EMBARGOED: 28 NOVEMBER 17:00

# HIV/AIDS in Africa
# Challenges and Opportunities

Dr. Olive Shisana

CEO, Human Sciences Research Council

Co-Chair of Global HIV Prevention Working Group

It is a great privilege for me to come back 10 years after we established SAHARA to be invited to open this conference here in Port Elizabeth.

This year's World AIDS Day focuses on the theme of Getting to Zero:

ZERO NEW HIV INFECTIONS.

ZERO DISCRIMINATION.

ZERO AIDS-RELATED DEATHS

We are entering this decade with the resolve and the hope that we have the means to reduce new infections, to end discrimination and to reduce AIDS-related deaths. Armed with new HIV prevention knowledge, global political commitment to reduce discrimination and available medicines to enable those living with the disease to live long, we feel renewed energy to tackle this epidemic.

## Challenges

The challenge of HIV/AIDS is still with us, given that Africa is still home to 68% of people living with the disease. This is the continent that is plagued by poor health care systems, poverty and is heavily dependent on foreign aid to provide care to those who are affected.

The burden of HIV/AIDS in Sub-Saharan Africa is not even, varying by region. The most severely affected region is Southern Africa, where the majority of people living with the disease reside The country with the highest HIV prevalence, Swaziland where 25.9% of the adult population is HIV positive, belongs to the Southern Africa region. Swaziland has surpassed Botswana, which has diligently implemented HIV prevention interventions and reported decline in incidence.

South Africa continues to home of the largest numbers of people living with HIV. It was in light of this dubious title, that the country embraced the HIV Testing and Counseling campaign that saw more than 14 million of its citizens take part over the past year. It is this kind of collective action with decisive political leadership that HIV upward trend can be reversed. **Age**

Young people, those aged 15-24 years, comprise a sizeable proportion of adults who are HIV positive. Many escape HIV infection, only to be infected once they reach ages 25 years or older. In South Africa, a third of women aged 25 to 29 years are HIV positive, the age where most begin to bear children. Interventions that enable them to bear children without risking HIV are needed and should be implemented vigorously to sustain the gains made in reducingHIV infections in this young population.

**Gender**

Women in Sub-Saharan Africa continue to be disproportionately affected by this disease given that six in ten people living with HIV are women. The power dynamics as well as the biological susceptibility of the female genital tract disadvantage women, thus increasing their vulnerability to HIV. The recent interim findings of the VOICE study that Tenofovir gel does not

protect women against HIV, contradicting earlier CAPRISA-04 study that showed the microbicide to work, is a serious setback to finding effective women controlled methods. We continue to hope that the FACTS 001 study that is still underway will shed more light on the role of Tenofovir in reducing new HIV infections. The hunt for efficacious microbicides must continue until women controlled methods are found.

**Discrimination**

A major challenge that continues to haunt Sub-Saharan Africa is stigma and discrimination against people living with HIV/AIDS, causing those with the disease to fail to take advantage of existing programmes for prevention, care or treatment. Even in death, stigma stalks families, often refusing to disclose the HIV status of their diseased member.

Groups of people who are often discriminated are women who have sex with women and men who have sex with men. Women who have sex with women often experience sexual abuse, called corrective rape mainly because they have different sexual preference. The South African soccer star Eudy Simelane, stabbed 25 times after being raped by several men, is a clear example of discrimination against lesbians. In our country, it is estimated that since 1998, 31 women who have sex with women have been murdered simply because they have different sexual preferences, despite the fact that the constitution of South Africa forbids discrimination on this basis.

For many years, HIV prevention did not focus on men who have sex with men, yet they have high prevalence, with figures ranging from 12% in

Soweto and Namibia to >40% in Cape Town and Mombassa. It is time that we focus attention on men who have sex with men in Sub-Saharan Africa and end discrimination against them. Homophobia is still very rife in our continent, believing that it is not part of our culture, with some countries criminalizing it. There has to be an end to discrimination against men who have sex with men, gays and lesbians. Zero tolerance against discrimination should include them.

**People with Disabilities**

Just like MSM and WSM people with disabilities are seldom considered a group needing special attention because there is a belief that they are not sexually active, yet they are vulnerable to sexual violence. They often become easy targets for sexual abuse because they may not be able to defend themselves. Furthermore, there has been failure to tailor programmes to people with disabilities, including those who are out of school or are blind. To reduce new infections requires that all the groups that are at high risk be included in a national response to HIV/AIDS.

**Mortality due to AIDS**

UNAIDS estimate that between 2001 and 2009 global AIDS mortality has not decreased, yet at the regional Sub-Saharan level, it has declined from 1.4 million to 1.3 million. This is good news. The major cause of decline in mortality is access to life saving ARVs, which has increased 20% in the last decade. Universal access to treatment in Botswana, Namibia and Rwanda has been attained and many other countries in Africa are also approaching universal access. This was made possible by a drop in the prices of ARVs as well as the generous contributions of countries of the North to the South.

In South Africa, despite the increase of facilities providing ARVs and improved financing, uptake is still not at the required level. Not many can argue that the current South African government has not demonstrated a will to provide treatment for HIV. Let us look at the facts:

- In 2009,-- the government expanded access to treatment, care and support to pregnant women, people who are co-infected with HIV and TB, and HIV exposed infants who test positive at birth. The result was a reduction of transmission of HIV from mother to child from 10% to 3.5% nationally (MRC)
- Government policy revised new treatment guidelines for ARV, ie, to initiate treatment for all those who test positive with a CD4 count of 350 or less. Despite this bold intervention, few are still coming to use the service.

**Opportunities**

Application of evidenced-based interventions, coupled with unprecedented determination to respond to HIV and reduction of prices of ARVs have contributed to great progress evident in the last decade.

In Sub-Saharan Africa, we are beginning to see a significant decline in new HIV infections, meaning that lives are being saved. What is even more encouraging is that in 21 most affected countries the decline has been as large as 25% or more, fewer infections.

The changes observed are largely due to behavioural interventions such as reduction in risky sexual behavior. Fewer people are having multiple sexual partners, many are now having protected sex with multiple sexual partners and young people are delaying initiating sex. Condom use among young people in many countries in the Southern African region are at an all time high, demonstrating that prevention messages are making a difference in behavior change

Biomedical interventions have also contributed to reduction in new infections.  Prevention of Mother to child transmission through use of antiretroviral therapy has contributed significantly to the reduction of HIV infection in children and also contributed to lower child mortality.

Another biomedical intervention with great potential for successs medical male circumcision which has been shown to reduce the risk of men acquiring HIV infection from their female sexual partners. It has provided one more major intervention to prevent new infections in Sub-Saharan Africa.

The latest evidence that ARV treatment protects uninfected sexual partners from HIV infection as shown in HIV Prevention Trial Network 052 is ground breaking. Translating such efficacious interventions to community effectiveness will require substantial human and financial resources as well as unprecedented mobilization to encourage those living with HIV to seek care early, a call complicated by still high levels of stigma.

For Sub-Saharan Africa, getting to ground Zero will require us to be intelligent in how we use the now diminishing financial resources and select interventions known to have a major impact on the epidemic. We must

implement combination intervention depending on the distribution of HIV in our own society. For some countries combination interventions might include to (a) accelerate uptake of women enrolling in the prevention of mother to child transmission of HIV, (b) discourage intergenerational and multiple partner behaviour (c) promote, distribute and market condom use not only to young people, but to older people, especially for women who use hormonal contraceptives, (d) scale up medical male circumcision to young men before they become sexually active and (e) encourage uptake of ARVs. To others the combination intervention might focus on high risk groups.

We all have a responsibility to stem the tide by redoubling our efforts so that by the time we hold another SAHARA conference 10 years from now, the war against HIV/AIDS in Sub-Saharan Africa will have been won.

Thank you