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Exchange
ON HIV AND AIDS, SEXUALITY AND GENDER

# Reflections on achieving an HIV-free generation in Africa

By Ann Ferrara

**What does it take to have an HIV-free generation, and how will we achieve HIV Zero? The UNAIDS Strategy Document *"Getting to Zero"* is a guide for prevention, treatment, care and support from 2011 to 2015. The goals are: Zero new HIV infections, Zero discrimination and Zero AIDS-related deaths (UNAIDS, 2010). It will take many individuals, organisations and governments cooperating to achieve this goal.**

The latest epidemiological data from UNAIDS had some 34 million people living with HIV and AIDS, with 23.5 million living in sub-Saharan Africa (SSA) in 2011. Of the estimated 2.5 million new infections worldwide, SSA accounts for 1.8 million. AIDS-related deaths are 1.7 million, with 1.3 million in SSA. Under-15-year-old HIV-positive children number 3.3 million, with 330,000 newly infected. About 230,000 children have died from AIDS-related illnesses.

Imagine a world where children will be born free of HIV; when pregnant women will not be HIV-positive, and therefore will not need ARVs for themselves or to protect their unborn children; a time when men and women will be able to have sex without the fear of HIV infection.

Gender-based violence (GBV) has contributed to the increase of new HIV infections in women and children, hence, HIV awareness campaigns have been targeting men to eliminate GBV[1] as one of the Millennium Development Goals (MDGs) to be achievable by 2015, and will help towards achieving an HIV-free generation.

Education and awareness can change attitudes and behaviours and prevent new HIV infections. This issue discusses successful classroom and community programmes such as Anke van deKwaak's article on Dance 4 Life, (see article on page 7) and Helen Lunn's article on Drama for Life (see article on page 14).

UNAIDS figures (2012) show the distribution of ARVs has increased in many parts of the world with SSA delivering to 56 per cent of those in need. The results as shown by the report reflecting on some countries, including South Africa, indicate progress at above 60 per cent towards delivering ARVs. With some 23 million people worldwide requiring lifelong ARVs (WHO, 2012), their continued accessibility and availability is key to achieving Zero HIV.

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To achieve Zero HIV, it must be recognised that people who are living with HIV and AIDS are, or will become, chronic care patients, necessitating greater access to and availability of ARVs. It will be important in 2013, to see how the gap between those in need of the drugs and those who have them will be closed. Treatment as Prevention (TasP), as outlined by the WHO (2012), underlines the need for extra focus on therapy adherence.

Not all children and adolescents born with HIV have been fortunate to access ARVs, hence the quest for new formulations that taste better, and are simpler to take. Children and youth born with HIV will need more adherence and social support to grow up on ARVs, and to help them have a healthy transition from childhood to adolescence, and from adolescence to adulthood.

In South Africa, the government has realised the need for early initiation of ARVs, but additional educational, counselling and social support is needed to fight stigma and discrimination. Stellenbosch University in South Africa offers an on-line Master's degree in HIV Management to students from more than 40 countries. The idea is to improve workplace policies needed now and in the future as people living with HIV and AIDS are able to enter the workforce, or

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## Editorial

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### Working towards an HIV-free generation

The UN Children's Fund believes a generation of babies could be born HIV-free if the international community stepped up efforts to provide universal access to HIV prevention, treatment and social protection.

According to a UNICEF report, millions of women and children, particularly in poor resource settings, fall through the cracks of HIV services due to their gender, social or economic status, location or education. It notes that while children have benefited from substantial progress made in the fight against AIDS, more needs to be done to ensure all women and children get access to the medicines and health services designed to prevent mother-to-child HIV transmission.

The UN estimates that 370,000 children were born with HIV in 2009, most of them in Africa, the region that bears the highest AIDS burden. To address this situation and speed up the pace towards an HIV-free generation, UNAIDS has evolved three strategic directions for a renewed global HIV response, whose success would significantly reduce new infections. They include revolutionising HIV prevention, catalysing the next generation of treatment, care and support and advancing human rights and gender equality for the HIV response.

Achieving this goal, says UNAIDS, will depend on "intensifying what we know works and focusing efforts where they are most needed." The UN agency also notes that analysis of the severity, scale, scope and impact of the epidemic will guide in delivering maximum results. The HIV response, UNAIDS argues, provides an opportunity to strengthen the social fabric, improve social justice and reinforce the systems that deliver critical services for the most vulnerable members of our communities.

Achieving this goal will also hinge on striking a balance between intensifying work in the hardest-hit countries and identifying other settings, such as cities, where the impact of HIV is affecting specific communities—particularly men who have sex with men, sex workers and their clients and people who use drugs. It behoves all stakeholders to work together to achieve an HIV-free generation.

return to work, with considerations for their clinic appointments, and in some cases, their disabilities. reducing maternal and infant mortality are among the MDGs to be realised by 2015. ARVs can help achieve this by reducing HIV in pregnancy and infancy and treating mothers and fathers, so that each child grows up with its parents.

## ARVs – Treatment as Prevention (TasP)

WHO's T*he Strategic Use of Antiretrovirals: To Help End The HIV Epidemic* requires governments to forge country strategies, some of which have been in place, but need expansion. ARVs have been part of the prevention efforts for more than 15 years, especially in the Prevention of Mother-to-Child Transmission (PMTCT), and in treating healthcare workers who have been exposed to HIV as well as victims of rape, by using Post-Exposure Prophylaxis (PEP). For HIV positive pregnant women, their chances of bearing a child without HIV have improved by changing from a single ARV (AZT or Nevirapine) to triple therapy. This is a dynamic area since the newest maternal and infant ARV prophylaxis information is being designed and implemented following WHO July, 2012 recommendations. The mother's CD4 count will determine what she receives; a CD4 count above 350 will require Nevirapine during pregnancy and until at least six weeks after she gives birth, or until one week after the infant has stopped breastfeeding. A woman whose CD4 count is below 350 will require lifelong triple therapy. This has a bearing on breastfeeding and formula feeding, and therefore, impacts infant prophylaxis. According to these guidelines, all pregnant women who are HIV-positive should be eligible for ARVs. Many studies and reviews have been conducted on the topic of breastfeeding versus formula feeding, since HIV transmission via breast milk is a known fact (BHIVA and CHIVA, 2012).

The newborn will be treated at birth and for six consecutive weeks to ensure a better chance of achieving an HIV- negative status. Adherence to the ARVs is especially important for lactating women, since HIV can be transmitted through breast milk.[2] With the burden of HIV falling on women, an increase in maternal and childcare programmes has been recommended by the Partnership for Maternal, Newborn and Child Health (PMNCH, 2011). There is a need to be aware of the role alcohol and drug abuse play in the increase of unintended and teen pregnancies.

In SSA, the highest HIV burden is among women (UNAIDS 2012). Socio-economic factors, including low education, hamper access and use of condoms by women and their partners. GBV has also contributed to an increase in HIV cases even where there is no conflict or war. Education is important for behaviour change. Unable to negotiate for themselves, many women are in relationships with men who have multiple partners. In countries like Swaziland where polygyny is practised, there is a focus on reaching the men through the *Max*ART programme (see article by Bongani Simelane, Laura Plattner , et al on page 11). There are also men in committed relationships with women or whom are married, who engage in sex with other men, thereby belonging to the category of Men Who Have Sex With Men (MSM), and who pose additional HIV risks. (See Louise Bourchier's article on page 4).

To have more impact on youth, programmes that involve them, especially drama and dance, are desirable. Two articles discuss the use of music, dance and drama in this issue: Anke van der Kwaak's article about dance4life shares the motivational force behind this international movement. In Helen Lunn's article about Drama For Life, we learn of the benefits of theatre in sharing difficult messages and how Drama For Life at the University of the Witwatersrand has an impact on the campus and in the communities that the students work in.

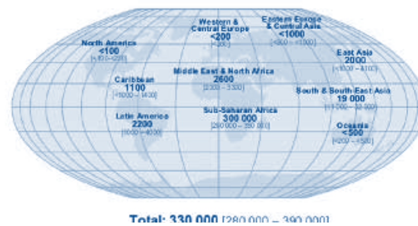
The internet has opened many new doors for communicating with the youth. E-mail and social networking sites increasingly provide space for sharing views and experiences. Greater access to computers seems important in public schools and libraries in the Western Cape Province. The mobile phone, through instant text messaging, is also important for strengthening adherence as discussed in Steve Snyder's article (See page 10). The good news is that people can receive the messages for free within South Africa.

Through the school nurses, HIV counsellors, peer counsellors and workshops hosted by the WCED's HIV/AIDS and Life Skills Department, the youth constantly asked where they could get free condoms and when the schools would be able to provide them, rather than having to get them from clinics. The WCED prefers that the youth are referred to local community clinics for sexual and reproductive health counselling, testing and treatment, or local NGOs that distribute condoms.

> **WHO's newest guidelines recommend that all pregnant women be allowed to start ARVs during pregnancy, regardless of their CD4 count.**

While many prevention messages have targeted teenagers, unintended pregnancies signify lack of condom use, especially in the Cape Town area. When girls attend the special clinics in Khayelitsha or Marie Stopes[3] for the termination of (early) pregnancy, they are offered contraceptive information and devices to prevent a similar pregnancy. The clinics and some hospitals provide Medical Male Circumcision (MMC) services, which are credited with a reduction of up to 60 per cent in the transmission of HIV and sexually-transmitted infections (STIs) through unprotected sex. They also offer the Human Papilloma Virus Vaccine to protect young women (aged 12-25 years) from cervical

Estimated number of children (<15 years) newly infected with HIV | 2011




Once children and youth are diagnosed HIV positive, they tend to need additional support. In Cape Town, HIV adolescent clinics have been established at Tygerberg Hospital and in Guguletu, as a community-based programme. In Khayelitsha, Treatment Action Campaign organises youth meetings, where HIV youth and young adults discuss their situations with one another, out of the clinic environment, and gain knowledge about their bodies and their treatments, as well as how to advocate for their rights. Botswana-Baylor's Children's Clinical Centre of Excellence in Gaborone, which started with 23 youth at their Adolescent Clinic in 2005 caters to more than 600 now, and is designed to meet the needs of HIV-positive youth. In 2011, the centre hoped to reach 4000 adolescents nationwide with ARVs. Through their Teen Clubs, they receive and offer peer support.

We have seen how important civil society organisations and NGOs have become in the fight against HIV on the ground, and taking care of people living with HIV and AIDS (PLHIV); e.g. TASO in Uganda and TAC in South Africa. They have been the backbone of the movement for defending the rights of HIV-positive people and finding providers of care and support for those who would otherwise be neglected or abandoned to die, especially in resource-poor settings.

Since 2010, recognising every person's human rights has had to be fitted in the UNAIDS campaign, and partner agencies have followed suit. Increasing access to ARVs at an early stage of HIV infection with a CD4 count of 350 or less is a measure that will increase longevity and hopefully, the quality of life. The Pre-Exposure Prophylaxis (PrEP) pill offers hope for discordant couples. Since the International AIDS Conference in Washington DC in July 2012, many results have been presented, and suggest that this is the future, since there is still no cure.

## Prevention of new HIV infections through research and development.

Many clinical trials have been conducted on HIV vaccines, microbicides, PEP and PrEP (WHO, 2012; Buchbinder & Liu, 2011). In South Africa, Mark Cotton has led clinical trial research on HIV and TB in children[4]. Meanwhile, other programmes seek to modify the high level of risk-taking behaviour among those with multiple partners e.g. sex workers and truck drivers: helping them to negotiate their situation, and learning how to provide more protection for themselves and their family members. While condom use has been promoted for more than 25 years, there has always been a need for more research into the behaviour change mechanisms and adherence – that is using them regularly for every sexual encounter. Imagine a young teenager of 16 fumbling to open the condom package and put on his first condom, or his girlfriend helping him, saying, she learned to use the women's condom. In South Africa, youth have admitted to peer counsellors of being afraid of embarrassing moments with their sexual partners[5]. Most peer educators know about condoms and increased usage has been reported among those they counselled (GOLD, 2011).

## Preventing more HIV-related deaths

As outlined in the UNAIDS Strategy, controlling TB has been another important factor in saving the lives of those affected by the double epidemic. In children, much is being done in South African research and clinical trials to examine this problem and possible issues in therapy adherence and drug resistance, especially in children who are most vulnerable (Bekker, et al, 2012; Hesseling, et al, 2012).

In her World AIDS Day 2012 statement, Dr Lucica Ditiu, Executive Secretary of the Stop TB Partnership, stated that there has been 113 per cent reduction in TB/HIV deaths, adding, TB has been the leading cause of death in people with HIV. Acceleration of these efforts is needed to achieve the goals of a 50 per cent reduction in deaths related to TB in HIV infected people by 2015, she said and called for integrating TB/HIV programmes and providing more outreach. Treatment with Isoniazid and Co-trimoxazole prophylaxis has been extremely important in protecting the lungs of HIV-positive patients, especially children (Madhi, et al, 2011). Currently, TB vaccine clinical trials are ongoing[6]. Clinical trials and other behavioural research into maximising the adherence to ARVs, continues, including: prevention methods, two of which are actually ARVs in pill form to be used as PEP or PrEP. The ongoing research into microbicides and the possibility of a vaginal gel, has adherence issues, but has been up to 80 per cent successful in protecting against HIV infection. Monitoring and evaluation (M&E) studies are critical components of documenting milestones towards achieving an HIV-free generation.

> **Controlling TB has been another important factor in saving the lives of those affected by the double epidemic.**

## ARVS helping to reduce HIV infections and deaths

Those who have had AIDS, and recovered from CD4 counts of less than 200 after taking ARVs for

*Young people attending an HIV conference. Individuals in this photo are not necessarily living with HIV. (Photo courtesy of SAfAIDS).*

6 to 12 weeks, have still had to fight opportunistic infections. One such infection is TB, and the double epidemic of HIV/TB is still a problem around the world. The recovery of an HIV patient's immune system is sometimes visible by their general physical improvement, especially putting on weight. In children, failure to thrive meant that they hadn't grown by normal standards. An additional nutritional component to the HIV/TB epidemics has been added[7]. Many families in South Africa are able to receive some nutritional supplements, especially for under-five-year-olds. Weight gain has become an indicator that they have been improving. When children are not as sick, or become less susceptible to infections, it means they might be able to play with other children and/or go to school. The measurement of CD4 counts and viral loads still has to be done at set intervals depending on the child's age. Since the CD4 count has become the most important number imaginable, parents/guardians and older teens look forward to hearing the good numbers as was told to this author by several clinicians and counsellors at KID-CRU, Tygerberg Hospital. It is motivating for good adherence, and according to Dr Cotton, adherence monitors have become an important part of the services KID-CRU provides.

Initially, the CD4 count and viral load together with AIDS-defining symptoms could diagnose the stage of HIV in a child, teenager or adult. A less than 200 CD4 count was used to define AIDS. Once ARVs were introduced,[8] a gradual shift came about, when research indicated that starting at a CD4 count of 350 saved lives. Since not all HIV-positive pregnant women have been treated with ARVs, it has been important that for the entire period of breastfeeding (BF), the mother would continue giving the infant ARVS. After weaning, she would continue for one more week with formula feeding that was not required, since ARV prophylaxis could be stopped after six weeks (due to no further transmission risk via the breast milk).

Since July, 2012, there are revisions from WHO, which are still being discussed in the UK, South Africa, and other countries. The concept is to offer ARVs to all pregnant and lactating HIV-positive mothers. This being a lifelong treatment, it means the number of women on ARVs will significantly increase globally[9]. However, infant ARV prophylaxis should stop at six weeks, unless otherwise indicated. Achieving a generation of HIV-free infants is in sight.

### HIV education and awareness programme for all

The children and youth have been raised with HIV awareness campaigns at the hospitals and clinics, at their schools and within their communities. They also get information from the internet. Many peer education programmes exist in SSA[10], including, Gold Peer Education, Planned Parenthood and LoveLife in South Africa. These independent organisations have also worked under the umbrella of the Peer Education for the Western Cape Provincial Health Department and the Western Cape Education Departments. Peer educators are selected from among the youth in high school. They are trained to be leaders who can coach other youth about all aspects of life, including respect and compassion, and assist those with emotional problems . They also learn to be good listeners with skills to help prevent teen or unplanned pregnancy and HIV. These are good qualities for a dynamic society that requires more responsible leaders in the future. Some of the programmes work beyond the schools into the neighbouring communities.

> **"When children are not as sick, or become less susceptible to infections, it means they might be able to play with other children and/or go to school."**

In South Africa, there is a national AIDS HELPLINE. Treatment Action Campaign has a local Cape Town number that can connect people with counsellors in most cities and townships. LoveLife offers a Youth Line and a Parentline to discuss difficult subjects. The South African Anxiety and Depression Group offers psychosocial care and support for individuals and families suffering from anxiety and depression, including feeling suicidal, due to their HIV status.

Another organisation important in recognising the legal issues and protecting human rights, including children's rights, is the AIDS Legal Network. Children heading households, orphans and vulnerable children, are among those supported by ALN.

Recently, United States Secretary of State, Hillary Rodham Clinton, received recognition by UNAIDS for the President's Emergency Plan for AIDS Relief (PEPFAR *Blueprint: Creating an AIDS-free Generation.* Together with Dr Nkosazana Dlamini Zuma, the Chairperson of the African Union Commission's, *Roadmap on shared responsibility and global solidarity for AIDS, TB and Malaria,* released in July, there is a response from and for Africa, with a shared commitment to collaborate, and mobilise the necessary funding and improvements, towards achievement of the Zero HIV goals. "The Blueprint builds on the remarkable results that have been achieved to date and sets a bold course for the future. The new US plan of action focuses on four critical pillars: saving lives, smart investments, shared responsibility and driving results with science (UNAIDS, 2012)" ▪

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