

Why Accelerate HIV Prevention?

A comprehensive approach to HIV prevention could avert 29 million out of 45 million cumulative new infections – 63 per cent of all new infections – that are projected to occur between 2002 and 2010.

Yet, with a very few exceptions and despite national and international efforts to stem the pandemic, rates of new HIV infections continued to rise in 2005 in many countries of sub-Saharan Africa, the most affected region in the world.

- Of the 5 million new infections recorded globally in 2005, 3.2 million (64 per cent) were in sub-Saharan Africa.

HIV/AIDS is the single greatest threat to the security and development of much of Africa, making it impossible to attain many of the globally agreed Millennium Development Goals. Without accelerated efforts to prevent its spread, HIV/AIDS will continue to roll back progress and hard won gains and intensify poverty and human suffering in Africa.

Rapidly growing demand for treatment will exceed available human and financial resources. More and more children will be orphaned, outstripping the capacity of families and communities to care for them. Millions more will become infected and die.

- Since the 1980s, **50 million people in Africa have been infected by HIV and 22 million have died**, the majority of them in their most productive years. In Nigeria 20 per cent of those currently living with AIDS are civil servants. Zambia could lose 20 per cent of its workforce by 2020. Mozambique may lose more than 19,000 teachers to AIDS in the years between 2000 - 2010.
- **Infant mortality**, which fell by half in much of Africa between 1960-1990, is again on the rise in several countries, due to HIV infection and reduced care resulting from parental deaths. A child whose mother dies is 3.3 times more likely to die herself, according to a study in Malawi.
- Similarly, **life expectancy**, once improving, has fallen by more than 15 years in five countries and by six-to-15 years in nine others. A child born today in Zambia can expect to live for only 32 years. In South Africa life expectancy dropped between 1995-2002 from 61.4 years to 51.4 years.
- Overall, **GDP growth drops by one per cent a year** in a country where HIV prevalence has reached 8 per cent.
- **AIDS deaths undermine Africa's ability to feed itself**, leaving children and the elderly to work the land. Agricultural production in Kenya, for example, is projected to drop by 2.4 per cent by 2010. Food insecurity is increasing in Africa, in part because of the impact of HIV/AIDS on agricultural production.
- **More than 12 million African children have been orphaned** due to AIDS, depriving them of the love, care, and guidance normally offered by parents. Many of them are homeless and impoverished, subject to exploitation and abuse.

Knowledge is Prevention Power

Everyone needs access to accurate information about HIV and AIDS. A vital step in successfully accelerating HIV prevention is understanding as much as possible about current patterns of HIV transmission in Africa, and about the underlying and contributing factors in the pandemic's spread.

- Women and children currently represent 60 per cent of those infected with HIV in Africa **and nearly half of all new infections occur among children and youth between the ages of 15 and 24.**
- Women, particularly young women, are at greater **physiological risk** of HIV infection. Women are twice as likely as men to contract HIV during sex.
- **Health care systems are weak** in Africa in general. In addition, there is a lack of facilities for treating sexually transmitted infections (STIs) and some STIs increase vulnerability to HIV infection.
- The **lack of counselling and services, particularly for young people**, constrains effective prevention. Many young people, particularly girls and young women, still do not have the information they need to protect themselves from HIV/AIDS. In some cases, denial of risk can be a significant danger: Despite the fact that South Africa has the largest number of infected people in the world, 66 per cent of South African respondents to a 2005 survey believed that they were unlikely to become infected.
- **Cultural and gender factors need to be addressed**, including patriarchal attitudes towards women and young girls, early sexual activity and early marriage and multiple sex partners. \ Engaging in sex with several partners during the same time period, for example, is emerging as a key risk factor for HIV infection, as people are 10-100 times more liable to pass the infection on within a month or so of becoming infected themselves.

Gender inequalities prevent girls from refusing high-risk sex and put them at high risk of rape and sexual exploitation. The prevailing taboos and sensitivities about sex-related matters needs to be overcome, so information is shared more widely and effectively. Men and boys must be involved in ending gender inequities and changing the patterns of male behaviour that put girls and women at risk.

- **Economic factors** such as drought, globalization, unemployment and growing impoverishment push women and youth toward risky, transactional sex. More options as well as more information are needed.

What is Needed

The global goal of Universal Access to prevention, care and treatment for HIV/AIDS by 2010 will only be attainable if prevention activities are successful. Accelerating prevention will require:

- Urgently tackling these problems, targeting efforts to those most at risk, such as women and marginalised youth, commercial sex workers, and those in highly mobile occupations.
- Identifying the most successful strategies in each country and expanding their reach, or "taking them to scale".
- Improving the availability and quality of health care.
- Increasing the resources available for prevention activities.

Overcoming Barriers to HIV Prevention

Preventing HIV calls for a multi-faceted and integrated approach that reaches the widest possible number of people with a mix of information and services. People need to be involved in designing the approach and in the issues that affect their health and behaviour.

When prevention activities are successful, people understand how the virus is spread and feel confident about their ability to protect themselves from infection. They have the necessary skills, tools and access to services and care. They have gained a new sense of their own competence, worth and well-being, and a new respect for and understanding of those affected by HIV/AIDS.

Some of the most common prevention activities include:

- HIV education in schools
- Peer education for high-risk groups (such as out-of-school youth and commercial sex workers).
- Mass communication campaigns to discourage risky behaviour.
- Testing, counselling and treatment for pregnant women.
- Condom distribution

Problems arise when these interventions are not well funded, designed and supplied; or if they are not implemented in an integrated and convergent way and available or relevant to those at the greatest risk for infection.

- Convincing young people to get tested for HIV will be effective only if there are youth-friendly testing facilities available close by whose staff offer compassionate advice and treatment.
- Pregnant women and girls who are HIV positive won't take advantage of treatment and care to prevent transmission of HIV to their unborn child if they fear that by doing so their HIV status will be known, and their husbands, families and neighbours will reject them.
- People who have no options except, for example, to exchange sex for money in order to buy food for their children are unlikely to heed behaviour-change messages that ignore their reality.
- Educating girls about HIV will not protect them from rape and sexual predators. Only collective and concerted social action can protect girls and prosecute those who assault and violate them.

HIV Education: Currently, research shows that **only about half of the young people in sub-Saharan Africa possess comprehensive knowledge about HIV**. By 2006 around a dozen sub-Saharan African countries had begun incorporating HIV education into school curricula. Since some 80 per cent of school-aged children are enrolled in primary school in most countries, if *all* primary schools provided HIV education significantly more children would be better prepared to avoid HIV infection.

Peer Education is a prevention strategy for reaching youth, either in school settings or for marginalized, out-of-school youth, mainly through community-based outreach programmes. While several African countries have peer education programmes, one estimate is that peer education reaches **only about half of young people at high risk of HIV infection**. Peer-education programmes need to be scaled up in all countries.

Communication Campaigns: Behaviour-change messages have a place in the overall prevention arsenal, but **are not always targeted, clear and detailed** enough to enable listeners to act on the advice provided. Countries need to identify the key audience and craft appropriate messages, as well as develop means to evaluate the success of communication activities.

Consistent and correct use of condoms is the only method to prevent HIV infection during sexual relations. Surveys in 19 African countries revealed that **only 41 per cent of young men and 23 per cent of young women had used a condom during casual sex in 2004**. Making condoms available to all sexually active people is an issue that must be resolved within each country, according to local culture and conditions—but it must be resolved.

Mother-to-Child Transmission: Helping HIV-positive pregnant women avoid transmitting the virus to their infants (prevention of mother-to-child transmission, PMTCT) is another critical prevention activity, described in Fact Sheet 6. **Improving the effectiveness of PMTCT programmes is highly dependent on eliminating stigma and discrimination against those who are HIV-positive.**

Five Barriers to Successful Prevention

1. Inadequate resources, a serious problem with many ramifications.
 - It leads to shortages of hospitals and clinics, equipment, supplies and skilled personnel. Health expenditure in most countries represents less than 10 per cent of national GDP.
 - It leads to prevention activities being undertaken only on a single track and/or on a small scale.
 - Without adequate resources the scope of successful activities cannot be broadened.
 - It means prevention efforts can't be monitored well, making it difficult to assess their success or failure.
2. Insufficient knowledge among health care providers and among teachers about HIV and AIDS, resulting in their inability to relay accurate information.
3. Stigma and discrimination against those living with HIV and AIDS.
4. Failure to take socio-cultural factors into account in prevention programmes.
5. Sensitivities about open discussion of sex in most societies. These block or limit the free exchange of information so necessary to preventing HIV.

Breaking the Barriers to Successful HIV Prevention

- Testing, counselling and treatment facilities should be widely available and affordable, particularly for young people.
- Health care personnel should be better informed about care and treatment of HIV and other STIs, and trained to treat all patients with compassion
- The pace of incorporating HIV education into school curricula and training teachers to present this information should be urgently stepped up
- Successful peer education programmes for those at high risk of infection should be rapidly expanded in scale
- High-risk groups should be involved in developing prevention activities
- Sexually active people should have easy access to affordable condoms
- National and local leaders should enforce laws against rape and speak out forcefully against sexual violence and cultural practices that increase the risk of HIV infection.
- Much stronger monitoring systems are needed and governments should report the number of new infections each year, compared to those in the previous year.

More Evaluation Critical in Behaviour Change

Certain prevention activities aim to modify behaviour that increases the risk of HIV infection. In Sub-Saharan Africa this largely means reducing the following behaviours:

- Having unprotected casual sex
- Having sex with multiple, concurrent partners
- Starting sexual activity at an early age
- Having sex with high-risk partners

Behaviour change can be difficult to achieve. Nevertheless, some successes seem to be emerging. For example, national HIV prevalence rates declined in Kenya and Zimbabwe in 2005 and **increased condom use, delayed age of sexual debut and fewer sex partners contributed to the declines**, according to UNAIDS findings. There were also some hopeful signs that shifts in behaviour occurred in Swaziland and South Africa.

- In Kenya, condom use with casual partners increased, especially among women: by 2003, 24 per cent were using condoms compared to 15 per cent in 1998. Also, the proportions of men and women with more than one sexual partner fell by more than half between 1993-2003. In addition, a 2004 study showed that more young men and women were delaying sexual debut; rates of sexually transmitted infections had dropped as well.
- In Zimbabwe, the fall in HIV prevalence rate among young women 15-24 years of age was significant - from 29 per cent to 20 per cent between 2000 and 2004 - and prevalence estimates among older women and male factory workers confirmed the trend of reduced new infections. The declines appear to be due to changes in behaviour, in particular increased condom use and a reduction in the number of sexual partners.
- In Swaziland a four per cent reduction in HIV infection among teenage girls was viewed by the Minister of Health as a sign that "the AIDS protection message is getting through."
- A 2005 national survey in South Africa found several indications of reported behaviour change among both young people and adults, mainly related to increased condom use and decreased numbers of sexual partners.

The main strategies in the behaviour-change arsenal include communication campaigns; HIV and Life Skills education in classrooms; peer education among out-of-school adolescents and high-risk groups; and condom distribution.

The success or failure of such approaches is often judged by looking at overall, national prevalence figures among those in the younger age groups. If prevalence rises, the activities are seen as having failed.

- Frequently, however, behaviour-change activities are undertaken only on a limited scale among a relatively small population group, so results may not be discernable in broad, national figures.

There are similar difficulties in assessing the impact of behaviour change communication media campaigns - such as those advocating condom use and discouraging casual sex.

One important UN contribution to accelerating HIV prevention will be working with African governments to improve their capacity to evaluate the success of behaviour change communication and other prevention measures. Once it is clear what works and why, resources can be devoted to accelerating and scaling up those activities.

An evaluation of an **HIV education curriculum** delivered for four years in 22 schools in KwaZulu-Natal, South Africa, for instance, found that:

- Those in the class had increased knowledge about HIV; no increases were noted among a control group.
- Students in the programme were more supportive of abstinence for teenagers than the control group.
- There was no increase in sexual activity among participants, nor did their intention to have sex increase.
- Teachers need more information, training and technical support.

A **Life Skills Education** programme carried out with UNICEF support since 2002 in nine countries (Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe) will be evaluated in 2006.¹

Summing Up

The success of behaviour change campaigns depends on crafting the right messages and ensuring that the services and tools (such as VCT or condoms) that people need to make the desired changes are available. Evaluation and assessment activities - to identify what is working well and why - are critical to successful behaviour change campaigns.

- Behaviour change is one element of a comprehensive approach to prevention.
- Evidence points to the effectiveness of behaviour change interventions.
- More research and evaluation is required before conclusions can be reached as to which specific interventions should be scaled up in each country.
- Part of accelerating prevention is making these assessments and moving forward to implement successful behaviour change strategies.

¹Life Skills Education provides reliable information about HIV and AIDS, while developing skills in decision-making, communication, negotiation, critical thinking, stress management and conflict resolution to help young people better protect themselves against infection.

Testing and Counselling

Testing and counselling play critical roles in HIV prevention by helping people to cope with the disease and avoid infecting others. But:

- Fewer than 10 per cent of people in Africa know their HIV status.
- Testing and counselling facilities are available only to about 24 per cent of the region's population.
- Often counsellors lack training or time, leading to poor quality services .
- Fear, denial, stigma and discrimination all keep people from taking advantage of the services that are available.

Surveys among adolescents and youth in several countries indicated they would not get tested if the services did not provide an accepting environment for them.

- Some young people in Swaziland reported travelling far from their homes to get tested in a clinic where no one knew them or their family. Most cannot afford to do this.
- In Ghana, young people complained that going for testing resulted in insults to them and their families and a presumption that they were "immoral" or had AIDS.

In many countries, people who are HIV positive also can now receive treatment that allows them to continue living and feeling well for years.

The *Masa* or New Dawn programme in Botswana has increased the number of people who know their HIV status by making testing a routine part of medical visits. This is good news in a country where HIV prevalence rates among those between the ages of 15 and 49 are about 35 per cent (in a total population of 1.7 million).

- In the *Masa* (New Dawn) programme, the test is not mandatory but is offered as a matter of course. Doctors report that few people refuse.
- After two years of the programme, more than one-third of the population know their HIV status. This is three times the proportion of those who know their status in most countries in Africa.
- Also encouraging is the fact that the number of women at antenatal clinics who tested positive dropped by 15 per cent between early 2004, when the programme started, and late 2005.
- AIDS activists in Botswana believe that more people are agreeing to be tested because of the hope generated by widely available treatment, underlining the close linkage between testing, treatment and prevention.

Reducing or eliminating the cost of testing can also have a major impact, as shown by the results of a small-scale, experimental programme at a clinic in Tanzania.

- When HIV testing was offered free of charge the number of people volunteering to be tested increased from an average of 4 to 15 per day.
- When a small fee (equivalent to about US\$1) was reinstated, the numbers dropped by half. When the free testing programme resumed, the numbers rose again to 15-18 people per day.
- The increase in numbers made testing more cost effective. Each test cost US\$170 when 4 people a day were tested. The per-test cost fell to US\$92 when 15 people a day were tested.

Ensuring that counsellors are able to provide sound advice to people who test positive is also critical. For pregnant women, for example, information on options related to childbirth and infant feeding is vital to preventing mother-to-child transmission. At present, shortages of trained nurses and counsellors threaten the quality of the counselling available in many countries (See Fact Sheet Five).

Summing Up

Testing, which includes voluntary counselling and testing (VCT) services as well as routine testing, has an important role in preventing HIV, but scaling-up testing faces obstacles in most African countries:

- The cost of testing.
- The stigma attached to being tested.
- Shortages of well-informed, well-trained personnel who can accurately counsel adults and young people.
- Limited access to treatment, reducing the incentive to get tested.

To expand testing, including VCT, will require:

- Increasing investments in health care systems and staff.
- Changing attitudes toward those living with HIV and AIDS.
- Making testing routine.
- Expanding opportunities for free testing and treatment.

Preventing Mother-to-Child Transmission

In most of sub-Saharan Africa, **HIV transmission during childbirth or breastfeeding is the second most common way that the virus is spread**, according to evidence available today.

- Worldwide, nearly 2,000 infants a day are infected with HIV during childbirth or via breastfeeding. Most of these infections occur in sub-Saharan Africa and most of the children die before their fifth birthday.

Preventing mother-to-child transmission (PMTCT) is vital to saving the lives of millions of young children.

- The percentage of children under five who died of AIDS rose from 2 per cent in 1990 to 6.5 per cent in 2003 in severely affected African countries.
- Lack of access to PMTCT services caused more than 600,000 new and preventable infections and 570,000 HIV-related deaths in children under 15 in 2005 alone. Ninety per cent of these deaths occurred in sub-Saharan Africa.
- Only about 10 per cent of pregnant women used PMTCT services in 14 African countries with high HIV prevalence studied in 2004.

In the industrialized world almost all mother-to-child transmission is prevented through routine HIV testing of all pregnant women and providing those who are HIV positive with a combined package of anti-retroviral treatment (ART), safe delivery practices, and advice and support on infant feeding.

In sub-Saharan Africa, however, HIV testing is not done routinely, largely because of fear of stigma and discrimination. Also ART is not available on the scale required; health systems lack capacity to ensure safe deliveries; replacement feeding is not a safe or possible option for many women; and most countries have severe shortages of trained PMTCT counsellors.

Accelerating HIV prevention in the region demands sharply increased commitment to filling all these gaps to prevent mother-to-child transmission of HIV.

Vast numbers of pregnant girls and woman are unaware that they can pass the virus to their infants and that there are ways to prevent this from occurring. The majority of women who give birth at home are unlikely to receive PMTCT information from the traditional birth attendants who assist them.

Information about mother-to-child transmission is not likely to be offered even when women attend antenatal clinics.

- In Burkina Faso, Ghana, Nigeria, Tanzania and Zambia between 18 per cent and 49 per cent of women who were tested for HIV and offered PMTCT services did not receive information about mother-to-child transmission, or what the consequences were for their baby of a positive test.

Many pregnant women also do not want to be tested for HIV. A lack of privacy, long waits, poor quality counselling and rules requiring women to return another day for counselling were among the factors found to discourage women from participating in PMTCT programmes. The fear of abuse from their partners was another reason women refused tests.

Accelerating Prevention of Mother-to-Child Transmission

Sharply increased investments in health care generally, and in PMTCT programmes in particular, can make the difference. For instance a PMTCT programme in South Africa's Western Cape brought transmission rates down from 30 per cent to 5 per cent in just a few years, mainly due to the quality of the provincial health system and high staffing levels.

Greater investments will make it possible to:

- Offer more PMTCT (and other prevention) programmes, including programmes that help women stay healthy longer, through nutritional support and treatment.
- Enable women to be tested, counselled and receive test results during just one visit.
- Train more counsellors, community volunteers, and traditional birth attendants to reach more women with reliable information and guidance on options if they are HIV-positive. Women living with HIV need to know options, for instance, about avoiding unwanted pregnancies, and also the potential dangers to infants from under nutrition and infections associated with replacement feeding.
- Improve conditions in health facilities to ensure that infants are not infected during childbirth.
- Intensify society-wide efforts to overcome stigma and discrimination against people living with HIV/AIDS and protect women against abuse.

As the Abuja PMTCT Call to Action, issued in December 2005, highlights so clearly, only concerted and coordinated efforts and comprehensive programmes can effectively protect women and children against HIV and see that those affected receive the care, treatment and compassion that are their rights.

Curing the Health Care System for Better HIV Treatment and Prevention

Until quite recently, very few people in Africa received treatment to alleviate the symptoms of AIDS, slow the progression of the disease and so extend their lives. But now some governments are able to offer free or low-cost treatment to larger numbers of people, thanks in part to the lower cost of anti-retroviral treatment (ART) as a result of global pressure and the increased resources coming from the international community.

- Worldwide, the number of people receiving antiretroviral therapy in low- and middle-income countries increased from 400,000 in December 2003 to 1.3 million people by December 2005.
- Botswana, Ethiopia, Senegal, Tanzania and Zambia have all eliminated user fees for HIV treatment.

The Acceleration of Prevention Initiative recognises that treatment and prevention are intimately linked. The availability and pace of both treatment and prevention must be increased if the pandemic is to be halted.

Treatment contributes to prevention by offering people hope rather than a future of escalating illness and death.

- In Brazil, where treatment is widely available, life expectancy for HIV-positive persons has increased by about five years on average.
- Demand for HIV testing increased by over 10 times when treatment became available in one area of South Africa.
- In developed countries, the availability of treatment has contributed to a 70 per cent reduction of AIDS deaths.

But:

- Despite progress in a few countries, region-wide **only about 10 per cent of those in need of ART receive it**—fewer than in any other part of the world.
- In Tanzania, for example, free treatment is being offered to 22,000 people, but 400,000 are in need of ART and 2 million are HIV-positive.
- Treatment rates for children are particularly low, usually below 5 per cent.

Ailing Health Care Systems

Expanding treatment at the rate required to meet the needs of all people living with HIV/AIDS requires robust health care systems. Yet most health systems in sub-Saharan Africa are under-funded and under-staffed.

- Countries in sub-Saharan Africa spend only between US\$2-\$10 per capita on health, compared to the needed investment of US\$30-to-\$40 per capita.
- About 750,000 health workers serve 682 million people in sub-Saharan Africa. There are fewer than five doctors per 10,000 people for most people.
- Urban/rural population disparities and income disparities further skew service delivery. Per capita health expenditure in South Africa is higher in wealthier provinces (around US \$190 for example) than in poorer, predominantly rural provinces (around US\$125). This pattern prevails in many countries.

As WHO Director-General Dr. Lee Jong-wook has said, “ The problem in many countries is getting the staff, medicines, vaccines and information to those who need them on time and in sufficient quantities. In too many countries, the health systems to do that either do not exist or are on the point of collapse.”

Low investment levels also mean shortages of equipment and supplies in hospitals and clinics. These conditions along with low salaries fuel large-scale flight by doctors, nurses, pharmacists and other skilled medical personnel to countries where salaries and working conditions are more inviting (a trend dubbed “the brain drain”).

- Around 20,000 doctors and nurses desert Africa every year.
- Ghana’s Health Ministry calculated that the brain drain had created a shortfall of doctors and nurses reaching 47 per cent and 57 per cent, respectively.

New Models Needed

To meet the challenges, WHO and national governments are developing health service delivery models that work with reduced numbers of trained healthcare workers and without expensive equipment or diagnostic tests.

The Integrated Management of Adolescent and Adult Illness (IMAI) system, for example, is a decentralized approach to integrated HIV management (including prevention, care and treatment). Its guidelines can be understood and applied by primary care providers in the most resource-poor settings.

Innovative approaches such as IMAI, combined with **increased resources** for health care, **reduced costs** to the poorest families, and **scaling-up** treatment opportunities can help prevent HIV by increasing the number of people who receive medical care, treatment, and testing and counseling. They will also help to reduce the toll taken by other killer diseases, such as malaria, in the region.

Prescription for Better Health Care and HIV Prevention

- WHO recommends that governments offer free HIV-related services, including treatment, to all; even low fees inhibit people from seeking care and decrease adherence to HIV treatment regimes.
- Salaries in the health care sector need to be raised to attract and retain skilled personnel.
- Governments need to shift existing resources to the health sector or develop innovative means of financing stronger health care systems and expanding access to ART.
- Donor countries concerned about HIV/AIDS prevention and treatment should consider support for strengthening Africa’s health sector and exert controls on the recruitment of health care personnel from African countries.
- Community-based resource people, including those living with HIV, need to be trained and supported to give quality care to others living with HIV.

Male Circumcision: Weighing the Pros and Cons

Male circumcision, a procedure that entails the removal of all or part of the foreskin of the penis, has been practised by some religions and communities for thousands of years.

It is attracting heightened attention and scientific scrutiny now because studies show that circumcised men have lower levels of HIV infection than uncircumcised men. Also, HIV prevalence is generally lower among populations that traditionally practice male circumcision than in those where most men are not circumcised.

About 20 per cent of men worldwide are believed to be circumcised, either soon after birth or at adolescence, usually for cultural, religious or hygienic reasons. Not all countries in Africa have statistics on the prevalence of male circumcision, but generally it is estimated that less than 20 per cent of men in southern Africa are circumcised, between 50 per cent and 80 per cent in East Africa and 80 per cent or more in most of the rest of the continent.

What Is Known?

Three trial studies in Eastern and Southern Africa have been undertaken (two of them are still ongoing) in recent years to assess through controlled research the benefits of male circumcision in preventing HIV transmission. The study in South Africa's Gauteng Province was halted earlier than planned because the results very strongly indicated that circumcision was protective against HIV transmission and researchers believed the procedure should be extended to all of the 3,274 men participating.

- **The circumcised men in the study were found to have 60 per cent less chance of contracting HIV than the uncircumcised men.**

If the two other trials still under way in Kenya and Uganda and involving 8,000 men produce results similar to those in South Africa, male circumcision will join tools such as male and female condoms as key means to prevent HIV infection.

Already, a groundswell of interest has been seen in Botswana and Swaziland, two of the countries most devastated by HIV/AIDS.

- Over 80 per cent of men surveyed in Botswana said they would like to be circumcised if the procedure were safe and affordable.
- In Swaziland, hospitals that once rarely performed circumcisions have been doing 10-15 a week and have lengthy waiting lists.

Debate is raging in Swazi society, which traditionally does not circumcise boys at any time. While some criticize the procedure as offensive to Swazi traditions and customs, others are demanding that the government promote circumcision as part of its public health policy.

Balanced Assessment

However much it may be proved to contribute to prevention, **male circumcision still cannot be called a magic bullet**. In West African countries where men are customarily circumcised, for example, HIV is still spreading.

Furthermore, the following issues are valid concerns:

- In settings where adequate healthcare facilities are not available, men anxious to protect themselves may undergo the procedure in non-sterile environments and/or the procedure may be performed by people not well trained or skilled.
- Men may wrongly believe that once circumcised they are fully protected against HIV, and thus fail to use condoms.
- During the healing period (about one month) following circumcision, men are actually at higher risk of HIV infection.

These suggest that **if circumcision is proven effective in protecting men from HIV infection, it needs to be viewed as one element in a comprehensive prevention package** that includes: consistent condom use, behaviour change and voluntary counselling and testing.

- Given the heightened interest in this procedure due to the results of the South Africa trial, governments should take steps now to ensure that male circumcision is conducted by trained practitioners in safe and well-equipped settings, to reduce the potential for complications. If properly performed under appropriate, sterile conditions, the rate of post-operative complications is very low, about 0.2 to 2 per cent.

Children and Youth: Cause for Alarm, Window of Hope

Worldwide, four young people between the ages of 15 and 24 contract HIV every minute —about 6,000 every day.

Nearly two-thirds of HIV-positive youth live in sub-Saharan Africa.

In sub-Saharan Africa *half* of all new infections are now occurring among 15-to-24-year-olds.

Girls and young women are disproportionately affected: they comprise two-thirds of those newly infected between the ages of 15 and 24. Overall, around twice as many females as males in this age group are infected; in some countries, such as South Africa, the ratio reaches five to one.

These sobering statistics underscore the need to make preventing HIV in youth a top priority. Reducing these numbers calls for dedicated efforts also to reach those children and adolescents who are not yet sexually active, and who thus represent a “window of hope” for halting the epidemic.

The prevailing high rates of infection correspond to a general lack of information about HIV/AIDS among young people:

- Surveys reveal that only about *half* of all young people in the region have comprehensive knowledge about HIV.
- Less than one-third of young women aged 15-24 fully understand how to avoid infection. Young men are better informed by about 20 per cent.

Young people - especially girls - have a right to:

- Receive reliable information on HIV prevention.
- Participate in developing prevention messages and disseminating them.
- Have access to sensitive, youth-friendly HIV testing, STI treatment or condoms.
- Be protected from rape, abuse, coercion and assault.

Even in countries with widespread epidemics (such as Cameroon, Central African Republic, Equatorial Guinea and Sierra Leone), less than 20 per cent of young women aged 15-24 have sufficient information about HIV prevention.

- Twenty per cent of secondary school students in Botswana, with one of the world’s highest prevalence rates, believe that they can tell by looking at a partner whether or not he or she is HIV-positive.
- In Nigeria, 60 per cent of the population is under the age of 24, and thus at high-risk for HIV infection, in a country with the third-largest number of people living with HIV/AIDS in the world (around 3.6 million in 2003).

Special Risks, Special Needs

In sub-Saharan Africa young people at the greatest risk of ignorance about HIV are:

- Children living on the streets
- Orphans
- Young and adolescent girls
- Refugees
- Injecting drug users
- Child soldiers
- Boys and girls involved in the commercial sex trade.

2006

**The year to accelerate
HIV Prevention in Africa**

The multiple problems faced by these young people demand comprehensive solutions. To protect them, the following are urgently needed:

- Reliable, unambiguous information about transmission and prevention, including special efforts to involve youths and to educate adolescent girls in particular about sexuality and HIV risk.
- Youth-friendly health services where they can be tested for sexually transmitted infections and HIV and where personnel are trained to work respectfully with adolescents.
- Changes in laws and social attitudes to discourage stigma, discrimination and sexual violence. Changes in laws prohibiting testing without parental permission.
- Condom availability.
- Participation of adolescents in crafting behaviour-change/prevention messages and delivering them to peers.

Life-Skills Education is a prevention activity taking place in many countries to help young people exercise their right to protection from HIV. Girls, especially, learn that they have a right to demand that partners use a condom or to refuse sex, and how to express themselves on these issues. Scaling up Life-Skills Education could help accelerate prevention of HIV in Africa.

Window of Hope

Children who are not yet sexually active also need information about HIV prevention and providing this could help slow the pandemic's spread within a generation.

Unlike the more difficult matter of helping sexually active adolescents change learned behaviours and attitudes, with younger children the task is simpler: **developing positive behaviours and attitudes from a young age, including:**

- Delaying the start of sexual activity
- Understanding the dangers of having multiple sexual partners
- Using a condom during sex
- Treating people living with HIV or AIDS with respect and compassion.

School-based curricula play a key role in teaching younger children about prevention, but not enough schools have integrated HIV/AIDS education into their curricula.

To stem the tide of HIV infection among children and youth, **society-wide efforts to impart information and life skills, and reduce high-risk sexual behaviour are required:**

- Countries should invest quickly in the development and implementation of age-appropriate curricula on HIV and AIDS.
- Teachers must be trained to address these issues factually and without embarrassment.
- Parents and religious and community leaders should reinforce the messages children receive in school. There needs to be open discussion in many different settings – at home, in community centres, at cultural, social and religious events.
- National leaders should create a supportive environment for prevention by providing needed services and enforcing laws that protect children from HIV and from sexual predators.
- The voice of young people should be listened to and respected.
- The media should develop creative programming for children and adolescents to reinforce prevention messages, making a special effort to reach the most vulnerable young people.

Women and Girls: Most Affected, Least Served

Women comprised 53 per cent of all those living with HIV in Africa in 2005; 77 per cent of all women living with HIV worldwide are in sub-Saharan Africa.

Africa is the only region in the world where more women than men are infected. For every 10 men infected, 13 women are HIV-positive.

The unequal position of women in most societies, disturbing levels of sexual abuse, violence and exploitation, and women's vulnerability to HIV infection are all fuelling the "feminization" of the epidemic.

The devastating burden of HIV/AIDS is falling primarily on women in sub-Saharan Africa, as the figures above show, and gender inequality is a key factor in the disease's spread. Social norms and beliefs and rigid social stratification maintain the low status of women, keeping them powerless to protect themselves from infection.

They lack the power to negotiate for safe sex and fend off attackers.

- Twenty nine per cent of Ghanaian adolescents surveyed in 1999 said their first sexual experience had been forced.

Boys and men refuse to use condoms and girls and women are powerless to insist.

Increasingly, girls and children are raped. The perceived low value of girl children is one reason, but there is also the widespread myth that having sex with a virgin cures HIV. Men also rape young girls in the hope that because they are young, they are free of HIV.

- A Zimbabwean NGO recorded more than 4,000 cases of sexual abuse against children in just one part of the country during 2005.
- In early 2006 the headmaster of a primary school in Zimbabwe was charged with raping six female pupils.

Older men, known in many countries as "sugar daddies," have sex with teenage girls in exchange for food, clothes or "luxury" items, such as cell phones.

- Research in South Africa found that girls who have sex with men five or more years older than themselves are *four times more likely* to be infected with HIV than those with partners closer to their own age.
- In KwaZulu-Natal, South Africa's most affected province, men from the town of Vulindlela work as migrants and return on the weekends, offering teenage girls money in exchange for sex. More than 25 per cent of teenage girls in Vulindlela are now HIV-positive, more than 50 per cent of young women aged 20-24 are infected, and around 66 per cent of women 25-29 have the virus.

Men also feminize the epidemic when they refuse HIV testing and then pass the virus on to their wives (polygamous situations mean multiple wives can be infected) and to their other sexual partners.

- Many wives report that their husbands refuse to allow them to be tested for HIV or receive treatment.
- Others say that husbands beat them and turn them out of their homes if they test positive or show signs of illness.
- Studies in South Africa and Tanzania found that women who were beaten by husbands or boyfriends were 48 per cent more likely to become infected with HIV than those who were not.

Summing Up

Preventing HIV/AIDS among women and girls depends upon empowering them to protect themselves.

It entails changing ideas, beliefs and practices. It calls for imposing and enforcing strict laws to prevent and penalize rape, sexual abuse and other forms of gender-based violence. It will need the full participation and engagement of all—most critically of men as partners in all aspects of change, as well as traditional and religious leaders—to modify traditional values and customs that disempower women.

- In Zimbabwe, government and NGOs have joined in a “Zero Tolerance for Child Abuse” campaign that educates communities about protecting girls against rape and abuse.
- South African NGOs launched a “Real Men Don’t Rape” campaign in early 2006 to address the country’s very serious problem of sexual violence.
- A community-based effort in Swaziland relies on adult volunteers as “a shoulder to lean on” for children, who report incidents or threats of abuse to this individual, who in turn contacts police authorities.
- Ghana has created a special police unit to investigate sex crimes.

Women are also the family members who care for those who are ill and dying of AIDS.

- If they lack knowledge about HIV transmission, they could become infected through bodily fluids during care, or during the preparation of bodies for burial, especially in traditional, rural communities.
- Care-related demands also undermine women’s efforts to earn income, further impoverishing them and increasing their vulnerability to exploitation following the death of a spouse.

A holistic approach to stemming the tide of HIV infections demands greater attention to issues of gender violence and gender inequalities in African societies. Girls and women need:

- Accurate, comprehensive information about how HIV is transmitted and can be prevented.
- Enforcement of laws and policies that condemn and punish sexual violence.
- Assisting women to acquire the skills they need to negotiate with sex partners over condom use and HIV testing and treatment.
- The creation of supportive family and community environments where men are full partners in ending gender discrimination and violence and where girls and women can build their self-esteem and confidence so they can defend themselves against HIV infection.

Four Broad Factors Fuelling the Pandemic

1. Economic and Poverty Factors

HIV is not a result of poverty, but poverty increases the risk of HIV infection, and HIV/AIDS exacerbates poverty and hunger.

Africa has both the highest poverty levels and the highest incidence of HIV/AIDS in the world. An estimated 46 per cent to 76 per cent of people in Africa live below the poverty line, according to the World Bank.

In the 1980s, as the HIV/AIDS epidemic was beginning to emerge, it found conducive conditions to establish itself in sub-Saharan Africa. Many countries were struggling to cope with social and economic problems, including legacies of colonialism such as mass poverty and limited education and health infrastructures. The demands of structural adjustment and Africa's enormous debt burden severely weakened the delivery of social services including the health infrastructure. Cyclical droughts and famines took devastating tolls, especially the drought which struck 20 African countries in 1984-1986. Countries 10 to 20 years into independence faced falling primary commodity prices and rising oil costs. Others were continuing the fight for freedom. And in still others, conflicts, power struggles and corruption undermined stability and deepened disparities and poverty.

Juggling these pressures and many development demands with limited national resources, and dealing with limited communication and health infrastructures, countries found their capacity to combat HIV constrained from the start. Social and cultural factors prevailing in much of Africa, and the underlying reluctance to openly acknowledge and confront a sexually transmitted disease of alarming virulence also gave the virus added footholds.

Many countries where only one per cent of the population was HIV-positive 15 years ago currently have prevalence rates of 10 per cent or higher, with almost all those affected being the poorest in societies.

An analysis of the relationship between AIDS-related deaths and poverty/ hunger in southern Africa found the following associations:

- Households without an economically active adult had 31 per cent less income than households with active adults.
- Households with two chronically ill adults had 66 per cent less income than households without chronically ill adults.
- Zambian families in which the head of household was chronically ill planted 53 per cent less than households without a chronically ill person.
- The death of just one wage-earning family member in Côte d'Ivoire lowered average household income by more than half.

Widows and orphans are frequently taken advantage of by family members and others. For example, women and children often lose their home and land once a husband/father dies, either to relatives in his family or outsiders who see an opportunity to seize property.

- The need to survive in such circumstances often forces the poorest women and children to engage in activities that expose them to high risk of HIV infection (such as commercial sex).

- Impoverished people have nutritional deficiencies and limited or no access to health care. Poor nutrition exacerbates HIV and without routine care HIV symptoms remain untreated, increasing the risk for HIV infection.
- Poverty is also associated with higher incidence of disease. In much of Africa malaria, bilharzia, intestinal parasites and tuberculosis are widespread, especially among children. The presence or history of these conditions increases susceptibility to HIV infection.
- Eradicating poverty, hunger and preventable disease is vital to HIV/AIDS prevention efforts.
- Accelerating HIV prevention will help to prevent further impoverishment.
- Poverty reduction and combating HIV/AIDS are Millennium Development Goals; progress on one goal leads to progress toward the other.

2. Educational and Informational Factors

Education services often fail to reach the poorest and most isolated in Africa. Yet research shows that if all children received a complete primary education, around 7 million new HIV infections could be prevented in a decade.

Girls are the least likely to obtain education, because they are expected to stay home and help with household chores, mind siblings, and care for ill family members. Yet girls who complete primary school are far more likely to have the knowledge and skills needed to avoid HIV infection than others, research shows.

- Surveys in 11 countries showed that **women with some schooling were nearly five times as likely as uneducated women to have used a condom the last time they had sex.**
- In Rwanda, women with secondary or higher education were five times more likely to know the main HIV transmission routes than those with no formal education.
- Surveys in 17 African countries showed that girls with more education tended to delay having sex and were more likely to insist that their partner use a condom.

Regular sources of information, with the exception of radio, are not available to most people in Africa, and in many countries illiteracy rates are high, limiting the usefulness of written messages and information.

Messages and the appropriate mediums for delivering them need to be developed, as without accurate information, people cannot fully understand what HIV/AIDS is, how it is passed from person-to-person, or how to prevent its spread.

- A recent survey in Botswana found that despite intensive HIV education efforts, 77 per cent of those surveyed thought the virus is spread by mosquitoes.

3. Social Factors

Two important social factors that are fuelling the pandemic include the **low status of women and the high rate of infections among children and young people between the ages of 15 to 24** in Africa. These subjects are explored in most of the other fact sheets and in depth in fact sheets 8 and 9.

Also associated with HIV's spread are **patterns of employment and population mobility in sub-Saharan Africa**, where porous borders, instability, conflicts and poor economic prospects all combine to propel people to leave established families and communities in search of livelihoods. Long-distance trucking, the mining industries and industrial/plantation farming are examples of situations where HIV's spread has been abetted when people are cut off from customary supports in isolating circumstances.

The **low social status of women and girls in most societies and associated low level of skills, education and poor employment opportunities make commercial sex work an option of last resort.** It is yet another social factor related to prevailing gender inequities that contributes to HIV's spread. Also related are the high incidence of divorce and polygamy, which expose women to greater risk of infection and which push them into commercial sex work.

Stigma and discrimination are potent fuellers of HIV's spread. The humiliation and abuse to which many of those living with HIV and AIDS are subjected by their families and communities make most people reluctant to learn their status, undermining efforts to provide testing, counseling and treatment, and thus ultimately undermining prevention.

Misconceptions about HIV (especially the notion that it is a form of divine punishment for 'immoral' behaviour) drive much of the stigma in many traditional communities in Africa.

A 2005 survey in South Africa found that tolerance for people living with HIV or AIDS was markedly greater in urban than rural areas. The result suggests that exposure to knowledge about the disease "normalizes" it, thus reducing discriminatory beliefs and practices.

4. Cultural Factors

A number of cultural rites and procedures, including circumcision, female genital cutting and other practices involving incisions ("scarification") put those undergoing them at risk when undertaken in a non-sterile environment, which is often the case in rural areas. Rituals and ceremonies related to puberty can also heighten the risk of casual sexual intercourse and rape.

In Tanzania, young people studied risk factors for HIV in their community and successfully petitioned District leaders to exert stricter control over rituals and ceremonies.

Early marriage, related to the rigid gender roles expected of women, heightens girls' risk of HIV. Young women are physiologically more vulnerable to infection and in a weaker position to negotiate safe sex with older husbands. Research suggests that young married women are more likely to be infected with HIV than those who are single.

Sending children to work for relatives in urban centres ("**fostering**") also exposes them to greater risk, especially since ill-treatment often prompts them to run away and live on the streets.

Some cultural traditions dictate that when a woman's husband dies, she automatically becomes her brother-in-law's wife. If the husband died of AIDS, this practice places the brother and his other wife or wives at high risk of contracting HIV.