



COMESA **HIV** and
AIDS Policy



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List of Acronyms

AEC	African Economic Community
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-Retroviral
AU	African Union
CCC	COMESA Competition Commission
CEDAW	Convention for the Elimination of All forms of Discrimination Against Women
CEDPD	Convention on the Elimination of Discrimination against People with Disabilities
CMI	COMESA Monetary Institute
COMESA	Common Market for Eastern and Southern African
CSO	Civil Society Organization
EAC	East African Community
ECOSOC	Economic and Social Council
FAL	Final Act of Lagos
FGM	Female Genital Mutilation
FORWARD	Foundation for Women's Health Research and Development
FTA	Free Trade Area
GBV	Gender-Based-Violence
GFTAM	Global Fund for Tuberculosis, AIDS and Malaria
GSAD	Gender Social Affairs Division
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICT	Information, Communication and Technology

IDU	Injecting Drug Use
IDPD	International Day of Persons with Disabilities
IPPA	International Planned Parenthood Association
IWD	International Women's Day
IYD	International Youth Day
LPA	Lagos Plan of Action
MCPs	Multiple and Concurrent Partnerships
MDGs	Millennium Development Goals
MMC	Medical Male Circumcision
MoH	Ministry of Health
MoJ	Ministry of Justice
MSM	Men who have Sex with Men
NGO	Non-Governmental Organization
OAU	Organisation for African Unity
PEP	Post-Exposure Prophylaxis
PEPFAR	Presidential Emergency Plan For AIDS Relief
PMNCH	Partnership for Maternal, New-born and Child Health
PMTCT	Prevention of Mother-To-Child Transmission
PPPs	Public Private Partnerships
PrEP	Pre-Exposure Prophylaxis
PTA	Preferential Trade Area
RIA	Regional Investment Agency
SSA	Sub-Saharan Africa
SADC	Southern African Development Community
SGBV	Sexual and Gender-Based Violence

SGBV	Sexual Gender-Based Violence
TB	Tuberculosis
UN	United Nations
UNCTOC	United Nations Convention against Transnational Organised Crime
UNGASS	United Nations General Assembly
UNICEF	United Nations Children’s Fund
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNODC	United Nations Office on Drugs and Crime
USA	United States of America
USAID	United States Agency for International Development
UTH	University Teaching Hospital
VSU	Victim Support Unit
WAD	World AIDS Day
WHO	World Health Organisation

Definition of Terms

Affirmative Action: A commitment to creating a state of equality by adopting and implementing deliberate measures that elevate the status of disadvantaged groups or persons.

Child Labour: Work being performed by children under the age of 16 that leads to the detriment and endangerment of the child's psychological, physical, social, spiritual and mental development.

Community: Refers to a social unit of any size that shares common values.

Culture: A whole range of complex and distinctive spiritual, material, intellectual and emotional attributes that characterise a society or social group.

Cultural practices: Functional roles and rituals that are culturally determined and assigned to both sexes.

Empowerment: The process of gaining access to and ownership of resources and developing one's capacities with a view to participating actively in shaping one's own life and that of one's community in economic, socio-cultural, political and religious terms.

Feminisation of poverty: A concept used to describe a state of poverty incidence that disproportionately affects women relative to other segments of the population.

Gender: Culturally and socially-constructed differences and relations between males and females. These vary widely among societies and cultures and change over time. Gender roles are learned behaviours in a given society or other social group. They condition which activities, tasks and responsibilities are perceived as appropriate to males and females, respectively. Gender relations are also relations of power which affect who can access and control tangible and intangible resources and make decisions. Gender roles are affected by age, socio-economic class, race/ethnicity, religion, and geographical, economic, political and cultural environments (ILO, ABC of Women's Workers rights and gender equality, 2007).

Gender-Based Violence (GBV): An act of aggression intended to cause physical, psychological, economic, social and emotional harm to a person due to their gender in society. Forms of gender-based violence may include rape, defilement, spouse battering, property grabbing, incest and sexual cleansing.

Gender-disaggregated data: Presentation of data by male/female classification.

Gender equality: A situation where women and men have equal conditions for realising their full Human Rights and potential to contribute to and benefit from socio-economic, cultural and political development of a nation, taking into account their similarities, differences and varying roles that they play (Government of the Republic of Zambia, National Gender Policy, 2000).

Gender equity: Fairness of treatment of different needs and interests of women and men taking into

account corresponding rights, duties, obligations, benefits and opportunities (ILO, ABC of Women Workers' Rights, 2007).

Gender analysis: Understanding the situation of women and men, boys and girls in terms of their constraints, needs, priorities and interests. It also identifies how public policies or programmes and projects affect women and men differently. Gender analysis results in gathering gender-disaggregated data which is very crucial when planning and implementing development projects and programmes.

Gender blind: Ignoring or failing to address the gender issues and concerns.

Gender gap: Gap in any area between women and men in terms of their levels of participation, access to resources, rights, remunerations or benefits.

Gender inequalities/gaps/imbalance: Discrepancies or differences between women and men, or boys and girls in terms of their conditions of how they access or benefit from resources that arise from their different gender roles.

Gender issues: Concerns that are related to injustice and inequality based on gender roles.

Gender mainstreaming: The process of assessing the implications for women and men of any planned action, including legislation, policies or programme in any area and at all levels. It is a strategy for making women's as well as men's concerns and experiences integral dimensions of the design, implementation, monitoring and evaluation of policies and programs in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated (ECOSOC).

Gender perspective: The views and ideas of both women and men are taken seriously; differentiation is made between the needs and priorities of women and men; action is taken to address inequalities or imbalance between women and men; and implications of decisions on the situation of women relative to men are considered.

Gender relations: Socially determined relations between and among women and men or boys and girls in how power is distributed between them.

Gender responsive: Being aware of existing gender gaps, disparities and their causes and taking action to address and overcome gender-based inequalities.

Gender roles: Functional responsibilities that may be assigned by society to males and females and are influenced by cultural, political, religious or economic situation.

Human Rights-Based Approach: A principle that ensures that due regard is given to safeguarding and protecting fundamental Human Rights entitlements in the planning, implementation, monitoring and evaluation of development policies, plans, strategies and programmes. Operationalisation of the principle should be accompanied by the identification of Human Rights right-holders and duty bearers.

Human Rights: Fundamental Freedoms and Human Rights that every person is entitled to in the

Constitution of the Republic of Zambia and international human rights conventions and agreements to which Zambia is party.

Human Trafficking: Recruitment, transportation, transferring, harbouring or receiving of a person through force, abduction, threat, coercion, fraud or deception for purposes of exploitation.

Poverty: The inability of an individual, family or community to attain a minimum standard of living.

Productive: Ability to produce value-added goods or services.

Role stereotypes: Rigidly held and over generalised beliefs that males and females by virtue of their sex possess distinct traits and characteristics.

Reproductive: Refers to the biological process by which new individual organisms/off-springs are produced.

Sex roles: The functions that females and males perform on the basis of their reproductive, physiological or biological makeup.

Sex: The biological differences between females and males that are naturally defined attributes of an organism.

Socialisation: A process through which a person learns all things that he/she needs to know to function as a member of a specific society.

Traditional Practices: Acts that are performed by people over and over again and which become part and parcel of one's day-to-day life and are usually subjects of the mainstream society.

Triple Roles of Women: Refers to the roles that women play as mothers, home carers and workers.

Introduction

HIV Situation in Eastern and Southern Africa in 2013

- **Prevalence: 18.5 million people living with HIV; 2.0 million children living with HIV;**
- **New Infections: 1.1 million new HIV infections; 120,000 new HIV infections among children;**
- **Access to Treatment: 8.2 million people receiving ART.**
- **AIDS related Deaths: 730,000 AIDS-related deaths.**

Global Situation of HIV in 2014

- **Prevalence: (36.9 million people living with HIV (34.3 million, were adults, 17.4 million were women, and 2.6 million were children below the age of 15)). Women accounted for 47 per cent of infections which signifies the feminisation of the pandemic.**
- **New Infections: (2 million new infections (adults and children below 15 accounting for 1.8 million infections among adults and 220,000 infections among children below 15 years)).**
- **AIDS-related Deaths: (1.2 million out of which 1 million were adults and 150,000 children).**

1.0. Introduction

1. The Common Market for Eastern and Southern African (COMESA) is a successor organisation to the Preferential Trade Area (PTA) and comprises independent sovereign States of Burundi, Comoros, Democratic Republic of Congo, Djibouti, Egypt, Eritrea, Ethiopia, Kenya, Libya, Madagascar, Malawi, Mauritius, Rwanda, Seychelles, Sudan, Swaziland, Uganda, Zambia and Zimbabwe. Its core mandate is to establish mechanisms for sustainable economic and social progress through increased regional economic cooperation and integration in all fields of development, particularly in trade, customs and monetary affairs. The regional integration agenda is driven by the ultimate objective of finally establishing the African Economic Community (AEC).
2. In 2008, COMESA agreed to an expanded free-trade zone including the East African Community (EAC) and Southern African Development Community (SADC). COMESA is home to 406 million people, or 43.4 per cent of Sub-Saharan's population of 936.1 million, and accounts for 36.9 per cent of the continent's 1.1 billion people. Since its formation in 1994, COMESA has made noticeable progress in realising its regional economic integration agenda through the initiation and implementation of various business and trade facilitation frameworks. The progress that the region has posted in trade and investments has, however, been compromised by disease burdens such as HIV and AIDS.
3. The COMESA Regional HIV and AIDS Policy is a guide to member States and other Stakeholders in the region on HIV and AIDS response. The Policy is inspired by Article 110 of its Treaty that commits Member States to "...the control of pandemics or epidemics, communicable and vector borne diseases that might endanger the health and welfare of citizens of the Common Market" (COMESA Treaty, Article 110). In addition, the Policy is backed by the African Union, Catalytic Framework to End AIDS, TB, and Eliminate Malaria in Africa by 2030; UNAIDS Strategy on Fast-Track to end AIDS and the Agenda 2030 Sustainable Development Goal 3: Ensure Good Health and well-being for all at all ages.

Situation Analysis

2.0. Situation Analysis

2.1. Global Context

4. The HIV pandemic has seamlessly affected all countries in the world. According to UNAIDS, in 2014 a total of 36.9 million people were living with HIV in the world out of which 34.3 million, 17.4 million and 2.6 million were adults, women and children below the age of 15, respectively. Women accounted for 47 per cent of infections which signifies the feminisation of the pandemic. In the same year, there were 2 million new infections with adults and children below 15 accounting for 1.8 million and 220,000, respectively. HIV-related deaths were 1.2 million out of which 1 million were adults and 150,000 children (UNAIDS, 2014).
5. In response, there have been several global initiatives such as the UNAIDS 2016 – 2021 Strategy on the Fast-Track to end AIDS. The Strategy seeks to end AIDS by 2030. The Strategy has targets to be achieved by 2020 and 2030. The Strategy is dovetailed around the 90-90-90 approach whose targets are that, by 2020, 90 per cent of all people living with HIV should know their HIV status, 90 per cent of all people diagnosed with HIV infection should receive sustained antiretroviral therapy and 90 per cent of all people receiving antiretroviral therapy should have suppressed viral loads. The Strategy ambitiously projects that by 2030, there will be “ZERO New HIV Infections, ZERO Discrimination and

ZERO AIDS Related DEATHS" (UNAIDS, 2014).

6. In addition, the Strategy focuses on the elimination of new HIV infections among children, ensuring that young people can access needed services for HIV and sexual and reproductive health, as well as empowering young women and ending GBV. The Strategy is a guiding instrument in fast-tracking responses against the pandemic and is aligned to goals of the UN 2030 Agenda for Sustainable Development.
7. The other key document is the UNAIDS GAP Report that identifies the 12 populations that have either been left out of or marginalised in the response. These include people living with HIV, adolescent girls and young women, prisoners, migrants, people who inject drugs, sex workers, gay men and other men who have sex with men and transgender people. Others are children and pregnant women living with HIV, displaced persons, people with disabilities and people aged 50 years and older. Under Goal 3.3 of the UN Sustainable Development Goals (SDGs), there is a renewed global commitment to "...end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases by 2030 (UN SDGs). These populations are particularly targeted with HIV and AIDS services as they are perceived to have been left out in responses to the pandemic.
8. Global commitment to ending HIV is also evident in the *"Common African Position for the Post-2015 Development Agenda"* which calls for ending the epidemics of HIV and AIDS, TB and Malaria. There is a further commitment to reducing the incidence of communicable and non-communicable diseases through, *inter alia*, scaling up universal access to comprehensive sexual reproductive health and rights (Common African Position (CAP) on the Post-2015 Development Agenda). Although there are still several challenges yet to be addressed in the response, regional and global initiatives have met with notable success as by 2015 there were 15 million people on treatment which was way above the targeted figure.

2.2. Regional Context

9. According to the African Union (AU), in 2013 there were an estimated 24.7 million people living with HIV in Sub-Saharan Africa (SSA), nearly 71 per cent of the global total. Ethiopia, Kenya, Malawi, Mozambique, Uganda, Tanzania, Zambia, Zimbabwe (all members of COMESA), Nigeria and South Africa accounted for 81 per cent of all people living with HIV in the region (AU). According to UNAIDS, in Eastern and Southern Africa, at the end of 2013, there were in Eastern and Southern Africa:
 - 18.5 million people living with HIV;
 - 2.0 million children living with HIV;
 - 1.1. million new HIV infections;
 - 120,000 new HIV infections among children;
 - 730,000 AIDS-related deaths; and

- 8.2 million people receiving ART.
10. Sub-Sahara Africa, to which COMESA belongs, is the epicentre of HIV and AIDS. HIV prevalence in the COMESA region varies between and across countries and ranges from 1 per cent in Mauritius through 7.2, 10.0, 14.3 to 26.0 per cent in Uganda, Malawi, Zambia and Swaziland, respectively. All countries in the region have developed national HIV and AIDS policies but success has been varied and patchy largely due to the resource-constrained nature of most economies.
 11. The COMESA Framework for the Multi-sectoral Programme on HIV & AIDS for COMESA: 2012-2015, provided a regional mechanism for HIV and AIDS response by Member States in-line with COMESA Treaty that commits Member States to "... control pandemics or epidemics, communicable and vector borne diseases that might endanger the health and welfare of citizens of the Common Market" (COMESA Treaty, Article 110).

Key HIV Drivers

3.0. Key HIV Drivers

12. Based on global experiences with HIV, it has been established that major drivers of HIV include: poverty; High movement of people and migrant labour; Gender inequalities (sexual and gender-based violence (SGBV), unequal power relations between men and women); illiteracy and lack of awareness of human rights; stigma and discrimination; alcohol and substance abuse; emergency situations such as civil conflicts and wars. Others are: multiple and concurrent sexual partnerships (MCPs); low and inconsistent use of condoms; low male circumcision rates; , cultural practices such as use of same sharps in initiation ceremonies and sexual cleansing; Polygamous marriages and female genital mutilation/cutting (FGM); early sexual debut; limited access to treatment and prevention of mother to child transmission; limited access to social protection services; child sexual abuse; lack of services for key populations; human trafficking; and other factors.

Challenges to the effective HIV and AIDS Response

4.0. Challenges to the effective HIV and AIDS Response

13. Challenges that affect the effective HIV and AIDS response in the region include:
 - a) Limited access to and sustainable treatment for people living with HIV and AIDS (women and men, young women and men adolescent girls and boys, and children
 - b) Limited HIV and AIDS prevention and treatment services including access to sexual and reproductive health services for women and men engaged in cross border trade including truckers;
 - c) Limited access to treatment and prevention services, life skills, knowledge and capacity including access to sexual and reproductive health services, especially for adolescents, young women, people living with disabilities, people living with HIV and AIDS, sex workers, men who have sex with men (MSM) and transgender people;
 - d) Limited access to social protection services for people at risk including women and men, people (women and men, girls and boys) living with HIV, elderly, and those affected;

- e) Limited integration of HIV and AIDS, cervical cancer, tuberculosis, and hepatitis B and C in routine health services to enable universal health coverage
- f) Gender inequalities and discrimination against women and girls, which result in sexual violence and other forms of violence; and cultural practices such as polygamy, child marriage, female genital cutting/mutilation (FGM); and
- g) Human rights violations including human trafficking, limited access to justice and legal services, limited human rights awareness among people living with HIV and AIDS.

Goals and Focus Areas of the Policy

- **Goals (Zero New Infection, Universal Access to Treatment and related Services, and Zero AIDS related Deaths)**
- **Thematic Areas (Human Rights, Universal access to HIV Treatment and related Services, Sexual and Reproductive Health, Human Trafficking, Emergency Situations, Conflicts and Human Displacements, Child Protection)**
- **Target Populations (Women, Men, Young People, Adolescents, Children, People with Disabilities, Aged People, Migrants, Cross Border Traders, Long Distance Drivers, Sex Workers, Drug Users, Women and Men in Uniform)**
- **HIV Management (Partnerships, Governance, Coordination, Sustainability and Data Management)**

COMESA Regional HIV and AIDS Policy

5.0. COMESA Regional HIV and AIDS Policy

14. The COMESA Regional HIV and AIDS Policy is a guide to member States and other Stakeholders in the region on HIV and AIDS response. The Policy is inspired by Article 110 of its Treaty that commits Member States to "...the control of pandemics or epidemics, communicable and vector borne diseases that might endanger the health and welfare of citizens of the Common Market" (COMESA Treaty, Article 110). In addition, the Policy is backed by the African Union, Catalytic Framework to End AIDS, TB, and Eliminate Malaria in Africa by 2030; UNAIDS Strategy on Fast-Track to end AIDS and the Agenda 2030 Sustainable Development Goal 3: Ensure Good Health and well-being for all at all ages.

5.1. Guiding Principles

15. The guiding principles of the Policy include:
 - **Leadership, Ownership and Commitment:** Implementation of continental and global commitment to eliminate new HIV infections and to end AIDS by 2030 is critical to the national and regional HIV and AIDS response. This calls for leadership, ownership and

inclusion of continental and global 90-90-90 targets towards the vision of “No AIDS-related Deaths by 2030”; in national HIV and AIDS response policies, strategies and programmes as well as local financing of the HIV and AIDS response in line with the Abuja Declaration on the allocation of 15 per cent of national budgets to the health sector.

- **Transparency, Accountability, Ownership and Leadership.** Mobilisation and delivery of HIV and AIDS resources should be founded on transparent and accountable systems; and ownership and committed leadership for sustainable and effective response
- **Human Rights Approach and Equity.** Observance of Human Rights contributes to the fight against HIV infection, and equal and equitable access to HIV and AIDS services. Development and implementation of all HIV and AIDS legislation, policies, strategic frameworks, programmes and activities should be informed and guided by the Human Rights perspective.
- All human beings should enjoy equal status and have equal entitlements and opportunities for the full realisation of their Human Rights, making choices and accessing assets, services and public goods without limitations imposed by legislation, policies, gender norms and stereotypes.
- **Empowerment.** HIV infection may lead to increased socio-economic vulnerability and, therefore, there is need for targeted empowerment and mitigation policies and programmes for people with HIV.
- **Evidence-based HIV and AIDS programming.** Programming for HIV and AIDS should be informed and guided by evidence-based research, data and information disaggregated appropriately.
- **Gender-responsiveness and equality.** All HIV programmes should be engendered in ways that address concerns and special needs of both women and men with a view to ensuring equal and fair access to services.
- **People with Disabilities.** Because of their inherent vulnerability, PWDs need targeted HIV prevention, treatment, care, support and impact mitigation policies and programmes.
- **Minorities.** By nature, minorities are vulnerable and, therefore, require special HIV protection programmes and services.
- **People with HIV.** Full, unimpeded and mutual participation in key-decision-making structures and in planning and implementation of HIV and AIDS policies, legislation and programmes by people with HIV is a fundamental aspect of Human Rights.

5.2. Vision

A COMESA region free from AIDS

5.3. Policy Goals

16. The goals of the Policy are aligned to the continental and global goals on HIV and AIDS. These are to:
 - i. Eliminate HIV-related discrimination in all spheres by 2030;
 - ii. Eliminate new HIV infections among all groups by 2030; and
 - iii. End AIDS-related deaths by 2030.

5.4. Overall Policy Objective

17. To free the COMESA region from the threat of HIV and AIDS in line with the African Union Catalytic Framework to End HIV/AIDS, TB and Malaria by 2030, Global UNAIDS Strategy on the Fast-Track to end AIDS and the UN Sustainable Development Goal 3: *Ensure healthy lives and promote well-being for all at all ages.*

5.5. Policy Objectives and Measures

18. The Policy has 21 specific objectives. Each objective focuses on a specific thematic area but all contributing to the prevention of new HIV infections, elimination of discrimination in HIV-related services, and elimination of AIDS-related deaths in the COMESA region, in every country, every gender, every age group and every population and contribute to the achievement of the SDG 3 on Good Health and Well-Being for all and all ages. Policy measures are presented under each objective below.

5.5.1. HIV and Human Rights

19. **Objective:** To promote policy, legal and regulatory environments that protect and promote the rights of all to non-discrimination in access to HIV and AIDS services delivery.

Measures:

20. Observance of Human Rights contributes to the fight against HIV infection. Mindful of this, Member States shall:
 - i. Ensure existence and implementation of policy, legal and regulatory framework that protect the rights of women, men, adolescent girls and boys, and children, especially the vulnerable and marginalized groups, to prevent and access HIV services, SRHRs without any discrimination.

- ii. Ensure domestication and implementation of internationally-agreed conventions on health, HIV and AIDS, and against all forms of discrimination such as the CEDAW.
- iii. Ensure that HIV and AIDS service delivery is inclusive and informed and guided by the Human Rights Approach.
- iv. Stiffen sanctions against stigma and discrimination, and gender based violence.
- v. Ensure confidentiality, gender-sensitive HIV and AIDS service delivery.
- vi. Promote integration of HIV and AIDS services in routine health service delivery systems to avoid designation of days, service corners or rooms for HIV and AIDS service delivery.
- vii. Address non-medical barriers to accessing HIV and AIDS services, including gender inequality, gender-based violence, and poverty.
- viii. Ensure access to social protection by vulnerable groups, PLHIV and those affected by HIV and AIDS.

5.5.2. Key Drivers of New HIV Infections

21. Objective: To build sustainable mechanisms to address the key drivers of HIV to prevention new HIV infections among women, men, adolescents, children and key populations.

Measures:

- 22. New HIV infections among adults and children continue to occur. The factors contributing to this include MTCT, gender inequalities, GBV, lack of information and knowledge among young women and men to protect themselves from HIV, limited access to HIV services by key populations, low condom use, lack of access to pre-exposure prophylaxis, low male circumcision in high prevalence settings, and other factors. To address the drivers of new HIV infections Member States and other stakeholders shall:
 - i. Address drivers of HIV infections – Mother to child transmission (MTCT), gender inequalities and vulnerabilities, limited HIV services for key populations, adolescents, traditional/cultural practices, child marriage, sexual abuse, people living with disabilities, limited access to treatment, and promote condom use and voluntary medical male circumcision (VMMC);
 - ii. Mainstream HIV in primary health care and other health services such as cervical cancer, prostate cancer, male erectile dysfunction, TB, malaria and SRH services;
 - iii. Invest in HIV prevention and treatment technologies;
 - iv. Monitor and follow-up women, men, adolescent girls and boys and children on treatment for adherence and viral load;
 - v. Document and share good practices on HIV and AIDS response.

5.5.3. HIV Treatment, Care and Support

23. Objective: To establish systems for robust and sustainable HIV and AIDS medicines, care and support logistics at both national and regional levels to enable universal access to HIV treatment

Measures:

24. According to UNAIDS GAP 2014 Report, three of five people living with HIV, are still not accessing anti-retroviral therapy. To address this gap, Member States and other stakeholders shall:
 - i. Take necessary measures to contribute to the attainment of UN sustainable development goals and targets on HIV and AIDS Treatment.
 - ii. Adopt the **Treat All Policy** and address the specific treatment needs of women, men, youth, adolescents and children.
 - iii. Facilitate local manufacturing of HIV medicines and medical commodities through PPPs.
 - iv. Utilize existing and future regional trade and investment protocols to promote the manufacturing of medicines and medical supplies, including pooling of procurement services for essential health commodities and supplies.
 - v. Monitor and follow-up women, men, adolescent girls and boys and children on treatment for adherence and viral load monitoring.
 - vi. Ensure strong supply chain management and scale up best practices.
 - vii. Increase investment in key populations and human resource for health.

5.5.4. HIV and Cross-Border Trade

25. Objective: To provide HIV prevention, treatment, care and support services to traders, truck/bus drivers and their assistants, and people living along regional transport corridors and key border-crossing points.

Measures:

26. Increased cross-border trade has come with heightened risk of HIV infection. To address this challenge, Member States shall:
 - i. Ensure availability of integrated HIV and AIDS prevention, treatment, care and support services, by trained personnel, along transport corridors and border points.
 - ii. Establish one-stop and integrated HIV treatment, care and support centres along regional transport corridors and border-crossing points.

- iii. Train immigration and customs personnel in HIV and AIDS, SRH and Maternal Health to provide necessary referral to services.
- iv. Establish a regional HIV and AIDS service access card on the pattern of the COMESA Yellow Card.
- v. Mainstream HIV and AIDS in national and regional trade and investment policies, and training of truck drivers.
- vi. Use the Tripartite (COMESA-EAC-SADC) agreement to review and harmonise national and regional HIV and AIDS policies
- vii. Closely work with owners of trucking firms and associations of truck drivers in HIV and AIDS programming planning

5.5.5. HIV and Maternal Sexual and Reproductive Health

27. Objective: To establish maternal and sexual and reproductive health-friendly systems for prevention of new HIV infections, and ensure access to HIV treatment, care and support for women of reproductive age.

Measures:

28. Access to HIV and comprehensive sexual and reproductive health services for women in the reproductive age is critical to the prevention of HIV among children and to keep mothers alive and health. For this to happen, Member States and other stakeholders shall:
- i. Ensure availability of maternal health, sexual and reproductive health facilities/services including commodities, and HIV and AIDS services including prevention of Mother-to-Child Transmission of HIV (PMTCT) including along regional transport corridors and at all border-crossing points;
 - ii. Ensure integration of maternal health and sexual and reproductive health and cervical cancer, family planning services in the training of HIV prevention, treatment, care and support personnel, including immigration and customs personnel at key cross-border points;
 - iii. Ensure mainstreaming of maternal health and sexual and reproductive health in national and regional trade policies for sustainable logistical supply of commodities;
 - iv. Promote and support initiatives that address emerging maternal and sexual and reproductive health-related challenges such as cervical cancer;
 - v. Mainstream HIV and AIDS in sexual and reproductive health and family planning policies and programmes, and ensure that the policies and programmes are formulated and implemented from a rights-based approach;

- vi. Build the capacities of women to know their sexual and reproductive health rights, and promote involvement of men in reproductive health services such as antenatal and post-natal services;
- vii. Ensure regular collection, consolidation and sharing of national and intra-regional maternal health-related data including access to SRH and HIV treatment;
- viii. Ensure full domestication and implementation of internationally-agreed conventions on maternity protection (such as the ILO Recommendation 183 and Recommendation 191).

5.5.6. HIV and Adolescent Sexual Reproductive Health

29. Objective: To improve protection of, and skills, capacity, knowledge and access to HIV and sexual reproductive health services, and prevent new HIV infection among adolescents, and young women and men.

Measures:

- 30. Most national health policies do not discretely define and target adolescent and young people sexual and reproductive health requirements in health service delivery. Member States shall address this challenge through:
 - i. Adopt and implement adolescent protective policies and legislation in health and social sector to enable access to services by all adolescents;
 - ii. Ensure financing for adolescent health priorities in health plans at all levels;
 - iii. Mainstream adolescent HIV and comprehensive sexual and reproductive health education in school, and medical training curricula;
 - iv. Build capacity for handling adolescent HIV and sexual reproductive health needs among health personnel, including development of practicing guidelines;
 - v. Establish adolescent HIV and sexual reproductive health corners in all health facilities and communities, and ensure access to information, counselling, and services including commodities;
 - vi. Ensure prevention, detection and treatment of HIV including sexually transmitted and reproductive tract infections;
 - vii. Ensure comprehensive care of adolescents living with or exposed to HIV;
 - viii. Promote voluntary medical male circumcision;
 - ix. Ensure existence of leadership and governance structures within the Ministry of Health and Education at all levels on adolescent health;

- x. Ensure age and sex disaggregated data in HIV and AIDS management and information systems;
- xi. Prevent and respond to harmful practices such as child marriages, and female genital cutting;
- xii. Ensure engagement and empowerment of adolescents, families and communities to play an active role in outreach, governance and accountability processes on their health and well-being;
- xiii. Promote HIV and AIDS, sexual and reproductive health peer learning among adolescents;
- xiv. Collaborate and work with UN agencies and other international organisations, NGOs that promote adolescent HIV and sexual reproductive health services, campaign against child marriage and other harmful practices;
- xv. Appoint from among opinion leaders such as political leaders, traditional leaders, First Ladies and music and sports celebrities adolescent HIV Prevention, sexual and reproductive health, and anti-child marriage ambassadors;
- xvi. Review and harmonise ages for consensual sex, and marriage;
- xvii. Criminalize child marriage (as Malawi has done);
- xviii. Support Round Tables of Spouses of COMESA Heads of State and Government in addressing child marriage

5.5.7. HIV and Paediatric Children

31. Objective: To prevent new HIV infections among children (aged 0-14), and ensure access to comprehensive ART services by those living with HIV.

Measures:

- 32. Currently, children are among underserved populations in HIV and AIDS services. In order to address this gap, Member States shall:
 - i. Invest in programmes for prevention of mother to child HIV Transmission (PMTCT services, treatment of all women and men living with HIV, and integration of antenatal care and PMTCT services, community support systems for pregnant and breastfeeding women)
 - ii. Mainstream Paediatric and children HIV and AIDS in medical training curricula;
 - iii. Establish Paediatric and children HIV and AIDS-friendly corners and/or centres of excellence in health facilities;
 - iv. Mainstream Paediatric and children HIV and AIDS in national health policies and strategies;

5.5.8. HIV and Child Labour

33. Objective: To prevent HIV infections among children through fighting all forms of child labour and exploitation.

Measures:

34. Child labour can be a vehicle for HIV transmission among children. COMESA Member States shall, therefore:
- i. Accelerate the domestication of internationally-agreed conventions, such as the Convention on the Rights of the Child (CRC), the African Charter on the Rights and Welfare of the Child (ACRWC) and the African Charter on Human and People's Rights (ACHPRs);
 - ii. Formulate and implement policies for long-term retention of children in schools;
 - iii. Review and harmonise national labour laws with a view to, among others, eliminating elements that fuel child labour and stiffening punishment of child labour-related offences;
 - iv. Build and strengthen institutional capacities of national labour-related structures (e.g. government labour departments and CSOs) to deal with child labour and exploitation prevention and restitution of survivors or victims of child labour and exploitation;
 - v. Intensify training of labour officers in matters of child labour and exploitation laws and regulations;
 - vi. Establish a national and regional database on child labour and trafficking;
 - vii. Strengthen national and regional systems for collecting, collation, storage, dissemination and sharing of child labour and child trafficking related data and information; and
 - viii. Establish national and regional centres for restitution of victims of child labour and exploitation.

5.5.9. HIV and Children on the Streets

35. Objective: To provide comprehensive HIV and AIDS services to children living on the streets.

Measures:

36. Street kids live in environments that expose to abuse, violence, extortion and other vices. These vices increase the risk of HIV infection. In order to address this challenge, Member States shall:
- i. Design and implement dedicated HIV and AIDS programmes for children on the street kids;
 - ii. Strengthen programmes for re-integration of street kids into communities; and
 - iii. Support and closely work with non-State actors that deal with street kids.

5.5.10. HIV and People with Disabilities

37. Objective: To prevent new HIV infections among people with disabilities and enable their access to HIV treatment, care and support.

Measures:

38. PWDs are particularly vulnerable to HIV infection. In order to address this challenge, Member States shall:
- i. Ensure domestication and implementation of internationally-agreed conventions on disability (especially the Convention on the Rights of People with Disabilities (CRPD));
 - ii. Implement the WHO Global Disability Action Plan 2014–2021: Better health for all people with disability;
 - iii. Mainstream disability in national surveys, national health management systems;
 - iv. Include disability in national and regional HIV and AIDS monitoring and evaluation frameworks;
 - v. Disaggregate disability data by age, sex, ethnicity and socio-economic status;
 - vi. Closely involve people with disabilities in formulating HIV and AIDS policies and legislation;
 - vii. Develop sign language and Braille-based HIV and AIDS services for the deaf and blind, respectively;
 - viii. Mainstream disability in national and regional HIV and AIDS policies, legislation and programmes, including HIV treatment guidelines;
 - ix. Ensure the development of disability-friendly HIV and AIDS facilities along regional transport corridors and at all border-crossing points;
 - x. Train HIV-positive PWDs in HIV counselling and testing and place them in counselling and testing centres and clinics; and
 - xi. Offer favourable import duties for local producers of Orthopaedic equipment and supplies.

5.5.11. HIV and Aged People

Objective: To provide comprehensive HIV and AIDS prevention, treatment, care and support services to women and men aged 50 and above.

Measures:

39. Aged people have not adequately been targeted with HIV services. To address this gap, Member States shall:
- i. Undertake demographic analyses of aged populations and gap analyses of their special HIV and AIDS needs;
 - ii. Mainstream aging and HIV in national social protection policies;
 - iii. Intensify training of oncologists;
 - iv. Mainstream aging in HIV prevention, treatment, care and support services;
 - v. Mainstream aging in HIV prevention, treatment, care and support sensitisation IEC materials;
 - vi. Establish and/or strengthen care facilities for the aged; and
 - vii. Intensify training of oncologists.

5.5.12. HIV and Human Trafficking

40. Objective: To combat human trafficking and its contribution to HIV infections.

Measures:

41. Trafficked people are vulnerable to inhuman conditions, sexual abuse, violence and other forms of Human Rights abuses which increase the risk of HIV infection. Member States shall address this challenge through:
- i. Domestication and implementation of all human trafficking-related international and regional conventions such as the Protocol to Prevent, Suppress and Punish Trafficking in Persons, the United Nations Convention against Transnational Organised Crime and the Ouagadougou Action Plan to Combat Trafficking in Human Beings;
 - ii. Ensure protection of women, men, youth and children from human trafficking through enactment and enforcement of laws, training, enlightenment and raising awareness among service providers and women, men, youth and children on human trafficking;
 - iii. Ensure mainstreaming of human trafficking awareness into school curriculum and community outreach programmes;
 - iv. Ensuring availability of HIV and AIDS, sexual and reproductive health, legal, and social protection, psycho-social, rehabilitation and re-integration services for survivors of human

- trafficking;
- v. Sensitization of immigration and customs officials to the link between human trafficking and HIV transmission;
 - vi. Establishment of a regional database on human trafficking and link it to other regional and international databases;
 - vii. Establishment and strengthening existing mechanisms for data and information-sharing on human trafficking;
 - viii. Improve training of immigration, customs and Police officials in modern methods of combating human trafficking including fighting corruption;
 - ix. Review and harmonise policies and legislation on human trafficking across the region; and
 - x. Stiffen penalties for human trafficking

5.5.13. HIV and Migration and Migrant Labour

42. Objective: To reduce vulnerability to HIV infection among migrants.

Measures:

43. Migration and migrant labour mobility in some cases increase vulnerability to HIV infection and, therefore, Member States shall:
- i. Fast-track implementation of all international conventions on migration and migrant labour;
 - ii. Mainstream HIV and ADS in migration and migrant labour policies, legislation and programmes;
 - iii. Review and harmonise migration and migrant labour-related policies and legislation;
 - iv. Collaboratively work with corporate/business entities that employ migrant labour in crafting innovative HIV prevention, treatment, care and support services;
 - v. Ensure that corporate/business entities that implement workplace HIV and AIDS policies and strategies roll them out to surrounding communities; and
 - vi. Offer fiscal incentives (e.g. tax rebates) to corporate/business entities that implement workplace HIV and AIDS policies and strategies and offer the same to surrounding communities.

5.5.14. HIV and Emergency Situations, Conflicts, War and Human Displacement

44. Objective: To prevent HIV infections among displaced persons and other victims of conflicts and war.

Measures:

45. Conflicts and war lead to human displacement and increase vulnerability to HIV infection. Cognisant of this, Member States and other stakeholders shall:
 - i. Mainstream HIV and AIDS in conflict and post-conflict management policies and programmes;
 - ii. Undertake comprehensive studies on the causative relationship among HIV, conflict and war;
 - iii. Build an evidence-based regional database on conflicts, war and HIV and AIDS;
 - iv. Closely work with other regional and international organisations that work in the area of conflicts, war and HIV and AIDS;
 - v. Establish user-friendly HIV and AIDS infrastructure and services in all transit and permanent refugee centres;
 - vi. Deepen HIV and AIDS knowledge and skills of personnel who deal with refugees;
 - vii. Build national and regional HIV and AIDS refugee-disaggregated databases; and
 - viii. Select and train peer HIV and AIDS counsellors from among refugees and Internally-Displaced Persons (IDPs).

5.5.15. HIV and Men and Women in Uniform

46. Objective: To build mechanisms for the provision of HIV prevention and treatment services for men and women in uniform.

Measures:

47. Men and women in uniform, especially those on peace-keeping missions, often work in environments that increase the risk of HIV infection. In order to address this challenge, Member States and other

stakeholders shall ensure that:

- i. HIV and AIDS are mainstreamed in all pre and in-service training programmes;
- ii. All men and women in uniform who are scheduled to go on peace-keeping missions are subjected to pre-departure HIV and AIDS briefing sessions;
- iii. Spouses of men and women in uniform are included in HIV and AIDS sensitisation programmes; and
- iv. Men in uniform are involved in maternal-related services such as antenatal and post-natal care.

5.5.16. HIV and Sex Workers

48. Objective: To reduce HIV infections among sex workers.

Measures:

49. Sex workers face a particularly high risk of HIV infection due to their vulnerability. To address this challenge, Member States and other stakeholders shall:
 - i. Closely involve sex workers in the formulation and implementation of HIV and AIDS policies and legislation;
 - ii. Select and train HIV and AIDS peer counsellors from among sex workers;
 - iii. Intensify HIV and AIDS information dissemination among sex workers;
 - iv. Work with and financially and materially support organised sex worker groups;
 - v. Design and implement socio-economic empowerment programmes for sex workers; and
 - vi. Sensitise the Police, immigration and other law enforcement officers to the special needs of sex workers.

5.5.17. HIV and Injecting Drug Users

50. Objective: To reduce HIV infections among injecting drug users.

Measures:

51. Injecting drug use is a proven vehicle for HIV transmission. Member States and other stakeholders

shall address this challenge through:

- i. Revision of laws that criminalise the use of drugs;
- ii. Undertaking comprehensive studies on the extent of injecting drug use at national and regional levels and its relationship to HIV;
- iii. Build a regional database on injecting drug use and link it to existing regional and international databases;
- iv. Mainstream injecting drug use in national and regional HIV and AIDS policies and programmes;
- v. Implement the United Nations Office on Drugs and Crime (UNODC) and UNAIDS measures and the GAP Report recommendations for addressing HIV and AIDS among injecting drug users;
- vi. Work with and financially and materially support organised groups that deal with drug users;
- vii. Mainstream drug and substance abuse in medical training curricula;
- viii. Build national and regional rehabilitation centres for addicts of drugs and substances; and
- ix. Improve injecting drug use-related data and information-sharing across the region.

5.5.18. Partnerships and HIV Response

52. Objective: To improve stakeholder involvement in multi-sectoral approaches to HIV and AIDS.

Measures:

53. Partnerships complement public resources in the delivery of HIV and AIDS services and, therefore, Member States and other stakeholders shall:
 - i. Build capacity for the development of bankable PPPs;
 - ii. Scale up collaboration and work with CSOs, FBOs and the private sector in developing and implementation of HIV and AIDS policies and programmes;
 - iii. Build PPPs in support of local production of drugs and supplies; and
 - iv. Closely involve communities in HIV and AIDS policy development and programme implementation.

- v. Encourage South-to-South knowledge sharing to bridge knowledge gaps.

5.5.19. Governance and HIV Response

54. Objective: To establish mechanisms for ensuring accountability, transparency and political will for HIV and AIDS policies and programmes.

Measures:

- 55. Good governance is key for ensuring effective and efficient responses against HIV and AIDS. Member States and other stakeholders will, therefore:
 - i. Establish and/or strengthen HIV and AIDS governance structures at national and regional level;
 - ii. Build and strengthen management skills for HIV and AIDS-related personnel; and
 - iii. Commit the highest political will to the implementation of HIV and AIDS policies and programmes.

5.5.20. Coordination of HIV Response

56. Objective: To establish and strengthen mechanisms for coordination of HIV and AIDS policies and programme.

Measures:

- 57. Currently, national and regional HIV and AIDS policies and programmes are inadequately coordinated. Member States and other stakeholders are determined to address this gap through:
 - i. Creation of robust mechanisms for coordination of national and regional HIV and AIDS policies and programmes;
 - ii. Establishment of regional mechanisms for sharing good practices and lessons learnt in HIV and AIDS policy formulation and programme implementation;
 - iii. Revision and harmonisation of national HIV and AIDS policies;
 - iv. Strengthening of the institutional capacity of the COMESA Gender and Social Affairs (GSAD) to monitor, evaluate and coordinate the status of implementation of national and regional HIV and AIDS policies and programmes;
 - v. Strengthening institutional capacities, linkages, information-sharing and coordination

- between and among national HIV and AIDS focal points, on one hand, and between them and the COMESA Gender and Social Affairs Division, on the other;
- vi. Establishment of a Health Desk in GSAD;
 - vii. Building a regional HIV and AIDS database;
 - viii. Restructuring of national HIV and AIDS multi-sectoral response structures with a view to raising their profiles in national key decision-making and national budgeting structures; and
 - ix. Establishment of a regional annual HIV and AIDS forum for the exchange of information and good practices
 - x. Facilitate the transfer of skilled health-care professionals across the region

5.5.21. Resource Mobilisation for Sustainable HIV Response

58. Objective: To build robust and sustainable national and regional HIV and AIDS funding mechanisms.

Measures:

59. Currently, effective implementation of most national and regional HIV and AIDS policies and programmes are stymied by severe budgetary constraints. To address this gap, Member States and other stakeholders shall:
- i. Undertake a comprehensive HIV and AIDS resource gap analysis;
 - i. Undertake a comprehensive HIV and AIDS resource gap analysis;
 - ii. Ensure domestic financing for health through the implementation of the 15 percent Abuja target for health budget, and establishment of HIV and AIDS Fund
 - iii. Establish a regional HIV and AIDS fund;
 - iv. Offer fiscal incentives (e.g. tax rebates) to corporate/business entities that support HIV and AIDS programmes and financing;
 - v. Rationalise HIV and AIDS funding at both national and regional levels with a view to avoiding duplication of effort and wastage of scarce resources and improving the quality of people-level outcomes and impacts;
 - vi. Collaboratively work with stakeholders such as the private sector, NGOs/CSOs and similar others in mobilising HIV and AIDS resources;
 - vii. Build human resources for HIV and AIDS health care;

- viii. Ensure expanded use of innovative communication tools for HIV and AIDS response; and
- ii. Ensure national and regional ownership of HIV and AIDS policies and programmes through improved political commitment and will at the highest level.

By 2020 (Achieve the 90-90-90 Treatment Targets)	By 2030 (End AIDS by ensuring achievement of following targets)
<ul style="list-style-type: none"> • 90% of all people living with HIV will know their HIV status. • 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. • 90% of all people receiving antiretroviral therapy will have viral suppression. 	<ul style="list-style-type: none"> • Zero new HIV Infections among women, men, girls and boys; • Universal Access to Treatment by ALL in ALL Settings and Groups; • Zero AIDS related Deaths)

Implementation Arrangements

6.0. Implementation Arrangements

6.1. Institutional Framework

60. The extent to which this Policy will effectively be implemented will be determined by the degree to which Member States will individually and collectively commit themselves to arresting the spread of HIV in the region. In this regard, it is hoped that GSAD's coordination capacity shall be strengthened in terms of human, financial and material resources. Based on their competitive advantages, all COMESA organs and the Secretariat shall be required to provide leadership and play significant roles in mainstreaming HIV and AIDS in their programmes. It will also be necessary to build institutional capacities of national multi-sectoral HIV and AIDS response structures.

6.2. Legal Framework

61. The formulation of this Policy was inspired by Article 110 of the COMESA Treaty that commits Member States to "...the control of pandemics or epidemics, communicable and vector borne diseases that might endanger the health and welfare of citizens of the Common Market". Consequently, implementation of this Policy shall be informed and guided by COMESA's health-related legal instruments and national HIV and AIDS legal frameworks.

Monitoring and Evaluation

7.0. Monitoring and Evaluation

62. To be able to ensure and track progress in implementation and documentation of success of the HIV and AIDS response programs, the COMESA HIV and AIDS policy implementation and targets tracking plan has been developed. It is presented as a separate document.
63. The implementation tracking plan presents the policy objectives, policy measures and targets to be achieved by 2020 and 2030 in-line with the global strategy on the Fast-Track to end AIDS, and the African Union Catalytic framework to end AIDS, TB and Eliminate Malaria in Africa by 2030. Member States will use the monitoring framework to track and report on national HIV and AIDS response and on the progress on HIV and AIDS targets and goals set out in this framework.

ANNEX

Annex 1: Global and Regional HIV and AIDS Situation Analysis

1.0. Global Context

1. The HIV pandemic has seamlessly affected all countries in the world. According to UNAIDS, in 2014 a total of 36.9 million people were living with HIV in the world out of which 34.3 million, 17.4 million and 2.6 million were adults, women and children below the age of 15, respectively. Women accounted for 47 per cent of infections which signifies the feminisation of the pandemic. In the same year, there were 2 million new infections with adults and children below 15 accounting for 1.8 million and 220,000, respectively. HIV-related deaths were 1.2 million out of which 1 million were adults and 150,000 children (UNAIDS).
2. In response, there have been several global initiatives such as the UNAIDS-2016 – 2021 Strategy on the Fast-Track to end AIDS. The Strategy seeks to end AIDS by 2030. The Strategy has targets to be achieved by 2020 and 2030. The Strategy is dovetailed around the 90-90-90 approach whose targets are that, by 2020, 90 per cent of all people living with HIV should know their HIV status, 90 per cent of all people diagnosed with HIV infection should receive sustained antiretroviral therapy and 90 per cent of all people receiving antiretroviral therapy should be virally suppressed. The Strategy ambitiously projects that by 2030, there will be “ZERO New HIV Infections, ZERO Discrimination and

ZERO AIDS Related DEATHS" (UNAIDS).

3. In addition, the Strategy focuses on the elimination of new HIV infections among children, ensuring that young people can access needed services for HIV and sexual and reproductive health, as well as empowering young women and ending GBV. The Strategy is a guiding instrument in fast-tracking responses against the pandemic and is aligned to goals of the UN 2030 Agenda for Sustainable Development.
4. The other key document is the UNAIDS GAP Report that identifies the 12 populations that have either been left out of or marginalised in the response. These include people living with HIV, adolescent girls and young women, prisoners, migrants, people who inject drugs, sex workers, gay men and other men who have sex with men and transgender people. Others are children and pregnant women living with HIV, displaced persons, people with disabilities and people aged 50 years and older. Under Goal 3.3 of the UN Sustainable Development Goals (SDGs), there is a renewed global commitment to "...end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases by 2030 (UN SDGs). These populations are particularly targeted with HIV and AIDS services as they are perceived to have been left out in responses to the pandemic.
5. Global commitment to ending HIV is also evident in the "*Common African Position for the Post-2015 Development Agenda*" which calls for ending the epidemics of HIV and AIDS, TB and Malaria. There is a further commitment to reducing the incidence of communicable and non-communicable diseases through, *inter alia*, scaling up universal access to comprehensive sexual reproductive health and rights (Common African Position (CAP) on the Post-2015 Development Agenda). Although there are still several challenges yet to be addressed in the response, regional and global initiatives have met with notable success as by 2015 there were 15 million people on treatment which was way above the targeted figure.

2.0. Regional Context

6. According to the African Union (AU), in 2013 there were an estimated 24.7 million people living with HIV in Sub-Saharan Africa (SSA), nearly 71 per cent of the global total. Ethiopia, Kenya, Malawi, Mozambique, Uganda, Tanzania, Zambia, Zimbabwe (all members of COMESA), Nigeria and South Africa accounted for 81 per cent of all people living with HIV in the region (AU). According to UNAIDS, in Eastern and Southern Africa, at the end of 2013, there were in Eastern and Southern Africa:
 - 18.5 million people living with HIV;
 - 2.0 million children living with HIV;
 - 1.1. million new HIV infections;
 - 120,000 new HIV infections among children;
 - 730,000 AIDS-related deaths; and

- 8.2 million people receiving ART.
7. SSA, to which COMESA belongs, is the epicentre of HIV and AIDS. HIV prevalence in the COMESA region varies between and across countries and ranges from 1 per cent in Mauritius through 7.2, 10.0, 14.3 to 26.0 per cent in Uganda, Malawi, Zambia and Swaziland, respectively. All countries in the region have developed national HIV and AIDS policies but success has been varied and patchy largely due to the resource-constrained nature of most economies.
 8. The COMESA Framework for the Multi-sectoral Programme on HIV & AIDS for COMESA: 2012-2015, provided a regional mechanism for HIV and AIDS response by Member States in-line with COMESA Treaty that commits Member States to "... control pandemics or epidemics, communicable and vector borne diseases that might endanger the health and welfare of citizens of the Common Market" (COMESA Treaty, Article 110).

3.0. HIV and Human Rights

9. Enjoyment of basic Human Rights is inherent for every person by dint of being human and is, therefore, not ascribed but a birth right. By extrapolation, this means that enjoyment of Human Rights should be assured to all human beings irrespective of health, social status or economic status. In this regard, people living with life-limiting illnesses such as HIV and AIDS should enjoy full Human Rights and have access to treatment, care and support like any other persons.
10. Evidence, however, demonstrates that getting infected with the HIV virus may compromise the ability of the affected person to enjoy full Human Rights. Quite often, this happens in environments where there is lack of or inadequate understanding of the pandemic which leads to stigma and discrimination. In such environments, affected persons are denied access to services such as education and health and are socially-excluded. Given their intrinsically-vulnerable nature, people with HIV, People with Disabilities (PWDs), women and children bear the heaviest brunt of Human Rights denials and abuses relative to their male counterparts. In some environments, inadequate policies and legislation, including poor enforcement mechanisms, further compromise access to health care services by these vulnerable groups.

4.0. Key HIV Drivers

11. Based on global experiences with HIV, it has been established that major drivers of HIV include extreme poverty, high mobility, migrant labour, sexual and gender-based violence (SGBV), illiteracy, stigma and discrimination, alcohol abuse and emergency situations such as civil conflicts and wars. Others are multiple and concurrent sexual partnerships (MCPs), low and inconsistent use of male condoms, low circumcision rates, sex work, men who have sex with men (MSM) and transgender people, including negative aspects of cultural practices such as use of same sharps in initiation ceremonies and sexual cleansing.
12. Certain cultural and traditional practices perpetrate female subservience in sexual relationships which enhances vulnerability of women to men. Polygamous marriages and Female Genital Mutilation (FGM) also fuel HIV infections. In some initiation ceremonies, adolescent girls are taught how to

handle men in sexual relationships which creates conditions for early sexual debut. Marriage in most traditional societies is considered as insignia of moral rectitude and social esteem but it puts pressure on girls to get married as soon as possible and, consequently, exposes them to the risk of infection.

13. HIV infections among women are further fuelled by unequal power relations between men and women in regard to access to vital economic assets such as land and credit, including inadequate participation in key decision-making structures at almost all levels of society. Limited access to economic assets by women relative to men results in undue dependence on the latter and, invariably, diminished capacity to engage in sexual relationships on equal terms.
14. Stigma and discrimination drive HIV infections in several ways one of which is that it enhances lack of openness among some HIV-positive persons who feel coming out in the open will attract social exclusion, rejection and shame. In most cases, stigma and discrimination are a consequence of lack of knowledge of the modes of HIV transmission.

5.0. Cross-Border Trade

15. Cross-Border Trade (CBT) is one of the vehicles for regional economic integration. The increase in CBT over the last couple of years has seen a rapid movement of people across the region and resulted in heightened exposure to communicable diseases such as HIV. While even in home environments people face the risk of HIV infection, absence from home for several days on business trips increases vulnerability to infection. Women are particularly at risk especially in instances where they seek transport from cross-border truck drivers and are made to spend several days with them. In some cases, intimate relationships develop either consensually or forced through threats of ejection from trucks in inhabited and hostile environments such as game parks.
16. Cross-border traders experience challenges relating to accessing HIV and AIDS services such as counselling, treatment, care and support. There have been initiatives to address these challenges along major regional transport corridors under various donor-supported programmes such as the USAID-funded Corridors of Hope (CoH). Some cross-border facilities, however, do not have gender-friendly sanitation and accommodation facilities, a situation that deprives women of their right to privacy. Absence of or inadequate gender-friendly facilities at border-crossing points sometimes causes women and men to share sleeping facilities resulting in heightened risk of sexual and gender-based violence, including HIV infection.

6.0. Truck Drivers

17. The rapidly increased flow of goods and services across the COMESA region has, invariably, seen an attendant spike in trade and business-related vehicular traffic between and among Member States. Movement of goods across borders using trucks has particularly spiked over the years and, according to COMESA, "...90% of goods traded...are transported through the road network" (COMESA, Framework for the Multi-sectoral Programme on HIV & AIDS for COMESA: 2012-2015:15). Truck drivers spend long periods away from their homes and often face social environments that put them at high risk of HIV infection. In most cases, long-distance truck drivers are targeted by sex workers who may not all

the time use protective barriers such as female condoms.

18. Programmes to address the challenge of HIV among long-distance truck drivers have largely been driven by external support such as that by the USAID-funded Corridors of Hope (CoH). The Programme operates along major intra-regional transport routes with designated integrated HIV and AIDS service centres. Experience, however, shows that, due to external dependence of the Programme and similar others, HIV and AIDS services on offer are not comprehensive, let alone sustainable.

7.0. People with Disabilities

19. According to WHO, there "...are more than one billion people living with a physical, sensory, intellectual or mental health disability in the world..." (WHO). Quite often, PWDs are subjected to stigma, sexual violence, discrimination and social exclusion. In the era of HIV, PWDs face a particularly high risk of HIV infection due to their vulnerability. Infection with HIV accentuates disability-related challenges (especially for women and girls) in regard to accessing HIV and AIDS services. Access to HIV and AIDS services further constrained by lack of or inadequate complements of medical staff trained in handling peculiar challenges faced by PWDs. Some health care settings also lack sign language or Braille facilities for blind HIV-infected PWDs. In the absence of sign language or Braille facilities, for example, confidentiality for PWDs in counselling and HIV-testing may be compromised by the need for a personal assistant or a sign language interpreter to be present in order to access HIV-related services.
20. Some countries in the region have made provisions for PWDs in their national HIV and AIDS strategic frameworks. The challenge, however, has been lack of implementation largely on account of lack of or inadequate political will and the resource-constrained nature of most Member States resulting in the lack of earmarked budgetary allocations for PWD-related HIV challenges. Evidence further shows that there are hardly any disability-disaggregated HIV and AIDS data at national and regional levels. This makes it impossible to realistically determine and document the extent of HIV prevalence among PWDs. In the case of CBT, PWDs also suffer from lack of user-friendly HIV and AIDS services.
21. At the global level, there have been initiatives to improve the health and welfare of PWDs among which are the Convention on the Rights of People with Disabilities (CRPD) and the *WHO Global Disability Action Plan 2014-2021: Better health for all people with disability* which was adopted by the 67th World Health Assembly (WHA). The Plan seeks to:
 - Remove barriers and improve access to health services and programmes;
 - Strengthen and extend rehabilitation, habilitation, assistive technology, assistance and support services, and community-based rehabilitation; and
 - Strengthen collection of relevant and internationally comparable data on disability and support research on disability and related services (WHO).

8.0. Maternal Health

22. At the end of 2011, the Partnership for Maternal, New-born and Child Health (PMNCH) estimated that out of the 38.6 million adults living with HIV globally, 7.3 million were women, in Swaziland HIV prevalence among pregnant women attending antenatal clinics rose from 4 per cent in 1992 to 43 per cent in 2004 and that each day, 1,800 children worldwide become infected with HIV – the vast majority of them new-borns (PMNCH). Over the recent past, COMESA has seen an upsurge in female traders at both national and regional levels. The phenomenal spike in female participation in CBT has come with maternal health-related challenges.
23. Specifically, there are concerns about the lack of user-friendly infrastructure and services for ensuring a balance between the productive and reproductive roles of women. While, for instance, improved female involvement in regional trade has been roundly lauded, there is little evidence of tangible initiatives to ensure that special needs pregnant or lactating female traders are mainstreamed in regional trade policies. Experience shows that pregnant or lactating female traders face serious challenges in accessing, for example, ante-natal or under-five services and Prevention of Mother-to-Child Transmission (PMTCT) of HIV along regional transport corridors. HIV-positive female traders also face challenges in accessing Antiretroviral (ARV) drugs along regional transport corridors. Counselling and testing for HIV facilities are inadequate and in cases where they are available, they are under-resourced in terms of both personnel and commodities such as ARVs and condoms.

9.0. Sexual and Reproductive Health Rights

24. Given WHO's definition of health "...as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity...", reproductive health is concerned with the continuum of reproductive systems and practices at all stages of life. In this regard, it implies individual rights to equal participation in making sexual and reproductive decisions, including the right to have satisfying and safe sex (WHO). Having safe sex includes freedom from coercive sexual relationships that might result in infection with sexually-transmitted diseases.
25. Due to several factors, such as negative cultural practices, high poverty levels, low education levels, unequal access to productive resources, limited participation in key decision-making structures and sexual and gender-based violence (SGBV), women and girls are at greater risk of HIV infection than their male counterparts. WHO, on the other hand, defines reproductive health rights as the "...recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence" (WHO).

10.0. Adolescent Sexual Reproductive Health

26. Adolescence stretches from the age of 11 to 18 years during which young people experience far-reaching and drastic physical, psychological, emotional and personality changes. It is during this period that adolescents become sexually-curious which makes them vulnerability to HIV infection. Relative to their male counterparts, female adolescents are particularly vulnerable to HIV infection largely due to gender-related cultural and traditional inequalities. In most traditional societies in the

region, for instance, female adolescents are not prioritised in the allocation of family resources for education and income-generating activities and not involved in key decision-making processes. Like women, female adolescents bear heavy responsibilities in caring for HIV-infected family members which results in missed educational and skills acquisition opportunities.

27. Prevention of HIV infection among adolescents is constrained by several factors which include some cultural norms that limit their access to HIV prevention services such as condoms. In addition, most health facilities do not have adolescent-friendly corners which results in the provision of adolescent sexual and reproductive health services within regular service delivery systems. There is also a gap in regard to the supply of health personnel with specialised skills for handling adolescent sexual and reproductive health-related challenges.
28. According to AVERT, a British HIV and AIDS Trust, at the end of 2013, there were 3.2 million children living with HIV around the world and 240,000 became infected in the same year, while 91 per cent of children living with HIV were in Sub-Saharan Africa. The gravity of HIV infections among children is, however, not matched by resources it deserves as concentration in terms of prevention, treatment, care and support is on adults. In addition, most health facilities lack specialist health personnel who are trained in paediatric HIV. While there has been a noticeable improvement in Prevention of Mother-To-Child Transmission (PMTCT) of HIV, little seems to have been done to isolate and deal with pediatric HIV in terms of national and regional policies and improved resource allocation.

11.0. Paediatric HIV

29. Over the years, the COMESA region has seen an increase in the number of children infected with HIV. According to UNAIDS, at the end of 2013, out of the 18.5 million people living with HIV in Eastern and Southern Africa, 2.0 million were children. Access to treatment, care and support for HIV-infected children has for a long time faced a number challenges. Firstly, there has been insufficient isolation of paediatric HIV and AIDS in national and regional responses. Secondly, paediatric HIV suffers from a paucity of trained health cadres as conventional training has mostly focused on adult populations. The non-prioritisation and inadequate mainstreaming of paediatric HIV in national and regional responses have translated into low budgetary allocations for treatment, care and support for HIV-infected children.

12.0. Child Labour

30. The International Labour Organisation (ILO) defines child labour "...as work that deprives children of their childhood, their potential and their dignity, and that is harmful to physical and mental development" (ILO). Specifically, child labour refers to work that is mentally, physically, socially or morally dangerous and harmful to children and interferes with their schooling by depriving them of the opportunity to attend school, obliging them to leave school prematurely or requiring them to attempt to combine school attendance with excessively long and heavy work. Under the United Nations Convention on the Rights of the Child (CRC):
31. "State party to the CRC have the obligation to undertake all appropriate legislative, administrative

and other measures for the implementation of the rights recognized in the CRC and the Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography. More specifically, the CRC requires States parties to take all appropriate national, bilateral and multilateral measures to prevent the inducement or coercion of a child to engage in any unlawful activity; the exploitative use of children in prostitution or other unlawful sexual practices and prevent the exploitative use of children in pornographic performances and materials. With respect to trafficking in particular, the CRC requires States parties to take all appropriate national, bilateral and multilateral measures to prevent the abduction of, the sale of or the trafficking in children for any purpose or in any form (Convention on the Rights of the Child).

32. Child labour is also prohibited under the ILO Convention No 182 on the Worst Forms of Child Labour which "...provides for the prohibition and the elimination of the worst forms of child labour, which include all forms of slavery or practices similar to slavery including trafficking.
33. Child labour involves both boys and girls and is used in both domestic and commercial work environments. Child labour causes children to work in dangerous and exploitative environments which heightens the risk of injury, infection and death. Due to several factors, such as high household poverty levels, limited school enrolment opportunities and high demand for cheap labour (especially on farms and plantations), all countries in the region experience various forms of child labour. In Ethiopia, as much as 60 per cent of children work to supplement their family incomes with half of them working in hazardous environments such as farms, textile factories and mines.
34. In the context of HIV, child labour is a potential vehicle for exposing affected children to HIV infection. Children affected by child labour, for instance, often live in conditions that expose them to alcohol, drugs, violence, illicit and forced sex and other forms of vices. Unfortunately, there is hardly any reliable information, let alone data, on the interaction between HIV and child labour. This gap makes it practically impossible to gauge the extent to which child labour contributes to HIV prevalence among children in the COMESA region. In the absence of tangible and reliable data and information on the causal relationship between HIV and child labour, it has not been possible for COMESA to craft any pro-active or re-active policies or programmes to address HIV within the context of child labour.
35. This and other challenges have been exacerbated by inadequate data and information-sharing on child labour-related issues. In addition, there are no comprehensive, robust and sustainable child labour monitoring and evaluation systems at both national and regional levels. A review of national labour and employment laws reveals glaring contradictions and inconsistencies in regard to the prescription of the minimum employable age. The fight against child labour in the region has also been stymied by porous borders and corruption among Police and immigration officials.

13.0. Child Marriage

36. According to the United Nation Children's Fund (UNICEF), marriage before the age of 18 is a fundamental violation of human rights. Globally, approximately 15 million girls are married before they turn 18. In developing countries, one in three girls will be married by the age of 18 (Foundation for Women's Health Research and Development (FORWARD)). Evidence further shows that in developing

countries, complications from pregnancy and childbirth are the leading causes of death for girls aged between 15 and 19 years. Between 2011 and 2020, it is estimated that more than 140 million girls will become child brides (ibid.).

37. In the context of HIV, child marriage creates conditions that heighten the risk of infection for affected children. This is largely because married children have no sex negotiating power and are often abused, especially in polygamous settings. It also compromises a girl's development by interrupting her schooling, limiting her opportunities for career and vocational advancement and placing her at increased risk of domestic violence. Child marriage also affects boys but to a lesser degree than girls (UNICEF).
38. Major drivers of early marriages include poverty, the perception that marriage provides 'protection', family honour, social norms, customary or religious laws that condone the practice, inadequate legislative and policy frameworks and a country's legal system. Child marriage is also driven by cultural and traditional beliefs and practices that edify early marriage as an insignia of social respect and honour. The continued existence in some countries in the region of dual legal systems, i.e. Statutory/written Law alongside Customary/unwritten Law, compromises efforts that are targeted at eradicating child marriage as the two systems differently interpret the age for marriage. In the case of Customary Law, a girl is fit to get married as soon as she attains the age of puberty and, from experience, this can happen as early as 10 years. Conversely, most national legal systems in the region prescribe anything between 18 and 21 years as legal ages for marriage.
39. In order to address the challenge of child marriage, Member States have been working with cooperating partners such as the United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), Plan International (PI), Safe the Children (StC) and the International Planned Parenthood Association (IPPA) in designing and implementing targeted programmes. There are also continuing initiatives by a number of Member States that involve engagement of chiefs and other traditional leaders in addressing negative aspects cultural and traditional practices that fuel early marriage.
40. Zambia, for example, has developed a strategic plan to end child marriage and is using it to roll out its nation-wide campaign against the scourge. On its part, Malawi has enacted a Bill that criminalises early marriage under which offenders will face up to 10 years imprisonment. Many countries in the region are also supporting the global campaign against child marriage under the theme of "Girls Not Brides" which is part of a global partnership involving more than 400 civil society organisations.

14.0. Human Trafficking

41. Although there is no reliable data on the connection between HIV infection and human trafficking, anecdotal evidence suggests that the vice increases the risk of infection among affected populations. In its Protocol to Prevent, Suppress and Punish Trafficking in Persons, the United Nations Convention against Transnational Organized Crime (UNTOC), Article 3, defines trafficking in persons as "... the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the

consent of a person having control over another person, for the purpose of exploitation (UNCTOC). According to UNCTOC, human trafficking has "...increasingly become a serious challenge world-wide. There are reports of men, women and children who are forcefully captured or lured with promises of employment but end up in living and working in slavery conditions".

42. COMESA Member States have not been spared from the scourge. A study conducted by the United Nations Office on Drugs and Crime (UNODC) in Malawi, Mozambique, South Africa and Zambia, for example, revealed "...that Mozambican victims include girls and women who are promised jobs as waitresses or sex workers in South Africa but are then sold in Johannesburg to brothels or to individuals as slaves or to mineworkers as wives" (UNODC). Tanzania, Zambia and Mozambique have been identified as human trafficking transit routes with South Africa as the final destination. Women and girls constitute the vast majority of those trafficked for purposes of sexual exploitation, while men are trafficked for purposes of labour. Children are generally trafficked for domestic servitude and child-minding. Recently, there has also been a rising trend in human trafficking for body parts.
43. Humans who are trafficked face increased risk of HIV infection given the conditions to which they are subjected. Most victims are physically and sexually abused and made to work in hazardous environments. Given the underworld and secretive nature of human trafficking, trafficked persons with ailments, including those with HIV, are not permitted access to appropriate medical care. Like in the case of child labour, efforts to fight human trafficking are impeded by several factors. These include weak immigration laws that allow perpetrators of the vice to get away with light or no custodial sentences, poor availability of reliable data and information on the extent of the vice and equally poor sharing of information between and among Member States.
44. Corruption among Police and immigration officials also frustrates efforts to fight the vice. Efforts to decisively fight human trafficking are further compromised by the non-ratification of relevant international conventions and agreements. Currently, for instance, only Botswana, the Democratic Republic of the Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania and Zambia have ratified the UN Protocol to Prevent, Suppress and Punish Trafficking in Persons.

15.0. Migration and Migrant Labour

45. Migration is usually defined as the movement of people from one place to another temporarily, seasonally or permanently, for a host of voluntary or involuntary reasons. The COMESA region has a long history of migrant labour which stretches back to pre-independence years. Copper mines in Zambia, for instance, drew migrant workers from Malawi, Mozambique, Zimbabwe and Tanzania. South African gold mines drew (and continue to draw) migrant labour from Botswana, Lesotho, Swaziland, Namibia and Mozambique. In fact, economies of countries such as Lesotho and Swaziland disproportionately depend on migrant labour that work in South African gold and diamond mines and on farms. Over the years, the composition of migrant labour in the region has diversified from mining and farm operations to include professional occupations.
46. What is common to all migrants is relocation from areas of usual residence and settlement in new

environments; which often implies leaving families and familiar social networks. Settlement in new environments away from home demands acquisition of new social networks and, perhaps, habits. In the era of HIV, labour migration is a potential vehicle for HIV transmission, especially in circumstances where opportunities for formal employment or engagement in income-generating activities are not available. The COMESA region has also seen a rising trend in sex tourism with those seeking sex travelling to countries with lax sex laws.

16.0. Emergence Situations, War and Human Displacement

47. According to UNAIDS, emergence situations, war and human displacement create conditions for increased vulnerability to HIV infection. During war or conflict, civilians are often subjected to mass displacement, human rights abuses and sexual violence. They are also left in conditions of increased socio-economic vulnerability and poverty that might force them to use commercial sex to survive. Violence against women, especially rape, has been widespread in recent wars and is used as a weapon of warfare. Girls and women of all ages have been raped, put in prison to satisfy the sexual needs of occupying soldiers, or tortured (ILO); all of which are potential vehicles for HIV transmission.
48. The abduction of over 200 school girls by Boko Haram in northern Nigeria and their forced marriage is an example of the gruesome effects of conflicts and wars. Like women, children face an increased risk of HIV infection as they are often forcibly recruited as combatants and used as sex slaves. According to the ILO, child soldiers are given drugs or alcohol to encourage them to fight (ILO). Drug and alcohol consumption exacerbates their vulnerability to social vices some of which might lead to HIV infection. Released child soldiers in South Sudan, for example, narrated horrific tales of physical and mental abuses that they were subjected to during their captivity.
49. Given the global nature of conflicts and wars and their potential to create conditions for increased risk of HIV infection, various UNGASS on HIV and AIDS have repeatedly called upon Member States, UN agencies, regional and sub-regional organisations, including Non-Governmental Organisations (NGOs), "...to incorporate as a matter of urgency HIV/AIDS prevention, care and awareness elements into their plans and programmes and provide HIV/AIDS awareness and training to their personnel". Conflicts and wars disrupt and destroy health infrastructure and redirect resources from planned development budgets.

17.0. Men and Women in Uniform

50. According to UNAIDS, "...uniformed services, especially young men and women, are highly vulnerable to HIV/AIDS because of their work environment, age, mobility and other factors that expose them to higher risk of infection than their civilian counterparts" (UNAIDS, Uniformed Services Programming Guide: A Guide to HIV/AIDS/STI programming options for uniformed services". Cognisant of this, the UN Security Council in 2000 adopted Resolution 1308 on the impact of HIV and AIDS on international peace-keepers. This was re-affirmed in 2001 by the UN Declaration that committed Member States to taking specific steps to address the impact of the pandemic on uniformed services.
51. Over the years, the COMESA region has experienced increased cases of conflicts and wars that have

called for occasional assembly of peace-keeping missions. The Horn of Africa and the Great Lakes region have particularly faced increased cases of conflicts and wars. Resolution of conflicts and wars in the region has mostly been undertaken within the UN and AU frameworks. Experience, however, shows that peace-keeping missions have suffered from inadequate funding which has not only compromised effective resolution of conflicts and wars but also delivery of comprehensive HIV and AIDS services.

18.0. Sex Workers

52. The UNAIDS defines sex workers as "Female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work in the COMESA region is a challenge at both national and regional levels. Although boys and men are also involved in sex work, the practice mostly involves adolescent girls and women. Poverty, inadequate opportunities for skills training and employment are among the most frequently cited reasons for engagement in sex work.
53. Sex workers often have multiple partners and often inconsistently use condoms as barriers against infection. This is compounded by differences in payments for protected and unprotected sex with the latter fetching more than the former. In other cases, sex workers find themselves in situations where they are powerless to negotiate safe sex as they are subjected to intimidation and other forms of violence. Like elsewhere in the world, addressing the challenges of sex work in the COMESA region faces several challenges.
54. Firstly, sex work is stigmatised, marginalised and criminalised in the majority of Member States and those who engage in it are systematically harassed and arrested by law enforcement officers. Sex workers are also subjected to embarrassing questions from health personnel whenever they seek HIV and AIDS services. In countries where sex work is criminalised, sex workers who get raped do not report to law enforcement agents for fear of arrest or public ridicule. Criminilisation of sex work, on the other hand, puts clients of sex workers at heightened risk of HIV infection. It also creates conditions for clients of HIV-positive sex workers to act as bridges between them and uninfected populations.
55. Secondly, there is the challenge of lack of or limited coordination between and among law enforcement agencies and health personnel in regard to handling sex work-related challenges. In certain cases, for instance, the Police may not attend to a sex worker who has been raped until she produces a medical report which might take a long time to procure. Experience also shows that there is lack of harmonisation and coordination of national sex work-related legislation. This makes it practically impossible to formulate, let alone implement, region-wide sex work policies and legislation. Initiatives that are targeted at dealing with sex work are further stymied by the treatment of sex workers as subjects, rather than as participants, in the formulation and implementation of policies and programmes.

19.0. Street Kids

56. Given the generally high poverty levels in the COMESA region, most Member States continue to

grapple with the challenge of increasing numbers of street kids. Street kids are particularly vulnerable to HIV infection due to environments in which they operate. Life on the street is associated with, among others, violence, extortion and sexual abuse which combine to exacerbate vulnerability of affected children.

57. Efforts to address HIV and AIDS-related challenges among street kids are often compromised by several factors. To start with, street kids have, for a long time, not been isolated as a special population group at high risk of HIV infection. Secondly, the low prioritisation of street kids in responses to the pandemic has equally translated into their low prioritisation in health budget frameworks. Thirdly, capture of street kids-related data and information is challenging as they are, at times, mobile. Finally, there are challenges related to the identification and verification of who genuinely qualifies as a street kid.

20.0. Injecting Drug Users

58. According to the UNAIDS GAP Report, there are close to 12.7 million people who inject drugs in the world out of which nearly "...1.7 million, or 13%, are also living with HIV" (GAP Report). In most countries in the COMESA region, consumption of drugs and substances is criminalised and face severe penalties. Severe penalties, which include long jail terms, drive drug and substance consumers underground and, consequently, crowd out them of available HIV and AIDS services. People who consume drugs and substances are stigmatised, discriminated and socially-excluded. Most COMESA Member States face the challenge of drug use, especially among the youthful population. Experience, however, shows that, instead of pro-actively addressing the challenge of drug use, many Member States have rafts of stiff and draconian laws that tend to drive drug-users underground.
59. Criminalisation of injecting drug use creates barriers to accessing HIV prevention, testing, treatment, care, support and impact mitigation services. Limited access to services increases the risk of transmission of the virus to sexual partners. The risk of HIV transmission among drug users is escalated in circumstances where same injection instruments are shared. Fear of arrest and prosecution causes HIV-positive drug users to miss out on treatment for drug-related complications which is compounded by inadequate knowledge of the interaction between drug use and HIV infection among most health workers.

21.0. Aged People

60. According to the UNAIDS GAP Report, the aged are among the 12 populations that are inadequately addressed in responses against the epidemic. It adds that there are "...4.2 million people aged 50 and older living with HIV...More than 2 million people aged 50 and older live in sub-Saharan Africa, which accounts for 60% of all people living with HIV over the age of 50" (GAP Report). Aged people are prone to HIV infection due to the myth that they face low risk on account of their advanced age and experience. The converse, however, is true as their vulnerability is all the more pronounced due to several factors. Most aged people are associated with poor livelihoods, inadequate access to health care, clean water and sanitation which compound their vulnerability to ill-health. Aged people also suffer the burden of care for orphans which further deepens their social deprivation, poverty and

vulnerability.

61. Efforts to address health-related challenges are stymied by lack of or inadequate data and information which leads to poor targeting of services. In addition, Most Member States have poor social security systems which are characterised by rustic payment systems and inordinate delays in processing claims. Existing social security systems only cover formal sector employees with the result that aged people who are not covered are excluded from health-related benefits. Lastly, most health systems have inadequate supply of oncologists which leads to inadequate capacity for diagnosis and treatment of aging-related health challenges.

22.0. Partnerships

62. The complex and cross-cutting nature of HIV demands responses that are multi-sectoral and inclusive of all stakeholders. Consequently, partnerships with traditional leaders, communities, civil society organisations (CSOs), faith-based organisations (FBOs) and the private sector in creating enabling policy and legal environments for HIV and AIDS policy and programme implementation are key to ensuring positive people-level outcomes and impacts.
63. Given the fact that traditional leaders are gate-keepers of inherited cultural and traditional norms and practices, they present a rare entry-point into communities for HIV and AIDS interventions. Some aspects of cultural and traditional norms, however, contribute to the spread of HIV and need to be addressed in responses to the pandemic. Involvement of traditional leaders, such as chiefs, in responses to HIV can be an effective vehicle for ventilating communities with messages against the pandemic and ensuring people-level ownership of various interventions. Currently, most interventions in the region anecdotally involve traditional leaders and see them as mere recipients of HIV and AIDS services rather than equal partners in policy and programme planning.
64. Community participation and partnerships are vital cogs in the fight against the pandemic. They ensure people-level ownership of interventions and are a reservoir of local traditional practices some of which might be promotive or inhibitive of responses against the pandemic. Effective community participation will, therefore, help in enlisting the support of local people for proposed interventions. On their part, CSOs and FBOs have proved useful partners in the fight against the HIV pandemic as they bring a rare skills mix and resources that ensure timely delivery of services. Their participation in national and regional responses has, however, been stymied by limited resource complements and over-reliance on external donor support.
65. On its part, the private sector has the proven capacity to complement public resources in all areas of the response against the pandemic. Given the resource-constrained nature of most Member States, the private sector presents a viable element in filling resource gaps in health funding. This is especially true in medical Research and Development (R&D) and production of medicines and supplies, including drug and supply logistics. In this regard, health-related Public Private Partnerships (PPPs) are useful vehicles for leveraging health resources from the private sector. The challenge, however, is

that most Member States have inadequate capacity to generate bankable PPP proposals.

23.0. HIV and AIDS Mainstreaming

66. Most national HIV and AIDS policies in the region reveal lack of or inadequate mainstreaming of the pandemic in national development planning frameworks. Consequently, many policies end up with HIV treatment, care, support and impact mitigation programmes that tend to crowd out special needs of most-at-risk populations such as women, children, adolescents, PWDs, the aged and minority groups. Lack of or inadequate mainstreaming of HIV and AIDS in national development programmes is primarily due to insufficient institutional capacity.

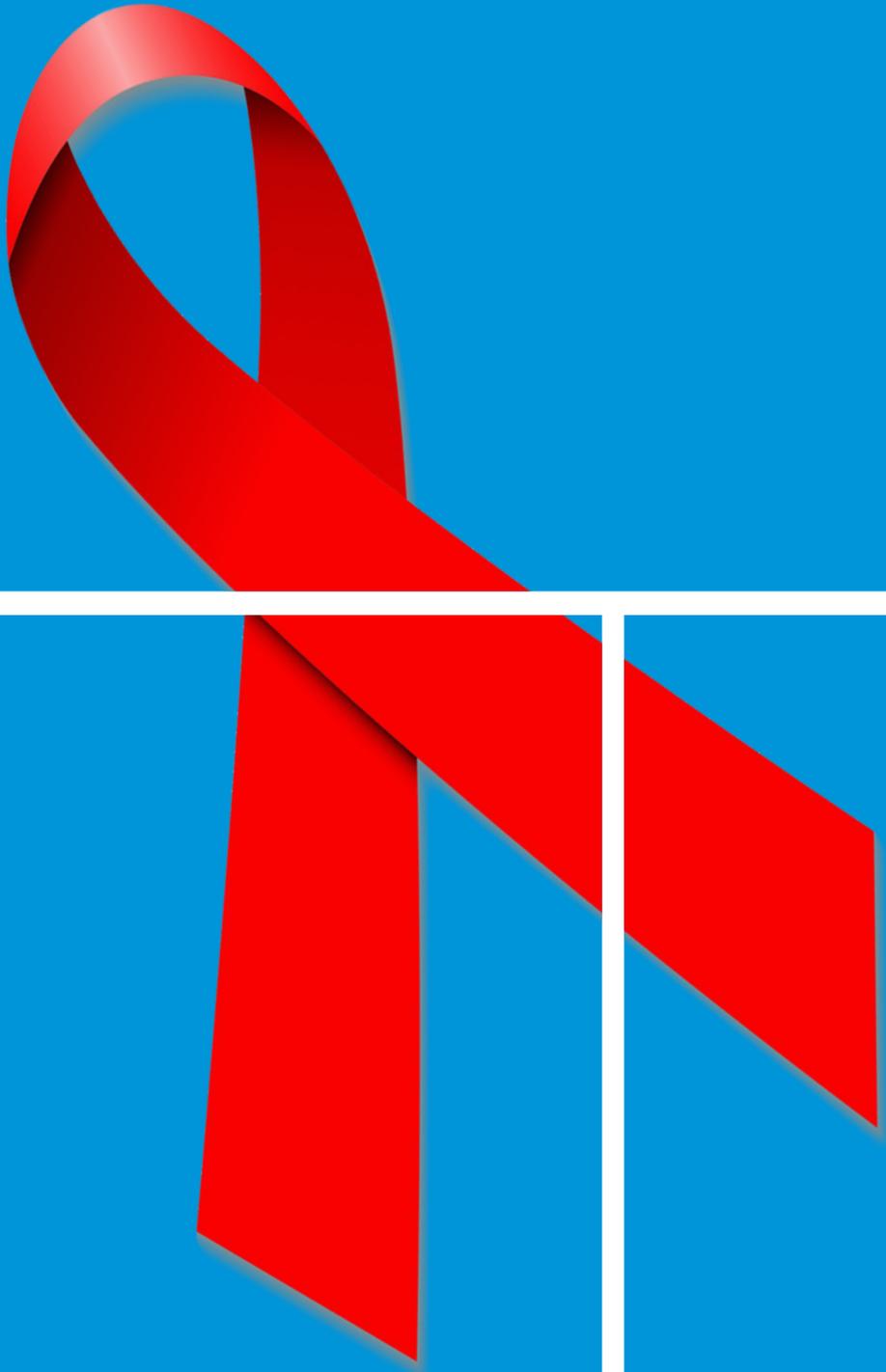
24.0. Governance, Regional Responses, Impact and Coordination

67. All Member States have established national multi-sectoral response coordination mechanisms, HIV and AIDS government committees and formulated national HIV and AIDS policies and strategic plans. They have also committed themselves to implementing HIV and AIDS declarations such as those by UNGASS, AU, SADC and other Regional Economic Communities (RECs). Specific regional initiatives include the AU HIV and AIDS Policy, EAC HIV and AIDS Workplace Policy, EAC Regional HIV Bill, SADC HIV and AIDS Strategic Framework, AIDS Watch Africa Strategic Framework and the Abuja Declaration.
68. In 2012, AU Member States adopted the Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa. The overarching goal of the Roadmap is "...to support African countries to exercise leadership to meet AIDS, TB, Malaria targets by 2015 and source African solutions to ensure universal access to health-related services for all those in need on a sustainable basis" (AU). It builds on a number of AU initiatives such as the Abuja Declaration on HIV-AIDS, TB and other related diseases, the Abuja Call for Accelerated Action towards Universal Access to HIV-AIDS, TB and Malaria Services and the Kampala Declaration on Actions on Maternal, New-born and Child Health. The inclusion of TB and other related diseases is an innovative strategy that provides opportunities for addressing HIV co-infections.
69. Studies done by the AU Commission shows several countries have made significant progress in the fight against HIV-AIDS, TB and Malaria. Specific examples include Prevention of Mother-to-Child Transmission (PMCT) of HIV, testing of blood donations, treatment of TB and reduction of malaria-related deaths. There are, however, gaps in regard to access to treatment, care and support, resource mobilisation and health systems strengthening (AU). Resource mobilisation-related challenges are largely due to the resource-constrained nature of most Member States and inadequate prioritisation of the pandemic in national budgeting frameworks. There is also the challenge of inadequate regional coordination and synergies in programme planning and implementation. In acknowledging this challenge, the AU Commission stressed the urgent need for efforts of continental and regional institutions to be coordinated in order to effectively support Member States to follow-up on commitments and to adequately address challenges in HIV-AIDS, TB and Malaria programmes (AU).
70. The Commission further observed that development partners and the UN System have continued to support national, regional and continental initiatives that are meant to enhance universal access

to treatment and other HIV impact mitigation interventions. Evidence, however, shows that these initiatives lack coordination, harmonisation, alignment and convergences. This is largely explained by the absence of robust and sustainable mechanisms for coordinating, monitoring and evaluation of national, sub-regional, regional and international HIV and AIDS commitments. Lack of or poor coordination has led to sub-optimal sharing of data and information between and among Member States resulting in duplication of effort, waste of scarce health resources and poor people-level outcomes and impacts.

25.0. Rationale

71. All countries in the COMESA region have developed national HIV and AIDS policies and strategic plans and implemented them with varying degrees of success. However, these have been done in silos resulting in lack of synergies, inability to coordinate national HIV and AIDS policies and programmes and duplication of effort. Non-coordination of policies and programmes have also led to inability to innovatively leverage internationally-available HIV and AIDS resources. This Policy shall be used to address these and other challenges and act as a framework for guiding Member States in their contribution to the realisation of the objectives of Article 110 of the COMESA Treaty and HIV and AIDS-related international conventions and agreements to which Member States are party. The Policy also presents a rare opportunity for Member States to take advantage of COMESA's strategic role in trade and investment promotion to do things differently and to innovatively develop and implement cutting-edge initiatives against the epidemic.



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