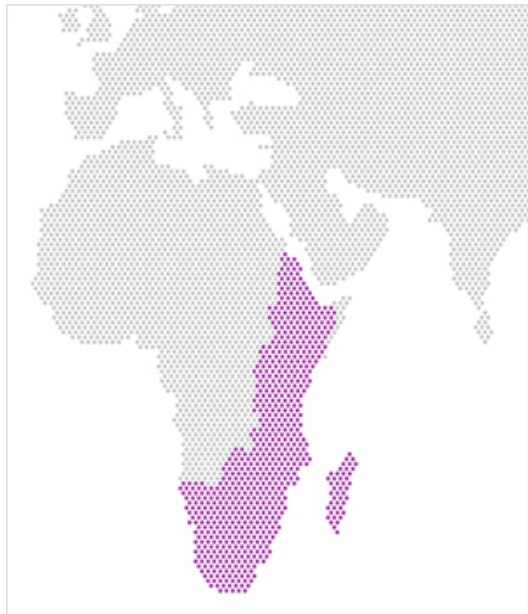


HIV and AIDS in East and Southern Africa regional overview

East and southern Africa updated August2017.png



East and Southern Africa (2016)

19.4 million people living with HIV

7% adult HIV prevalence

790,000 new HIV infections

420,000 AIDS-related deaths

61% adults on antiretroviral treatment

51% children on antiviral treatment

Source: UNAIDS Data 2017

KEY POINTS:

- East and Southern Africa is the region most affected by HIV in the world and is home to the largest number of people living with HIV.
- The HIV epidemic in this region is generalised but young women, men who have sex with men, sex workers, prisoners and people who inject drugs are at an increased vulnerability to infection.
- Improved availability of provider-initiated and community based HIV testing services now means three out of four people living with HIV are aware of their status.
- As the number of people living with HIV in East and Southern Africa has increased, so too has the provision of antiretroviral treatment.
- Although laws and cultural traditions vary between Eastern and Southern African countries, there are a number of ingrained cultural, structural and legal barriers that act as barriers to HIV prevention.

Explore this page to find out more about [populations most affected by HIV](#), [testing and counselling programmes](#), [prevention programmes](#), [antiretroviral treatment](#), [barriers to HIV prevention](#) and the [future of HIV and AIDS in East and Southern Africa](#).

East and Southern Africa is the region that is hardest hit by HIV. It is home to 6.2% of the world's population but has 19.4 million people living with HIV, over 50% of the total number of people living with HIV in the world. In 2016, there were 790,000 new HIV infections, 43% of the global total. [1](#)

South Africa accounted the one third (270,000) of the region's new infections in 2016, with another 50% occurring in eight countries: Mozambique, [Kenya](#), [Zambia](#), [Tanzania](#), [Uganda](#), [Zimbabwe](#), [Malawi](#), and Ethiopia. [2](#)

Just under half a million people (420,000) died of AIDS-related illnesses in East and Southern Africa in 2016, although the number of deaths has fallen significantly from 760,000 in 2010. [3](#)

Despite the continuing severity of the epidemic in the region, huge strides have been made towards meeting the UNAIDS 90-90-90 targets. In 2016, they reported that 76% people living with HIV in the region are now aware of their status, 79% who know their status are on treatment, and 83% of those on treatment have achieved viral suppression.⁴

Between 2010 and 2016, new HIV infections declined by 56% among children (0-14 years) to an estimated 77,000. Among adults, the decline over the same period was just 24%, although there is significant variation between countries. Declines in new infections were greatest in Mozambique, Uganda and Zimbabwe. While in Ethiopia and Madagascar, the annual number of new infections actually increased over the same period. ⁵

Women are disproportionately affected by HIV in the region, accounting for 56% of adults living with HIV. ⁶ In 2015, there were approximately 4,500 new HIV infections among young women every week, double the number seen in young men.⁷

Although East and Southern Africa's HIV epidemic is generalised, meaning it affects the population as a whole, certain groups such as sex workers and men who have sex with men have significantly higher HIV prevalence rates. For example, in Botswana HIV prevalence is 22.2% among the general population,⁸ however a study carried out in 3 districts found HIV prevalence among sex workers to be 61.9%.

In 2014, more than 20% of new HIV infections in the region were among key affected populations and their sexual partners despite these groups making up a much smaller percentage of the total population. Despite this, programming for key populations remains insufficient and many face stigma, discrimination and legal barriers that prevent them from accessing HIV services.⁹

In 2015, drought in Southern Africa caused by the El Niño climate cycle brought food insecurity to some countries and caused additional challenges for the region's HIV response.¹⁰

Key affected populations in Eastern and Southern Africa



Young women and HIV in East and Southern Africa

In 2016, HIV prevalence among young women (15-24 years) was double that of young men in the region (3.4% compared to 1.6%) although in some countries the disparity between genders is even greater. ¹¹

The reasons why young women are disproportionately affected by HIV in the region are numerous

and complex. For example, research by the ALL IN Initiative found high levels of transactional sex between young women and men in Botswana and age-disparate sexual relationships between young women and older men in Swaziland, both of which increase young women's vulnerability to HIV.¹²

Recent studies from 2017 in Zimbabwe and Uganda also provide evidence that inter-generational relationships are a major driver for HIV infection among young women, who may find it difficult to negotiate condom use with their older partners. Both studies found young married women with partners 16 or more years older were at three times greater risk of HIV infection than those with partners 0-15 years older. Marriage patterns in Zimbabwe and Uganda are comparable with many other parts of East and Southern Africa, so researchers have suggested similar correlations between age-disparate relationships and increased HIV prevalence among young women elsewhere in the region.¹³

A 2014 UNAIDS assessment of demographic and health surveys carried out in the region suggests that young women face higher levels of spousal physical or sexual violence than women from other age groups.¹⁴ Again, this heightens HIV risk - for example, a South African study found that young women who experienced intimate partner violence were 50% more likely to have acquired HIV than young women who had not experienced violence.¹⁵

Although knowledge regarding HIV prevention among young people is improving, in population-based surveys conducted across the region between 2000-2008 and 2009-2015, still only 37% of young women and 41% of young men displayed comprehensive and correct knowledge.¹⁶

Children and HIV in East and Southern Africa

The main route for HIV transmission among children is through birth (see later section on preventing mother-to-child transmission). However, East and Southern Africa also has high levels of underage, child and forced marriage.

In 2015, Girls Not Brides estimated that child marriage affected 37% of girls in Eastern and Southern Africa.¹⁷ This equates to 7 million child brides.¹⁸ As ever, there are regional differences. For example, in South Sudan 9% of women are married before they are 15 and 52% are married before they are 18. Similarly, in Ethiopia, 16% of women are married before they are 15 and 42% are married before they are 18. Whereas in Swaziland, 1% are married before they are 15 and 7% before they are 18.¹⁹

Girls who marry as children are more likely to be beaten or threatened by their husbands than girls who marry later. They are also more likely to describe their first sexual experience as forced. As minors, child brides are rarely able to assert their wishes, such as whether to practice safer sex.²⁰ These factors all increase HIV risk.

Increased political will to curb child marriage is growing. In April 2015 Malawi passed a new Marriage Act that increased the age of marriage to 18 years. Similarly, Ethiopia has developed the National Strategy on Elimination of Harmful Traditional Practices, which addresses child marriage and female genital mutilation (FGM). In 2013, Zambia launched a three-year national campaign to end child marriage by amending relevant laws and policies to ensure that girls are legally protected from child marriage and by working with traditional leaders to end the practice in their communities.²¹

Sex workers and HIV in East and Southern Africa

Sex workers are also at particularly high risk of HIV in East and Southern Africa. Although regional information about this population is limited, data provided by eight countries in 2014 put the median HIV prevalence at 22%, with significant differences between countries.²² Zimbabwe, Botswana and Swaziland all reported prevalence of above 50% among sex workers in 2014.²³ In South Africa, HIV prevalence among this group was estimated at 72% in Johannesburg, 40% in

Cape Town and 54% in Durban in 2015.²⁴

A 2015 assessment by UNAIDS and the World Bank of 18 countries in East and Southern Africa found female sex workers were identified in all 18 national AIDS plans or strategies as a group which was essential to reach with effective HIV programmes.²⁵ Despite this, the overall coverage of prevention programmes for sex workers in the region is difficult to determine due to the lack of reported data.²⁶

The percentage of female sex workers who said that they had used a condom with their most recent client in 2011 exceeded 75% in Ethiopia, Mauritius, Rwanda, Swaziland and Uganda, and it was at least 60% in Angola, Eritrea and Zimbabwe.²⁷ In Lesotho, where HIV prevalence among female sex workers was estimated at 71.9% in 2016, condom use with the last client stood at 64.9%.²⁸

In some cases, sex workers have no access to condoms or are not aware of their importance. In other cases, police are actively confiscating or destroying condoms found in sex workers' possession. For example, a 2012 study by the Open Society Foundation in Kenya, South Africa and Zimbabwe found evidence of physical and sexual abuse and harassment of sex workers who carry condoms. Police were also using the threat of arrest on the grounds of condom possession to extort and exploit sex workers.²⁹

Extreme sexual violence, including gang rape and forced unprotected sex, has been documented among sex workers in the region, including while being arrested and in detention. For example, in Adama, Ethiopia, nearly 60% of female sex workers reported work-related violence.³⁰ In Mombasa, Kenya, this figure was 79%.³¹ Modelling estimates in Kenya show that a reduction of approximately 25% in HIV infections among sex workers may be achieved when physical or sexual violence is reduced.³²

Men who have sex with men (MSM) and HIV in East and Southern Africa

While data on [men who have sex with men \(sometimes referred to as MSM\)](#) in East and Southern Africa is limited, HIV prevalence is believed to be high at 14% with variation between countries.³³ Country surveys conducted between 2013 and 2015 report prevalence of between 9.9% and 32.9%.³⁴

A number of studies suggest that the majority of men who have sex with men in the region also engage in heterosexual sex, often with wives or other long-term female partners.³⁵ The HIV epidemic among men who have sex with men is therefore interlaced with the epidemic in the wider population.³⁶

Regional data on condom use among men who have sex with men are limited, but 2011 and 2012 studies from selected areas in Kenya, Mauritius and Rwanda reported estimates of around 50-55%.³⁷

The vast majority of national AIDS plans or strategies in the region identify men who have sex with men as a key population. However, specific programmes for men who have sex with men are extremely limited and constrained by widespread homophobia.³⁸

People who inject drugs (PWID) and HIV in East and Southern Africa

Kenya, Madagascar, Mauritius, Mozambique, South Africa and Tanzania are all home to significant populations of people who inject drugs (sometimes referred to as PWID). Although regional data is limited, country surveys among people who inject drugs suggest high HIV prevalence.³⁹

In Kenya, HIV prevalence among people who inject drugs was 18% in 2011, compared to 5.6% among the general population.⁴⁰ In 2012, the country introduced needle and syringe programmes (NSPs) and opioid substitution therapy (OST) to help reduce HIV transmission among this population.⁴¹ In 2015, nearly 90% of people who inject drugs reported using a clean syringe last

time they injected compared to 51.6% in 2012.⁴²

NSPs and OST are also being scaled up in Tanzania where it is estimated that 35% of people who inject drugs are living with HIV.⁴³ The HIV prevalence among women in Tanzania who inject drugs is thought to be twice that of men who inject drugs. The reasons for this are not fully known, although possible factors include women who inject drugs being involved in sex work or being last in line when syringes are shared.⁴⁴

In 2015, an estimated 19.4% of people who inject drugs in South Africa were living with HIV.⁴⁵ A 2015 study in five South African cities found 32% of men and 26% of women who inject drugs regularly shared syringes and other injecting equipment and nearly half reused needles.⁴⁶

Data from 2013 collected in Kenya, Mauritius, Seychelles and Tanzania shows that many people who inject drugs acquire HIV before they reach the age of 25 years.⁴⁷

HIV testing and counselling (HTC) in East and Southern Africa

In recent years, a number of countries in the region such as Botswana, Kenya, [Uganda](#), Malawi and Rwanda have implemented national campaigns to encourage uptake of HIV testing and counselling (HTC). In 2016, 76% of people living with HIV had knowledge about their status - an improvement from 72% in 2015. ⁴⁸

A number of different strategies have been used to increase delivery and access to HTC services in the region. For example, home based testing in South Africa has increased HIV testing in rural settings, as well as encouraging couples' counselling and testing.⁴⁹ A number of other countries also have pilots for self-testing services in place including Malawi, Zambia and Zimbabwe.⁵⁰

Kenya has adopted a number of innovative approaches to HIV testing in recent years, including targeted community-based HIV testing and door-to-door testing campaigns. In 2015, the Kenyan government announced plans to introduce self-test kits.⁵¹ As a result, there has been a dramatic rise in the number of people testing for HIV in the country. In 2008, 860,000 people were being tested annually for HIV, by 2013 this had increased to 6.4 million.⁵²

HTC services have been steadily expanding across Lesotho, particularly at a community level, rising from 2.7% of adults taking an HIV test in 2004 to 35% in 2011.⁵³ In 2014, Lesotho implemented provider initiated testing and counselling, which is when service providers offer HTC rather than waiting for an individual to request it. However, this has been compromised by a lack of health staff and frequent HIV test kit shortages.⁵⁴

In 2015, UNITAID, Population Services International and partners began implementing self-testing in Malawi, Zambia and Zimbabwe through the four-year STAR (Self-Testing Africa Research) Project. Between 2015 and 2017, the STAR Project is distributing nearly 750,000 self-test kits across the three countries. One of the goals of the project is to generate evidence on the feasibility, acceptability and impact of self-testing that will then inform official World Health Organization (WHO) global guidance on the intervention.⁵⁵

I decided to get tested so that I could be aware of my HIV status. I have big dreams that I would like to achieve in life like everybody else and I want to stay healthy and prevent myself from HIV infection. I also encourage my friends and fellow young people to go for HIV testing regularly and take control of their lives.

HIV prevention programmes in East and Southern Africa

A number of countries in East and Southern Africa have conducted large-scale prevention programmes in an effort to contain and reduce their HIV epidemics.

In 2015, Ethiopia, Malawi, Swaziland and Zimbabwe looked at how to revitalise their national prevention programmes. In the same year, government representatives of Kenya, Zimbabwe and South Africa met to plan the development of a regional roadmap to accelerate scale-up of combination HIV prevention services at local levels and increase investments for combination HIV prevention.⁵⁷

Programmes for young women

Programmes and initiatives launched to scale-up HIV prevention services for young people, especially for young girls and women, gathered pace in East and Southern Africa in 2015.

Case study: DREAMS

This ambitious US \$385 million programme aims to reduce HIV infections among adolescent girls and young women in Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. It focuses on social isolation, economic disadvantage, discriminatory cultural norms, orphanhood, gender-based violence and education. Its aim is to achieve a 40% reduction in HIV incidence among females aged 15-24 in the hardest-hit areas of the DREAMS countries by the end of 2017.⁵⁸

Case study: ALL IN

Launched in 2015, the ALL IN programme focuses on four key action areas: engaging, mobilising and empowering adolescents as leaders and actors of social change; improving data collection to better inform programming; encouraging innovative approaches to reach adolescents with essential HIV services adapted to their needs; and placing adolescent HIV on political agendas to encourage action and mobilise resources. The programme particularly aims to increase the meaningful participation of adolescents in decision-making processes and strengthen youth-led social movements.⁵⁹

For example, in a number of countries ALL IN is collaborating with, and mobilising adolescent groups to advocate for the review of laws on the age of consent for sexual and reproductive health and HIV information and services. Additionally, rapid assessments conducted for ALL IN has shed light on how HIV affects adolescents of different ages, which has prompted countries to recognise that adolescent data are weak and lacking in specificity. This recognition has become a catalyst for national programmes to acknowledge that they could be doing more for adolescents.⁶⁰

In 2013, ministers of health and education from countries across the region committed to the implementation of a raft of gender-transformative HIV programming to address the barriers that prevent girls and young women from accessing services. These include keeping girls in school, comprehensive sexuality education, girl-friendly sexual and reproductive health services, eliminating gender-based violence and female genital mutilation, and economic and

Condom availability and use

Condom availability for men aged 15–64 years varied widely by country, with only five countries meeting the United Nations Population Fund (UNFPA) regional benchmark of 30 male condoms distributed per man per year (2011–2014).[62](#)

Namibia had the highest level of availability of male condoms, with 54 available per man per year, followed by Swaziland (51), Botswana (50), Zimbabwe (33) and Lesotho (31). In Angola and South Sudan only 5 and 0.4 condoms per man per year were available, respectively.[63](#) Women in the region were even more underserved: female condoms accounted for a small fraction of the condoms procured in 2015.[64](#)

Population-based surveys conducted between 2009 and 2015 in the region indicate that condom use at last sex among adults aged 15–49 years who had sexual intercourse with more than one partner within the past 12 months was only 23% among men and 33% among women. There was substantial variation among countries, ranging from as low as 7% among men in Madagascar to 69% among women in Namibia and 83% among men in Swaziland. Demographic and Health Surveys conducted between 2008 and 2015 found that condom use among men who paid for sexual intercourse in the preceding 12 months was higher, at about 60% on average.[65](#)

Prevention of mother-to-child transmission (PMTCT) in East and Southern Africa

Significant progress has been made in the prevention of mother-to-child transmission (PMTCT) of HIV in East and Southern Africa.

Between 2010 and 2015, new HIV infections declined by 66% among children (0–14 years) to an estimated 56,000.[66](#) This impressive decline in infections is due to the rapid increase in PMTCT services, from 61% coverage in 2010 to 90% in 2015. This equates to 861,000 pregnant women who are living with HIV on antiretroviral treatment (ART) in the region.[67](#)

In 2015, seven countries (Botswana, Mozambique, Namibia, Rwanda, South Africa, Swaziland and Uganda) had PMTCT coverage of 90% or above, and four countries (Malawi, Tanzania, Zambia and Zimbabwe) had coverage of 80% or above. At the other end of the scale, Madagascar had just 3% coverage and Angola and South Sudan had coverage of around 40%.[68](#)

Voluntary medical male circumcision (VMMC) in East and Southern Africa

In 2007, the World Health Organization (WHO) and UNAIDS recommended [voluntary medical male circumcision \(VMMC\)](#) as a key component of HIV prevention in countries with a generalised epidemic, following the discovery that male circumcision could reduce the risk of sexual transmission of HIV from females to males by 60%.

Studies from 2009–2011 indicated that circumcising 80% of men in 14 priority countries in East and Southern Africa in five years could avert 3.4 million new infections over the next 15 years and save \$16.5 billion in treatment costs.[69](#) As a result, WHO and UNAIDS launched a joint strategy to accelerate the scale-up of VMMC in the region, calling for 80% coverage of adult male circumcision by 2016.[70](#)

Tremendous progress was made between 2008 and 2014. Countries such as Kenya, Ethiopia and Tanzania have achieved or exceeded the 80% target while Mozambique, South Africa, Uganda and Zambia have reached between 50–79% of eligible men. However, in Lesotho, Malawi, Namibia, Rwanda and Zimbabwe, less than 35% of eligible men have been circumcised.[71](#) Progress appeared to have faltered in 2015 as the number of men circumcised was lower in 8 out of the 14 priority

countries (Botswana, Ethiopia, Lesotho, Rwanda, Uganda, United Republic of Tanzania, Zambia and Zimbabwe). An estimated 2.6 million males were circumcised in 2015, compared with 3.1 million males in 2014.⁷²

Antiretroviral treatment (ART) in East and Southern Africa

Antiretroviral treatment (ART) programmes have been scaled-up dramatically in East and Southern Africa over the past decade.

In 2016, there was an estimated 11.7 million people on antiretroviral treatment in region. This represents 79% of people living with HIV and aware of their status. In the same year, paediatric treatment coverage increased to 51% from 19% in 2010.⁷³

By the end of 2015 all countries in the region were at least implementing 2013 WHO treatment guidelines, which expanded eligibility for ART for people with a CD4 count of 500 or less. Many countries, including Kenya, Malawi, Namibia and Uganda, have begun adopting the 2015 WHO recommendation to immediately offer treatment to people diagnosed with HIV. Lesotho officially adopted and began the roll-out of 'test and treat' guidelines in April 2016, Botswana launched a 'treat all' strategy in June 2016, and South Africa started offering treatment immediately following diagnosis before the end of 2016.⁷⁴

Although South Africa has the largest number of people (3.9 million) with HIV, followed by Kenya (940,000 people), on ART. Despite this significant number, South Africa's treatment coverage only reaches just over half of those who need it and falls below the regional average.⁷⁵ Conversely, treatment coverage was highest in Botswana at 83% and Rwanda at 80% in 2016.⁷⁶

Other countries including Malawi, Mozambique, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe have all increased treatment access by at least 25% between 2010 and 2015.⁷⁷

However, weak health and community systems continue to undermine scale-up of testing and treatment. Further gaps in the provision of treatment are caused by humanitarian emergencies - for example, the drought caused by El Nino in 2015 which has seen food insecurity increase in Southern Africa. Food insecurity often increases risky behaviour, such as transactional sex, leaving people more vulnerable to HIV. For people living with HIV, food insecurity can make ART adherence more difficult thereby disrupting HIV treatment. This increases the risk of drug resistance and HIV transmission.⁷⁸

As a result of these gaps, approximately 50% of all people living with HIV in East and Southern Africa had achieved the viral suppression necessary to prevent onward HIV transmission in 2016.⁷⁹

However, high prices, weak infrastructure and capacity challenges means that viral load testing is availability of viral load testing varies between cities and countries. Data reported to UNAIDS from 12 countries in the region showed that about 44% of people accessing antiretroviral therapy in East and Southern Africa also had accessed routine viral load testing in 2016. Eritrea is currently the only country in the region which completely lacks a national policy on routine viral load testing.⁸⁰

Pre-exposure prophylaxis (PrEP)

In late 2015, South Africa became the first country in the region to fully approve pre-exposure prophylaxis (PrEP), the use of antiretroviral drugs to protect HIV-negative people from HIV before potential exposure to the virus. A month later, Kenya followed suit. As of 2016, Kenya, South Africa and Zimbabwe have been implementing projects to investigate the uptake and impact of PrEP, specifically with young women and girls in high-incidence areas.⁸¹

Barriers to HIV prevention in East and Southern Africa

Economic barriers

Increased funding is at the centre of efforts to improve HIV and AIDS service provision in East and Southern Africa. Over a decade, between 2006 and 2016, resources available for HIV services in the region have more than doubled reaching an estimated US\$ 9.6 billion at the end of 2016. [82](#)

For example, 30% of HIV funding in both Zimbabwe and Kenya comes from domestic sources and private individuals with the remainder of the country's HIV response funded internationally.[83](#)[84](#) Similarly, in Lesotho 34% of funding for the country's HIV response came from domestic resources in 2015[85](#). Whereas, in Tanzania, 97.5% of the country's HIV response is funded internationally.[86](#) Similarly, Malawi's national HIV response is still largely funded by external sources, although the country's domestic contribution increased from 1.7% in 2010/2011 to 14.3% for 2013/2014.[87](#)

The exception in the region is South Africa, where approximately 80% of the national response is financed through domestic resources.[88](#)

In countries such as Uganda and Swaziland, the commitment to providing life-long HIV treatment is predicted to put huge pressure on domestic finances.[89](#)

In the context of declining international resources for overseas aid, coupled with the rapid economic growth across the region, in 2015 the East African Community and the South African Development Community endorsed action frameworks on sustainable financing that commit countries to increase domestic spending, address inefficiencies in health services, and explore innovative financing mechanisms in the next five years.[90](#)

Raising taxes has the potential to increase health expenditure in some countries but not all.[91](#) For example, Zambia's economy is expected to grow by nearly 5% a year between 2011 and 2017, creating an additional \$21.8 per capita in healthcare spending. By contrast, Swaziland has a projected growth of minus 0.1% for the same period, and therefore has very limited scope to increase domestic spending on healthcare.[92](#) External borrowing is also an option but many countries in the region already have high levels of debt compared to their economic output.[93](#)

Social and cultural barriers

Stigma and discrimination

HIV-related stigma and discrimination remains a major barrier to tackling the HIV and AIDS epidemic in East and Southern Africa. Cultural beliefs about HIV and AIDS around contamination, sexuality and religion have played a crucial role in the development of HIV-related discrimination.[94](#) Moreover, studies have shown how healthcare workers' negative and discriminatory views towards HIV-positive people are influenced by, and often similar, to those in the general population.[95](#)

In 2016, the AIDS & Rights Alliance for Southern Africa (ARASA) described as "inconsistent and uneven" the progress made against the stigma and discrimination people living with HIV in the region face.[96](#)

However, a number of countries are seeing a reduction in HIV-related stigma. For example, in Kenya 92% of women and 95% of men surveyed in Kenya's 2014 Demographic and Health survey said they would be willing to care for a relative who became ill due to HIV. 77% of women and 84% of men said that they would be willing to buy fresh vegetables from someone with HIV, and 88% of both women and men agreed that a female teacher who has HIV but is not sick should be allowed to continue teaching. All these levels have improved since the Kenya Demographic and Health Survey began measuring HIV-related stigma in 2003.[97](#)

The region remains a largely hostile environment for men who have sex with men, sex workers, transgender people, and people who use drugs, and people from key affected populations often

experience heightened levels of stigma and discrimination as a result. For example, young men who have sex with men are significantly more likely to experience bullying at home, in schools and communities than their heterosexual counterparts.⁹⁸

The stigma experienced by people from key affected populations often prevents them accessing HIV services.⁹⁹ For example, evidence cited by the African Sex Worker Alliance in Kenya, South Africa, Uganda and Zimbabwe found sex workers experienced very high levels of stigma, with stigma towards male sex workers who have sex with men even higher due to homophobia. Many sex workers said they did not wish to disclose their occupation to healthcare providers and considered stigma and discrimination as a major barrier to HIV testing.¹⁰⁰

The status of women

Women and girls often face discrimination in terms of access to education, employment and healthcare. In the region, men often dominate sexual relationships. As a result, women cannot always practice safer sex even when they know the risks involved.¹⁰¹

Gender-based violence has also been identified as a key driver of HIV transmission in the region. Despite 15 of 19 countries in the region having laws against domestic violence and sexual offences, more than 30% of ever married or partnered women aged 15–24 years experienced physical or sexual violence from a male intimate partner in the previous 12 months in Uganda, Tanzania, Zambia and Zimbabwe. This figure was 50% among girls aged 15–19 years in Namibia.¹⁰²

Legal barriers

In many countries, there are laws criminalising people who expose others to HIV or transmit the virus sexually. Supporters of criminalisation often claim they are promoting public health or justify these laws on moral grounds.¹⁰³ However, ARASA and others working in the HIV response argue that overly broad criminalisation of HIV exposure, non-disclosure and transmission in the region continues to stigmatise people living with HIV, which undermines public health initiatives, and is ultimately damaging to HIV prevention.¹⁰⁴

The criminalisation of sex work, drug use, and same sex practices, as well as the lack of legal recognition of gender identity, compounds key affected populations' inability to access HIV services.¹⁰⁵ Out of 19 countries in the region, 17 criminalise some aspect of sex work and 15 criminalise same-sex relationships¹⁰⁶ and many governments or influential institutions such as churches promote homophobia and discrimination against people on the grounds of sexual orientation and gender identity. Some progress has been made however, with both the Seychelles and Mozambique repealing provisions that criminalise sex between men in 2016.¹⁰⁷

Community-based services that address legal and social barriers faced by key affected populations and people living with HIV can challenge these structural issues.¹⁰⁸ For example, in Kenya the Bar Hostess Empowerment Programme has trained local sex workers as paralegals who have learnt about local and national laws and then educated other sex workers about their rights.¹⁰⁹

The future of HIV and AIDS in East and Southern Africa

Tackling the HIV epidemic in East and Southern Africa is a long-term task that requires sustained effort and planning from both domestic governments and the international community.

In order to meet UNAIDS' targets by 2020 the region must diagnose more than 5.3 million people living with HIV who did not previously know their HIV status, start an additional 5.2 million people on ART, and ensure an additional 5.3 million people living with HIV achieve viral suppression.¹¹⁰

Girls and young women must be placed at the centre of the response if the region is to drastically reduce HIV. This means meaningfully addressing gender inequality and inequity, tackling harmful traditional practices such as child marriage, and increasing educational opportunities.¹¹¹

As the HIV epidemic develops, countries in East and Southern Africa will need to assess how to allocate what are currently limited resources. For example, increased linkages between sexual and reproductive health (SRH) and HIV services, which Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia and Zimbabwe have been piloting since 2011, has been shown to increase access and uptake for both SRH and HIV services. Further scale-up of integrated programmes must continue. However, fundamental barriers to treatment, particularly HIV-related stigma and discrimination and HIV-specific criminal legislation, must also be overcome. Removing such barriers would encourage more people to get tested and seek out treatment, reducing the burden of HIV across the region.

Civil society and communities are also vital to the future of East and Southern Africa's HIV response. Encouragingly, national and regional support for community mobilisation efforts grew in 2015, with increasing interest from several governments in understanding the unique contributions of community groups in addressing HIV.¹¹²

Serious challenges remain in terms of key affected populations, including the criminalisation of same-sex sexual relations, drug use and sex work, insufficient implementation of harm-reduction programmes, and insufficient protection of people from discrimination, harassment, violence and abuse arising from sexual orientation or gender identity. In many countries the prioritisation of key populations within national AIDS plans and strategies has not resulted in sufficient financial allocation and programme implementation to address their needs.¹¹³ However, in some countries, key affected community networks are emerging and regional networks now exist for female sex workers and men who have sex with men. These networks are essential for strengthening the response for key affected populations.¹¹⁴

Insufficient financial resources, combined with the lack of strategic information, has led to many high-impact HIV prevention programmes not being implemented to the necessary standard or scale in the region. For example, most countries do not have systems for unique identification of individuals, which makes tracking people across prevention and treatment services difficult. This leads to inaccuracies in the reported data. Moreover, there is a lack of technical capacity, human resource availability and coordination in some countries which prevents effective data from being collected.¹¹⁵ These systems must be strengthened to enable the region's HIV response to be evidence-based, and ultimately more effective.

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