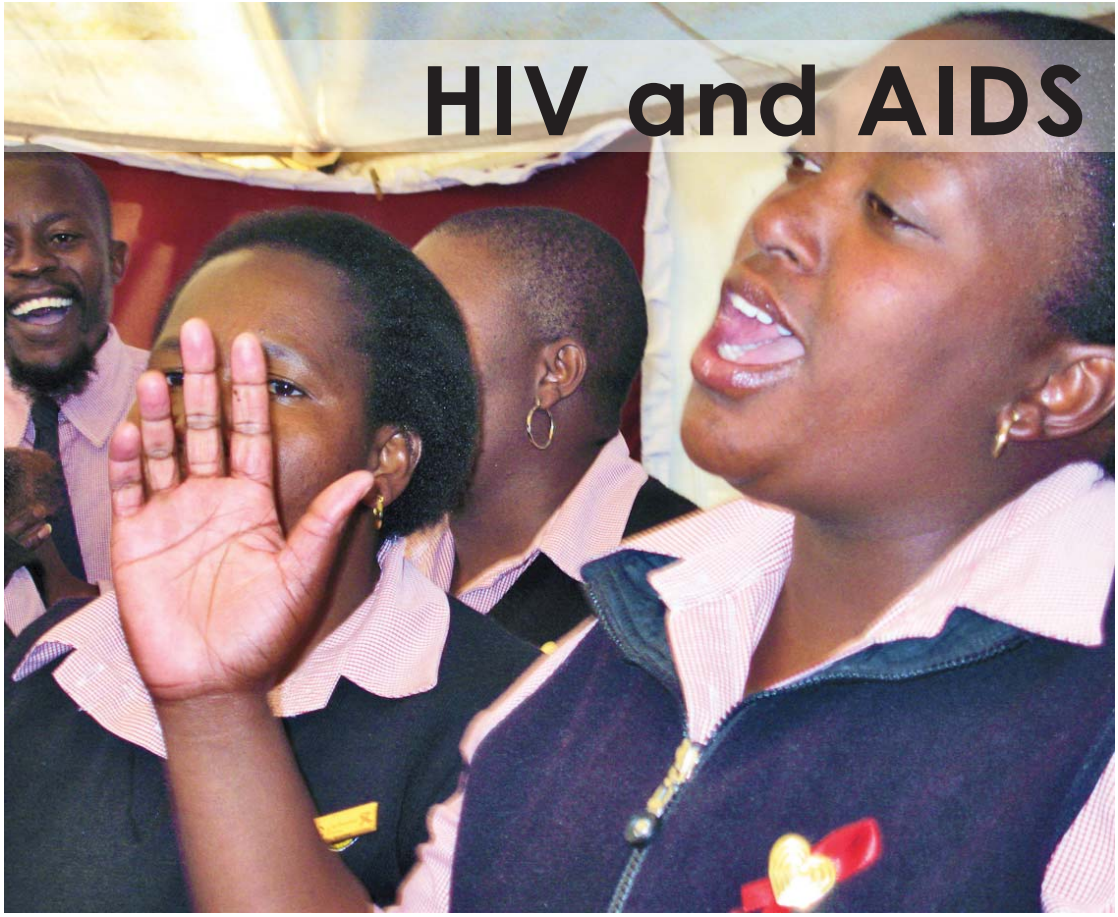
HIV and AIDS

5



Let us Grow, an organisation offering peer education, care and support in Orange Farm, Johannesburg, South Africa. Photo: Colleen Lowe Morna

Key points

- SADC is still the world's most heavily HIV-affected region. While prevalence is slowly declining, six SADC countries are the only in the world still with HIV prevalence rates over 10%.
- Prevalence is higher in women than in men in most SADC countries. Prevalence in women is two times higher in South Africa and Tanzania and 2.2 times higher in Angola. HIV prevalence in young women is about double young men in eight countries.
- The surge of HIV and AIDS in Madagascar calls attention to the necessity of inclusive, people-centred prevention in all countries as HIV can rapidly spread beyond a relatively contained epidemic in key populations. Investment is urgently needed for HIV and AIDS control in Madagascar where only 22% of people living with HIV (PLHIV) know their status and 22% are on antiretrovirals (ARVs)[1].
- SADC must continue crucial steps to eradicate AIDS as a public health threat by 2030. In the absence of an HIV cure or vaccine, SADC must prepare to sustain extensive treatment programmes for many years beyond 2030.
- There is continued emphasis on prevention, especially of vertical transmission to children, for adolescent girls and young women, adolescent boys and young men, and key populations.
- Investment by funders into condoms, critical in HIV prevention, has declined. Thus, highly subsidised condoms are no longer as readily available.
- Botswana and Namibia are the only countries in Africa, and with high HIV prevalence, to achieve the status of being on the path towards elimination of vertical transmission to children (or fewer than 750 new HIV infections per 100 000 births).[2]
- All SADC countries have an HIV and AIDS policy, strategy or plan, most of which are up to date and revised regularly.

[1] UNAIDS, 2023 data, https://aidsinfo.unaids.org/, accessed 25 July 2024
[2] UNAIDS (2024), The Urgency of Now: AIDS at a crossroads. Geneva: Joint United Nations Programme on HIV/AIDS.

- Globally, Eswatini, Botswana, Zimbabwe, Zambia and Malawi are amongst the nine countries that have already achieved the 95-95-95 targets. Lesotho and Namibia are amongst the ten countries on track to achieve the targets by 2025. Women are still more likely than men to have been tested, accessed ARV therapy, and achieved viral suppression in most countries (global target is 95% of all people living with HIV know their status, 95% of those diagnosed with HIV access antiretroviral treatment (or 90% of all PLHIV) and 95% of those on ARVs (or 86% of all PLHIV) achieve viral suppression).
- With health systems straining to provide prevention, testing, access to treatment and supporting treatment adherence for large numbers of PLHIV, community organisations are being called on for prevention, treatment and care services.
- Access to treatment continues to lag for children.

Introduction

We cannot partly end a pandemic. Leaders can end AIDS as a public health threat only by overcoming it everywhere, for everyone

In the Foreword to the 2024 Global AIDS Update, "The Urgency of Now: AIDS at a Crossroads," Winnie Byanyima, UNAIDS Executive Director, reminds us that "we cannot partly end a pandemic. Leaders can end AIDS as a public health threat only by overcoming it everywhere, for everyone."[3] She calls on global leaders to invest as required in their responses and reform policies to ensure prevention, testing, treatment and adherence for everyone, especially key populations and those most at risk. SADC has made tremendous progress, with impressive achievements in many countries. The plea highlighted in this chapter from medical researchers and professionals in Madagascar, where HIV and AIDS appear to be surging, is a reminder that no country can afford complacency.

SADC, which accounts for 5% of the world's overall population,[4] has 17.4 million people living with HIV or 43.6% of the world's total. HIV prevalence rates are declining in many countries, with Eswatini now the only country in the world with a national adult prevalence rate over 20% and prevalence in women over 30%. However, progress is uneven. Prevalence rates vary between some districts within countries and remain much higher than national averages among key populations, such as sex workers. Access to treatment continues to lag for children. Declines in prevalence and new infections are the result of substantial investment and wide-ranging prevention and treatment programmes. Until there is a vaccine or a cure for HIV, these programmes must be sustained for many years beyond 2030.

The road to ending HIV and AIDS as a public health threat has many twists and turns. COVID 19 had major negative impacts on HIV services. MPox, which is spreading in the DRC and has been declared a public health emergency of international concern, is more common and has more severe outcomes in people living with HIV (PLHIV). Evidence shows that the impact of climate change - drought and floods which are displacing populations and disrupting livelihoods - also negatively affects access to HIV services and treatment adherence.[5]

The Global AIDS Strategy 2021 - 2026 sets out the following interlinked priorities:

- Strategic Priority 1: maximise equitable and equal access to HIV services and solutions.
- Strategic Priority 2: break down barriers to achieving HIV outcomes.
- Strategic Priority 3: fully resource and sustain efficient HIV responses and integrate them into systems for health, social protection, humanitarian settings and pandemic responses.

[3] UNAIDS (2024) The Urgency of Now. Op Cit.
[4] https://data.worldbank.org/indicator/SP.POP.TOTL, accessed 15 October 2024
[5] See for instance, Orievulu, K. et al. Economic, social and demographic impacts of drought on treatment adherence among people living with HIV in rural South Africa: A qualitative analysis. Climate Risk Management 36 (2022) 100423. https://doi.org/10.1016/j.crm.2022.100423.

The ten result areas of the five-year plan are:

1: Primary HIV prevention for key populations, adolescents and other priority populations, including adolescents and young women and men in locations with high HIV incidence.
2: Adolescents, youth and adults living with HIV, especially key populations and other priority populations, know their status and are immediately offered and retained in quality, integrated HIV treatment and care that optimise health and well-being.
3: Tailored, integrated and differentiated vertical transmission and paediatric service delivery for women and children, particularly for adolescent girls and young women in locations with high HIV incidence.
4: Fully recognised, empowered, resourced and integrated community led HIV responses for a transformative and sustainable HIV response.
5: People living with HIV, key populations and people at risk of HIV enjoy human rights, equality and dignity, free of stigma and discrimination.
6: Women and girls, men and boys, in all their diversity, practice and promote gender-equitable social norms and gender equality, and work together to end gender-based violence and to mitigate the risk and impact of HIV.
7: Young people fully empowered and resourced to set new direction for the HIV response and unlock the progress needed to end inequalities and end AIDS.
8: Fully funded and efficient HIV response implemented to achieve the 2025 targets.
9: Systems for health and social protection schemes that support wellness, livelihood, and enabling environments for people living with, at risk of, or affected by HIV to reduce inequalities and allow them to live and thrive.
10: Fully prepared and resilient HIV response that protects people living with, at risk of, and affected by HIV in humanitarian settings and from the adverse impacts of current and future pandemics and other shocks.

The cross-cutting issues include:

i. Leadership, country ownership and advocacy: leaders at all levels must renew political commitment to ensure sustained engagement with and catalyse action from key and diverse stakeholders.
ii. Partnerships, multisector approaches and collaboration: partners at all levels must align strategic processes and enhance strategic collaboration to fully leverage and synergise the contributions to ending AIDS.
iii. Data, science, research and innovation: data, science, research, and innovation are critically important across all areas of the Strategy to inform, guide and reduce HIV related inequalities and accelerate the development and use of HIV services and programmes.
iv. Stigma, discrimination, human rights and gender equality: human rights and gender inequality barriers that slow progress in the HIV response and leave key populations and priority populations behind must be addressed and overcome in all areas of the Strategy.
v. Cities, urbanisation and human settlements: cities and human settlements as centres for economic growth, education, innovation, positive social change and sustainable development to close programmatic gaps in the HIV response.

The Global AIDS Strategy outlines three specific targets to address inequalities that contribute to HIV vulnerability (referred to as the three tens). These are:

- Less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence.
- Less than 10% of people living with HIV and key populations experience stigma and discrimination.
- Less than 10% of countries have punitive legal and policy environments that deny or limit access to services.

The Global AIDS Strategy sets specific targets related to treatment, the 95 - 95 -95 goals:

- 95% of all people living with HIV know their status.
- 95% of those diagnosed with HIV access antiretroviral treatment (which equates to 90% of all people living with HIV).
- 95% of those on ARVs (or 86% of all people living with HIV) achieve viral suppression.

The strategy has other specific targets, some of which are referenced throughout this chapter.

Table 5.1: Key HIV data, 2023

Indicators	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
HIV prevalence																
Overall prevalence adults aged 15 - 49 (%)	1,5	16,6	<0,1	0,17	25,1	18,5	0,4	6,7	1,5	11,5	9,7		17,1	3,8	9,8	10,5
Women who are HIV positive as a % of total	69	63	50	64	64	62	47	63	37	65	64		65	69	62	63
Women aged 15 to 49 HIV prevalence rate	2,0	21,4	<0,1	0,8	30,3	23,5	0,4	8,4	1,1	14,5	12,7		22,6	5,1	12,6	13
Men aged 15 to 49 HIV prevalence rate	0,9	11,8	<0,1	0,5	19,9	13,4	0,4	4,8	1,8	8,3	6,6		11,5	2,5	6,9	7,9
Prevalence women/prevalence men	2,2	1,8	1	1,6	1,5	1,8	1	1,8	0,6	1,8	1,9		2	2	1,8	1,7
HIV prevalence among young women (15-24)	0,7	5,6	<0,1	0,3	7,5	6,6	0,1	2,4	0,4	6,2	5		8,4	1,4	3,7	4
HIV prevalence among young men (15-24)	0,3	2,7	<0,1	0,2	4,5	3	<0,1	1,5	0,4	2,4	2,2		3,8	0,7	1,5	2,8
Prevalence young women/prevalence young men	2,3	2,1	1	1,5	1,7	2,2	1	1,6	1	2,6	2,3		2,2	2	2,5	1,4
Prevention																
Sex workers																
HIV prevalence (%)			0,5	7,5	60,8			49,9	18,2		29,9		62,3			40,2
% sex workers who received at least 2 HIV prevention interventions (PIs) in past 3 mons	51	90		38	9	31		68		57			34	90		79
Men who have sex with men																
HIV prevalence (%)	3	32	1,8	7,1	27,2	26		12,9			7,8		29,7		22,8	8,1
% of all MSM who received at least 2 HIV PIs in the past 3 months				39	29		28	65		31	33		10	4	5	26
Proportion of people who know their status																
Percent of people living with HIV who know their HIV status	72	97	69	87	>98	95	22	95	24	89	93		95	87	96	95
Condom use at last high-risk sex																
Condom use at last high-risk sex - women	32,1		29,3	22,6	53,9	77,7	4,1	49,9		36,7	65,9		60,0	21,7	34,5	64,7
Condom use at last high-risk sex - men	63,3		62,1	30,7	67,3	81,3	9,1	76,3		46,5	82,2		68,4	43,4	53,5	82,0
Elimination of vertical transmission																
Coverage of pregnant women who receive ARV to prevent vertical transmission (PVT) (%)	89	>98		40	>98	93	27	96	79	90	92		97	>98	93	88
Vertical transmission rate (%)	13,5	1,2		25,5	3,3	5		6,2		9,7	5,3		2,4	8	6,6	7,4
Knowledge																
Comprehensive knowledge of HIV and AIDS	32,3	47,2	20,4	36,8	49,5	35,5	24,1	41,9	31,8	30,6	58,3		45,8	43,1	41,7	46,4
Knowledge about HIV prevention among young women aged 15-24	32,5	47,4	19,1	36,4	49,1	37,6	22,9	41,1	4,4	30,8	61,6		46,1	40,1	42,6	46,3
Knowledge about HIV prevention among young men aged 15-24	31,6	47,1	23,9	41,5	50,9	30,9	25,5	44,3	30	30,2	51,1		45,6	46,7	40,6	46,6
Treatment - Antiretroviral therapy																
% of those living with HIV who are on ART	50	95	65	86	93	89	22	91	24	86	89		77	82	95	95
Women aged 15 and over receiving ART (%)	56	98	65	90	>98	93	29	94	21	91	92		81	84	97	98
Men aged 15 and over receiving ART (%)	43	90	70	91	82	83	17	89	26	80	87		71	79	94	91
Children aged 0 to 14 receiving ART (%)		66		44	>98	80	7	72	68	67	58		63	66	71	63
Viral suppression																
Percent of people living with HIV who have suppressed viral loads (86% indicates achievement of 95-95-95)	27	94	45	77	92	88		87	18	77	87		71	79	92	91

Source: Gender Links computations and UNAIDS 2023 data, https://aidsinfo.unaids.org, accessed 25 July 2024

Table 5.1, compared with previous Barometer reports, shows:

- HIV prevalence rates in Southern Africa continue to fall slowly, yet remain the highest in the world. Eswatini, Lesotho, Botswana, Mozambique, South Africa and Zimbabwe are the only countries worldwide with prevalence rates above 10%.
- In Southern Africa, HIV is still predominantly a heterosexually driven pandemic. In Comoros, Mauritius and Seychelles transmission is mainly within key populations.
- Prevalence in women is higher than in men; two times higher in South Africa and Tanzania and 2.2 times higher in Angola. This is indicative of an expanding epidemic, as prevalence increases rapidly in women before it begins to increase in men.
- There is a particularly marked difference between young women and young men. Prevalence is more than two times higher in young women than young men in Angola, Botswana, Lesotho, Mozambique, Namibia, South Africa, Tanzania and Zambia.
- People who know their HIV status is over 95% in Botswana, Eswatini, Lesotho, Malawi, South Africa, Zambia and Zimbabwe. It is over 80% in DRC, Mozambique, Namibia and Tanzania, but as low as 22% in Madagascar and only 24% in Mauritius.
- Coverage of adults and children living with HIV receiving antiretroviral therapy (ART) has improved dramatically, but ranges from 22% in Madagascar and 24% in Mauritius to over 90% in Botswana, Eswatini, Malawi, Zambia and Zimbabwe. There is a major disparity between coverage of adults on ART and children on ART, with notable exceptions being Eswatini and Mauritius where a higher percentage of children than adults living with HIV are on ART. This reflects low priority accorded to addressing the challenges of testing and treatment for children.
- Women are generally much more likely than men to be on ART. The exceptions are Comoros, DRC and Mauritius where higher percentages of men living with HIV are on ART.
- Data on viral suppression is not available for all countries. However, for those countries where this data exists, there is good progress. Botswana, Eswatini, Lesotho, Malawi, Namibia, Zambia and Zimbabwe all have suppression rates over 86%.
- Coverage of ART for elimination of vertical (mother-to-child) transmission is improving rapidly. Where coverage is over 95% the vertical transmission rate is falling - South Africa's achievement of 2.4% transmission is notable given the size of the South African epidemic. However, vertical transmission rates remain unacceptably high in Angola (14%) and DRC (26%) - pointing to the need for continued vigorous efforts.

HIV prevalence

As stated in the introduction, HIV prevalence in SADC continues to decline, but still has the highest prevalence rates in the world (the only countries with prevalence over 10%).



Umguza Rural District Council HIV and STI IEC material, Harare, Zimbabwe.
Photo: Tapiwa Zvaraya

Figure 5.1: HIV prevalence in SADC, 2023

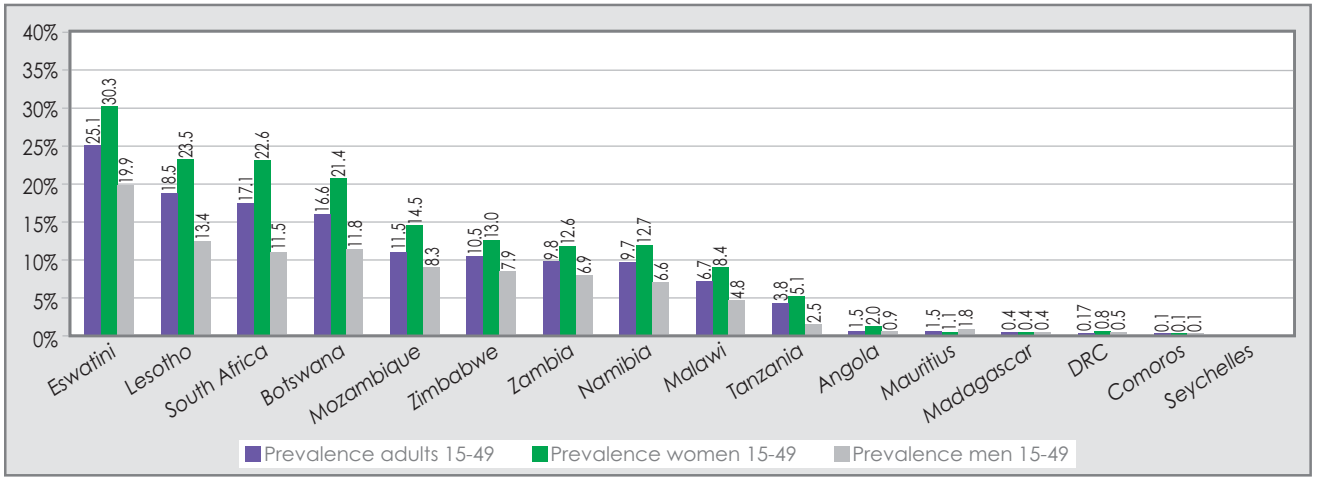


Table 5.2: HIV prevalence in SADC, 2023

Country	Prevalence Adults 15 - 49	Prevalence Women 15 - 49	Prevalence Men 15 - 49	Prevalence Young women	Prevalence young men	Ratio Young women: young men
Eswatini	25,1	30,3	19,9	7,5	4,5	1,67
Lesotho	18,5	23,5	13,4	6,6	3	2,20
South Africa	17,1	22,6	11,5	8,4	3,8	2,21
Botswana	16,6	21,4	11,8	5,6	2,7	2,07
Mozambique	11,5	14,5	8,3	6,2	2,4	2,58
Zimbabwe	10,5	13	7,9	4	2,8	1,43
Zambia	9,8	12,6	6,9	3,7	1,5	2,47
Namibia	9,7	12,7	6,6	5	2,2	2,27
Malawi	6,7	8,4	4,8	2,4	1,5	1,60
Tanzania	3,8	5,1	2,5	1,4	0,7	2,00
Angola	1,5	2	0,9	0,7	0,3	2,33
Mauritius	1,5	1,1	1,8	0,4	0,4	1,00
Madagascar	0,4	0,4	0,4	0,1	0,1	1,00
DRC	0,17	0,8	0,5	0,3	0,2	1,50
Comoros	0,1	0,1	0,1	0,1	0,1	1,00
Seychelles						

Key for all tables Very good Medium Low Very low Insufficient data

Source: Gender Links compiled from UNAIDS 2023 Data [6]

Figure 5.1 and Table 5.2 show wide variations in the HIV pandemic across SADC. The data shows that:

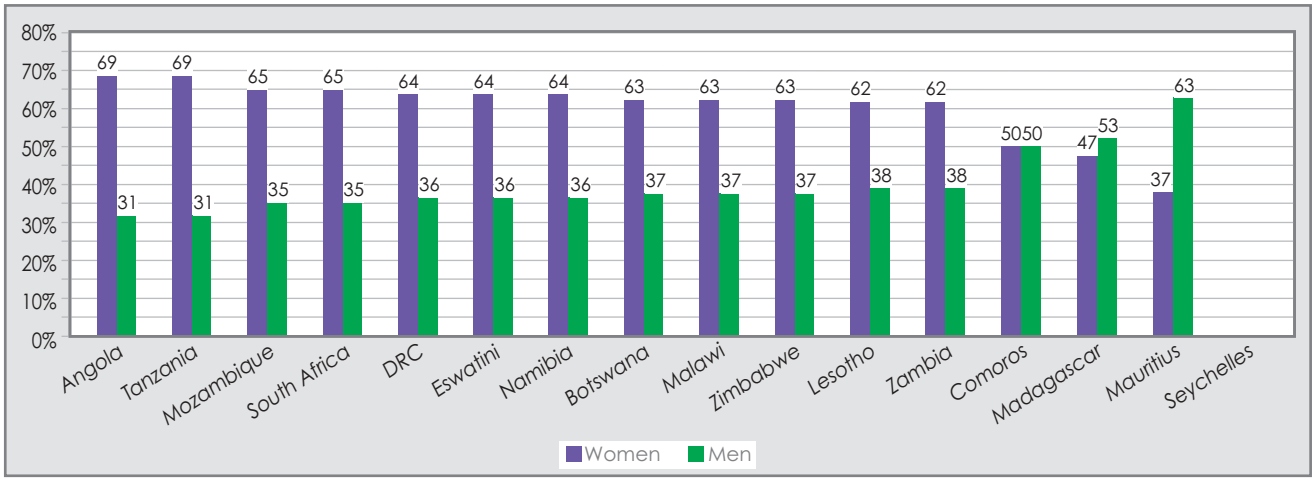
- Adult prevalence rates range from 0.1% in Comoros to 25.1% in Eswatini.
- Eswatini is the only country, in SADC and globally, with over 20% prevalence rate and prevalence in women over 30% (shaded in orange in the table). Lesotho, South Africa, Botswana, Mozambique and Zimbabwe have adult prevalence rates between 10 and 20% (shaded in yellow in the table).
- Most of SADC has a generalised, heterosexual pandemic with higher prevalence in women than in men. Prevalence rates are particularly higher for young women compared to young men. Though the difference is narrowing, in Mozambique, Zambia, Angola, Namibia, South Africa, Lesotho, Botswana and Tanzania HIV prevalence in young women is more than double that in young men.

[6] UNAIDS 2023 Data https://aidsinfo.unaids.org/, accessed 25 July 2024

- The island nations have epidemics largely present in key populations. The epidemic in Madagascar is becoming generalised and prevalence is now about equal in women and in men, where previously it was higher in men. Prevalence in young women in Mauritius is now equal to young men, though overall prevalence is still higher in men.
- Seychelles, whose population is only about 120 000 and which has a very low prevalence rate, has small total numbers of people living with HIV. Thus, very little data is available, and Seychelles is missing from much of the discussion in this chapter. Comoros and Mauritius have larger populations and more data available.

HIV disproportionality affects women in SADC and globally. Societal factors, such as gender inequalities, social norms, and gender-based violence contribute to women's HIV risk.

Figure 5.2: Proportion of Women and Men Living with HIV %, 2023



Source: Gender Links, derived from UNAIDS 2023 Data

Figure 5.2 shows the proportions of women and men for all people living with HIV across SADC. In most countries, the proportion of women living with HIV is higher. The highest proportions are in Angola and Tanzania. Madagascar and Mauritius are the only member states with more men than women living with HIV.

Only in Madagascar and Mauritius are there more men than women living with HIV

HIV transition metrics

Various indicators have been suggested to track progress of the transition from "high HIV incidence and mortality to low levels of transmission and effectively managed care." Some of these are:

[7] Amon JJ, Eba P, Sprague L, Edwards O, Beyrer C. Defining rights-based indicators for HIV epidemic transition. PLoS Med. 2018 Dec 21;15(12): e1002720. doi: 10.1371/journal.pmed.1002720. PMID: 30576316; PMCID: PMC6303010 accessed 27 September 2024.
[8] AVAC. Metrics for Epidemic Transition: A glossary. https://avac.org/wp-content/uploads/2023/03/AR2019_Metrics-Epidemic-Transition.pdf, accessed 27 September 2024.

Change in incidence of HIV (new infections) compared to a baseline of 2010[8]
HIV incidence is the estimated number of new HIV infections.

Table 5.3: Change in incidence of HIV (new infections per 1000 uninfected adults) 2010 - 2023

Country	2010	2023	Rate of reduction
Zimbabwe	11,07	1,48	87%
Malawi	6,9	0,98	86%
Lesotho	22,34	5,02	78%
Zambia	9,21	2,09	77%
Botswana	13,14	3,15	76%
Eswatini	31,98	7,69	76%
South Africa	13,12	4,55	65%
DRC	0,72	0,25	65%
Mozambique	12,66	4,49	65%
Angola	1,88	0,72	62%
Namibia	9,14	3,75	59%
Tanzania	3,46	1,55	55%
Comoros	0,03	0,02	33%
Mauritius	1,28	1,47	-15%
Madagascar			

Source: Gender Links compiled from UNAIDS 2023 Data

As table 5.3 shows, the change (reduction) in incidence from 2010 to 2023 varies from negative change in Mauritius where incidence has increased to 87% reduction in Zimbabwe. Many SADC countries have made tremendous progress in reducing incidence (new infections) from very high levels. Zimbabwe, Malawi, Lesotho, Zambia, Botswana and Eswatini have made the most significant progress. No data was available for Madagascar.

Change in AIDS-related deaths compared to a baseline of 2010
AIDS-related deaths are deaths caused by the advanced stage of HIV infection, acquired immuno-deficiency syndrome, commonly referred to as AIDS.

Table 5.4: Decrease in AIDS-related deaths compared to 2010

Country	2010	2023	Rate of decrease
DRC	43000	11000	74%
Malawi	37000	11000	70%
South Africa	150000	50000	67%
Zimbabwe	57000	19000	67%
Tanzania	53000	25000	53%
Eswatini	6200	3100	50%
Lesotho	7600	4000	47%
Mozambique	71000	44000	38%
Botswana	6100	3900	36%
Namibia	5500	3700	33%
Zambia	25000	17000	32%
Angola	15000	12000	20%
Comoros	100	100	0%
Mauritius	1000	1000	0%
Madagascar	1200	3100	-158%
SADC Total	**478700**	**207900**	-57%
SADC as % of Global	**27%**	**33%**	
Global Total	**1800000**	**630000**	65%

Source: Gender Links compiled from UNAIDS 2023 Data

Table 5.4 shows that the rate of decrease in AIDS-related deaths varies, from a negative figure for Madagascar where the death rate is increasing to 74% in DRC. Malawi, South Africa and Zimbabwe have high rates of decrease as well. Several countries, such as Botswana, had quite steep decreases in AIDS-related deaths between 2000 and 2010.

The incidence to prevalence ratio

This comprises two desirable outcomes: long, healthy lives for people living with HIV and a rapid reduction in new infections. The metric assumes average life expectancy of 30 years after a person acquires HIV infection. The calculations show that the HIV and AIDS epidemic (or total number of people living with HIV) will decline when there are fewer than three new HIV infections per 100 people living with HIV per year. This is an incidence to prevalence ratio of three.

Table 5.5: Incidence: Prevalence ratio

Country	2000	2010	2020	2023
Botswana	9,64	4,19	1,76	1,15
Zimbabwe	7,76	6,1	1,47	1,19
Malawi	10,22	6,19	1,74	1,23
Zambia	10,15	6,76	3,35	1,69
Lesotho	12,04	6,61	2,31	1,78
Eswatini	15,74	7,66	2,09	1,83
South Africa	14,54	5,85	2,24	1,9
Namibia	13,56	6,18	2,63	2,65
Tanzania	9,29	7,27	4,44	3,13
Mozambique	17,9	10,25	5,43	3,33
DRC	9,04	7,03	4,93	4,02
Comoros	15,09	11,71	5,85	4,79
Angola	14,46	11,18	5,95	4,86
Mauritius	30,48	10,31	8,4	8,64
Madagascar				

Source: Gender Links compiled from UNAIDS 2023 Data

Table 5.5 shows that the ratio of incidence to prevalence has continued to improve. Eight countries now have ratios below three and Tanzania and Mozambique are very close.

Overall indices can mask inequalities in access especially for young people and key populations

Overall indices such as the three above can mask inequalities in access to services, especially for young people and key populations. The prevention section of this chapter outlines progress, as well as numerous bottlenecks remaining for expanding services to key populations.

Comprehensive evaluation of progress on transition needs to consider four categories of indicators:

1. Coverage of evidence-based prevention and treatment interventions for all.
2. Incidence / prevalence data as well as AIDS related deaths.
3. Stigma and discrimination.
4. Legal and policy environment.

Policies, laws and resources

Article 27.1: State Parties shall take every step necessary to adopt and implement gender sensitive policies and programmes, and enact legislation that will address prevention, treatment, care and support in accordance with, but not limited to, the Maseru Declaration on HIV and AIDS and the SADC Sponsored United Nations Commission on the Status of Women Resolution on Women, the Girl Child and HIV and AIDS and the Political Declaration on HIV and AIDS.

Article 27.2: State parties shall ensure that the policies and programmes referred to in sub-Article 1take account of the unequal status of women, the particular vulnerability of the girl child as well as harmful practices and biological factors that result in women constituting the majority of those infected and affected by HIV and AIDS.

ICPD: 8.27 All countries, as a matter of some urgency, need to seek changes in high- risk sexual behaviour and devise strategies to ensure that men share responsibility for sexual and reproductive health, including family planning, and for preventing and controlling sexually transmitted diseases, HIV infection and AIDS.

SADC Sponsored UN Resolution on Women, the Girl Child and HIV and AIDS: In 2016 the CSW passed a SADC-sponsored resolution, put forward on behalf of SADC by Botswana: The SADC Sponsored United Nations Commission on the Status of Women Resolution on Women, the Girl Child and HIV and AIDS. Among others, the resolution calls on governments, the private sector and development partners to: give full attention to the high levels of new HIV infections among young women and adolescent girls and their root causes; attain gender equality and the empowerment of women and girls; eliminate all gender-based violence and discrimination against women and girls and harmful practices, such as child, early and forced marriage and female genital mutilation and trafficking in persons, and ensure the full engagement of men and boys to reduce women and girls' vulnerability to HIV.

All SADC member states have established agencies to lead coordination and champion efforts to prevent and manage HIV and AIDS.

All SADC countries have HIV strategies or plans and national coordinating agencies

These have different names, such as National AIDS Councils (NACs), National AIDS Coordinating Agency and so on. These agencies work closely with UNAIDS, which brings together the efforts and resources of 11 United Nations system organisations to unite the world against AIDS. The agencies lead the development and review of national policies and strategies, using data to target high impact solutions.

Table 5.6: Most recent HIV and AIDS policy or strategy in SADC countries

Country	Most recent HIV strategy	Year
Angola	National Strategic Plan for HIV/AIDS, Viral Hepatitis and Sexually Transmitted Infections (STIs) (PEN VII 2024-2028)	2024
Eswatini	Eswatini National Multisectoral HIV and AIDS Strategic Framework (NSF) 2024-2028	2024
Botswana	The Botswana HIV Prevention Road Map 2023-2025	2023
South Africa	The National Strategic Plan for HIV, TB and STI's - 2023-2028	2023
Namibia	National Strategic Framework for HIV and AIDS Response in Namibia 2023/24 to 2027/28	2023
Mozambique	Plano Estratégico do Nacionale de combate HIV e SIDA - PEN V 2021 - 25	2021
Malawi	Malawi National Strategic Plan for HIV and AIDS 2020-2025	2020
Zimbabwe	Zimbabwe National HIV and AIDS Strategic Plan IV (2021-2025).	2020
Seychelles	National Strategic Plan for HIV, AIDS & Viral Hepatitis 2019 - 2023	2019
Lesotho	National HIV and AIDS Strategic Plan 2018/19 - 2022/23	2018
DRC	Plan Strategique National De La Riposte au VIH/SIDA 2018-2021	2018
Tanzania	Health Sector HIV & AIDS Strategic Plan 2017 - 2022 (HSHSP IV)	2017
Zambia	National HIV & AIDS Strategic Framework 2017 - 2021 National Comprehensive Condom Strategy and Operational Plan 2020 - 2025	2017 2020
Mauritius	Republic of Mauritius. National HIV Action Plan 2023 - 2027	2017
Madagascar	Plan Strategique National de Reponse aux Infections Sexuellement Transmissibles et au SIDA a Madagascar 2013 - 2017	2014
Comoros	National Strategic Plan 2011 - 2015	2011

Source: Gender Links internet search

Table 5.6 shows that all SADC countries have an HIV and AIDS policy, strategy or plan. The majority are up to date and revised regularly, which is indicative of the attention being paid to HIV in SADC.

Prevention: Elimination of vertical (mother-to-child) transmission

Article 27.3: State Parties shall:
a) Develop gender sensitive strategies to prevent new infections.
BPFA +20 Africa Declaration: (h) Scale up combined preventive HIV/AIDS measures for young women and girls and expand programmes to eliminate mother-to-child transmission.

SADC SRHR Strategy: HIV and AIDS ended as a public health threat by 2030 (SDG 3.3.).

ICPD: 7.32 Information, education and counselling for responsible sexual behaviour and effective prevention of sexually transmitted diseases, including HIV, should become integral components of all reproductive and sexual health services.

The SADC-sponsored UN Resolution on women, girls, HIV and AIDS

- Achieve universal access to comprehensive HIV prevention, programmes, treatment, care and support to all women and girls and achieve universal health coverage.
- Enhance the capacity of low- and middle-income countries to provide affordable and effective HIV prevention and treatment products, diagnostics, medicines and commodities and other pharmaceutical products, as well as treatment for opportunistic infections and co-infections, and reduce costs of lifelong chronic care.
- Eliminate mother-to-child transmission and keep mothers alive.
- Provide combination prevention for women and girls for the prevention of new infections, to reverse the spread of HIV and reduce maternal mortality.
- Avail comprehensive data disaggregated by age and sex to inform a targeted response to the gender dimensions of HIV and AIDS.
- Build up national competence and capacity to provide an assessment of the drivers and impact of the epidemic.
- Support action-oriented research on gender and HIV and AIDS, including on female-controlled prevention commodities.



The gap in testing, treatment and viral suppression between children and adults is one of the widest gaps in the HIV response. Launched in July 2022, The Global Alliance to End AIDS in Children (Global Alliance) brings together 12 African countries, of which seven (Angola, DRC, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe) are in SADC. The Global Alliance is mobilising leadership, funding and action to end AIDS in children as a public health threat

by 2030. The 12 countries together accounted for 66% of new HIV infections and 64% of AIDS-related deaths among children globally in 2021.[9]

Challenges with HIV testing and treatment for children have resulted in glaring gaps in coverage of care

The many challenges for providing care to young children have contributed to this gap. One challenge is early testing for newborn children. The commonly used adult HIV test shows the presence of antibodies produced in reaction to HIV. As babies are born with antibodies from their mother, such tests at birth detect these maternal antibodies and do not signify if the baby has acquired infection or not. Newborns require more complex PCR (Polymerase Chain Reaction) tests which detect HIV's genetic material, or RNA. PCR tests are now becoming available where newborn babies receive care, enabling tests to be done and results received immediately. Otherwise, babies require subsequent tests, meaning having to wait and potentially return to the health centre several times before valid results are obtainable. Furthermore, as HIV infection in children is very low in rich nations, there is very little economic incentive for pharmaceutical companies to invest in developing paediatric treatment. Paediatric treatment is more complex than adult formulations as it must change as the child grows, and it is more practical in liquid form as children struggle to swallow tablets.

The Global Alliance focuses on four pillars:[10]

1. Accessible testing, optimised treatment and comprehensive care for infants, children and adolescents living with and exposed to HIV.
2. Closing the treatment gap for pregnant and breastfeeding girls and women living with HIV and optimising continuity of treatment.
3. Preventing and detecting new HIV infections among pregnant and breastfeeding adolescent girls and women.
4. Addressing rights, gender equality and the social and structural barriers that hinder access to services.

Pillar one of the strategy centres on testing, treatment and care for infants, children and adolescents living with and exposed to HIV. This section focuses on infants and children below the age of 14, adolescents are addressed in other sections of this chapter.

Table 5.7: New infections in children 0 - 14

Country	1990	2000	2010	2021	2023	Decline 2021 - 2023
Mozambique	4 400	27 000	34 000	16 000	12 000	25%
South Africa	9 300	72 000	28 000	8 300	6 500	22%
DRC	12 000	15 000	10 000	6 600	6 300	5%
Tanzania	22 000	31 000	13 000	7 500	5 700	24%
Zimbabwe	25 000	33 000	17 000	4 700	3 600	23%
Angola	2 200	5 300	7 400	4 100	3 200	22%
Zambia	13 000	20 000	9 900	4 500	3 200	29%
Malawi	16 000	27 000	15 000	2 500	2 100	16%
Eswatini	200	3 100	1 300	500	500	0%
Lesotho	1 000	4 300	1 800	1 000	500	50%
Namibia	1 000	4 000	1 600	500	500	0%
Botswana	1 500	4 800	1 400	200	100	50%
Mauritius	100	100	100	100	100	0%
Comoros						
Madagascar						
Total SADC	**107 700**	**246 600**	**140 500**	**56 500**	**44 300**	**22%**
SADC as % of Global	**38%**	**47%**	**47%**	**40%**	**37%**	
Global	**280 000**	**530 000**	**300 000**	**140 000**	**120 000**	**14%**

Source: Gender Links compiled from UNAIDS 2023 Data

[9] UNAIDS (2024) Transforming Vision into Reality: The 2024 Global Alliance Progress Report on Ending AIDS in Children by 2030. Joint United Nations Programme on HIV/AIDS. Geneva
[10] Ibid

Table 5.7 shows that new infections in children increased in most SADC countries until the early 2000s, numbers then fell quite sharply as access to ARVs to prevent vertical transmission increased. New infections in children across SADC declined 22% between 2021 and 2023. This varied by country, ranging from 0% to 50%, with promising decline in SADC countries that are members of the Global Alliance, except DRC. The decline was 15% across Global Alliance countries[11] and 14% globally.



The Ministry of Health in **Comoros** instituted a prevention of mother-to-child transmission programme. All pregnant women are advised during their first antenatal visit to be tested for HIV. As of 2021, all pregnant women living with HIV have been initiated on ARVs and their babies are tested at one month old. To date, all babies are HIV negative. The programme's success is encouraging other women to be tested. By 2025 Comoros aims to achieve zero new infections in infants born to mothers living with HIV, to have 75% of pregnant women knowing their HIV status, and a 75% reduction in the number of new infections compared with 2020.[12]

Mirroring the Global AIDS strategy, The Global Alliance to End AIDS in Children has set specific targets related to children and treatment. The table below outlines progress against these targets.

- **First:** 95% of children living with HIV know their HIV status
- **Second:** 95% of children who know their HIV status are accessing treatment
- **Third:** 95% of children accessing treatment are virally suppressed



HIV test kit displayed during a Mutare field visit in Zimbabwe.
Photo: Tapiwa Zvaraya

Table 5.8: Progress towards achieving the 95-95-95 targets in children, 2015 - 2023

Country	2015			2021			2023		
	First 95	Second 95	Third 95	First 95	Second 95	Third 95	First 95	Second 95	Third 95
Angola	11	>98		20	>98		27	>98	
Botswana	73	92		91	77		80	83	
Comoros					91			89	67
DRC	20	90		55	88	82	52	85	82
Eswatini	81	89		>98	88	94	>98	85	95
Lesotho	61	88		83	89	93	95	84	96
Madagascar	<1	83		8	93		8	87	
Malawi	41	88	66	80	86	75	88	83	84
Mauritius	36	>98		88	>98	48	72	94	56
Mozambique	43	91			88	64	77	88	76
Namibia		86			78	89		75	95
South Africa	71	73	68	86	72	73	87	73	75
Tanzania	47	88		70	86	91	78	86	92
Zambia	74	91		78	87	91	82	88	94
Zimbabwe	44	>98		62	>98	79	63	>98	89
Global	**47**	**84**	**67**	**62**	**87**	**80**	**66**	**86**	**84**

Source: Gender Links compiled from UNAIDS 2023 Data[13]

[11] UNAIDS (2024) Transforming Vision into Reality. Op Cit
[12] WHO Africa. Comoros on the path to ending mother-to-child HIV transmission, 1 December 2022. https://www.afro.who.int/countries/comoros/news/comoros-path-ending-mother-child-hiv-transmission#:~:text=By%202025%20Comoros%20aims%20to,new%20infections%20compared%20with%202020, accessed 30 September 2024.
[13] UNAIDS 2024 Data https://aidsinfo.unaids.org/, accessed 25 July 2024

Table 5.9: HIV exposed children who receive Early Infant Diagnosis (EID)

Country	% of children who receive virological test within 2 months (EID)	No of infants who received EID	Percentage of global
Namibia	95	10500	1%
South Africa	90	245000	33%
Botswana	86	7200	1%
Malawi	85	29000	4%
Zimbabwe	84	41200	6%
Zambia	77	36800	5%
Mozambique	75	93700	13%
Tanzania	71	50700	7%
Lesotho	66	4400	1%
Mauritius	50	70	
Eswatini	41	2900	0%
Angola	13	3200	0%
DRC	12	3000	0%
Total SADC		**527670**	**71%**
Global		**747000**	

Source: Gender Links compiled from UNAIDS 2023 Data

Table 5.9 shows the percentage of HIV exposed children in SADC who received early infant diagnosis (EID), which is a virological HIV test, within two months of birth. Over 90% of children born to mothers living with HIV in Namibia and South Africa received EID, while over 80% of such children received EID in Botswana, Malawi and Zimbabwe. In 2023 SADC accounted for 71% of all children globally who received EID.

A major challenge for countries is sustainably tracking infants after their mothers have been enrolled for lifelong ART during pregnancy. This is important as infants can contract HIV during breast feeding.



South Africa is instituting universal testing for all infants at 18 months.[14]



With support from the US Presidents Emergency Fund for AIDS Relief (PEPFAR), **Tanzania** is linking registration of HIV-exposed infants with their first immunisation visit and actively tracking these children. This has increased the proportion of infants who receive early testing.[15] Integrating HIV services into routine maternal and child health services is critical for sustainability.

The death of any child from AIDS-related causes is not only a tragedy, but also an outrage

Poor access to testing and treatment results in higher rates of AIDS-related deaths in children than in adults. In the foreword to the 2024 Global Alliance report, Winnie Byanyima, executive director of UNAIDS says, "The death of any child from AIDS-related causes is not only a tragedy, but also an outrage. Where I come from, all children are our children. We must be the generation that ends AIDS in children."[16]



Mobile assistance from the Matabeleland Aids Council in Zimbabwe, Southern Africa. Photo: Gender Links

[14] UNAIDS (2024) Transforming Vision into Reality. Op Cit.
[15] Ibid
[16] Ibid

Table 5.10: AIDS-related deaths children 0-14

Country	1990	2000	2010	2021	2023	Decline 2021 - 2023
Mozambique	2 000	15 000	20 000	9 500	7 800	18%
Tanzania	11 000	21 000	12 000	4 400	3 800	14%
DRC	6 100	10 000	8 300	3 800	3 200	16%
Angola	1 200	3 200	5 100	3 700	2 900	22%
Zambia	6 300	14 000	6 800	3 100	2 300	26%
Zimbabwe	13 000	25 000	12 000	3 000	2 300	23%
South Africa	4 100	44 000	18 000	1 900	1 500	21%
Malawi	7 700	18 000	12 000	1 800	1 400	22%
Madagascar	100	100	500	1 000	1 000	0%
Lesotho	500	2 800	1 500	500	500	0%
Botswana	1 000	3 000	1 000	200	100	50%
Mauritius	100	100	100	100	100	0%
Comoros						
Namibia						
Total SADC	**53 100**	**156 200**	**97 300**	**33000**	**26900**	**18%**
SADC as % of Global	**38%**	**45%**	**42%**	**37%**	**35%**	
Global	**140 000**	**350 000**	**230 000**	**89 000**	**76 000**	**15%**

Source: Gender Links compiled from UNAIDS 2023 Data

Table 5.10 illustrates changes in numbers of AIDS-related deaths in children between 1990 and 2023. AIDS-related deaths in children increased very quickly from 1990 to 2000, then began to decline - decreasing 18% between 2021 and 2023. A number of countries had rates of decline higher than the average. Even with the decline, children still account for about one-eighth of all AIDS-related deaths.

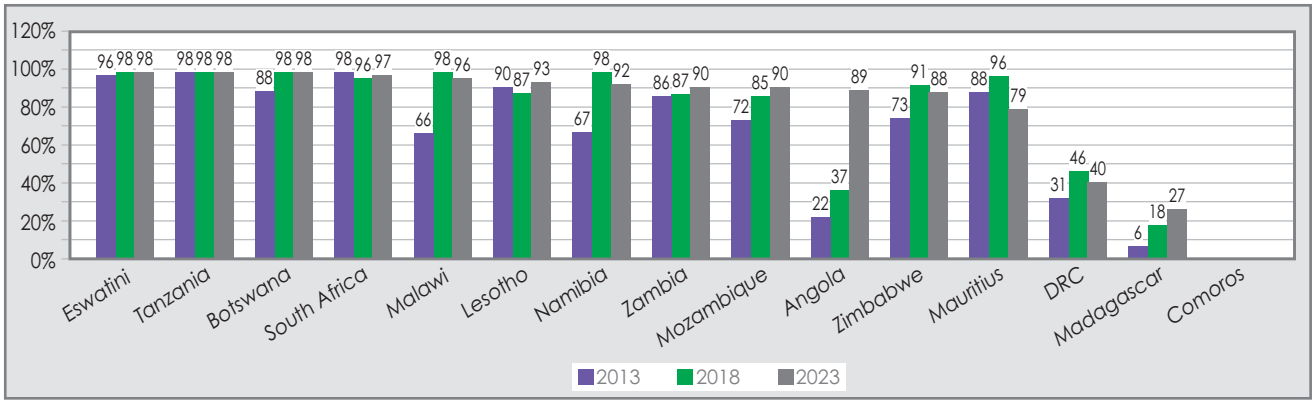
Continuing research and developing new treatment formulations helps drive decreases in AIDS-related deaths in children. For instance, the WHO recommended Dolutegravir (DTG) in 2018. DTG is shown to be highly effective and safe for children in non-research situations in Botswana, Eswatini, Lesotho, Malawi, Tanzania and Uganda.[17]



Mozambique is implementing multi-month dispensing of a DTG-based regimen for children older than two years. Viral suppression has improved in children moved to the new regimen and Mozambique has expanded coverage to 1780 sites nationally.[18]

Pillar two seeks to close the treatment gap for pregnant and breastfeeding girls and women.

Figure 5.3: ART Coverage (%) for pregnant women living with HIV 2013, 2018 and 2023



Source: Gender Links compiled from UNAIDS 2023 data

[17] Bacha JM, et al. Realizing the Promise of Dolutegravir in Effectively Treating Children and Adolescents Living with HIV in Real-world Settings in 6 Countries in Eastern and Southern Africa. Pediatr Infect Dis J. 2023 Jul 1;42(7):576-581. doi: 10.1097/INF.0000000000003878. Epub 2023 Feb 14. PMID: 36795586; PMCID: PMC10259212. Accessed 28 September 2024.
[18] UNAIDS (2024) Transforming Vision into Reality. Op Cit.

Figure 5.3 reflects tremendous progress in ART access for pregnant women living with HIV between 2013 and 2023. Five member states have achieved at least 95% coverage. Angola has made marked progress from 2018 to 2023, increasing from 37% to 89% coverage. Increased effort is needed in DRC and Madagascar. The Global Alliance target is for 100% of all pregnant women living with HIV to receive lifelong antiretroviral therapy. Coverage in countries fluctuates, showing the difficulties of maintaining high coverage rates.

Table 5.11: Pregnant women on ART 2013 - 2018 - 2023 and vertical transmission

Country	No of pregnant women receiving ART for prevention of vertical transmission			Vertical transmission rate %		
	2013	2018	2023	2013	2018	2023
South Africa	360 163	300 826	264 889	4	3	2
Mozambique	83 766	109 464	112 645	19	14	10
Tanzania	74 206	76 465	70 002	12	10	8
Zambia	45 271	48 409	43 474	16	14	7
Zimbabwe	54 842	59 621	43 281	13	8	7
Malawi	33 969	44 526	32 469	18	7	6
Angola	5 668	9 633	21 117	29	25	13
DRC	7 802	11 376	9 894	33	29	26
Namibia	9 412	12 531	9 766	13	5	5
Botswana	12 290	12 497	8 392	5	2	1
Eswatini	10 332	11 269	6 924	9	4	3
Lesotho	10 126	8 122	6 305	10	8	5
Madagascar	62	279	635			
Mauritius	95	109	109	10	8	11
Comoros	1	7	11			
Total SADC	**708 005**	**705 134**	**629 913**			
SADC as % of global	**64%**	**64%**	**64%**			
Global	**1 100 000**	**1 100 000**	**980 000**			

Source: Gender Links compiled from UNAIDS 2023 data

Table 5.11 shows how numbers of pregnant women on ART is changing in different countries. For a number of countries with more mature epidemics, the number has peaked and is now beginning to decline. However, the number is still increasing in Mozambique, Angola, Madagascar and Mauritius. It is noteworthy that even with continued increase in total numbers, vertical transmission rates are still declining. SADC accounts for a more or less constant 64% of pregnant women on ART globally.

Eliminating vertical transmission requires that the vertical transmission rate falls below 5%. Even while transmission rates are falling, only five countries (South Africa, Namibia, Botswana, Eswatini and Lesotho) have been able to maintain a transmission rate of 5% or lower. Another four countries have rates between 6% and 10%, while DRC is 26%.

It is hoped that long-acting injectable treatment formulations will improve adherence by avoiding the need to take medication every day. Research is showing that injectable formulations can be effective with adolescents. Further research is needed to be confident these are effective and safe during pregnancy and breast feeding.[19]

Pillar three focuses on prevention of new infections in pregnant and lactating women.

This includes a target to reduce new HIV infections in adolescent girls and young women to less than 50 000 by 2025, which is covered in more detail in another section of this chapter.

The PEPFAR funded DREAMS programme provides broad educational, livelihood and social support to adolescent girls and young women

[19] UNAIDS (2024) Transforming Vision into Reality. Op Cit.

in selected districts of 16 African countries, including Botswana, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe in SADC. The results suggest that this approach is effectively reducing new infections.[20]

Prevention and re-testing need to be integrated into routine post-natal care services.

Pillar four focuses on addressing rights, gender equality and the social and structural factors for accessing services. This includes efforts to achieve the 2025 global AIDS target of fewer than 10% of women, key populations and people living with HIV experience gender-based inequalities and violence. For example, ensuring that women and girls have equal access with boys and young men to education.

The World Health Organization has validated only 18 nations globally for elimination of vertical transmission of HIV (or fewer than 50 new HIV infections in children per 100 000 births). Most are countries in Europe and the Caribbean with very low adult prevalence rates. Botswana and Namibia are the only African, and high HIV prevalence countries, to achieve the status of being on the path towards elimination (or fewer than 750 new HIV infections per 100 000 births).[21]

Prevention of other new infections

2025 Targets and commitments in the 2021 Political Declaration on AIDS

- Reduce new HIV infections to under 370 000 by 2025.
- Ensure that 95% of people at risk of HIV infection, within all epidemiologically relevant groups, age groups and geographic settings, have access to and use appropriate, prioritised, person- centred and effective combination prevention options.
- Tailor HIV combination prevention approaches to meet the diverse needs of key populations, including among sex workers, men who have sex with men, people who inject drugs, transgender people, people in prisons and other closed settings and all people living with HIV.
- Reduce the number of new HIV infections among adolescent girls and young women to below 50 000.
- Ensure availability of pre-exposure prophylaxis (PrEP) for people at substantial risk of HIV and post-exposure prophylaxis for people recently exposed to HIV.
- 95% of people within humanitarian settings at risk of HIV use appropriate, prioritised, people-centred and effective combination prevention options.[22]

Twenty-eight countries joined the Global Prevention Coalition (GPC) in 2017 and 2018, including 12 in SADC (Angola, Botswana, DRC, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe). These countries accounted for 76% of all new infections in 2016. With focused attention to HIV prevention, they reduced their share of new infections to 67% by 2022. Twelve more countries (including Madagascar in SADC) joined the GPC in 2022. The forty members of the GPC accounted for 76% of all new infections in 2022 or just over one million new infections.[23]

GPC issued the HIV Prevention 2025 Road Map in mid-2022, updating guidance for national HIV

[20] USAID. DREAMS: Partnership to Reduce HIV/AIDS in Adolescent Girls and Young Women. https://www.usaid.gov/global-health/health-areas/hiv-and-aids/technical-areas/dreams, accessed 30 September 2024.
[21] UNAIDS (2024) The urgency of now: AIDS at a crossroads. Geneva: Joint United Nations Programme on HIV/AIDS.
[22] UNAIDS (2021) Global AIDS Update. 2021. Op Cit.
[23] UNAIDS (2024) HIV Prevention - From Crisis to Opportunity. Joint United Nations Programme on HIV/AIDS. Geneva:

responses to achieve the 2025 targets. The overall goal remains to reduce the number of new infections to fewer than 370 000 per year by 2025, with 95% of people at risk of HIV having equitable access to and using appropriate prioritised, person-centred and effective combination prevention options.

The roadmap refined the five pillars to guide HIV responses to reflect the evolving nature of the HIV epidemic. The pillars now emphasise people-centred approaches, addressing persistent inequalities, promoting integrated service delivery, and speeding up introduction of new technologies.

The five pillars are:

1. Key Populations: prevention for and with sex workers, gay men and men who have sex with men, people who inject drugs, transgender people and prisoners.
2. Adolescent Girls and Young Women: prevention in settings with high HIV incidence.
3. Adolescent Boys and Men: prevention in settings with high HIV incidence (including voluntary medical male circumcision (VMMC) and testing and treatment).
4. Condom Programming: Promotion and distribution of male and female condoms, and lubricants.
5. ARV-based Prevention: Pre-exposure prophylaxis, post-exposure prophylaxis, treatment as prevention including for elimination of vertical transmission.

Table 5.12: Number of new infections (all ages) 2010, 2016 and 2023

Country	2010	2016	2023	Reduction 2010 - 2023	Reduction 2016 - 2023
Zimbabwe	79000	42000	15000	81%	64%
Malawi	58000	34000	12000	79%	65%
Lesotho	19000	12000	4800	75%	60%
Eswatini	15000	9200	4200	72%	54%
Botswana	14000	10000	4100	71%	59%
Zambia	64000	69000	23000	64%	67%
South Africa	340000	230000	150000	56%	35%
Namibia	13000	8900	6000	54%	33%
Mozambique	160000	140000	81000	49%	42%
DRC	37000	27000	21000	43%	22%
Angola	28000	23000	16000	43%	30%
Tanzania	87000	100000	53000	39%	47%
Comoros	100	100	100	0%	0%
Mauritius	1000	1000	1100	-10%	-10%
Madagascar					
SADC Total	**915100**	**706200**	**391300**	**57%**	**45%**
SADC as % of global	**44%**	**39%**	**30%**		
Global	**2 100 000**	**1 800 000**	**1 300 000**	**38%**	**28%**

Source: Gender Links compiled from UNAIDS 2023 Data

Table 5.12 shows changes in the numbers of new infections among all ages in SADC since 2010. There have been impressive rates of decline in new infections - with Zimbabwe, Malawi, Lesotho, Eswatini and Botswana all recording more than 70% reductions between 2010 and 2023. These countries may achieve the goal of 88% reduction by 2025. Other countries have declined more slowly, notably South Africa (56%), Mozambique (49%) and Tanzania (39%).

Key populations

Pillar 1 focuses on prevention with and for key populations, such as sex workers (SW), gay men and men who have sex with men (MSM), people who inject drugs(PWID), transgender (TG) people and prisoners.

Table 5.13: HIV prevention coverage among key populations in SADC GPC countries

Indicator	Angola	Botswana	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mozambique	Namibia	South Africa	Tanzania	Zambia	Zimbabwe
Condom use of sex workers with most recent client, % (reported by SW)	id	76	48	50	62	id	65	id	42	id	72	id	95
Condom use at last anal sex among men who have sex with men (MSM) (%)	id	78	57	80	46	id	79	id	55	72	id	58	69
Condom use transgender people (%)	id	id	52	id	id	id	50	id	id	77	id	id	82
Condom use at last paid sex act, % (reported by men)	71	id	34	id	90	13	75	31	67	83	id	56	90
% of PLHIV on ART - sex workers*	42	88	id	id	id	id	90	id	id	70	id	86	83
% of PLHIV on ART - MSM*	id	74	id	id	id	id	93	id	id	44	id	id	83
% of PLHIV on ART - PWID*	id	id	id	id	id	id	id	id	id	id	id	id	id
Population size estimate for female sex workers in 1000s **	id	id	526	7	8	191	39	224	9	146	id	126	id
% of all SW who received at least 2 HIV PIs in the past 3 months	51	90	38	9	31	93	68	57	id	34	90	id	79
Pop size estimate MSM 1000s**	id	id	195	4	6	17	50	64	2	310	id	20	23
% of all MSM who received at least 2 HIV PIs in the past 3 months	3	32	39	29	26	28	65	31	33	10	4	5	26
Pop size estimate PWID 1000s**	id	id	168	<1	id	2	8	14	id	83	36	12	id
% of all PWID who received at least 2 HIV PIs in the past 3 months	id	id	23	37	id	100	id	40	id	17	11	3	id
Pop size estimate TG people 1000s**	id	id	57	id	id	Id	5	id	id	179	id	4	id
% of all TG people who received at least 2 HIV PIs in the past 3 months	id	id	12	id	id	id	id	id	id	2	id	6	28

Source: Gender Links derived from UNAIDS (2024) HIV Prevention: From Crisis to Opportunity

Table 5.13 is an overview of service provision to key populations in the SADC countries which are GPC partners. The paucity of data, indicated by the number of boxes which are grey and id (insufficient data), is indicative of the low priority accorded to providing services to key populations.

Table 5.14: Policy and structural factors affecting services to key populations

Country	Key populations												
	National strategy includes key elements of recommended package					% who avoided health care due to stigma & discrimination				Criminalisation of key populations			
	Sex workers	Gay men & other MSM	People who inject drugs	Transgender people	Prisoners	Sex workers	Gay men & other MSM	People who inject drugs	Transgender people	Sex workers	Gay men & other MSM	People who inject drugs	Transgender people
Angola	> Half	> Half	None	< Half	< Half	id	id	id	id	N	N	id	Y
Botswana	> Half	< Half	None	< Half	< Half	id	id	id	id	Y	N	Y	N
DRC	All	> Half	Some	< Half	< Half	id	17.8	14	18	Y	N	N	N
Eswatini	> Half	> Half	None	< Half	> Half	34	id	id	id	Y	Y	Y	N
Lesotho	> Half	> Half	None	id	id	8	id	id	id	Y	N	Y	N
Malawi	< Half	< Half	None	> Half	< Half	49	12.9	id	id	Y	Y	Y	Y
Mozambique	> Half	> Half	< Half	id	id	id	id	id	id	N	N	Y	N
Namibia	> Half	> Half	None	id	None	id	id	id	id	Y	Y	Y	N
South Africa	> Half	> Half	> Half	> Half	> Half	id	id	id	id	Y	N	Y	N
Tanzania	> Half	> Half	> Half	< Half	> Half	id	id	id	id	Y	Y	Y	N
Zambia	> Half	> Half	> Half	> Half	> Half	id	id	id	id	Y	Y	Y	Y
Zimbabwe	> Half	> Half	None	> Half	> Half	39.3	8.3	id	10.8	Y	Y	Y	N

Source: Gender Links derived from UNAIDS, 2024. HIV Prevention - From Crisis to Opportunity

Table 5.14 shows how many countries criminalise different key populations - Chapter 8, Sexual Orientation and Gender Diversity, has more in depth information on the criminalisation of LGBTQI people. Evidence from around the world shows that criminalisation contributes to driving HIV in key populations, as people are reluctant to come forward to receive services. As noted at the beginning of this chapter, it is not possible to address a pandemic for some people and not for others. Only Angola and Mozambique do not criminalise sex work. Very few national strategies pay enough attention to services for key population groups. Further, the scant data available about stigma and discrimination suggests that stigma is rife, which reduces access to services.

As long as members of key population groups are not accessing at least 2 prevention interventions there will be continued spread of HIV, both within these groups and beyond. The number of red boxes showing poor prevention services to different key populations is reason for great concern. The target is for 95% of people at risk of HIV infection, within all epidemiologically relevant groups, age groups and geographic settings, to access and use appropriate, prioritised, person-centred and effective combination prevention options.

The case study below is an example of a people-centred programme designed to address accessibility of HIV services for key populations.



Moonlight services: Reaching key populations with comprehensive SRH services

The Matabeleland AIDS Council (MAC), a Voice and Choice SAF grantee in southwestern Zimbabwe, realised that certain groups such as artisanal miners, long distance truck drivers and sex workers were not accessing sexual and reproductive health (SRH) and HIV services. The normal health facility operating hours, along with stigma and discrimination they encountered, deterred these groups from accessing health services.

MAC therefore expanded their mobile integrated SRH and HIV services to provide suitable services to these groups in all six districts of Matabeleland South and Midlands Provinces where they work. The mobile services visit a convenient location, once per month on an appointed day, often in the evening.

Nighttime services are provided at strategic hotspot locations, such as business centres and where people converge for entertainment and to socialise. MAC either uses nearby rooms or sets up a tent to create a safe, private, confidential space. Services are all offered at the same place, enabling clients to have a "one-stop shop" for integrated SRH and HIV services. MAC health providers are experienced and sensitive to their clients' unique needs, reducing the stigma associated with seeking health services.



Staff offering moonlight services in Zimbabwe. Photo: Matabeleland Aids Council

In addition, through a peer outreach model, peers from the different target groups give health talks and distribute coupons for free access to follow up services at any Matabeleland AIDS Council outreach site. Through the mobile services and peer outreach, MAC reaches large numbers of people with an array of services, including providing condoms and lubricants, family planning services, HIV self-testing and PrEP. Most clients welcomed the programme as they are very mobile due to the nature of their jobs.

MAC provides services to approximately 240 clients through the once-a-month moonlight services at six service points. Female sex workers comprise about 65% of clients served.

The Moonlight health services model is an innovative approach to providing SRH and HIV services to key populations. It provides a safe space to access services, resulting in increased service uptake for key populations and diverse groups, contributing to improved health outcomes.

Many clients of the Moonlight programme return regularly for health services, at the same or other service points. MAC has noted good uptake of condoms and lubricants. Clients express, through various feedback mechanisms, that they prefer the moonlight service option to regular service provision.

Source: Matabeleland AIDS Council, report to Gender Links. October 2024

Adolescent girls and young women

Pillar 2 focuses on prevention in high incidence settings with and for adolescent girls and young women.

Table 5.15: Selected prevention service outcome indicators among adolescent girls and young women (15-24 years) in SADC GPC focus countries, 2022

Country	Condom use non-regular partners (young women, 15-24 yrs, %)	Condom use non-regular partners (young men, 15-24 years, %)	% of priority districts with full progs for young women & male partners	% of AGYW in high HIV incidence communities reached with PIs	Proportion of women who experienced IPV (15-49)	Laws requiring parental consent for adolescents to access HIV testing services, age of consent	Girls who completed lower secondary education
Angola	31	46	id	id	id	Yes, <12	32
Botswana	id	id	56	4	id	Yes, <16	92
DRC	25	33	id	id	id	Yes, <18	52
Eswatini	55	74	80	100	id	Yes, <12	54
Lesotho	84	83	90	34	id	Yes, <12	55
Malawi	53	73	id	21	id	Yes, <14	21
Mozambique	51	48	33	46	id	Yes, <12	11
Namibia	68	84	42	19	id	Yes, <14	62
South Africa	61	73	50	6	30.3	Yes, <12	91
Tanzania	id	id	id	61	id	Yes, <14	27
Zambia	34	49	28	37	25.3	Yes, <16	50
Zimbabwe	54	81	89		19	Yes, <16	53

Source: Gender Links, derived from UNAIDS (2024) HIV Prevention: From Crisis to Opportunity

Table 5.15 summarises selected prevention indicators for adolescent girls and young women in the SADC countries which are members of the GPC. The proportions of young women and young men using condoms with a non-regular partner is only high in Lesotho. Eswatini, Lesotho and Zimbabwe have good coverage of programmes for young women, while Mozambique, Namibia, South Africa and Zambia have poor coverage.

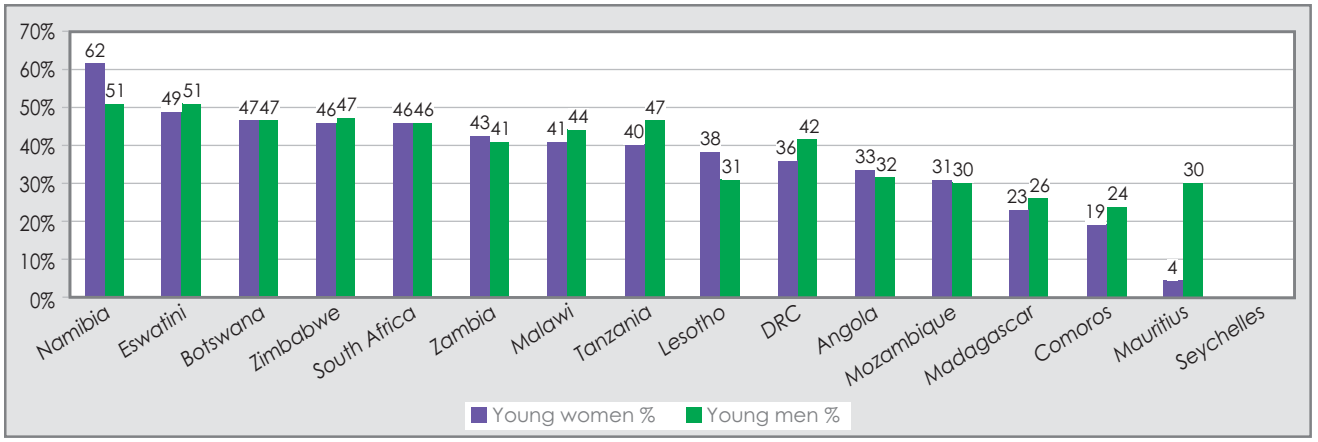
Programmes have focused on districts with high incidence while those with more moderate incidence levels have poorer coverage, but still account for high absolute numbers of new infections. Even where programmes exist, the percent of women reached is widely variable, ranging from 6% in South Africa to 100% in Eswatini.

Botswana and South Africa have good secondary education completion for girls, while Mozambique, Malawi, Tanzania and Angola have low completion rates. Access to secondary education is shown to be a protective factor for child marriage, early sexual activity and contracting HIV.

Comprehensive, accurate knowledge of HIV and AIDS

The goal is to ensure that at least 90% of adolescents and young people receive comprehensive sexuality education in schools, in line with UN international technical guidance.

Figure 5.4: Knowledge on HIV prevention among young people



Source: Gender Links, compiled from UNAIDS 2023 data

Figure 5.4 shows that levels of comprehensive HIV knowledge, defined as specific, accurate knowledge about prevention and transmission, are still well below the goal of 90%. All countries in the region have policies to provide skills-based HIV and sexuality education, but this is often not prioritised. Knowledge levels are much higher in young women than men in Namibia, very similar between young women and men in other countries and higher in men than women in Tanzania, DRC, Comoros and Mauritius.



Mossel Bay Mobile HIV Outreach in Western Cape, South Africa, conduct HIV testing in the community. Photo courtesy of David Marcus

Pillar 3 focuses on prevention in high incidence settings with and for adolescent boys and men (including VMMC services).

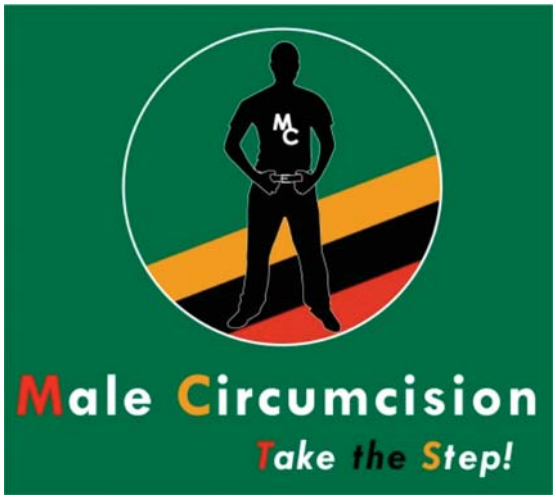
Table 5.16: HIV prevention among adolescent boys and men

Indicator	Botswana	Eswatini	Lesotho	Malawi	Mozambique	Namibia	South Africa	Tanzania	Zambia	Zimbabwe
National male circumcision prevalence (15-24 years) (%)	23	5	70	29	66	22	60	82	37	19
National male circumcision prevalence (15-49 years) (%)	26	29	69	28	47	26	id	80	32	14
Condom use with non-regular partners (men 15-49 years) (%)	id	83	81	73	47	82	68	35	54	82
% of PLHIV on ART (men 15+ yrs)	88	92	81	86	78	87	68	92	90	93
% of PLHIV virally suppressed (men 15+ years)	87	90	79	81	70	81	62	90	87	88
% performance towards 2025 targets (15-34 years)	5	13	100	11	27	20	58	100	90	25
VMMC coverage (15-34 years) (%)	51	47	54	44	76	65	51	94	78	34

Source: Gender Links derived from UNAIDS (2024) HIV Prevention: From Crisis to Opportunity

Table 5.16 shows selected indicators of prevention programming for boys and men, especially voluntary medical male circumcision (VMMC). VMMC programming is concentrated in 15 priority countries, including Botswana, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe in SADC.

Fewer than 40% of young men aged 15 - 24 have accessed VMMC in six countries. The best coverage is 82% in Tanzania, with Lesotho, Mozambique and South Africa being between 60 and 70%. Research suggests that poorer and rural populations are least likely to be accessing VMMC programmes.



Zambia's voluntary male circumcision initiative poster.

Table 5.17: Numbers of voluntary medical male circumcisions (VMMCs) conducted in SADC

Country	2015	2018	2023
Tanzania	435 302	885 599	586 860
Zambia	222 481	482 183	521 195
South Africa	485 552	572 442	215 716
Mozambique	198 340	311 891	162 993
Zimbabwe	188 732	326 012	155 617
Malawi	108 672	199 399	119 161
Namibia	18 549	34 942	21 654
Lesotho	25 966	26 448	12 807
Botswana	15 722	24 207	9570
Eswatini	12 952	14 316	4747
SADC Total	**1 712 268**	**2 877 439**	**1 810 320**
SADC as % of Global	**65%**	**70%**	**70%**
Global Total	**2 623 788**	**4 135 786**	**2 594 873**

Source: Gender Links compiled from UNAIDS 2023 Data

Table 5.17 shows that annual numbers of VMMCs increased from 2015 to 2018 then were severely impacted by the COVID pandemic. Only Malawi, Tanzania and Zambia have achieved their targets in 2023. Countries in SADC provide 70% of the global total of VMMCs conducted, with Tanzania accounting for 23% of global total and Zambia 20%.

Countries in SADC conduct 70% of global VMMCs

Table 5.18: Number of new infections (young people 15 - 24) 2010, 2016 and 2023

Country	2010	2016	2023	Reduction 2010 - 2023	Reduction 2016 - 2023
Zimbabwe	27 000	14 000	4 400	84%	69%
Eswatini	6 400	3 600	1 500	77%	58%
Malawi	17 000	11 000	4 000	76%	64%
Lesotho	6 700	4 500	1 700	75%	62%
Botswana	5 100	3 700	1 400	73%	62%
South Africa	150 000	96 000	55 000	63%	43%
Zambia	22 000	23 000	8 200	63%	64%
DRC	9 200	7 300	5 000	46%	32%
Mozambique	55 000	53 000	31 000	44%	42%
Namibia	3 500	3 100	2 100	40%	32%
Angola	8 100	6 000	4 900	40%	18%
Tanzania	21 000	8 500	19 000	10%	-124%
Comoros	100	100	100	0%	0%
Mauritius	200	200	200	0%	0%
Madagascar					
Total SADC	**331 300**	**234 000**	**138 500**		
SADC as % of Global	**49%**	**47%**	**38%**		
Global	**680 000**	**500 000**	**360 000**		

Source: Gender Links compiled from UNAIDS 2023 Data

Table 5.18 shows the decline in new infections in young people aged 15 - 24 (both female and male) between 2010, 2016 and 2023. Rates of decline are highest in Zimbabwe, Eswatini, Malawi, Lesotho and Botswana. SADC's share of the global new infections in young people has decreased from 49% in 2010 to 38% in 2023.

Adolescence is a phase of development during which young people exert their independence, but still need support and constructive guidance from their parents and guardians. Open discussion about sexuality and other issues in their lives is very critical. The case study below highlights a programme which fosters such communication.



Intergenerational Dialogue Mupangayi Secondary School, Shurugwi District

Women in Communities (WICO) Zimbabwe, a Voice and Choice SAF grantee, worked with selected schools in Shurugwi district of southwestern Zimbabwe to improve access to integrated SRH and HIV services for adolescent boys and girls. The "I Am My Daughter's/Son's Keeper" programme included health clubs, prefects trained as peer educators and supporting teachers to develop stigma-free school environments.

An important component of the programme was intergenerational dialogues between parents or guardians and their children, mediated through the schools. One school which hosted such dialogues was Mupangayi Secondary School.

The intergenerational dialogue at Mupangayi Secondary School was an opportunity to address issues creating tension and misunderstanding between adolescents and their parents/ guardians. It allowed parents to express their fears and concerns regarding their children and



Intergenerational dialogues in action in Zimbabwe. Photo: Women in Communities

children to express their feelings of being misunderstood. The session began with an open discussion for parents/guardians and their children to voice some of the issues and tensions occurring.

Examples of concerns raised included:
Tendai Nyoni[24] is a Form 4 girl living with both her parents. Her parents really try to provide the school resources she needs, and she has above average grades. Recently she asked for a cell phone to help with research for her studies. Though reluctant, Tendai's parents succumbed to her persistence and bought her the phone. They later noticed she spent more and more time on the phone and became very secretive about it. This worried the parents and created friction between them and Tendai.

Brian Zimuto, a boy in Form 4, lives with his uncle as both his parents work in South Africa. They are very supportive of their son and buy him trendy clothes and gadgets. After school Brian visits the very busy township, hanging around with older out of school boys who seem to have a negative influence on his behaviour. His grades were dropping, and his behaviour suggested he is abusing alcohol and other substances.

Chipo Chizana, a Form 3 girl, lives with her maternal grandmother. She did not complete her O' level (school leaving examination) the first time because she fell pregnant and eloped with her young boyfriend. The relationship did not work out and she soon returned to her grandmother. She re-entered school as a Form 3 student. She is keen to work harder and better but faces ridicule and stigma from other learners who do not seem to understand her situation.

It used to be taboo for a father to discuss menstrual hygiene with his daughter.

Boys copied their fathers' drinking habits.

One-on-one family discussions followed the open dialogue. Learners began to appreciate that parents are keen to know what is happening with their child at all times, more for their protection than to blame them. Parents also listened to their children's perspectives. This led to better understanding and appreciation of each either's viewpoints. The general consensus was that it is important to have open dialogue at all times between children and their parents/guardians for better SRHR and HIV outcomes. The dialogue improved communication and relationships, increasing trust between the adolescents and their parents. Some comments from parents and adolescents were:
"Today we learnt a lot about bridging the gap between parents and children. We realised that we need to communicate better with our children by being more open with them all the time. This helps prevent them from seeking help elsewhere which may be misleading. The use of phones was discussed at length, and we agreed that learners should focus on making the best use of the technology and not abuse it," said one mother.

"I am a learner at Mupangayi secondary school in Ward 11 of Shurugwi district. Today we had a visit from WICO Zimbabwe who took us through ways of improving communication between us and our parents. This may be academic problems or social problems like abuse and negative peer pressure. We need to accept guidance from our parents and guardians as they have our best interests at heart. We are very grateful for the opportunity for dialogue with our parents."

Adolescents and young people are more likely to make healthy choices if they have good and correct information about sexuality in line with their needs, and not imposed on them. An open and stigma-free environment at home and school, where they can ask questions, encourages young people to translate the information into attitudes and behaviours to make healthy decisions in their lives. They need access to contraception and HIV prevention to prevent unwanted pregnancies and sexually transmitted infections, including HIV.

Source: WICO Zimbabwe, Report to Gender Links. October 2024

[24] All names in the case have been changed to protect the child's identity.

Condoms

Pillar 4 recognises that condoms are a key component of HIV prevention strategies and indicates condoms have had a significant impact on reducing new HIV infections.

Table 5.19: Condoms distributed across SADC, 2019 to 2023

Country	2019	2020	2022	2023
South Africa	635 981 213	558 190 486	403 740 579	548 365 152
Malawi	154 442 236	81 219 283	120 240 675	130 991 775
Zimbabwe	94 849 706	82 720 989	119 595 390	115 494 666
Mozambique	95 715 852	84 273 291		108 672 876
Tanzania	32 664 445	26 828 131	133 615 400	94 487 900
Angola	19 782 000			23 236 848
Zambia	19 392 644	17 252 787	17 442 392	21 479 580
DRC		36 169 500	2 500 150	18 007 773
Eswatini	12 144 576	14 809 730	9 900 949	13 368 228
Lesotho	4 018 032		1 480 676	8 969 580
Namibia		34 000 000	11 414 992	2 925 648
Madagascar	17 682 860	11 469 917		1 259 982
Seychelles	452 772	223 447	343 422	261 677
Comoros	930 007	650 064		233 811
Botswana	41 148 720	26 932 500	38 987 700	
Mauritius	975 119			
SADC total	**1 130 180 182**	**974 740 125**	**859 262 325**	**1 087 755 496**
SADC as % of global	**41%**	**39%**	**29%**	**38%**
Global total	**2 753 451 961**	**2 509 145 066**	**2 982 666 039**	**2 890 411 803**

Source: Gender Links compiled from UNAIDS 2023 Data

Table 5.19 shows huge fluctuations in condom availability in different national HIV programmes. SADC's share of global condom distribution has varied between 29% and 41%. In 2021, South Africa accounted for 19% of all condoms distributed worldwide. Investment by PEPFAR and the Global Fund (the two largest funders of condom programmes) into condoms has declined. Thus, highly subsidised condoms that have been available for many decades are not so readily available any longer.[25]

Table 5.20: Condom use, selected determinants of use, distribution

Country	Condom use with non-regular partners (%)		Knows condom as prevention method (%)		Woman justified to insist on condom use if husband has STI (men 15-49 years) (%)	# of condoms distributed/ sold per couple-year* (age range 15-64 years - 2021)	% of condom distribution need met (2021)
	Women 15-49 years	Men 15-49 years	Women 15-49 years	Men 15-49 years			
Angola	27	46	66	78	59	1	3
Botswana	id	id	id	id	id	54	id
DRC	24	33	56	73	68	0	1
Eswatini	66	83	91	87	94	28	79
Lesotho	78	81	92	88	92	2	6
Malawi	49	73	75	75	82	22	100
Mozambique	42	47	55	65	61	id	id
Namibia	66	82	88	90	93	15	46
South Africa	60	68	id	id	id	20	63
Tanzania	28	35	id	id	id	8	42
Zambia	35	54	83	87	73	3	16
Zimbabwe	65	82	84	88	87	30	100

Source: Gender Links derived from UNAIDS, 2024. HIV Prevention - From Crisis to Opportunity

[25] UNAIDS (2024) The urgency of now Op Cit.

According to Table 5.20, Eswatini, Malawi and Zimbabwe have reasonable to good condom distribution, meeting most or all of the need.

Condom use with non-regular partners is poor in many countries, even though knowledge of condoms as a prevention strategy is high.

ARV-based Prevention

Pillar 5, ARV-based prevention includes:

- PrEP (pre-exposure prophylaxis) which involves taking an ARV before sex by anyone at high risk of contracting HIV;
- PEP (post-exposure prophylaxis) which involves taking ARVs after high-risk sex (usually rape) to prevent HIV; and
- Viral suppression in as many people living with HIV as possible to ensure they do not transmit HIV.

Table 5.21: Antiretroviral-based prevention scorecard for SADC countries in the GPC

Indicator	Angola	Botswana	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mozambique	Namibia	South Africa	Tanzania	Zambia	Zimbabwe
% of all PLHIV diagnosed	58	97	83	97	94	id	94	86	95	94	95	93	95
% of all PLHIV on ART	46	93	82	95	86	18	93	81	91	75	94	90	94
% of all PLHIV virally supressed	id	93	id	93	85	id	87	71	86	69	92	87	89
% of all PLHIV virally supressed (women 15+)	id	97	id	95	88	id	93	74	90	74	96	89	93
% of all PLHIV virally supressed (men 15+)	id	87	78	90	79	id	81	70	81	62	90	87	88
% of estimated PrEP need met (%)	id	48	12	id	id	0	53	id	id	61	75	id	id
Composite PrEP score (0-10 points based on regulatory, guidelines and coverage)	id	6	3	id	10	0	5	id	10	6	10	8	8

Source: Gender Links, derived from UNAIDS. 2024. HIV Prevention - from Crisis to Opportunity

Table 5.21 shows that many SADC countries have made impressive gains towards the three 95% goals, with higher levels of viral suppression in women than in men. This means that more men are still able to transmit HIV which continues to drive new infections in younger women. PrEP roll out is still quite slow.

Table 5.22: Number of people using PrEP at least once in the year

Country	2018	2019	2020	2021	2022	2023
South Africa	8184		106 401	346 667	406 170	803 171
Zambia	3823		110 714	147 397	162 695	184 256
Malawi		459		10 971	23 104	72 335
Tanzania				41 335	162 477	59 332
Namibia					29 826	49 904
Lesotho	7279	35 478		15 749	28 128	30 993
Zimbabwe	4982	8351	48 583	7061	79 602	30 396
Eswatini			9125			27 961
DRC			553		8650	23 349
Botswana	38	1954	2259	5149	13 380	14 537
Madagascar					459	678
Seychelles	4	26	3	1	5	4
Mauritius	3			19	102	
Mozambique	1934		18 513	57 717		
Total SADC	**26 247**	**46 268**	**296 151**	**632 066**	**914 598**	**1 296 916**
SADC as % of Global	**33%**	**36%**	**56%**	**69%**	**36%**	**37%**
Global total	**79 881**	**129 910**	**524 877**	**911 825**	**2 569 923**	**3 529 845**

Source: Gender Links compiled from UNAIDS 2023 Data

Table 5.22 shows the expansion of PrEP in different countries from 2018 to 2023. Expansion has been patchy, except in South Africa, which accounted for 23% of global PrEP in 2023. The global coverage of PrEP reached 3.5 million in 2023, which is still well below the target of ten million by 2025.

There is considerable on-going research to develop new forms of PrEP, including long-acting (LA) injectable PrEP. With long-acting PrEP, a person at risk receives one injection twice a year. The advantage is in not needing to take a daily pill. The research is extremely promising.

Large-scale roll-out of PrEP requires regulatory approval, development of guidelines and production of generic and more affordable PrEP medications. Those at high risk of contracting HIV should be aware of PrEP, including possible side effects and long-term impacts and have the choice to use this game changing bio-medical advancement.

People need to be able to choose prevention methods that work for them

Rolling out cheap and high-quality PrEP production may take several years. LA Cabotegravir has been registered in 17 countries (including Botswana, Malawi, Mozambique, South Africa, Tanzania, Zambia, Zimbabwe in SADC) and by the European Medicines Agency, and has been submitted for registration in Namibia.[26] Gilead Sciences announced on 2 October 2024, that it had signed royalty-free, non-exclusive licensing agreements with six generic manufacturers to increase access to injectable lenacapavir (which is also a long acting medication) to be made available in 120 high-incidence, resource-limited countries. The International AIDS Society applauded the move and called for further expansion as the agreement does not cover several high incidence countries.[27]

Another option, which has been approved in Botswana, Eswatini, Lesotho, Malawi, Namibia, South Africa, Zambia and Zimbabwe in SADC, is the dapivirine vaginal ring. A woman inserts this flexible silicone ring into her vagina, near the cervix, and leaves in place for a month. The ring releases ARVs slowly to counteract any HIV. A version effective for three months, which should less expensive, is expected to be available in 2025 or 2026.[28] It is important that people are able to choose prevention methods that work best for them.

Treatment

Article 27.3

b) Ensure universal access to HIV and AIDS treatment for infected women, men, girls and boys

UNAIDS 95/95/95: Target (2) By 2025, 95% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; Target (3) By 2020, 95% of all people receiving antiretroviral therapy will have viral suppression.

As discussed previously in this chapter, the Global AIDS Strategy includes targets for: 95% of all people living with HIV know their status; 95% diagnosed with HIV accessing antiretroviral treatment; 95% on ARVs achieve viral suppression.

[26] Worldwide registration: cabotegravir PrEP. London: ViiV Healthcare; 2024 https://viivhealthcare.com/content/dam/cf-viiv/viivhealthcare/en_GB/pdf/cab-prep-wwrs-03-may-2024.pdf accessed 28 September, 2024.
[27] IAS statement: IAS calls for global access as Gilead announces lenacapavir licensing. https://www.iasociety.org/ias-statement/ias-calls-global-access-gilead-announces-lenacapavir-licensing accessed 4 October 2024.
[28] UNAIDS (2024) The urgency of Now. Op Cit.

Table 5.23: Progress to achieving the 95-95-95 goals in SADC, 2015 and 2023

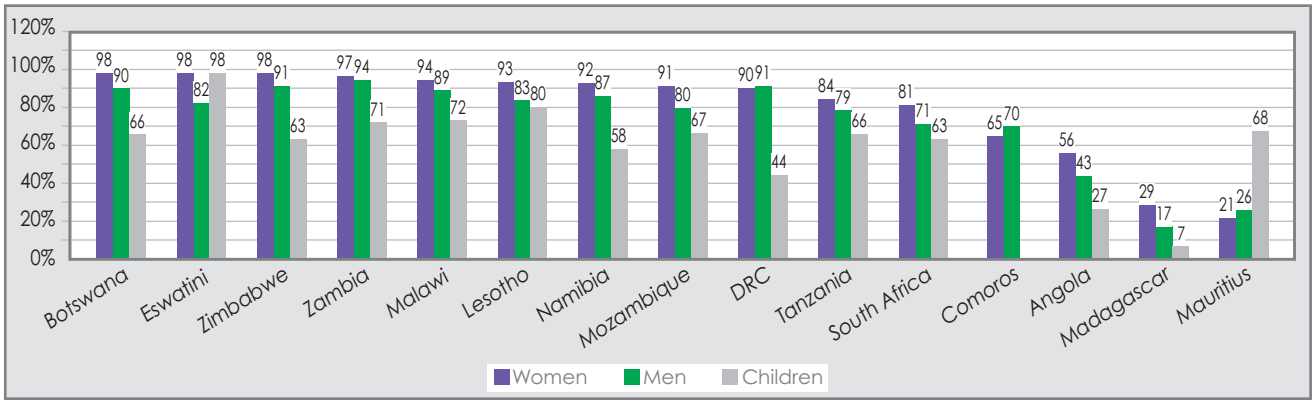
Country	Progress to achieving 95-95-95 in women over 15		Progress to achieving 95-95-95 in men over 15	
	2015	2023	2015	2023
Eswatini	95, 75 ---	>98, >98, >98	90, 59,---	95, 86, >98
Botswana	85, 90--	>98, >98, >98	81, 83,---	96, 94, >98
Zimbabwe	89, 75--	>98, >98, 96	78, 73,---	95, 95, 95
Zambia	84, 78--	97, >98, 98	76, 87,---	96, >98, 97
Malawi	89, 78, 90	97, 97, 96	78, 66, 87	94, 95, 95
Lesotho	95, 58--	96, 97, >98	87, 54,---	93, 90, >98
South Africa	90, 64, 85	96, 84, 92	83, 57, 83	94, 75, 91
Namibia	88, 66--	95, 96, >98	79, 71,---	91, 95, >98
Mozambique	71, 66--	92, >98, 90	56, 55,---	85, 95, 90
DRC	41, 73--	91, >98, 90	35, 55,---	91, >98, 89
Tanzania	72, 69--	88, 95, 97	63, 56,---	86, 93, 97
Angola	60, 48--	80, 70, ---	50, 40,---	72, 60, --
Comoros	39, 93--	72, 91, ----	31, 98,---	71, >98, 62
Madagascar	5, 79--	29, >98, ---	3, 93,---	18, >98, --
Mauritius	15, >98--	21, >98, 72	27, >98,---	26, >98, 75
Global	**78, 68--**	**91, 91, 94**	**66, 64, 84**	**83, 86, 94**

Source: Gender Links compiled from UNAIDS 2023 data

Table 5.23 shows progress towards achieving the 95-95-95 targets by 2025, disaggregated by women over 15 and men over 15. The table shows there has been great progress between 2016 and 2023 for both women and men. However, women are still more likely to have been tested, to have accessed ARV therapy and to have achieved viral suppression than men in most countries.

Men are more likely to have been tested, accessed ARVs and achieved viral suppression in Mauritius. There is more attention to men living with HIV in Mauritius as the country's epidemic is largely among key populations. As with other HIV indicators, the island nations have much lower testing rates than SADC mainland nations. Five SADC nations (Eswatini, Botswana, Zimbabwe, Zambia and Malawi) are amongst the nine countries globally that have already achieved the 95-95-95 targets. Lesotho and Namibia are amongst the ten countries on track globally to achieve the targets by 2025.[29]

Figure 5.5: ART coverage for those living with HIV (%)



Source: Gender Links, compiled from UNAIDS 2023 data

[29] UNAIDS (2024) The urgency of Now. Op Cit.

Figure 5.5 shows great progress in access to ARVs across SADC, with smaller proportions of men living with HIV accessing ARVs than women in most countries except Mauritius, DRC and Comoros, and the smallest proportion being children, except in Mauritius and Eswatini where children are the highest proportion.

Table 5.24: Number of people on Antiretroviral Therapy

Country	2010	2015	2023	Increase 2010 - 2023 %
Madagascar	266	1234	16 790	6212%
DRC	43 790	121 762	444 592	915%
Mozambique	218 991	802 659	2 088 982	854%
Angola	22 036	71 541	160 392	628%
Tanzania	244 225	620 057	1 389 882	469%
Mauritius	654	2521	3080	371%
South Africa	1 407 392	3 682 691	5 936 501	322%
Zambia	349 076	758 646	1 273 804	265%
Malawi	250 953	595 634	896 805	257%
Eswatini	60 757	147 587	213 416	251%
Zimbabwe	363 261	835 472	1 233 934	240%
Namibia	77 453	130 272	202 604	162%
Lesotho	94 287	153 459	241 462	156%
Botswana	159 350	255 119	339 716	113%
Total SADC	**3 292 491**	**8 178 654**	**14 441 960**	
SADC as a % of Global	**43%**	**48%**	**47%**	
Global	**7 700 000**	**16 900 000**	**30 700 000**	

Source: Gender Links compiled from UNAIDS 2023 data

Table 5.24 shows how the number of people on antiretroviral therapy has expanded dramatically since 2010. The global target is for 34 million people to be on ART by 2025. There are now 14 441 960 people living with HIV, 83% of all those living with HIV, who are on ART in SADC. South Africa alone accounts for 19% of the global total of people living with HIV who are on ART. The rate of increase of people on ART has been highest in Madagascar.



A group of medical academicians and practitioners from **Madagascar** wrote an impassioned plea for support and resources to enable Madagascar to curb an enormous increase in the numbers of people that are being infected with HIV.[30] Even with limited capacity for testing across the country, the group quoted several indicators as evidence the country needs an urgent and substantial investment in generalised testing and access to ARVs: a surge in STIs; increased HIV positivity rates in sex workers and pregnant women in some areas; and AIDS defining conditions and late stage AIDS illnesses. While HIV has largely been concentrated within key populations in Madagascar, the group raised serious concerns regarding surging new infections and AIDS-related deaths in key populations and possibilities of a more generalised epidemic expanding, pleading for increased funding to implement the national HIV strategy.

This is a stark reminder that all countries must be very vigilant about HIV and reinforces the pressing priority of inclusive strategies that reach key populations.

The case study below illustrates one programme's efforts to re-enrol people who have dropped out of treatment.



HIV and AIDS screening in Madagascar. Photo: Zoto Razanadratefa

[30] Andrianarimanana-Köcher D, Rakotoarivelo RA, Randria MJdD, et al. Call for action: addressing the alarming surge of HIV in Madagascar. BMJ Glob Health 2024;9:e015484. doi:10.1136/bmjgh-2024-015484 https://gh.bmj.com/content/9/4/e015484.full accessed 21 July 2025

Strong in Jozi: Focus on Men's Health


Matthew Mathable.
Photo: Let us Grow

Matthew Mathabe is a young man in his early 40s living with HIV in Orange Farm, an informal settlement south of Johannesburg, South Africa. Like most young men who from Orange Farm, Mathabe has had many challenges in his life.

Growing up in a community and family marked by poverty and unemployment, Mathabe began abusing various substances at a very young age. One day Mathabe went home after using substances and got into a heated argument with his mother. His mother was admitted to Baragwanath Hospital after the argument and, after a few days, she passed away.

After his mother's passing, life became very difficult for Mathabe. Most of his family members and the community blamed Mathabe for his mother's passing. His brother and sister left him in the house and moved on with their lives. Mathabe yearned to be independent, but each day he faced bitterness from people in the community who did not want him anywhere near them or their children, they believed Mathabe to be a bad influence on their children.

Mathabe contended with rejection and hatred each day of his life. During this time, he found out he had contracted HIV, which became another struggle in his life. He went to a local clinic to start his ART (HIV treatment) but that was also not easy for him. Most of the clinic knew him and his background and were very judgemental. This led to Matthew stopping his treatment.

In May 2024 Mathabe was at home when he saw a group of young men wearing white T-shirts with the slogan," Strong in Jozi." Strong in Jozi is an awareness campaign led by ANOVA Health Institute, working in partnership with local organisations such as Let us Grow, running in Orange Farm since the beginning of 2024. (Jozi is a slang name for Johannesburg). Strong in Jozi targets men in and across Johannesburg, encouraging access to health services educating men about their health especially HIV, AIDS and prostate cancer, as well as GBV. The door-to-door awareness programmes educate men in the community and offer clinic referrals. Mathabe learnt about the programme through outreach to men in his community.


Strong in Jozi team from Orange Farm, South Africa.
Photo: Let us Grow

These young men told Mathabe about proper condom use, ARV'S, PEP and other health information. This was good news to Mathabe as he was longing to go back on treatment, but he did not know how to. He also needed a health facility (clinic) that could assist with his other health issues, such as TB. The group of young men told him that they were from Let us Grow organisation and gave him directions to go to the office.

A few days later, Mathabe visited Let us Grow offices where a loving team of young people received him, some living with HIV just like him. Mathabe explained his challenges to one of the field workers. saying that he would like to get back on treatment at another health facility. The field worker and co-ordinator arranged a referral for Matthew to a clinic in another extension (area) where people do not know him. The Let us Grow co-ordinator also offered to take Mathabe to the clinic to give him moral support and show him love and acceptance.

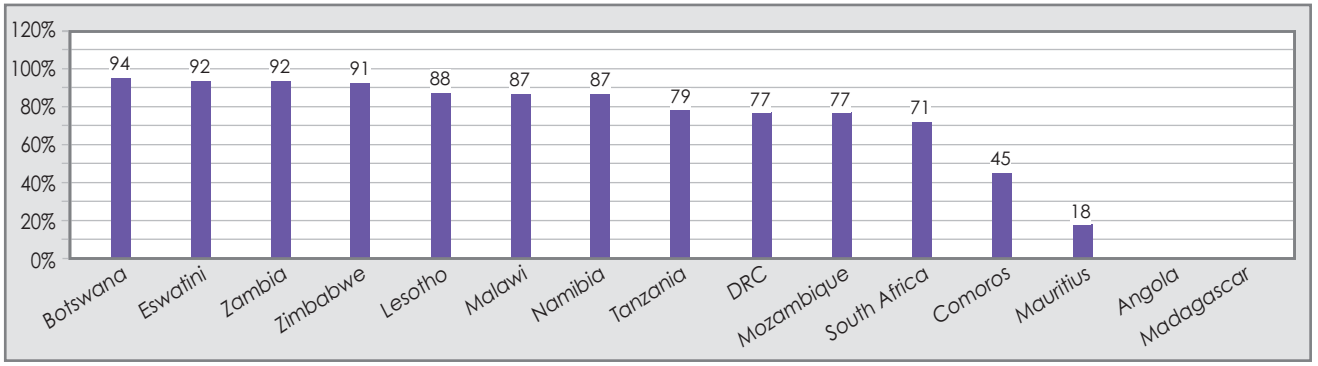
Mathabe is now back on treatment and has joined the group of field workers. Every day he encourages young men to test for HIV and to take their treatment. He feels so loved by his team members and nobody is judging him, regardless of what they know about him. Through the Voice and Choice Fund Let us Grow is able to make change and reach out to people in the community, one person at a time.

Source: Let us Grow report to Gender Links, October 2024

Viral suppression

UNAIDS TARGET 3: 95% of all people receiving antiretroviral therapy will have viral suppression.

Figure 5.6: Percent of people living with HIV who have suppressed viral loads



Source: Gender Links compiled from UNAIDS 2023 data

Figure 5.6 shows tremendous progress towards viral suppression with seven countries already over 86% which is the target for 2025 (note that 86% of all people living with HIV is equivalent to 95% of 95 % of 95%). Data on suppression is not available from Angola or Madagascar. Mauritius still has a low rate of suppression.

Health systems across SADC strain to fulfil the need to continue HIV prevention, testing, access to treatment for new patients and support to patients to adhere to treatment for life. There are reports of patients who feel better stopping their treatment or failing to take it regularly as is required. Poor adherence can lead to AIDS illness, death, antiretroviral resistance, and viral transmission. Adherence Clubs are a common initiative to support stable patients to adhere to their treatment. These Clubs may be based at a health facility or in the community. Group members meet once every two to three months and are issued with their pre-packaged ARVs, as well as medication for any other co-morbidities. In some areas they are also issued with prophylaxis for Tuberculosis (TB). The Adherence Club facilitator checks on all members and refers any that have problems to the health facility for further support. All members have their blood drawn to check their viral load and have other routine medical checks once or twice a year. Those who default on these visits should be followed up by home visits.

A study conducted in Ekurhuleni (an area with one of the highest prevalence rates in South Africa) with 730 members of Adherence Clubs meeting in health facilities, ranging in age from 20 to 69 with a median age of 39, identified factors associated with poor adherence[31] as:

- presence of co-morbidities which may be a result of the number of different medications patients are taking every day;
- changing from several ART tablets to a 1 pill a day formulation, which may result in patients feeling better and thinking they do not need the one pill any longer;
- longer duration of club membership, which may be resulting in treatment fatigue; and
- age - members who are older than 30 were more adherent than younger members, which may be a result of their feeling more welcome in the health facility.

It is important for health systems to be aware of factors that promote adherence and factors associated with poor adherence to be able to address these issues in the club meetings. Factors may be different in different settings.

[31] Ndoro T, Ndlovu N, Nyasulu P (2022) Factors associated with ART adherence among HIV-positive adherence club members in Ekurhuleni Metropolitan Municipality, South Africa: A cross-sectional study. PLoS ONE 17(11): e0277039. https://doi.org/10.1371/journal.pone.0277039 https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0277039 Accessed 30 September, 2024.

Costs of HIV programmes

The cost of large HIV treatment programmes places a heavy strain on fragile health systems in SADC

The cost of HIV programmes takes a heavy toll on fragile economies in SADC. Figures reported for South Africa, for instance, show domestic annual expenditure of $1.42 billion and international contributions of $443 million.[32] Comparable figures for Seychelles, with a relatively small HIV burden, are $3.3 million from domestic public resources, $47 000 from domestic private sources and $45 000 from international sources.[33]

The Government of Zimbabwe established the **Zimbabwe AIDS Levy** through legislation in 1999. The AIDS Levy is funded by a 3% levy on individual income and corporate taxes, which is collected in the National AIDS Levy Trust and administered by the National AIDS Council (NACA). In 2023 this amounted to about $30 million, which gave the NACA flexibility to identify local priorities, cover gaps in donor funding, and power to convene donors and key actors to improve coordination of effort. Budgets are provided as follows: 50% for antiretroviral therapy programme, 10% prevention, 6% M&E and coordination, 5% enabling environment and 23% and 4% for programme logistics support and assets respectively. The Ministry of Health and Child Welfare monitors expenditure and results, including allocations to civil society, and the fund is audited annually. Zimbabwe is able to make strategic long-term investments in aspects of the HIV programme such as condoms where donor funding is fluctuating.[34]

HIV and TB co-infection

The UN High level meeting on TB in 2016 committed to ending TB, which is both preventable and curable by 2030. TB is still a leading cause of death among people living with HIV.

Table 5.25: TB-related deaths in people living with HIV

Country	2000	2010	2022	Rate of decrease 2010 to 2022
Tanzania	54 000	41 000	5 100	88%
Malawi	13 000	18 000	3 600	80%
Zambia	19 000	14 000	2 800	80%
Mozambique	20 000	21 000	4 300	80%
DRC	25 000	19 000	5 100	73%
Eswatini	2 400	2 400	650	73%
South Africa	121 000	88 000	31 000	65%
Angola	1 900	9 100	3 300	64%
Lesotho	4 200	4 700	2 400	49%
Botswana	3 900	2 100	1 100	48%
Namibia	4 600	2 100	1 100	48%
Zimbabwe	14 000	8 100	6 000	26%
Madagascar	37	55	370	-573%
Mauritius	7	2	15	-650%
Comoros	0	0	1	
Seychelles	0	0	0	
Total SADC	**283 044**	**229 557**	**66 836**	**71%**
SADC as % of Global	**39%**	**42%**	**39%**	
Global	**720 000**	**550 000**	**170 000**	**70%**

Source: Gender Links compiled from UNAIDS 2023 data

[32] UNAIDS (2024) Country Factsheet South Africa 2023. https://aidsinfo.unaids.org/ Accessed 24 July 2024.
[33] UNAIDS (2024) Country Factsheet Seychelles 2023. https://aidsinfo.unaids.org/ Accessed 24 July 2024
[34] HIV Multisector Leadership Forum. 2024. Zimbabwe AIDS levy: Investing locally for HIV prevention A case study. https://hivpreventioncoalition.unaids.org/sites/default/files/attachments/the_zimbabwe_aids_levy_investing_locally_for_prevention.pdf

Table 5.25 compares the number of TB related deaths in people living with HIV in 2000, 2010, and 2022. The global target is to reduce the rate of deaths due to TB in people living with HIV by 80% compared to a 2010 baseline by 2025. The global rate of decline by 2022 was 70%. SADC's decline was not very different at 71%. Tanzania, Malawi, Zambia and Mozambique have achieved the target already and DRC and Eswatini had rates of decline that were higher than the global average. These are commendable results in view of the serious disruption to TB programmes caused by COVID-19. SADC accounts for about 40% of all TB related deaths in people living with HIV.

MPox

MPox, previously known as Monkey Pox, is a viral disease that produces a fever, pains and skin lesions. While the infection is often mild, it is more severe in people with compromised immune systems, children and pregnant women. MPox has been found for some time in the DRC and the tropical forests in West Africa. The latest MPox outbreak, whose epicentre is in the DRC, was declared a Public Health Emergency of Continental Security by the Africa Centres for Disease Control and Prevention (Africa CDC) on August 13 2024. The WHO declared it a Public Health Emergency of International Concern (PHEIC) on August 14.

A recent update from the Africa CDC is that MPox has spread to 16 countries in all five regions of Africa, with South Africa being the only other SADC country to experience cases so far.[35] MPox has affected more men than women and leads to severe illness in children. Over 40% of those that have contracted MPox around the world are people that are living with HIV. One of the routes of MPox transmission is through sex. Condoms reduce sexual transmission.

The Africa CDC is working to secure vaccines for MPox. By mid-September 2024, it had 4.3 million doses out of a target of 10 million and was anticipating further pledges, including from the United States President, Joe Biden. The Coalition for Epidemic Preparedness Innovations is contributing $72 million for vaccine development and $145 million for manufacturing of the vaccine in Rwanda.[36]

Care work

Article 27.3

c) Develop and implement policies and programmes to ensure appropriate recognition of the work carried out by care givers, the majority of whom are women, the allocation of resources and the psychological support for caregivers as well as promote the involvement of men in the care and support of people living with HIV and AIDS.

SDG 5.4

Recognise and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.

[35] Africa CDC. 2024. Outbreak Report, 13 September 2024: Mpox Situation in Africa. https://africacdc.org/download/outbreak-report-13-september-2024-mpox-situation-in-africa/ accessed 11 October 2024

[36] Africa CDC. Communique of 3rd Meeting of the Committee of Heads of State and Government of the Africa CDC, 23 September 2024. https://africacdc.org/news-item/communique-of-3rd-meeting-of-the-committee-of-heads-of-state-and-governement-of-the-africa-centres-for-disease-control-and-prevention-africa-cdc/ accessed 11 October 2024.

SADC sponsored UN resolution on Women, Girls and HIV: Recognise women's contribution to the economy and their active participation in caring for people living with HIV and AIDS and recognise, reduce, redistribute and value women's unpaid care and domestic work through the provision of public services, infrastructure.

BPFA +20 Africa declaration: Reduce, recognise and redistribute unpaid care work, which falls disproportionately on women and girls, by investing in infrastructure and time-saving technology and emphasising shared responsibilities between women and men, girls and boys.

The HIV response is very deeply community rooted. In the early 2000s, hundreds of poorly resourced and poorly supported community home-based care groups provided essential care to many millions of people living with HIV and people desperately ill with AIDS. They often also cared for the ill people's children, who too often became orphans when one or both of their parents died. With the advent of ARVs the need for home care lessened and many groups disbanded. However, as the epidemic persists, health systems are strained to continue prevention, testing, access to treatment and supporting adherence for large numbers of people living with HIV. Many community organisations are regrouping and new organisations are forming, to support efforts in:

- Adherence and retention support including facilitating adherence clubs and collecting ARVs for the clubs.
- Follow up of people living with HIV that are not coming for their medication and routine tests.
- Distribution of condoms and lubricants.
- Linkage to HIV treatment.
- Information on life skills-based HIV and sexuality education.
- HIV, SRH and health promotion, including linkage to VMMC and PrEP.
- HIV testing.
- Treatment literacy.
- TB screening and referral for testing.
- DOTS support (for TB treatment).
- Follow up for other co-morbidities such as hypertension.
- Legal services.
- Legal literacy.
- Needle-syringe distribution.

The Global AIDS Strategy 2021-2026 goal is for community-led organisations to deliver:
- 30% of testing and treatment services
- 80% of HIV prevention services
- 60% of programmes supporting the achievement of societal enablers.

The specific goals for community-led prevention and treatment recognise the critical role of communities and have encouraged renewed emphasis on support for community efforts. However, funding still largely flows to, or at least through, organisations based in donor countries and large national organisations located outside of high prevalence communities. There are efforts to develop ways to better monitor and account for the volume of services being delivered by community-based organisations, including organisations of people living with HIV and of key populations. To achieve these goals, there is an urgent need for adequate resourcing for community groups to sustain the vital work they do. Critical questions remain regarding care worker remuneration and the impact of unpaid care work by family, mostly women, still happening in homes. These issues require greater consideration and inclusion within strategic planning.

Many community groups are supporting HIV prevention, testing, access and adherence to treatment



Let us Grow, a Voice and Choice SAF grantee working in Orange Farm, an informal settlement south of Johannesburg, is an organisation that provided home-based care at the height of the AIDS crisis in the early 2000s. It now supports community and government efforts for HIV prevention, focusing on condom distribution, providing safe spaces for men who have sex with men to come forward for HIV testing and access to treatment and follow up of people living with HIV who are defaulting on their ARVs. Let us Grow has a number of male volunteers, thus meeting one of the SADC Gender Protocol's targets of increasing male involvement in care work.

Many other organisations have peer supporters from affected groups. For example, many programmes around the world include Mentor Mothers, sometimes under different names. Along with other issues, Mentor Mothers often support pregnant women living with HIV to prevent vertical transmission to their children. There are also Mentor Brothers who support other men, as well as peer sex workers and peer young people.



Condom distribution initiative by Orange Farms' Let us Grow organisation in South Africa. Photo: Let us Grow

The case study below is an example of peer adolescent girls and young women who are promoting access to SRHR and HIV prevention in Zimbabwe.



Adolescent girls and young women peer Advocacy Champions for HIV Prevention

Youth Aspire Development Trust, a Voice and Choice SAF grantee, worked with 25 adolescent girls and young women (AGYW) Sexual and Reproductive Health and Rights (SRHR) Advocacy Champions in Chitungwiza, not far from Harare in Zimbabwe. The young women received comprehensive training on SRHR, HIV prevention and advocacy skills to become effective advocates with their peers and others within their communities.

The Advocacy Champions led many outreach activities, such as workshops, seminars, and one-on-one sessions, which increased SRHR & HIV awareness and knowledge. Tanatswa[37] for example, educated her peers about the importance of HIV testing and safe sexual practices. She organised weekly discussion groups at her school, where she shared information and answered questions. Her efforts led to a number of students getting tested for HIV. Tanatswa's leadership and dedication earned her recognition from both her peers and the school administration. Altogether, champions held 109 school-based sessions within the first six months of 2024.

In collaboration with local health facilities, the programme helped link young people to SRH and HIV services, including HIV counselling, testing and treatment. Two clinics in Chitungwiza



Advocacy Champions led many outreach workshops, seminars, and one-on-one sessions in Chitungwiza, Zimbabwe. Photo: Youth Aspire Development Trust

[37] All names in the case study are pseudonyms.

(PZAT and Population Services Zimbabwe) attested at a feedback meeting that the SRHR Advocacy Champions' work increased the number of young people using their services. The Champions referred and sometimes accompanied young girls and women, including some with disability, to the clinics. Health workers applauded YADT for training and supporting the Champions and also recommended they should be well compensated to keep them motivated and ensure continuity.

The Champions also influenced behaviour change, for both adopting safer sexual practices and being more confident to seek SRH services. Tanyaradzwa focused on reaching out to young women in her neighbourhood. She made door-to-door visits, providing information on SRHR services and encouraging young women to visit local health facilities. Tayaradzwa's personal approach helped break down barriers and build trust. As a result, many young women previously hesitant to seek SRHR services felt more comfortable doing so. Tanyaradzwa's efforts contributed to increased uptake of contraceptive services.

Another key achievement was engaging with the community and community leaders to tackle stigma and misconceptions surrounding HIV and SRHR. More than 500 community members, including parents, teachers and local leaders, participated in dialogues and awareness campaigns. This broader community involvement helped create a more supportive environment for young people seeking SRHR and HIV services without fear of judgment or discrimination.



Open dialogues can reduce misconceptions - Chitungwiza, Zimbabwe.
Photo: Youth Aspire Development Trust

Marvellous addressed stigma and HIV misconceptions in her community. She organised community dialogues and invited local leaders to participate. Through honest conversations, Marvellous helped change negative attitudes and reduce stigma associated with HIV. After the dialogues, the United Methodist Church and Apostolic Faith Mission (AFM) Assembly have held open discussions with youth about HIV prevention and stigma.



Raising awareness in the Chitungwiza, Zimbabwe community.
Photo: Youth Aspire Development Trust

The sessions have increased awareness and understanding among young people, reducing misconceptions and promoting a supportive environment for those living with HIV. These churches are playing a crucial role in changing community attitudes and encouraging proactive health behaviours among youth. This has strengthened the community's overall response to HIV.

Champions also focus on women leaders in churches and held a workshop with 30 of these from 12 churches in early 2024. Women leaders such as pastors, chairwomen, youth leaders and Sunday school teachers better understand the issues that girls now face.

2263 young people in Chitungwiza were engaged through school visits, community workshops, and social media campaigns, which broadened the project's impact by the end of June 2024, nearing the project's target of 2500 by the end of December. This case study highlights the importance of peer-led initiatives in addressing SRHR and HIV prevention challenges and underscores the potential for scaling up such programmes.

Source: Youth Aspire Development Trust, report to Gender Links. October 2024.

Next steps

SADC, which is still the most heavily affected region in the world by HIV, must continue urgent steps to eradicate AIDS as a public health threat by 2030. These include:

Redoubling efforts for HIV prevention:

- New and innovative ways must be found to keep raising awareness about the reality of HIV and influence behaviours to reduce risk and encourage testing to be aware of one's status.
- Urgently review legislation that criminalises sex work and men who have sex with men/women who have sex with women, to enable service provision to everyone.
- Engage community leaders and communities, the media, politicians and opinion leaders to address stigma and discrimination at all levels.
- Mobilise political will at all levels to address gender inequalities and the GBV epidemic facing girls and women in SADC.
- Continue to focus on prevention of vertical transmission of HIV to children, with a particular focus on adolescent and young mothers.
- Embrace the Education Plus Initiative with comprehensive sexuality education and seek to have as many adolescent girls and boys as possible in secondary school.
- Be prepared to roll out new technologies such as long-acting PrEP swiftly.

Generate new impetus for HIV control particularly in Madagascar where the epidemic could spiral out of control.

Continue efforts to focus more on testing, treatment and care for children.

Continue to invest in the search for an effective vaccine, even as new therapies and treatments are developed.

Seek to integrate HIV services with other services e.g. adolescent health, school health, SRHR including control of STIs, maternal and child health, services for older people etc.

Continue efforts to ensure that men and other groups that are not accessing testing and treatment do so.

Expand programmes to control Cervical cancer and redouble efforts to control TB, including vaccination for pre-adolescent girls against the human papilloma virus (HPV), which predisposes women living with HIV to develop cervical cancer, as well as regular cervical cancer screening for all women living with HIV and enhancing TB case finding and treatment.

Support and effectively resource community-led responses for major aspects of the HIV response. The need for multi sectoral collaboration is very clear. Health services must collaborate with community initiatives. Expand collaboration with social and education services. Acknowledge the critical role of the community in HIV prevention, care and support and find simple ways to demonstrate the contribution of community organisations to the overall programme.

Scale up domestic resource mobilisation for the HIV response!

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