

## Highlights and Perspectives: Eastern and Southern Africa

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This document draws out key trends and themes emerging from the UNAIDS 2008 Global Report that are relevant to Eastern and Southern Africa. The full 2008 Global Report, Summaries and Fact Sheets are available at [www.unaids.org](http://www.unaids.org) and at [www.unaidsrستا.org](http://www.unaidsrستا.org)

### Time for assessment – Background and Context to Report

The 2008 Report on the global AIDS epidemic emerges at the halfway mark between the 2001 Declaration of Commitment and the 2015 target of the Millennium Development Goals to reverse the epidemic by 2015. The launch of this latest report also occurs only two years before the agreed target date for moving as close as possible towards universal access to HIV prevention, treatment, care, and support. It uses data submitted by countries reporting on progress against targets agreed in 2001.

### Globally – considerable progress – yet Southern Africa remains at the epicenter

A six fold increase in financing for AIDS responses in low- and middle-income countries between 2001 and 2007 is beginning to bear fruit globally but distinct challenges remain in Southern Africa which remains at the heart of the global epidemic. Sub-Saharan Africa accounted for 67% of all people living with HIV and for 72% of AIDS deaths in 2007 and unlike other regions, the majority of people (61%) living with HIV in the region are women. Nine countries in Southern Africa continue to bear a disproportionate share of the global AIDS burden – 35% of HIV infections and 38% of AIDS deaths in 2007. HIV prevalence among adults exceeds 15% in eight countries (see Figures 4 and 5 from the Global Report Summary – also annexed to this document). The highest prevalence was noted in Swaziland with an estimated 25.9 % of adults aged 15-49 reported as HIV positive - the highest in the world. Although, the epidemic in South Africa appears to have stabilized the country continues to have the highest numbers of people living with HIV in the world with an estimated 5.7 million people living with the virus. The severity of the epidemic in the region underscores the need for intensified and accelerated action towards universal access to HIV prevention, treatment, care and support.

Although globally the epidemic is stabilizing it is doing so at an unacceptably high level. Globally, there were an estimated 33 million [30.3 million—36.1 million] people living with HIV in 2007. Globally the annual number of new HIV infections declined from 3.0 million [2.6 million—3.5 million] in 2001 to 2.7 million [2.2 million—3.2 million] in 2007.

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## Treatment

The rapid expansion of treatment access in resource-limited settings is saving lives, improving quality of life, and contributing to the rejuvenation of households, communities and entire societies - yet significant challenges remain especially in increasing access to treatment for the rural poor and people displaced by conflict, political or economic strife or through natural disaster. There are also major challenges in addressing the complex needs of people infected with both HIV and tuberculosis – particularly in resource-poor settings. By the end of 2007, an estimated 3 million people in low- and middle-income countries were receiving antiretroviral treatment; this is a 50% increase since December 2006 and a 10-fold rise over the last five years.

Globally, 30% of those who were estimated to need antiretrovirals in 2007 were receiving them. Although in real numbers the most people receiving antiretrovirals are in sub Saharan Africa the gap in meeting the need remains highest. Increases in treatment access have been extraordinary in some countries, for example, in Namibia, where treatment coverage was only 6% in 2003, 57% of individuals in need were on antiretrovirals in 2007. In Rwanda, antiretroviral coverage increased to more than 60% in 2007.

Despite the existence of affordable medications, too few people living with both HIV and tuberculosis are receiving treatment for both conditions. The failure to make optimal use of existing diagnostic and treatment regimens results in considerable illness and death. An estimated 22% of tuberculosis cases in Africa—and, in some countries in Southern Africa, as many as 70%—occur in people living with HIV.

## HIV prevention

Although the epidemic in Eastern and Southern Africa has stabilized to a degree some countries need to urgently redouble their HIV prevention efforts - for example new information from Kenya suggests that in 2007, HIV prevalence ranged between 7.1% and 8.5%—compared with the 2003 estimate of 6.7%. In Mozambique the epidemic continues to grow, in some provinces in the central and southern zones of the country, adult HIV prevalence has reached or exceeded 20%, while infections continue to increase among young people (ages 15 – 21). Uganda's adult HIV prevalence appears to have stabilized at 5.4%, however signs of a possible resurgence in sexual risk-taking could cause the epidemic in that country to grow again.

Studies reveal that Zimbabwe's epidemic has declined in recent years, with a significant drop in HIV prevalence in pregnant women from 26% in 2002 to 18 % in 2006 and from 21% to 14 % among pregnant women, ages 15 – 24, over the same period. The decline is being partially linked to reports of safer sexual behaviour, with evidence of more people avoiding sex with non-regular partners and of decreasing numbers of adult men paying for sex\*\*

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\* Although Zimbabwe has invested in HIV prevention more needs to be done to understand the impact of the current political and economic crisis on the country's ability to maintain and build on its response to HIV and AIDS.

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Among serodiscordant heterosexual couples in Uganda, the uninfected partner runs an estimated 8 % chance of contracting HIV each year, underscoring the importance of tailored prevention initiatives for such couples. Similarly, focused attention is needed to reduce the prevalence of multiple concurrent partnerships, which can lead to the rapid spread of HIV infection within sexual networks.

Comprehensive HIV prevention programmes, that includes a strong emphasis on social mobilization and male involvement, addressing risk and vulnerability, multiple and concurrent partnerships (including age-disparate/intergenerational sex and transactional sex) and that promote increased male circumcision and neonatal circumcision should be at the heart of national AIDS responses. A greater investment in improved surveillance and monitoring of the effects and evolution of the epidemic are essential to tailor national responses to national epidemics. And further research on specific drivers of the epidemic on the structural drivers of the epidemic including the relationship between alcohol and HIV is essential.

The 2001 Declaration of Commitment on HIV/AIDS recognized HIV prevention as the “mainstay of the response.” Last month the United Nations Secretary General, Ban Ki-moon, called for urgent mobilization to accelerate the prevention response in Southern Africa:

*In countries where adult HIV prevalence is 15 % or greater, nothing short of a full-scale mobilization across society will successfully address the problems posed by HIV. However, in many such countries, young people remain poorly educated about HIV, coverage for basic HIV prevention services is far too low and few workplaces provide essential HIV prevention activities. Every available tool appropriate to national circumstances must be brought to scale, including population-wide campaigns on the risks associated with concurrent partnerships; energetic promotion of universal knowledge of HIV serostatus; adult male circumcision; prevention programmes focused on young people and populations most at risk; prevention activities in the workplace; and comprehensive services to prevent mother-to-child transmission. As treatment is scaled up, it should be closely linked with HIV prevention efforts.*

**Report of the Secretary-General, A/62/780**

*Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to the millennium Development Goals* [www.unaidsrstea.org](http://www.unaidsrstea.org)

**Prevention of Mother to Child Transmission**

In the 2001 Declaration of Commitment on HIV/AIDS, countries pledged to ensure that 80% of pregnant women in all countries who access antenatal care are offered HIV prevention services. Although cost-effective interventions emerged years ago to prevent mother-to-child HIV transmission, children still accounted for one in six new HIV infections globally in 2007. The vast majority of these infections occurred during pregnancy or delivery, or as a result of breastfeeding.

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In Botswana, where the national government has made prevention of mother-to-child transmission (PMTCT) a major priority, the country had reduced the rate at which children born to HIV-infected mothers contract HIV themselves to only 4% by 2007, demonstrating the feasibility of dramatic progress in resource-limited settings. An increase in the successful uptake of PMTCT services is reported in Swaziland, Rwanda, Seychelles, Malawi, Namibia, South Africa, Lesotho and Kenya in addition to Botswana. Declines in service uptake have been observed in Angola, Tanzania and Zambia.

As prevention of mother to child transmission of HIV is scaled up it should include systematic provider-initiated prevention support during pregnancy as well as HIV testing after delivery as evidence suggests that pregnancy itself may increase the risk of HIV vulnerability pregnant women.

### **Women and Girls**

Young women in South Africa face greater risks of becoming infected than men: among 15-24 year olds, they account for around 90% of new HIV infections.

Structural interventions that keep girls in school, increase women's economic independence and legal reforms to recognize women's property and inheritance rights, should be prioritized by national governments and international donors. According to a recent study in Botswana and Swaziland, women who lack sufficient food are 70% less likely to perceive personal control in sexual relationships, 50% more likely to engage in intergenerational sex, 80% more likely to engage in survival sex, and 70% more likely to have unprotected sex than women receiving adequate nutrition.

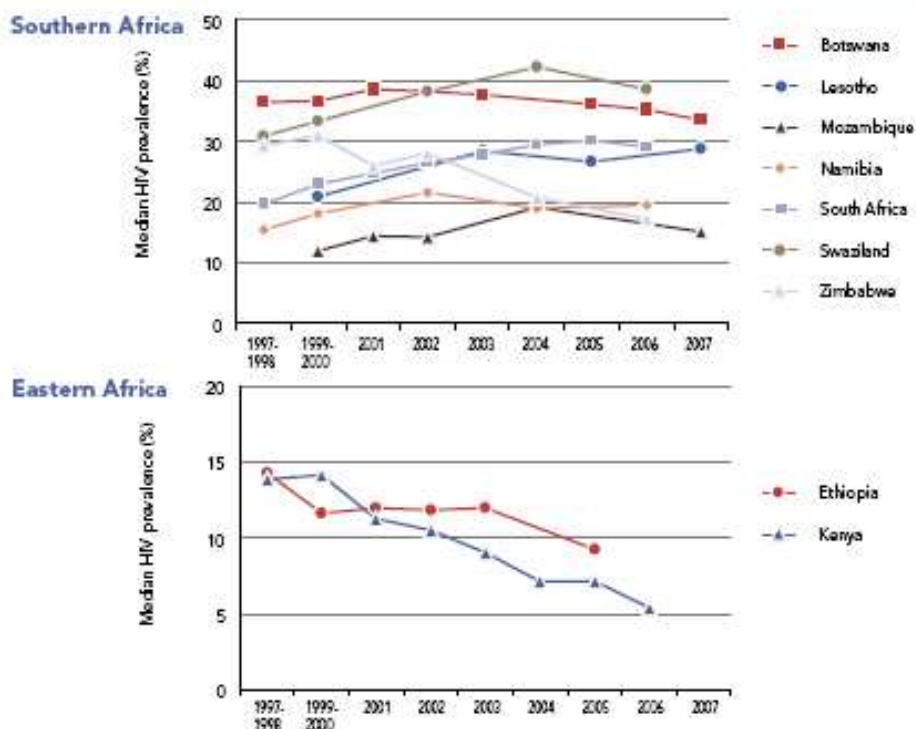
### **Involvement of people living with HIV**

While leadership from heads of government and national ministries is critical, effective national responses depend on commitment and action from diverse actors. Especially in countries where HIV is hyper endemic, leadership on HIV is needed from all walks of life, including community groups, faith-based organizations, private businesses, young and old. Above all, people living with HIV must be empowered to help lead national responses. According to nongovernmental informants, however, only about 20% of civil society groups have access to financial assistance for programmes and capacity building.

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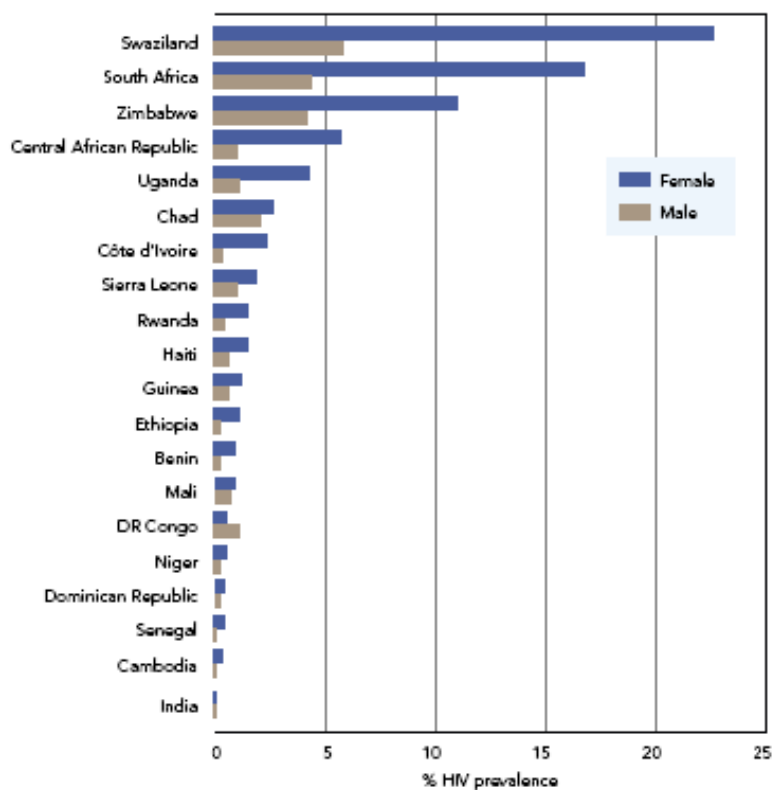
Annexes – Figures 4 and 5 from the 2008 Global Report Executive Summary

**FIGURE 4** HIV prevalence (%) among pregnant women attending antenatal clinics in sub-Saharan Africa, 1997–2007



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**FIGURE 5** HIV prevalence (%) among 15–24 years old, by sex, selected countries, 2005–2007



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