of treatment will be escalated. It can never be in the public interest nor can it ever be reasonably justifiable in a democratic society that provision of life saving medication like HAART is withheld with the ultimate result that the group of people so deprived become more infections to others or die in our hands. The actions of the state in so far as they deny non-citizen inmates access to HAART enrolment is unlawful.

Source: (Botswana) Sunday Standard: 25 August 2014)

Protocol @ work

Namibia has made significant progress in the provision of ART services. In 2003 about 2% of the people in need of the treatment received it. By 2011 69%, and by the end of March 2012, 82% of the population in need received ART services. Out of all people who got the antiretroviral treatment 70.3% were alive on ART at the end of March 2012.

South Africa has rapidly scaled up its ART programme, which is the largest in the world. Close to two million South Africans have accessed treatment to date, compared to one million in 2009. Legislators hope that three million will be receiving treatment by 2015.

Swaziland's antiretroviral drugs are 100% domestically funded, which means that the treatment programme is less reliant on international donors and more sustainable. Despite notable improvements in making treatment more accessible, these gains have been felt more by adults living with HIV. Access to treatment for children continues to be inadequate, with only 54% of children eligible for treatment receiving it in 2012.

Saving lives

A lower rate of deaths from AIDS-related illnesses is transforming societies: More people have regained their health and returned to work or to taking care of their families. The region now sees fewer funerals; less time is spent caring for the ill and more time is spent on productive activities. In 2013 1.1 million people died of AIDS related causes, a decline of 39% since 2005.[37] South Africa reduced the number of deaths between 2005 and 2011 by 27%, or approximately 100 000 deaths.[38] Botswana, meanwhile, saw the largest per capita reduction at 71%. Even with the impressive reduction in deaths, six countries in SADC still accounted for a combined total of 32% of the deaths due to HIV and AIDS globally in 2013: 13% South Africa; 5% Mozambique; 5% Tanzania; 4% Zimbabwe; 3% Malawi and 2% Democratic Republic of the Congo.[39]

New evidence from the international randomisd Strategic Timing of Antiretroviral Therapy (START) programme suggests that treatment outcomes are improved by early initiation of ART, the test and treat model, where those that test positive for HIV are immediately initiated into treatment, rather than waiting until their CD4 count falls below 350 as is current practice.[40] There is therefore impetus to increase the numbers that are on treatment even further. This will require much more engagement at community level in much expanded testing, support for adherence to treatment and resupply of antiretroviral medication.

Challenges to expanding treatment

Overstretched and understaffed health systems in the region face many challenges as they struggle to further expand treatment programmes. Some of these include:

- Retaining patients in treatment.
- HIV stigma and discrimination still prevent those that need care and treatment from accessing it and adhering to it. This is parti-cularly true for marginalised groups that are the subject to other forms of stigma such as people with disabilities, sex workers, LGBTI, prisoners and refugees.
- Side effects of the ARVs, including fat deposits, which contribute to stigma.
- Poor data availability and management, both crucial to keep growing numbers of patients in the system.
- Reliance on external funding for treatment programmes. Very few countries in the region can fund their own programmes. However, there is growing commitment to mobilise domestic funds and much greater emphasis on prudent management of available funds.
- Infrastructural capacity, especially laboratories, and few ART sites, meaning that clients must travel long distances to access their medication
- Skills shortages of health personnel. A response in the region has been task shifting so that nurses and other personnel take on more responsibility. South Africa, for instance, has trained over 10 000 professional nurses specifically for ART roll out in the Nurse Initiated Management of ART (NIMART).
- The cost of ARVs, especially second and third line regimens, which will become needed as treatment programmes mature.
- Reaching more men earlier and keeping them in care and treatment.
- Improving treatment for children. Botswana and Namibia have met their goal of 80% of eligible children on treatment and South Africa and Swaziland have been able to get more than 50% of eligible children on treatment. However, few countries provide

[37] UNAIDS. Global Fact Sheet, 2014.
[38] UNAIDS 2012 World AIDS Day Report: Results.
[39] http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf accessed 18 July, 2014.
[40] UNAIDS. 2015. Implications of the Start Study Data.

treatment to more than three out of 10 children who need it.
- The numbers of new HIV infections is increasing at a rate that outpaces treatment: for every two people enrolled in HIV treatment, five become newly infected.
- Pervasive trust in traditional healers rather than Western medicine, leading often to delays in seeking care.

These challenges require continued and expanded emphasis on and investment in community mobiliation. Winning the battle against HIV requires a whole package of wellness, stigma reduction, opportunistic infections management, ART, and nutrition in addition to medication.

Post Exposure Prophylaxis (PEP) is provided for in policies but not easily accessible: UNAIDS and UNIFEM reports recognise gender-based violence (GBV) as one of the leading factors in HIV infection, usually due to lacerations and other trauma. Treatment can help to reduce the likelihood of infection after sexual violence and is an important factor in caring for women and girls who have been sexually abused. Twelve SADC countries (excluding Angola, Lesotho and Zimbabwe) have policies requiring that health facilities administer PEP after a sexual assault and 13 countries have policies aimed at preventing sexually transmitted infection after sexual assault.

Photo by Trevor Davies

The risk of tuberculosis and HIV co-infection remains high: Sub-Saharan Africa accounts for 80% of the global number of people living with both TB and HIV. The region has made major strides to reduce TB deaths, which include:
- Intensified TB case-finding: everyone that is enrolled in HIV care should be screened routinely for TB;
- Isoniazid preventive therapy for those without active TB;
- Infection control for TB in all HIV care facilities to prevent the spread of TB;
- Initiating ART early, regardless of CD4 count, for those with active TB.

There has been some progress in controlling co-infection: In 2011, ten countries (Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe) tested 76% of TB patients for HIV. However, there is a need to intensify these efforts to further reduce deaths. TB-related deaths among people living with HIV had declined by 36% worldwide between 2004 and 2012. WHO estimates that scaling up collaborative HIV and TB activities prevented about 1.3 million people from dying between 2005 and 2012. More people with TB are now receiving ART. Ten countries represent more than 80% of the global number of notified HIV positive people with TB receiving ART. Six of these - South Africa, Mozambique, Tanzania, Zimbabwe, Zambia and Malawi, are in SADC.

HIV and cervical cancer co-infection is common: Co-infection of HIV with the human papilloma virus (HPV), which causes cervical cancer, is common. The two viruses have similar risk factors and both can be sexually transmitted. Progression of human papillomavirus infection to early cervical cancer is much more common in women living with HIV. A number of initiatives, such as the Forum of African First Ladies against Breast and Cervical Cancer have spearheaded efforts to expand access to cervical cancer screening through integrating cervical cancer screening and responses into HIV services and plans. There are promising moves to introduce and rapidly roll out a vaccine against HPV to school going age girls. The incidence of cervical and breast cancer is increasing and is becoming more common in younger women. It is anticipated that cervical and breast cancer will be the leading causes of death in women in the region by 2025.

Swaziland: For a stigma-free generation

Thembi Manana of Mandlangempisi in the Hhohho region has been living with HIV for ten years. Every day she takes a positive step towards life, never defaulting on her antiretroviral treatment. With life in her step, she provides home-based care in her community - going from house to house - urging people to get tested, counselling and caring for others living with HIV and related illnesses. As a rural health motivator or *umgcugcuteli*, the Ministry of Health incentivises her important work by paying her an allowance of E300.

Manana (47), lives openly with HIV. She got tested in 2004 after a friend living with HIV told her to get tested. It took bravery and courage, but she refused to live in denial. Coupled with a series of counselling sessions, she began taking anti-retroviral treatment. Although she is living a healthy positive life, after coming out publicly with her status, she has had to endure daily stress, abuse and discrimination due to the persistent stigma of HIV. For her, living with the virus has not been as difficult as living with the stigma.

When Manana disclosed her status to her partner and father of her children, in spite of their long relationship and having lived together for years, he refused to support and accept her status, and deserted her. Even her family treated her with scorn and accused her of promiscuity.

"When I talked about it, people thought I had gone crazy. Some women said I would steal their men and infect them with HIV. Others did not believe me when I shared my status with them, because I did not show any symptoms," explains Manana.

Manana maintains that while people are entitled to their beliefs, HIV is a reality and everyone should know their status. Although many people do get tested, many also do not speak out due to the discrimination and stigma. She says that people do not even tell their intimate partners out of fear and rejection. Unfortunately this only perpetuates the stigma and also fuels the spread of HIV.

Sadly, this stigma has also led people to believe the untruth that there is no life being HIV positive. The truth is HIV is a very manageable disease. As Manana demonstrates, with the correct treatment and a healthy lifestyle, people can live a long life.

Source: http://www.genderlinks.org.za/article/swaziland-for-a-stigma-free-generation-2014-10-01

Care work

The Protocol requires member states to develop and implement policies and programmes to ensure the appropriate recognition of the work carried out by caregivers; the majority of whom are women, to allocate resources and psychological support for care givers as well as promote the involvement of men in the care and support of People Living with AIDS.

Nomcebo Manzini, former head of UN Women Southern Africa Regional Office (UN Women SARO) writes in the foreword to the guidebook *Why should we care about unpaid care work* that: "Unpaid care work is a major contributing factor to gender inequality and women's poverty. The assumption that unpaid work is elastic and valueless is a major concern to women. Feminist and gender analysts have consistently called for a thorough analysis of the implications of excluding unpaid work on women's time, opportunities and economic growth and development in general. The amount and intensity of unpaid care work in Southern Africa has been exacerbated by the HIV and AIDS pandemic."[41]

For two decades, HIV led almost inevitably to AIDS, which is a cocktail of many opportunistic infections - diarrhoea, thrush, TB, cervical cancer, pneumonia, shingles, meningitis and others. For many it was a slow "wasting away", with some days and even weeks or months better than others.

[41] http://www.sarpn.org/documents/d0000919/P1017-Unpaid_Care_Work.pdf

Photo courtesy of http://www.afronline.org/wp-content/uploads/2010/11/childaids.jpg

In many SADC countries, the high morbidity and mortality from HIV and AIDS placed significant demands on already under-resourced health care services. Formal health care systems in these countries had not recovered from the health sector reforms and structural adjustment programmes of the mid-1990s. HIV-positive people occupied a significant proportion of hospital beds in most SADC countries.

The long term and progressive nature of HIV and AIDS meant that the health care needs of those infected changed over time from basic clinical treatment of opportunistic infections to day-to-day palliative care and support. HIV-positive people can be healthy for years before succumbing to illness and death. The health infrastructure could not provide palliative care to so many thousands of very ill people, most with little hope of recovery. In many cases this care was transferred to the family and community, primarily undertaken by women and girls.

The elderly and children provided care as a generation of able-bodied men and women were decimated by the unrelenting progression of HIV across whole communities. Caring for an AIDS patient can increase the workload of a family caretaker by one third. This is a burden in any family but particularly onerous for the poor, who already spend much of their day earning a subsistence living. A rural woman interviewed in Southern Africa estimated that it took 24 buckets of water a day, fetched by hand, to care for a family member ill with AIDS - water to wash the clothes, the sheets and the patient after regular bouts of diarrhoea.

Driven almost entirely by a strong sense of duty and compassion, a "rag tag" army of community caregivers who provide support to their neighbours and kin, sprang up across the region. Community and home-based care (C&HBC) programmes remain popular in Southern Africa and are renowned for their ability to provide a continuum of care for the chronically ill, the affected children and older people, in their homes in a relatively cost effective, sustainable and comprehensive manner that complements institutional care. The C&HBC model, driven by community volunteers, enhances the capacity of families and communities to offer affordable quality care for vulnerable people.

Botswana: Association for Psychosocial Rehabilitation provides a circle of care

The Botswana Association for Psychosocial Rehabilitation (BAPR) is a well-established organisation that has developed the necessary human and physical resources needed by families living with or affected by HIV. BAPR has effective counselling workshops that include alcohol, drug and all forms of physical, psychological, and sexual abuse that increase the rate of HIV in the population of Lobatse. BAPR works hand in hand with government officials, clinics, hospitals, social services, schools, Court Presidents and the business community in Lobatse.

Key objectives include to:

- Improve the quality of life of Orphans and Vulnerable Children (OVCs), their families, caregivers and people infected or affected by HIV and AIDS, GBV, stigma and discrimination.
- Provide integrated services and support to people, families and communities living and/or affected with HIV and AIDS, GBV, mental illness and substance abuse.
- Establish and conduct ongoing sessions for established support groups and empower them with skills to provide services, income generating and nutritional development projects to people and OVC's infected or affected by HIV in their communities.

Key activities include psychosocial rehabilitation; HIV and AID support; substance abuse prevention; GBV (sexual, mental physical and emotional abuse) prevention; daily door to door visits to clients; training primary care providers of the people with HIV AND AIDS and mentally challenged; training home based care workers and lay counsellors in psychosocial rehabilitation; providing OVCs with meals, counselling, life skills development and school-work assistance; referrals and advocacy; income generating Horticulture Project and Integrated Childhood development services (IECD).

BAPR has consistently struggled with funding and personnel challenges since 2005 but it has continued to provide service to its clients. The funding challenges have forced some committed staff and volunteers to seek employment elsewhere and the few who remain are receiving half-salaries or no salaries at all.

Source: SADC Gender Protocol@WorkSummit, Botswana 2015

Protocol @ work

A 2009 study conducted by the Voluntary Services Overseas Regional AIDS Initiative for Southern Africa (VSO-RAISA) and the World Health Organization (WHO), showed that women and girls comprised up to 80% of volunteer care providers in C&HBC programmes due to the division of labour based on traditional gender roles and the perception of volunteering and non-economic activities. First, the conventional division of gender roles in societies assigns the role of care provider to women. Society views women and girls as mothers, housewives and care providers. Secondly (and related to the first point), care provision is often seen as informal, voluntary work and not necessarily considered a formal economic activity.[42]

The study found that care providers have unregulated working conditions. Legal frameworks to protect their rights were non-existent or weak and organisations that use volunteers neglect their responsibilities and obligations towards them. The volunteers remain unrecognised, overwhelmed by work, psychologically burdened by others' problems and inadequately supported. In short, they were in dire need of assistance.

HIV and AIDS has been an emergency and care providers have provided a service in resource limited settings under extremely difficult conditions. Most become worse-off economically because of care giving.[43] Care providers therefore expect some financial or material compensation for their services, as their patients also expect a lot from them. WHO has stated that "there exists virtually no evidence that volunteerism can be sustained for long periods: as a rule, community health workers are poor and expect and require an income".[44]

Care work in the time of ART

As treatment has rapidly become more available across the region, the health care system was once again able to provide care to those living with HIV. Caregivers, who shouldered the weight of the morbidity, mortality and despondency associated with AIDS in the difficult times before treatment, have been largely side-lined in this roll out. However, as the programme seeks to expand, it is now widely acknowledged that the formal health sector alone cannot achieve this and that there is vital community mobilisation and outreach needs for the expansion to succeed.[45]

It is therefore critical to consider the potential role of community and home-based caregivers in the future. Some areas in which caregivers will continue to be needed are:

Ongoing engagement in the HIV continuum of care, including provision of psychosocial support; awareness raising for all forms of prevention, including PMTCT; treatment readiness and continuing support for treatment adherence; as well as community mobilisation to decrease stigma. Services undertaken by care providers may be classified in three categories: prevention, treatment and support. Table 7.7 details the types of activities included in each area.

Table 7.6: Services undertaken by care providers[46]

Prevention	Treatment	Support
• Condom distribution • Family planning education • Community education on sexually transmitted infections • Infant feeding guidance • Education on infection prevention and control • Awareness raising with populations that are being left behind - adolescents, men, older people • Community education on HIV testing • Counselling for HIV testing • Home testing • Education on anti-retroviral treatment • Stigma reduction, especially with regard to people with disability, sex workers and LGBTI.	• Adherence support • Refilling prescriptions • Treatment follow-up • Treatment of minor ailments • Training household members in treatment literacy and adherence • Facilitating referrals of clients to health centres/professionals • Follow up of mothers and their infants that are in the PMTCT programme • Palliative care	• Advice on positive living • Support for orphaned children • Providing psychosocial support to clients and their families • Helping clients to access transport • Physical care • Nursing care • Training household members in care and support • Assisting with household chores • Nutrition support • Referring clients and their families to social services and other agencies • Resource mobilisation

[42] VSORAISA and WHO, 2009.
[43] Ibid.
[44] Lehmann U and Sanders D, "Community health workers: What do we know about them? The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers".. A report by School of Public Health University of the Western Cape. Evidence and Information for Policy, Department of Human Resources for Health. Geneva, 2007.
[45] See for instance, UNAIDS AND MÉDECINS SANS FRONTIÈRES, 2015. Community Based Antiretroviral Therapy Delivery. Experiences of Medecins Sans Frontieres.
[46] VSO-RAISA, WHO Africa (2009) "Scaling up HIV Prevention, Treatment, Care and Support in Community and Home-based Care Programmes and Reducing the Burden of HIV and AIDS Care on Carers in SADC".

Care giving for children:[47] In many Sub-Saharan countries, extended families have assumed responsibility, with little public support,[48] for more than 90% of all double orphans and single orphans not living with the surviving parent.[49] The largest increase in AIDS deaths, orphan hood and vulnerability over the coming years will occur in those countries where extended families' resources are already stretched. As the numbers of orphaned and vulnerable children rise, it becomes increasingly difficult for families to meet the growing need for childcare.[50]

VSO-RAISA argues that scaling up HIV and AIDS services in C&HBC programmes requires fundamental changes on many levels. Recognising the rights of care providers, and providing a supportive environment for them to provide quality care, is a fundamental entry point to addressing this challenge.

The responsibility for making these fundamental policy changes rests with those who hold power and have a duty to respect, protect, promote and fulfil the rights of care providers - national governments, donors, civil society and other key players involved in the fight against HIV and AIDS. It is now time to recognise the contributions of community volunteers in the fight against HIV and AIDS, and to support and empower them to understand and claim their rights.[51]

Care work policy and legislation

In 2010, inspired by Article 27(c) of the SADC Protocol on Gender and Development (THE PROTOCOL) and Gender and Media Southern Africa (GEMSA), VSO-RAISA developed the *Making Care Work Count Policy Handbook.*

The objectives of the handbook include influencing the development, adoption, implementation and enforcement of policy frameworks that promote the recognition and support of care providers in the context of HIV and AIDS, and to promote public engagement on care work related issues. The handbook proposes six principles that need to inform care work policies:

- **Remuneration:** People doing the work of government have a right to be financially rewarded.
- **Logistic and material support:** It is imperative that care providers have access to care kits as well as other support, such as uniforms for identification, bicycles, food packs, monthly monetary allowances, soap, free medical treatment, and financial support for income generating projects, raincoats, umbrellas, agricultural inputs, stationery and transport allowances, among others, to provide quality care.
- **Training and professional recognition:** Protocols of training and accreditation should be developed through a governing body within the region to regulate and standardise the training.
- **Psychosocial support:** Care for care providers should be prioritised with psychosocial support programmes developed and provided.
- **Gender equality:** The gender dimensions of HIV and care work should be recognised and catered for.
- **Public private partnerships:** There is a need to advocate for stronger public private partnerships in the delivery of PHC services through C&HBC programmes.

Summary: Men care: Takunda Chesa is founder of Voice of Children Care in Chegutu, Zimbabwe. *Photo by Colleen Lowe Morna*

A number of SADC countries have developed Care Work policies or at least guidelines on care work, notably Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe

There has been some progress, but more work is needed on policies: Work in advocating for policies on Care Work needs to take account of the massive

[47] http://www.unicef.org/publications/files/Africas_Orphaned_and_Vulnerable_Generations_Children_Affected_by_AIDS.pdf
[48] United States Agency for International Development, et. al., Coverage of selected services for HIV AND AIDS prevention, care and support in low and middle income countries in 2003, Policy Project, USAID, Washington, D.C., June 2004. p. v. Note: Coverage levels presented in this source are based on reports available from governments and larger organizations. The report notes that "Statistics available on support for orphans and vulnerable children probably understate the true amount of support provided since many small community groups provide support to small numbers of children without outside donor support so their statistics are often not reported to the central level." See also Tanzania Commission for AIDS, National Bureau of Statistics and ORC Macro, Tanzania AIDS Indicator Survey 2003-04, TACAIDS, NBS and ORC Macro, Calverton, Maryland, USA, 2005, p. 16
[49] Monasch, Roeland, and J. Ties Boerma,'Orphanhood and childcare patterns in sub-Saharan Africa: An analysis of national surveys from 40 countries', AIDS, vol. 18, suppl. 2, 2004, pp. S55-S65.
[50] Foster, Geoff, 'The capacity of the extended family safety net for orphans in Africa', Psychology, Health & Medicine, vol. 5, no. 1, 2000, pp. 55-62
[51] http://www.vosesa.org.za/sadcconference/papers/7.pdf

shift that has occurred in the HIV field and encourage retraining and recognition of the vital role that these women and men have played and continue to play in their communities.

Care work campaigns take root at the local level: Although progress is slow at the national level, an important development over the last year is the extent to which care work campaigns have taken root at the local level. Gender Links has incorporated a care work module into the training and action plans of the 400 Centres of Excellence for Gender in Local Government in ten SADC countries. This is leading to greater in-kind support and/or remuneration at these levels.

Remuneration of care workers is a key priority: Different countries offer different models for paying care workers. There is no standardised approach that is regulated in care work policy and legislation or labour law.

There needs to be a cohesive government response to training and retraining care workers: Policies should be clear about criteria for trainees, standardised content and a decentralisation strategy so that people away from urban centres have access to training opportunities. Care workers require retraining to equip them for new roles in an era of ART.

Men need to be encouraged to get involved as care givers: The previously held assumption that men cannot be involved in care work is gradually changing, but more effort is needed on this front and more men must assume this responsibility.

Protocol @ Work

Tanzania: A holistic approach to treatment and care

Grassroots Female Communicators Association (GRAFCA) in Tanzania is partnering with community based organisations in Kilagano Ward to provide training workshop on HIV and AIDS stigma reduction, response and prevention.

Community Based care project programme Tanzania.
Photo courtesy of www.pathfinder.org

By May 2015, 76 women, 39 men, and four children (all boys) have been diagnosed as HIV positive. All of them have been registered at Mgazini Dispensary, the only reliable health facility in the community. At the dispensary, they are served with ARVs and special energy powder as well as counselling sessions earmarked for them. The sessions have included family and primary care givers training as a response to AIDS and everyday care for a diagnosed loved one. "I wish this project could have come earlier, many of our loved one's could have survived," noted Batholomew Mkanula, the Kilagano Ward Councillor.

In the past, the communities from Kilagano Ward were examined and treated at the Mission Hospital Peramiho which is about 40 kilometres from Mgazini village. However, when the Task Force started visits and talking to the communities on the importance of taking HIV and AIDS tests, the community responded well. 119 people tested positive. Unlike the past, several now receive counselling on HIV and AIDS. Premature deaths have been reduced. The sick get medication and care givers training on how to administer care.

The workshop's curriculum is governed by community-based programmes training on delivering better care and support for people with HIV and AIDS administered to and with local leaders as well as families affected by HIV and AIDS. The project links religious leaders, village leaders, dispensary health workers and doctors. Emphasis is made on the ways in which care givers can and must continue to be part of the AIDS response. The group conducts workshops on Sundays and public holidays as these are the times when community people can take a break from their farm activities.

Source: SADC Protocol @ Work Summit, Tanzania 2015

SGP Post-2015

UNAIDS is challenging the world to set targets to stop HIV infections for an AIDS free generation. UNAIDS is targeting 90% of tested and HIV positive people to be initiated on ART and targeting 90% of those on treatment with viral suppression by 2020 with these percentages rising to 95% by 2030. These targets may be ambitious, but the target of zero new infections through maternal to child transmission is certainly attainable.

SADC needs to lead the way in this regard. South Africa is showing the rest of the region that it is possible to rapidly increase the numbers on treatment. South Africa has set a goal of more than 4.5 million on treatment. To achieve this, the country is planning to test at least eight to nine million people per year. The Minister of Health says he is often asked if the country can afford such a massive treatment roll-out to which he responds, "Can we afford not to?"[52]

SADC countries need to continue to build on gains made in tackling HIV and AIDS: The intensified global and national efforts to expand access to a continuum of care from prevention, through treatment, care and support is beginning to turn the course of the HIV pandemic. It is important that governments continue to allocate budgets to fund HIV prevention, treatment and care programmes. Zimbabwe, for instance, has an AIDS levy on all income tax which provides a "home-grown fund" for treatment and other support.

Policies have been developed within the region but there is need to analyse these to determine to what extent the policies address gender issues and to monitor implementation to ensure that the gender issues are indeed receiving sufficient attention. Post-2015, these HIV and AIDS policies must be finalised, adopted and rolled out.

Renewed emphasis on prevention: SADC cannot win the fight against HIV by treatment alone. Treatment must be accompanied by increased and continued attention to prevention to reduce new infections. This includes both traditional prevention methods as well as the continued quest for a vaccine.

Focus more attention on adolescents (15 - 24): HIV is now the leading cause of death in adolescents in Africa.[53] Most adolescents do not know their status and thus are not accessing treatment. The world cannot reach zero new infections without paying specific attention to adolescents. In SADC there is need to focus on young girls specifically. The Post-2015 the Protocol, must include targets and indicators specific to prevention, treatment and support of adolescent girls. Mainstreaming age appropriate sex education and comprehensive HIV knowledge in primary and secondary school curricula should be a priority for Post-2015. In addition, women and girls will be less vulnerable to HIV and AIDS, and its effects if gender equality in other thematic areas is achieved.

Production of ARVs on the continent: SADC is dependent on ARVs which are produced in other regions of the world. A critical part of the expanded treatment programme must be production of these lifesaving drugs in Africa.

World AIDS Day vigil in Mauritius 2013. *Photo: Gender Links*

Investing in integrated and holistic programmes which include social benefits or and skills development to improve HIV and sexual and reproductive health outcomes, has been shown to work. The post-2015 agenda must advocate more holistic and inclusive approaches in prevention, treatment and care, to ensure all people and vulnerable groups are targeted, reached and their specific needs are also prioritised.

[52] Dr. A. Motsoaledi, Presentation to the International AIDS Conference, July 19, 2014
[53] World Health Organization, Health for the World's Adolescents: A second chance for the second decade, WHO, Geneva, 2014.

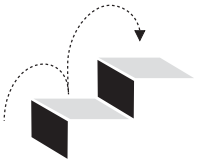
Tackle stigma, increase testing and treatment among key populations: SADC has generally done well in promoting and conducting testing, but more needs to be done to target sex workers, men who sleep with men and women who sleep with women, people who inject drugs, prisoners and migrants. With high HIV prevalence in these communities it is crucial to build on interventions that reduce stigma and provide medical and other services to these groups. The Post-2015 agenda, must ensure they are involved in the design, implementation and monitoring of the programmes. In doing so, testing 90% of the population by 2030 is possible and will help ensure reduction in new infections and AIDS-related deaths. The Post-2015 Protocol must include time-bound targets for continual increase of treatment coverage to ensure that treatment and prevention, outpaces the rate of infection. At least 90% of those that are eligible for treatment should access it by 2020 and 95% by 2030.

Elimination of mother to child transmission of HIV: Roll out and coverage of PMTCT across the region has increased but gaps persist. Post-2015 agenda should up the target to ensure 100% pregnant mothers tested for HIV and 90% of those that test positive start treatment. Governments must adopt the 2013 WHO guidelines on antiretroviral therapy and improving service delivery; and integrate maternal and child health and paediatric HIV treatment and other care services, so that women and their children receive care from the same providers during a single visit. SADC countries also need to pay attention to the other pillars of PMTCT - prevention of new HIV infections in mothers and girls who will become mothers as well as increasing provision of family planning for all women, including those living with HIV. To eliminate transmission from mothers to babies SADC countries also need to improve follow up of mothers and ensure that they continue to take ARVs, at least as long their babies are breast feeding.

It is time to move from draft policies and guidelines to adopting policies and legislation to regulate care work: The policy work undertaken so far demonstrates the importance of such initiatives in placing a specific focus on care work in the context of the Protocol. Although strides are being made, women still bear the brunt of community level work and are still under-resourced, poorly trained and undercompensated. Ongoing engagement between parliamentarians and civil society is a very important to ensure that policies are not only gender-sensitive, but also move from drafts to adoption. Where policies are in draft they need to finalised, taking into account changes in the HIV landscape, adopted and implemented.

Other steps that need to be prioritised Post-2015, particularly in relation to care work are:

- ***Greater engagement of care providers in the development process:*** The importance of active engagement of care providers in national processes to review and/or develop C&HBC policies is critical. A regional care providers' network needs to be established.
- ***Expansion of the scope of care work from HIV and AIDS to all long term illnesses:*** As roll of out ARV's will mean less direct nursing for care workers, there is room to expand the scope that care workers can be equipped to advise on. These can include treatment adherence support and follow up, awareness about screening for cervical and breast cancer as well as hypertension and diabetes. Care givers can be equipped to educate their communities on a variety of illnesses.
- ***Promoting community and local government involvement in care work:*** Full involvement of community members and local governments will not only help in increasing understanding of the work that care givers do, it will also decrease the burden if everyone plays their part.
- ***Cultivating "champions":*** It is important to identify regional "champions" to effectively roll out advocacy initiatives. Engaging influential figures in society - including members of parliament, first ladies and retired presidents such as Kenneth Kaunda and Festus Mogae - is critical in scaling up advocacy initiatives. Such champions can share their experiences and inspire others.
- ***Involving men in C&HBC programmes*** to improve the dissemination of HIV and AIDS information in communities. However, most initiatives have largely focused on recruiting male adults. To ensure sustainability of such community based interventions, it is critical to also mobilise and actively engage male youths.



Next steps

- ***Post-2015:*** Lobby for stronger and improved HIV and AIDS targets and indicators in the reviewed the Protocol, to ensure women and girls' burden is dramatically reduced with zero new infections and universal treatment
- ***SADC countries need to continue to build on gains made in tackling HIV and AIDS, but increase and speed up efforts in the run up to 2030:*** The intensified global and national efforts to expand a continuum of care from prevention, through treatment, care and support is beginning to turn the course of the HIV pandemic. Governments, organisations and community members must avert HIV and AIDS "fatigue." Collaboration between and commitment amongst states must ensure increased investment in HIV prevention, treatment and care.

- ***Tackle stigma associated with men who sleep with men, women who sleep with women, sex workers, prisoners, refugees and injecting drug users:*** With increased HIV prevalence in these communities it is increasingly important to build on interventions that reduce stigma and provide medical and other assistance to these groups.
- ***Move from draft policies and guidelines to adopting policies and legislation to regulate care work:*** The mutual reinforcement of HIV AND AIDS and gender inequality must be recognised and urgently mitigated in policy and in practice. The policy work undertaken so far demonstrates the importance of such initiatives in placing a specific focus on care work in the context of the SADC Protocol on Gender and Development.
- ***Engage with care providers in the development process:*** The importance of active engagement of care providers in national processes to review and/or develop C&HBC policies is critical. SADC should use 2015 to establish a regional care providers' network, to ensure that at least ground work for post-2015 care work policies and initiatives is complete for the post-2015 period.
- ***Expand the scope of care work from terminal HIV and AIDS care to community based awareness and support*** as roll out of ART will mean less direct nursing for care workers, there is room to expand the scope of conditions that care workers can be equipped to advise on. These can include awareness about HIV prevention, TB as well as screening for cervical and breast cancer. Care givers can be equipped to educate and support their communities in community care for those on ARVs as well as on a variety of illnesses.
- ***Promote community and local government involvement in care work:*** Full involvement of community members and local governments will not only help in increasing understanding of the work that care givers do, it will also decrease the burden if everyone plays their part.
- ***Involve men in C&HBC programmes has proven to be effective in reducing the burden of care on women and girls:*** Men are highly mobile and vocal, and their increased participation in C&HBC programmes can help improve the dissemination of HIV and AIDS information in communities. However, most initiatives have largely focused on recruiting male adults. To ensure sustainability of such community based interventions, it is critical to also mobilise and actively engage male youths.
- ***Encourage traditional leaders to help promote change:*** Addressing gender disparities in community care and support and challenging risky cultural and traditional practices and attitudes can be more effective when involving men and traditional leaders. Traditional leaders play an important role in challenging and changing some of the traditional and cultural attitudes, beliefs and practices related to care.
- ***Improve collection and analysis of data*** is critical if we are to end AIDS. All countries need to be able to target their prevention and treatment efforts more effectively to where they will yield the greatest results.
- ***Improve Monitoring and Evaluation systems:*** There is need to define the mechanisms for monitoring and evaluating the implementation of the national care work policies once they have been finalised and approved by governments. Issues to consider include, among others, who will monitor, which tools will be applied, how monitoring will be undertaken, at what frequency, and what would be the role of care providers in the process. It may happen that a good policy is in place but implementation is slow, or that key stakeholders and target groups are not aware of the existence of such a policy.

Photo courtesy of 20x20aids.org