HIV and AIDS 5



Screening for HIV and AIDS in Madagascar. Photo: Zoto Razanadratefa

KEY POINTS

- SADC accounts for 46% of all people and 58% of the adolescents living with the Human Immunodeficiency Virus (HIV) in the world.
- The world missed the 2020 "90-90-90" targets set by UNAIDS (90% know their status; 90% on treatment and 90% virally suppressed) but made considerable progress.
- None of the prevention targets were met: 1.5 million new infections occurred globally in 2020 compared to the target of 500,000. SADC registered 587,000 new infections, compared to a target of 192,000.
- Of the eight countries in the world which achieved the 90-90-90 targets four are in Africa (Eswatini, Botswana, Malawi in SADC) and one (Uganda) in East Africa. A further 11 countries globally reached the overall 73% viral suppression target, including Zimbabwe, Lesotho, Namibia and Zambia in SADC; Kenya and Burundi in East Africa, but did not achieve one of the three 90s.
- The United Nations High Level Meeting in June 2021 adopted a new Global Strategy to address inequalities and end AIDS by 2030. This strategy has even more ambitious and urgent targets than the previous one.
- Eswatini has already achieved the 2025 target of 95- 95- 95.
- With the largest HIV burden in the world (7.8 million people living with HIV or 21% of the world total), South Africa's achievement of 92-72-66 is noteworthy.[1]
- The COVID-19 pandemic is disrupting HIV services. Much adaptation relies on community care givers.
- There is evidence that people living with HIV are at higher risk of serious illness and death as a result of COVID-19 than the general population.

[1] HIV & AIDS statistics South Africa, https://www.unaids.org/en/regionscountries/countries/southafrica, accessed 10 August 2021.

Introduction

Despite the raging COVID-19 epidemic, UNAIDS and partners convened hundreds of consultations around the globe to develop a new and more urgent Global AIDS Strategy 2021 - 26 End Inequalities, End AIDS. The strategy is still guided by the vision to end AIDS as a public health threat by 2030, founded on three zeros - Zero Discrimination, Zero new HIV infection and Zero AIDS related deaths. By the close of the previous strategy 84% of people living with HIV knew their HIV status, 73% were accessing treatment, 66% were virally suppressed. This meant that globally the world had missed the 90-90-90 targets set for 2020 in 2015 but showed that progress can be made with sufficient political will.



The new strategy builds on three interlinked strategic priorities:

- Strategic Priority 1: maximize 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.

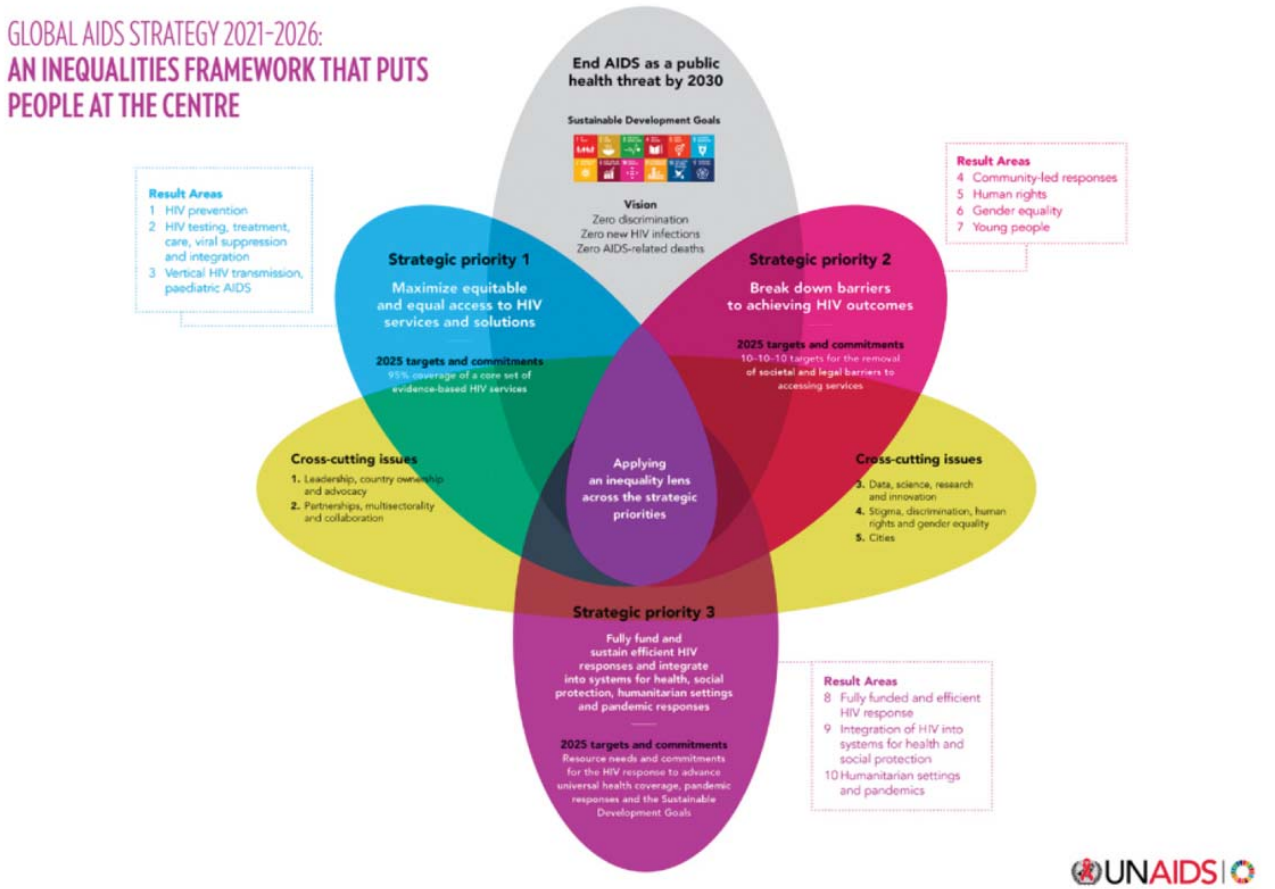
The ten result areas of the five-year plan are:

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 optimize 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 recognized, 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:

1. 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.
2. Partnerships, multi-sectoral collaboration: Partners at all levels must align strategic processes and enhance strategic collaboration to fully leverage and synergize the contributions to ending AIDS.
3. 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.
4. 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.
5. 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.

Source: UNAIDS 2021.[2]



[2] UNAIDS Global AIDS Strategy 2021-2026 - End Inequalities. End AIDS, https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy, accessed 10 August 2021.

Table 5.1: Key HIV data 2020

INDICATORS	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
HIV and AIDS Prevalence																
Overall prevalence adults aged 15 - 49 (%)	1.8	19.9	<0.1	0.7	26.8	21.1	0.3	8.1	1.7	11.5	11.6		19.1	4.7	11.1	11.9
Women who are HIV positive as a % of total	56	59	50	61	60	61	45	61	30	57	62		62	59	57	55
Women aged 15 to 49 HIV prevalence rate	2.3	24.8	<0.1	1.1	35.0	26.1	0.3	10.3	1.0	14.4	14.7		24.7	6.0	14.1	14.7
Men aged 15 to 49 HIV prevalence rate	1.3	15.2	<0.1	0.4	18.2	16.0	0.3	5.7	2.3	8.6	8.3		13.5	3.3	8.0	9.1
HIV prevalence among young women (15-24)	1.0	8.8	<0.1	0.4	12.2	9.0	<0.1	3.7	0.3	3	5.1		10.4	2.2	6.0	5.9
HIV prevalence among young men (15-24)	0.4	4.2	<0.1	0.2	4.7	3.9	<0.1	1.9	0.4	2.4	2.6		3.5	1.1	2.3	2.9
Sex workers																
HIV prevalence (%)	8	42.2	0.8	7.5	60.8	71.9	5.5	49.9	15		29.9	4.6	57.7	15.4	48.8	42.2
Condom use (%)	71.7	75.7	35.8	73.9	5.9	27	62.8	65	67,2		42.3	16	86.1	72.4	78.5	43.4
Men who have sex with men																
HIV prevalence (%)	2	14,8	0.4	7.1	27.2	32.9	14.9	12.9	17.2		7.8	13.2	18.1	8.4		21.1
Condom use (%)	59.1	77.5	56.2	50.6	79.6	46.4	57.2	79.4	53.1		54,8		71.8			69.2
Prevention																
Proportion of people age 15+ who know their HIV status																
Percent of people living with HIV who know their HIV status	54	91	88	75	>95	94	16	91		81	90		92	84	86	93
Condom use at last high risk sex																
Condom use at last high risk sex - women	32.1		28.4	22.6	53.9	76.0	5.0	49.9		42.0	65.5		61.4	30.3	34.5	66.7
Condom use at last high risk sex - men	63.3		59.7	30.7	67.3	76.6	13.1	76.3		46.5	79.7		73.1	46.5	53.5	85.4
Elimination of mother-to-child transmission																
Coverage of pregnant women who receive ARV for PMTCT (%)	68	>95		39	95	>95	17	>95	>95	>95	>95		>95	84	80	87
Mother to child transmission rate	18.6	1.9		27.8	3.7	6	39	6.3	13	13.5	3,8		3.9	11.1	13.4	8.7
Knowledge																
Comprehensive knowledge of HIV and AIDS	32.4	47.2	20.4	20.4	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	18.6	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	24.9	50.9	30.9	25.5	44.3	30	30.2	51.1		45.6	46.7	40.6	46.6
Attitudes																
% of women who say a woman has the right to insist on a man using a condom	36	47		46	60	63	50	59	54	17	23	68	50	49	63	67
% of men who say a woman has the right to insist on a man using a condom.	47	43		41	53	67	49	62	46	30	17	62	47	50	55	71
Treatment - Antiretroviral therapy (ART)																
% of those living with HIV who are on ART	33	87	62	75	>95	82	14	86	21	68	88		72	82	81	93
Women aged 15 and over receiving ART	39	95	63	74	>95	87	16	89	21	73	92		78	90	84	>95
Men aged 15 and over receiving ART	27	77	60	>95	94	74	12	83	21	62	82		63	74	80	92
Children aged 0 to 14 receiving ART	15	62	na	31	>95	83	7	73	48	64	75		47	54	58	72

Source: Gender Links computations and UNAIDS data, 2021.

Table 5.1 below shows that:

- In SADC, HIV and AIDS prevalence rates are beginning to fall slowly. There are now only two countries with HIV and AIDS prevalence above 20% (Eswatini and Lesotho), two with prevalence between 19% and 20% (Botswana and South Africa), four with prevalence between 11% and 12% (Mozambique, Namibia, Zambia and Zimbabwe).
- In Southern Africa HIV and AIDS is still predominantly a heterosexually driven pandemic, with women comprising the highest proportion of those living with HIV and AIDS, except for the islands (Comoros, Madagascar, Mauritius and Seychelles) where transmission is mainly within key populations. Very small populations in Comoros and Seychelles mean that data for these two countries is sparse.
- Coverage of adults and children receiving Antiretroviral Therapy (ART) has improved dramatically, but ranges from 14% in Madagascar to over 95% in Eswatini, 93% in Zimbabwe and over 80% in Botswana, Lesotho, Malawi, Namibia, Tanzania and Zambia.
- Women are generally much more likely than men to be on ART. One major exception is DRC where men are more likely to be on ART. In Mauritius the proportion is the same.
- Coverage of ART for Prevention of Mother to Child Transmission (PMTCT) is generally high but still low in post conflict countries such as Angola and the Democratic Republic of the Congo (DRC), and is not a priority in the islands, since this is not a primary means of transmission. Despite this, transmission rates from mother to child remain unacceptably high: 13.5% and 13.4% in Mozambique and Zambia, pointing to the need for more vigorous efforts to re-test mothers throughout pregnancy and breast-feeding.
- Responses among women to the question: "a woman has the right to insist on a man using a condom" varies from 17% in Mozambique to 68% in Seychelles. Amongst men this ranged from 17% in Namibia to 71% in Zimbabwe.



Male and female condoms. Photo Zoto Razanadratefa

Many gains have been made in the fight against HIV over more than three decades, and especially in this century. The chapter expands on these gains. However, most of these are critically threatened as a result of the COVID-19 crisis, which has impacted on communities across the globe in multiple devastating ways.

Experts from HIV epidemiology, research, vaccine development, and community mobilisation have emerged at the forefront of the fight against COVID-19 across the world. Established funding mechanisms such as the Global Fund were swiftly "pivoted" into also addressing COVID-19 needs. Expertise, analytical capacity, laboratories and testing, surveillance and monitoring systems developed through HIV funding are now underpinning COVID-19 responses. Activists and community organisations that have long been active in the HIV arena are leading efforts to support community prevention and management of COVID-19.

The Chapter starts with an analysis of COVID-19, HIV and AIDS. It touches on the vaccine roll out and the potential impact on HIV and AIDS. The impact is expanded on in each of the main sections - prevalence; prevention; treatment; care and the recommendations at the end.

COVID-19, HIV and AIDS

Inequalities highlighted in the new Global AIDS Strategy 2021-2026[3] are glaring in the COVID-19 response. Many HIV services experienced disruption during COVID-19 lockdowns when citizens struggled to access health facilities; were afraid to access health facilities, or when health workers were overwhelmed with COVID-19 cases. Testing services and new initiations on ART dropped in 2020 across most of SADC[4]. Prevention services, such as Voluntary Medical Male Circumcision (VMMC), suffered.

Overall HIV referrals were 37% lower in 2020 than in 2019 and HIV testing dropped by 41%[5]. In Africa, referrals dropped 29% and drug-sensitive TB diagnosis and screening services by 28%[6]. In community sites across the reporting countries in Africa, drug-sensitive TB diagnosis and screening services fell 58% between April and September 2020 relative to the same time period in 2019.[7]

Some HIV services, especially treatment, adapted quickly and continued provision during and after the COVID lockdowns. Adaptations included multi-month dispensing of antiretroviral therapy (ARV) and other essential medicines, often in collaboration with community based groups. Namibia achieved four to six month's supply of ARVs to 97% of the 172 000 people on treatment[8] supplemented by home delivery of different forms. In the second half of 2020, at least 80% of those receiving treatment from more than 1000 health facilities supported by PEPFAR across 11 countries in Africa received ARVs in time. Men and women showed similar uptake[9].

A study by the Global Fund which surveyed 15 health facilities in 24 countries in Africa (including DRC, Eswatini, Madagascar, Malawi, Mozambique, Namibia, South Africa, Zambia and Zimbabwe in SADC) and seven in Asia in mid-2020 found decreased attendance in all sites; reduced general health education campaigns, reduction of antenatal visits (by 5% in Africa compared to 66% in Asia)[10].

Fifty percent of health facilities in African countries reported health staff ill with COVID-19 across all levels of health workers (including community health workers)[11]. This underscores the crucial importance of training and provision of adequate protective materials for all health workers. Only 38% of health facilities in Africa had sufficient Personal Protective Equipment (masks, disinfectants, gloves, and hand sanitizers) for all workers. Of these facilities, only 61% had surgical masks for all workers. 67% of health facilities in Africa reported up to 10% absenteeism between April and September, 2020. The majority of health workers are women.

Fragile health systems are poorly equipped to support the COVID-19 response. Only 11% of African facilities were able to conduct antigen rapid COVID-19 tests and only 8% could conduct the PCR tests. Health facilities are not well equipped to support roll out of COVID -19 vaccines: 23% of African health facilities did not have the requisite needles and syringes for vaccination.[12]

A recent World Health Organisation (WHO) report found that the risk of developing severe or fatal COVID-19 is 30% greater in PLHIV compared to people without HIV. HIV infection was associated with increased mortality, in Africa, but not in Western Europe or the Americas (sample sizes in

[3] UNAIDS Global AIDS Strategy 2021-2026 - End Inequalities. End AIDS, https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy, accessed 10 August 2021.
[4] Global HIV Prevention Coalition. 2021. Preventing HIV infections at the time of a new pandemic. A synthesis report on programme disruptions and adaptations during the COVID-19 pandemic in 2020, https://www.unaids.org/en/resources/documents/2021/20210701_HIVPrevention_new_pandemic, accessed 08 August 2021.
[5] Global Fund; 2021. The impact of COVID-19 on HIV, TB and malaria services and systems for health: a snapshot from 502 health facilities across Africa and Asia https://www.theglobalfund.org/media/10776/covid-19_2020-disruption-impact_report_en.pdf accessed July 20, 2021.
[6] Ibid
[7] Ibid
[8] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.
[9] Harris TG, et al. Resilience of HIV activities during COVID-19 pandemic at health facilities in Africa. Conference on Retroviruses and Opportunistic Infections, 6-10 March 2021. Abstract 186
[10] Global Fund. Op Cit.
[11] Ibid
[12] Ibid.

other regions were too small to draw conclusions). The presence of underlying conditions increased the risk of mortality. Factors which increased the risk of in-hospital death among PLHIV were: being more than 65 years old, male, diabetes and hypertension.[13]

The World Health Organization (WHO) recommends that PLHIV should stay as healthy as possible, regularly access and take their ART and prevent and manage any other conditions such as diabetes and hypertension. The WHO also recommends that PLHIV should be prioritised for vaccination in most settings. By July 2021, 40 countries reported to have prioritised PLHIV for COVID-19 vaccination.[14]



Sharing the word across South Africa

In 1992, Prudence Mabele decided to break the silence on HIV and encourage everyone she came in contact with to know and understand HIV. She founded the Positive Women's Network in 1996. Mbele identified a general lack of knowledge around HIV and AIDS in people she interacted with. She insisted that with a healthy life PLHIV could still live long and healthy lives, that it is not the end of life.

Using this work as inspiration, the Siyakhula team has made it their mission to inform and change their community's perceptions on HIV and AIDS. The team is determined to educate their community on the importance of medicating on time and regularly, and switching to a positive attitude.

The team works to reduce the number of people dying due to factors such as feeling too embarrassed to go and seek help or medication. To tackle stigma, the team conducts door to door visits with community members to make sure they know they are supported and never alone. Door to door visits allow team members to provide medication on time, counselling, companionship, awareness of HIV as well as to share food that is donated periodically from different well-wishers.



Positive thinking: South African AIDS activist Prudence Mabele.
Photo courtesy of UNAIDS

The COVID-19 pandemic has taken its toll on the initiative. The need for protective clothing, sanitisers as well as social distancing have made the door to door initiative more difficult to carry out. Some members of the community believe that the COVID-19 vaccine will make them more sick, creating a new barrier to administering medication. In addition to HIV awareness, the team has now taken on the role of creating awareness on COVID-19 to aid their programme. The team continues to empower their community members in spite of the perceptions.

Source: Mkhize, Truth. Siyakhula Community Project. Alliance SRHR Most Significant Results. Voice and Choice Campaign, 2021

[13] WHO 2021. Clinical features and prognostic factors of COVID-19 in people living with HIV hospitalized with suspected or confirmed SARS-CoV-2 infection. https://apps.who.int/iris/bitstream/handle/10665/342697/WHO-2019-nCoV-Clinical-HIV-2021.1-eng.pdf, accessed July 24, 2021.
[14] WHO warns that HIV infection increases risk of severe and critical COVID-19, https://www.who.int/news/item/15-07-2021-who-warns-that-hiv-infection-increases-risk-of-severe-and-critical-covid-19, accessed July 24, 2021

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 take 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.

Many national HIV plans and strategies need to be updated

Table 5.2 below shows that all the SADC countries have an HIV and AIDS policy, strategy or plan. With the exception of Mauritius, the HIV and AIDS policies for all countries include other STIs and often also include TB. Though there are some plans that should have been reviewed, and others that require review now, it has not been easy to concentrate on policy in the midst of COVID-19. However, it is anticipated that the new Global Strategy 2021-2026, which was endorsed by a High Level UN meeting in June, will give impetus to policy reviews at country level.

Table 5.2: Most recent HIV and AIDS policy or strategy

Country	Most recent HIV strategy	Year
Zimbabwe	Zimbabwe National HIV and AIDS Strategic Plan IV (2021-2025).	2020
Angola	National strategic plan (NSP) for HIV, viral hepatitis, and other sexually transmitted infections. 2019-2022	2019
Botswana	Third National Strategic Framework for HIV/AIDS 2019 - 2023	2019
Seychelles	Third multi sectoral National Strategic Plan for HIV, AIDS & Viral Hepatitis 2019 - 2023	2019
Eswatini	National Multisector HIV & AIDS Strategic Framework 2018 - 2023	2018
Lesotho	National HIV and AIDS Strategic Plan 2018/19 - 2022/23	2018
South Africa	Let our actions Count: South Africa's National Strategic Plan for HIV, TB and STI's 2017 - 2022	2017
Tanzania	Health Sector HIV & AIDS Strategic Plan 2017 - 2022 (HSHSP IV)	2017
Zambia	National HIV & AIDS Strategic Framework 2017 - 2021	2017
Namibia	National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 - 2021/22	2017
Mauritius	National HIV Action Plan 2017-2021	2017
Mozambique	Plano Estratégico do Nacionale de combate HIV e SIDA 2016 -2020 (PEN IV)	2015
Malawi	National Strategic Plan for HIV and AIDS 2015 - 2020	2015
DRC	Plan Strategique National de lute contre le VIH et le SIDA 2014 - 2017	2014
Madagascar	Madagascar National Strategic Plan for STIs and AIDS (2013-2017)	2014
Comoros	National Strategic Plan 2011 - 2015	2011

Source: GL Audit of SRHR Policies and Laws 2020 .

Table 5.3: SADC HIV and AIDS laws scorecard

Country	Criminalising trans-gender people	Criminalising sex work	Criminalising same sex sexual acts	Drug use/ possession an offence	Parental consent for adolescents HIV test	Criminalising transmission/ non-disclosure of HIV	Restricted entry/stay of PLHIV	Mandatory HIV test for marriage/ work
Angola								
Botswana								
Comoros								
DRC								
Eswatini								
Lesotho								
Madagascar								
Malawi								
Mauritius								
Mozambique								
Namibia								
Seychelles								
South Africa								
Tanzania								
Zambia								
Zimbabwe								

KEY Not criminalised; No data; Criminalised; Parental consent younger than 14/16; Parental consent if younger than 12; No, but prosecutions exist based on general criminal laws; Prohibit short and/or long stay and require HIV testing or disclosure for some permits

Source: 2021 UNAIDS Global AIDS Update.[15]

[15] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.

Table 5.3 shows that the legal framework in SADC is patchy with regard to protecting the rights of members of key populations such as sex workers and people in same sex relationships. Approximately 32% of new infections in East and Southern Africa are in Key Populations. One of the goals of the new strategy is 10-10-10 for societal enablers. One of these goals is to ensure that less than 10% of countries have restrictive legal and policy environments that lead to the denial or limitation of access to services. Criminalisation of most key populations hinders their access to services and will continue to fuel the HIV epidemic. This issue will require attention in the next five years.



Article 27. 3: State Parties shall:
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.

UNAIDS 90/90/90:
- By 2020, 90% of all people living with HIV will know their HIV status.
- By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.
- By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.

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.

HIV Prevalence

Table 5.4: Number of people living with HIV (LHIV), different groups

Country	All people LHIV	Women 15+ LHIV	Men 15+ LHIV	Adolescents LHIV	Young People LHIV	PLHIV over 50
South Africa	7 800 000	4 800 000	2 700 000	370 000	660 000	1 400 000
Mozambique	2 100 000	1 200 000	710 000	130 000	270 000	250 000
Tanzania	1 700 000	1 000 000	610 000	110 000	190 000	350 000
Zambia	1 500 000	850 000	520 000	90 000	190 000	250 000
Zimbabwe	1 300 000	720 000	470 000	81 000	120 000	240 000
Malawi	990 000	600 000	330 000	74 000	110 000	210 000
DRC	510 000	310 000	120 000	51 000	69 000	72 000
Botswana	370 000	220 000	150 000	12 000	28 000	92 000
Angola	340 000	190 000	100 000	24 000	44 000	34 000
Lesotho	280 000	170 000	110 000	13 000	26 000	65 000
Namibia	210 000	130 000	71 000	11 000	19 000	49 000
Eswatini	200 000	120 000	72 000	11 000	20 000	34 000
Madagascar	42 000	19 000	21 000	1 000	3 400	3 600
Mauritius	14 000	3 200	9 500	200	1 000	3 300
Comoros	200	100	100	0	100	
Total SADC	17 356 200	10 332 300	5 993 600	978 200	1 750 500	3 052 900
Global	37 700 000			1 700 000	3 300 000	8 100 000
SADC % Global	***46%***			***58%***	***53%***	***38%***

Source: Compiled from UNAIDS 2021 data.[16]

Table 5.4 shows the number of people living with HIV in different age groupings in SADC, compared to global totals. With 17.4 million people living with HIV, SADC accounts for 46% of all those living with HIV globally; 58% of all adolescents (aged 10 to 19) and 53% of young people (aged 15 to 24) living with HIV. With 7.8 million people living with HIV, South Africa has the largest epidemic in the world, accounting for 45% of the total in SADC and 21% of the global total of PLHIV. Mozambique accounts for 12% of the SADC and 6% of the global total of PLHIV. Tanzania accounts for 10% and 5% respectively. SADC accounted for 38% of PLHIV over the age of 50; an increase from 33% in 2020. This suggests that those that are living with HIV in SADC are living longer lives.

SADC, with 4,6% of the world's population, accounts for 46% of the total number of PLHIV, 58% of adolescents, 53% of young people and 38% of people over 50 living with HIV in the world

[16] https://aidsinfo.unaids.org/

Table 5.5: HIV Prevalence in SADC 2021

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	26,8	35	18,2	12,2	4,7	2,6
Lesotho	21,1	26,1	16	9	3,9	2,3
Botswana	19,9	24,8	15,2	8,8	4,2	2,1
South Africa	19,1	24,7	13,5	10,4	3,5	3,0
Zimbabwe	11,9	14,7	9,1	5	3	1,7
Namibia	11,6	14,7	8,3	5,1	2,6	2,0
Mozambique	11,5	14,4	8,6	6	3	2,0
Zambia	11,1	14,1	8	6	2,3	2,6
Malawi	8,1	10,3	5,7	3,7	1,9	1,9
Tanzania	4,7	6	3,3	2,2	1,1	2,0
Angola	1,8	2,3	1,3	1	0,4	2,5
Mauritius	1,7	1	2,3	0,3	0,4	0,8
DRC	0,7	1,1	0,4	0,4	0,2	2,0
Madagascar	0,3	0,3	0,3	0,1	0,1	1,0
Comoros	0,1	0,1	0,1	0,1	0,1	1,0
Seychelles (n/d = no data)	n/d	n/d	n/d	n/d	n/d	n/d

Source: Compiled from UNAIDS 2021 data.[17]

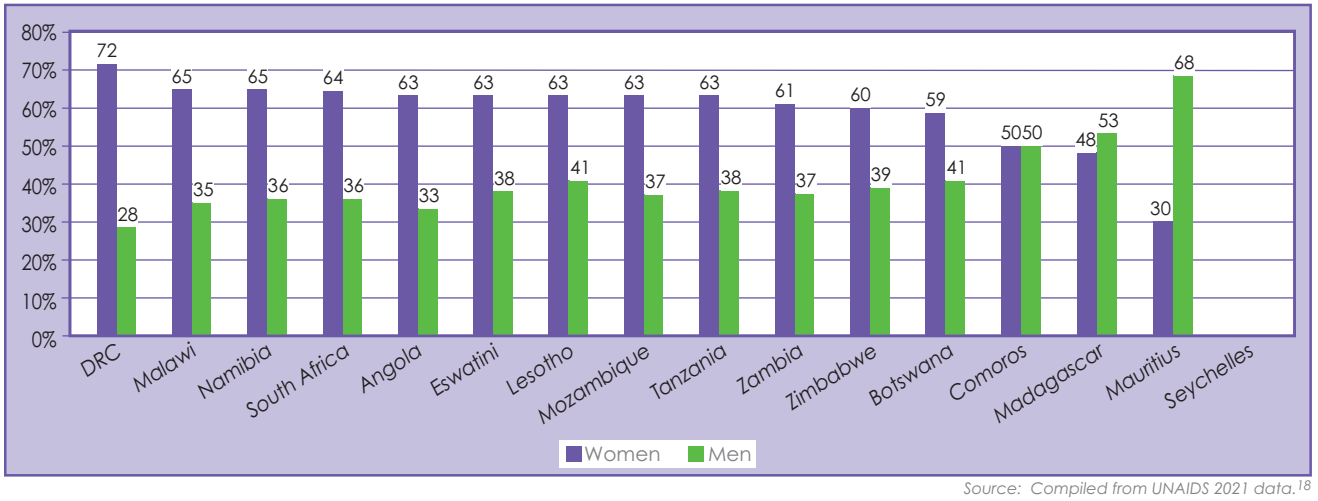
Table 5.5 shows wide variations in the HIV pandemic across SADC. The data shows that:

- Adult prevalence rates range from 0.1% in Seychelles to 26.8% in Eswatini. Prevalence in Botswana is now below 20% while that in South Africa is slightly higher than it was in 2020, due to higher prevalence among men. Eight SADC countries (Zambia, Mozambique, Namibia, Zimbabwe, South Africa, Botswana, Lesotho and Eswatini) have adult prevalence rates above 10%.
- Seychelles, with a population of 96,387 and a very low prevalence, has such small total numbers of people living with HIV that percentages are of little value. This explains the absence of Seychelles data and discussion in this chapter. Comoros and Mauritius have populations of 864,355 and 1.4 million respectively. They thus have more data available.
- The island nations have pandemics that are largely driven by key populations. As a result, prevalence is higher in men than in women. In contrast, HIV and AIDS is a heterosexual pandemic in the rest of SADC.
- The differences in prevalence rates are particularly high for young women as compared to young men. Table 5.5 shows that HIV prevalence is three times higher in young women than young men in South Africa and at least double in Eswatini, Zambia, Angola, Botswana, Lesotho, Namibia, Mozambique, Tanzania and DRC.



[17] https://aidsinfo.unaids.org/ accessed on 30 July, 2021.

Figure 5.1: Proportion of Women and Men Living with HIV in 2020



Source: Compiled from UNAIDS 2021 data.[18]

Figure 5.1 shows the proportion of women and men living with HIV across SADC. There are more women living with HIV in most of SADC with a marked difference in DRC (72% women compared to 28% men), and slightly lower in Malawi, Namibia and South Africa. Slightly more men than women are living with HIV in the island nations. This is particularly marked in Mauritius (68% men and 30% women).

Table 5.6: Progress towards achieving the 90-90-90 goals in SADC

Country	90-90-90 (all)	90-90-90 (children aged 0-14 years)	90-90-90 (women aged 15+ years)	90-90-90 (men aged 15+ years)	Viral suppression level (all)
Eswatini	>98->98-94	>98->98-91	>98->98-95	94->98-94	97
Botswana	91-95->98	62->98-94	94->98->98	88-87-97	85
Malawi	91-94-93	73->98-72	94-94-95	90-92-94	81
Zimbabwe	93->98-88	71->98-72	96->98-90	92->98-88	82
Namibia	89-97-91	80-92-80	92->98-92	86-94-89	80
Lesotho	93-87-97	83->98-91	94-92-97	93-79-97	79
Zambia	85-94-93	57->98-83	88-94-93	84-95-93	75

Source: Gender Links, with data from UNAIDS Special Analysis 2021.[19]

Table 5.6 shows the seven countries in SADC who are acknowledged globally for making significant progress towards the 90-90-90 goals. It is notable that Eswatini (with the highest global HIV prevalence) is also the country with the highest achievement and has already achieved the 2025 targets.



Eswatini's success is ascribed to strong national leadership and commitment, international support and intensive community mobilization and engagement. King Mswati III declared HIV a national emergency in 1999. Since then, traditional leaders and urban mayors have been

[18] Ibid
[19] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, available at: https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.

in the forefront of the efforts to curb HIV. Civil society is actively engaged in awareness raising and service provision, including peer support. Nearly 40% of the national HIV budget is from domestic sources with additional support from international donors.[20]

While some countries in SADC have made tremendous progress, this is not even across the region. Many factors contribute to the differences. The example of Zimbabwe and Mozambique is cited for instance. Zimbabwe has been a leader in HIV testing and treatment. Zimbabwe's national AIDS Levy has mobilised significant domestic funding, communities are strongly engaged, and the country has received consistent international financial and technical support. This has enabled achievements that are consistent with the 90-90-90 targets. Achievements in neighbouring Mozambique, with a history of weak service provision, high levels of poverty, many years of armed conflict, and impacted by climate change related emergencies, are below the regional average.[21]

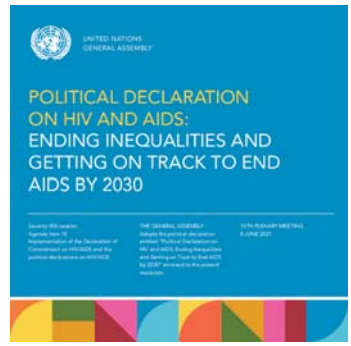


Eswatini is taking the lead in ending AIDS. Photo: Thandokuhle Dlamini

The new global strategy includes commitment to reach the new 95-95-95 testing, treatment and viral suppression targets within all demographics, groups and geographic settings, ensuring that at least 34 million people living with HIV access treatment by 2025.

Elimination of Mother to Child Transmission

Targets for the Elimination of Mother to Child Transmission in the 2021 Political Declaration on AIDS[22] are:

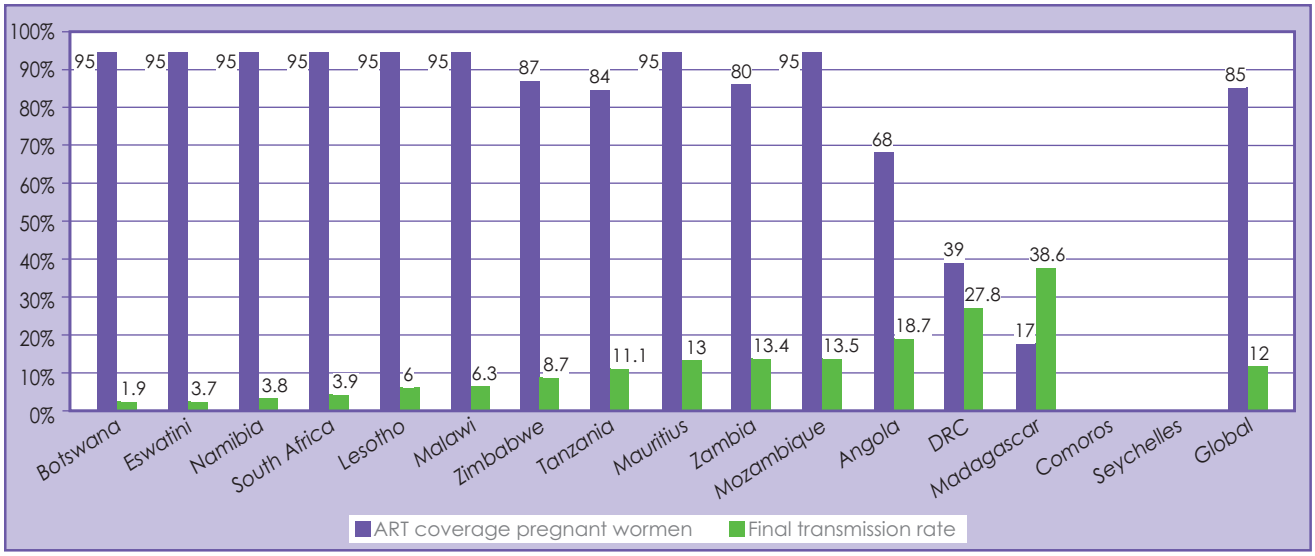


- Ensure that all children diagnosed with HIV are provided treatment that is optimized to their needs.
- Ensure that 75% of all children living with HIV have suppressed viral loads by 2023 and 86% by 2025, in line with the 95-95-95 HIV treatment targets.
- Ensure that 95% of pregnant women have access to testing for HIV, syphilis, hepatitis B and other sexually transmitted infections.
- Ensure that 95% of pregnant and breastfeeding women in high HIV burden settings have access to re-testing during late pregnancy and in the post-partum period.
- Ensure that all pregnant and breastfeeding women living with HIV are receiving life-long antiretroviral therapy, with 95% achieving and sustaining viral suppression before delivery and during breastfeeding.
- Ensure that all HIV-negative pregnant and breastfeeding women in high HIV burden settings or who have male partners at high risk of HIV in all settings have access to combination prevention, including Pre exposure prophylaxis (PrEP), and that 90% of their male partners who are living with HIV are continuously receiving antiretroviral therapy.
- Ensure that 95% of HIV-exposed children are tested by two months of age and after the cessation of breastfeeding.

[20] Ibid
[21] Ibid
[22] United Nations General Assembly, 2021 Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030, https://undocs.org/A/RES/75/284, accessed 20 July 2021.

The Start Free, Stay Free, AIDS Free programme was launched in 2015 with bold targets to address HIV in children, adolescents and women as a critical component of the fast track programme to end AIDS by 2030. The START FREE component aimed to prevent children from acquiring HIV during pregnancy, birth and throughout breastfeeding. The programme put specific focus on 23 countries of which 21 are in Africa and 12 - Angola, Botswana, DRC, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe - are in SADC. The 21 countries in Africa accounted for 83% of all pregnant women living with HIV in 2020, 80% of children living with HIV and 78% of young women aged 15 - 24 newly infected with HIV. Six countries (Nigeria, 19%, Mozambique 11%, South Africa 11%, Tanzania 9%, DRC 8% and Zambia 7%) accounted for about 65% of children acquiring HIV in 2020.[23]

Figure 5.2: Elimination of Mother to Child Transmission, 2020



Source: Compiled from UNAIDS 2021 data https://aidsinfo.unaids.org/

Figure 5.2 reflects tremendous progress. Eight countries have achieved at least 95% or better coverage of pregnant mothers living with HIV on ART. However, the figures also illustrate how fragile gains are. Coverage rates in Zimbabwe, Tanzania and Zambia have declined since 2019. Seven countries - Botswana, Eswatini, Namibia, South Africa, Lesotho, Malawi and Zimbabwe - have achieved a final transmission rate of less than 10%. Figure 5.2 also reflects gaps in progress. Though Angola is making progress in improving coverage, DRC and Madagascar are still far behind, with much higher levels of transmission.



In South Africa, failure to achieve viral suppression among pregnant women is mainly a result of late entry into antenatal care and late initiation of antiretroviral therapy. Some pregnant women do not access testing and never begin antiretroviral therapy (ART). Others begin ART but do not remain engaged in care throughout pregnancy and breastfeeding. Many women acquire HIV during pregnancy or breastfeeding experiencing high viral load, with increased potential for vertical transmission. It is important to track and re-engage mothers who drop out of care and to offer retesting for mothers during pregnancy and breastfeeding.[24]

[23] Start Free, Stay Free, AIDS Free Final report on 2020 targets, https://www.unaids.org/en/resources/documents/2021/start-free-stay-free-aids-free-final-report-on-2020-targets, accessed 10 August 2021.
[24] Start Free, Stay Free, AIDS Free Final report on 2020 targets, https://www.unaids.org/en/resources/documents/2021/start-free-stay-free-aids-free-final-report-on-2020-targets, accessed 10 August 2021.

Table 5.7: Pregnant women on ART 2010 - 2019

Country	ART coverage pregnant women	Final trans-mission rate	No. pregnant women receiving ART	Early Infant Diagnosis (EID)	New HIV infections averted due to PMTCT	No. HIV exposed, uninfected children
Botswana	95	1,9	12171	>95	2 500	180 000
Eswatini	95	3,7	8852		1 800	140 000
Namibia	95	3,8	14951		2 100	140 000
South Africa	95	3,9	299033	87	52 000	4 000 000
Lesotho	95	6	7461	71	1 700	120 000
Malawi	95	6,3	41391	79	10 000	540 000
Zimbabwe	87	8,7	51229	76	11 000	800 000
Tanzania	84	11,1	77036	55	18 000	1 000 000
Mauritius	95	13	125	64	<100	1 100
Zambia	80	13,4	50209	65	12 000	700 000
Mozambique	95	13,5	107148	83	20 000	930 000
Angola	68	18,7	19044	2	4 100	260 000
DRC	39	27,8	12456	11	3 100	320 000
Madagascar	17	38,6	259		<100	1 100
Comoros			3			
Seychelles						
Total SADC			701368		138 300	9 132 200
Global	85	12	1100000		220000	15 400 000
SADC as percent of global			64%		63%	59%

Source: Compiled from UNAIDS 2021 data.[25]

Table 5.7 shows the numbers of pregnant women who accessed ART in 2020; the percentage who accessed Early Infant Diagnosis (EID), the number of new infections averted and the number of HIV exposed but uninfected children. A total of 701,368 women in SADC received ART for their own health as well as to prevent the transmission of HIV infection to their children. This is about 64% of the global total. South Africa alone accounts for 43% of the women that accessed ART for PMTCT in SADC and 27% of the global total. SADC accounted for 138,300 averted new infections which is 63% of infections averted globally and SADC has 9, 132, 200 children that have been exposed to HIV but are uninfected. South Africa alone accounts for 26% of the global total of number of children that are HIV exposed and uninfected.

Since 2015, 15 countries have been validated as having eliminated mother-to-child transmission of HIV and/or syphilis. None of these are in Africa where base prevalence rates are very high. UNAIDS has introduced a path to elimination for countries with mother-to-child transmission less than 5%, maternal ART coverage rates higher than 90% and which achieve other specified case rates. Countries with a case rate of acquiring HIV less than 250 per 100 000 live births are categorized as "gold"; "silver" if their rate is less than 500 and "bronze" if their rate is less than 750.

Four SADC countries (Botswana, Eswatini, Namibia and South Africa) had mother-to-child transmission rates in 2020 of less than 5%. Lesotho and Malawi are close to bringing their rates under 5%. Botswana could be granted silver status (with a case rate of 406 per 100 000 births in 2020). Similarly, Namibia could be eligible for bronze status (case rate of 542 per 100,000 births)[26].

[25] https://aidsinfo.unaids.org/
[26] Start Free, Stay Free, AIDS Free Final report on 2020 targets, https://www.unaids.org/en/resources/documents/2021/start-free-stay-free-aids-free-final-report-on-2020-targets, accessed 10 August 2021.

Table 5.8: HIV transition metrics

Country	2000	2019	2020
Zimbabwe	7.12	2.92	1.95
Malawi	9.75	3.1	2.08
Botswana	9.34	2.49	2.37
Eswatini	13.37	2.23	2.42
Namibia	12.84	3.29	2.65
Lesotho	13.33	3.22	2.72
South Africa	16.76	2.63	2.98
Global	11.32	4.37	3.86
DRC	9.01	4.37	3.88
Tanzania	10.2	4.52	3.92
Zambia	9.27	4.08	4.75
Mozambique	17.9	5.92	4.76
Comoros	22.86	4.65	5.07
Angola	19.68	7.56	6.4
Mauritius			7.06
Madagascar	20.78	15.14	14.16

Source: Compiled from UNAIDS 2021 data.[27]

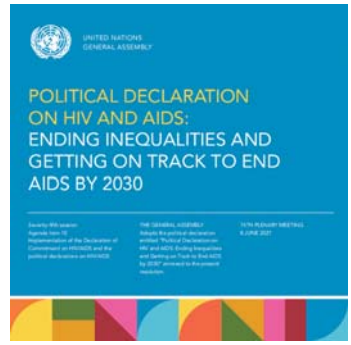
The incidence to prevalence ratio captures two desirable outcomes: long, healthy lives for people living with HIV and a rapid reduction in new infections. The metric assumes an average life expectancy of 30 years after a person acquires HIV infection. The calculations show that the AIDS epidemic (or 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 3.

Table 5.8 shows that transition metrics for SADC countries have been improving since 2000. Data for 2020 indicate that Zimbabwe, Malawi, Botswana, Eswatini, Namibia, Lesotho and South Africa have achieved the tipping point of 3 and should all experience a decline of the AIDS epidemic. Zimbabwe now has the lowest incidence to prevalence ratio (1.95). Madagascar (14.16) has the highest. The only country which experienced increase in the metric between 2019 and 2020 is Comoros. Globally the incidence-prevalence ratio declined to 3.86.

Prevention

2025 Targets and Commitments in the 2021 Political Declaration on AIDS

- Reduce new HIV infections to under 370,000.
- 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, prioritized, 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 (MSM), people who inject drugs (PWID), 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, prioritized, people centred and effective combination prevention options[28].



[27] https://aidsinfo.unaids.org/
[28] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.

The Prevention Road Map adopted in 2016 sought to achieve commitments towards reducing new HIV infections by 75% to fewer than 500,000 by 2020. These commitments include the following anticipated reductions in SADC:

Table 5.9: Global reduction in infection targets

Country	2016	2020 target
South Africa	260 000	88 000
Mozambique	70 000	30 000
Zambia	50 000	14 000
Tanzania	45 000	14 000
Zimbabwe	37 000	16 000
Malawi	32 000	11 000
Angola	21 000	5000
Lesotho	19 000	5000
DRC	10 000	3000
Namibia	9000	3000
Eswatini	8000	3000
TOTAL		192,000

Source: UNAIDS 2016: 2020 Prevention Road Map.[29]

Table 5.9 shows the targets for SADC countries in 2020. The region aimed to reduce new HIV cases to 192,000. Instead (as demonstrated in Table 5.10) the regional registered 587, 000 new infections.

Table 5.10: New infections and HIV incidence, 2021

Country	New infections						HIV incidence in adults (15-49)
	All	Change 2010-2020	Women (15+)	Men (15+)	Adolescents	Children (0-14)	
South Africa	230 000	-45	140 000	77 000	38 000	12 000	7,8
Mozambique	98 000	-33	55 000	30 000	17 000	13 000	7,2
Zambia	69 000	-6	39 000	21 000	12 000	8 300	6,8
Tanzania	68 000	-35	37 000	21 000	8 700	10 000	2,1
Zimbabwe	25 000	-66	13 000	7 300	3 000	5 100	2,9
Angola	22 000	-26	11 000	5 200	3 100	5 200	1,1
Malawi	21 000	-64	12 000	5 800	3 000	2 500	2,2
DRC	20 000	-50	8 500	2 300	2 100	8 800	0,23
Botswana	8 900	-37	5 400	3 300	1 200	<500	7,51
Lesotho	7 700	-59	4 600	2 700	1 000	<500	9,1
Madagascar	6 000	159	2 500	2 900	500	<1000	0,39
Namibia	5 500	-48	3 400	1 799	1 000	<500	4,3
Eswatini	4 800	-64	2 900	1 500	1 000	<500	10,4
Mauritius	1 000	-24	<500	<1000	100	<100	1,4
Comoros	100	-30	<100	<100	0		0,01
Seychelles							
Total SADC	587 000		334 300	181 799	91 700		
Global	1 500 000	-31			150 000		
SADC as a percentage of global	**39%**				**61%**		

Source: Compiled from UNAIDS 2021 data.[30]

[29] HIV Prevention 2020 Road Map - Accelerating HIV prevention to reduce new infections by 75%, https://www.unaids.org/sites/default/files/media_asset/hiv-prevention-2020-road-map_en.pdf, accessed 24 July 2020.
[30] https://aidsinfo.unaids.org/

Table 5.10 shows that the number of new infections is continuing to decline slowly, but not at a rate that will achieve the end of AIDS by 2030. The global total of 1,5 million (1 500 000) new infections in 2020 is three times higher than the goal for 2020 and four times greater than the target for 2025. SADC contributed 39% of global new HIV infections overall, with South Africa contributing 15%, Mozambique 7% and Tanzania and Zambia 5% each. Although the absolute number of new infections in Madagascar is comparatively low at 6000, Madagascar is the only country in SADC which is still seeing an increase in new infections. The change in new infections between 2010 and 2020 is 159%. The greatest reductions in new infections in the same period are in Zimbabwe (66%) and Malawi and Eswatini (64%).

SADC is also responsible for a staggering 61% of new HIV infections in adolescents globally which underscores the need for increased efforts in HIV prevention amongst adolescents. South Africa is responsible for 25% of all new infections in adolescents in the world, Mozambique 11%, Zambia 8% and Tanzania 6%. HIV incidence is also beginning to decline, with the highest rates of 10,4 and 9,1 per 1000 population in Eswatini and Lesotho. When the actual infections in 2020 is compared with the targets set in the Prevention Road Map (Table 5.11), it is clear that there is much work still required to end AIDS by 2030. The SADC total of 587,000 is also three times higher than the target of 192,000.

The Global HIV Prevention Coalition (GPC) brings together United Nations Member States (including the 25 highest HIV burden countries or the high priority countries), donors, civil society and implementers to strengthen and sustain political commitment for primary prevention. The coalition focuses on generating commitment, speed, investment and accountability towards large-scale, high coverage and good-quality implementation. Twelve SADC countries: Angola, Botswana, DRC, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe are included in the high priority group, which is receiving more focus and support for prevention activities.

Table 5.11: Prevention Score Card for SADC countries in the GPC *(scores 0 to 10)*

Country	Adolescent girls, young women and male partners	Sex workers	MSM	PWID	Condoms	VMMC	PreP
Angola	3	5			3		0
Botswana	5	5	6		9	3	5
DRC	4			0	3		3
Eswatini	7	4	3	3	7	5	8
Lesotho	8	4	5		8	8	10
Malawi	4	5	3		8	2	4
Mozambique	4	4		2	4	7	3
Namibia	5	6			8	5	8
South Africa	5	6	7	2	8	6	5
Tanzania	3	5	2	4	2	10	4
Zambia	3	5			5	9	6
Zimbabwe	4	6	5		8	6	5

KEY High Medium Low No data

Source: Gender Links compiled from HIV Prevention Score Card 2020.[31]

The scores in Table 5.11 are based on indicators that provide insight into the state of prevention programmes. Countries such as Lesotho are doing very well, while more investment is needed in DRC for instance. Many programmes are in an average range, which provides a foundation for continued investment to reach the ambitious 2025 targets.

[31] UNAIDS Scorecards and Posters, https://hivpreventioncoalition.unaids.org/global-dashboard-and-country-scorecards/, accessed 10 August 2021.

Globally, the HIV pandemic is largely driven by new infections in certain key populations - sex workers, people who inject drugs, men who have sex with men, transgender people and prisoners and their partners. The proportion of new infections in key populations in east and southern Africa is increasing. In 2020 it is estimated that 32% of new infections were in: sex workers (8%), people who inject drugs (1%), gay men and other men that have sex with men (4%), transgender women (1%) and clients of sex workers and sexual partners of other key populations (18%).



In **Madagascar** HIV prevalence in the general population is believed to be 0.3% with high prevalence in key populations (Sex Workers, Men who have Sex with Men and Injecting Drug Users). Inconsistent use of condoms, multiple concurrent partners, widespread transactional sex, high sexually transmitted infection incidence and gender inequality fuel the spread of HIV in both key populations and the general population. Even though there are no reports of antenatal HIV prevalence of over 1%, the assessment found that Madagascar may be close to becoming a high-prevalence epidemic. The report recommended collection of more data with expanded HIV testing and case management.[32]

In east and southern Africa the epidemic is still mainly driven by new infections in adolescent girls and young women. The STAY FREE component of Start Free Stay Free AIDS Free, focused on preventing adolescent girls and young women from acquiring HIV as they grow up. The targets for adolescent girls include:

- Reduce the number of adolescent girls and young women newly infected with HIV to less than 100 000 by 2020.
- Provide voluntary medical male circumcision for HIV prevention to 25 million additional men by 2020, with a focus on young men aged 10-29 years.

The decline in new infections in adolescent girls from 280,000 to 200,000 is still double the target. Rates of decline varied across the focus countries, from over 50% in Eswatini to less than 10% in Angola and Zambia.[33] As the target for 2025 is half of that for 2020, there is need for reinvigorated investment into prevention.

Table 5.12: Selected indicators on Young Women and Men

Country	Condom use with non-regular partner Young Women 15 -24	Condom use with non-regular partner Young Men 15 -24	% who had multiple sexual partners sexually active Young Women 15 -24
Angola	33	52	3
Botswana			
DRC	24	31	5
Eswatini	71	93	4
Lesotho	82	79	9
Malawi	53	73	2
Mozambique	51	48	4
Namibia	64	78	5
South Africa	47	68	8
Tanzania	30	34	
Zambia	34	49	3
Zimbabwe	54	81	3

Source: UNAIDS GPC Scorecard HIV Prevention among young women.[34]

[32] Raberahona, M et al (2020). Is Madagascar at the edge of a generalised HIV epidemic? Situational analysis. Sexually Transmitted Infections. 97. sextrans-2019. 10.1136/sextrans-2019-054254. https://www.researchgate.net/publication/341466440_Is_Madagascar_at_the_edge_of_a_generalised_HIV_epidemic_Situational_analysis/link/5ec7f2c092851c11a881409c/download accessed 20 July 2021

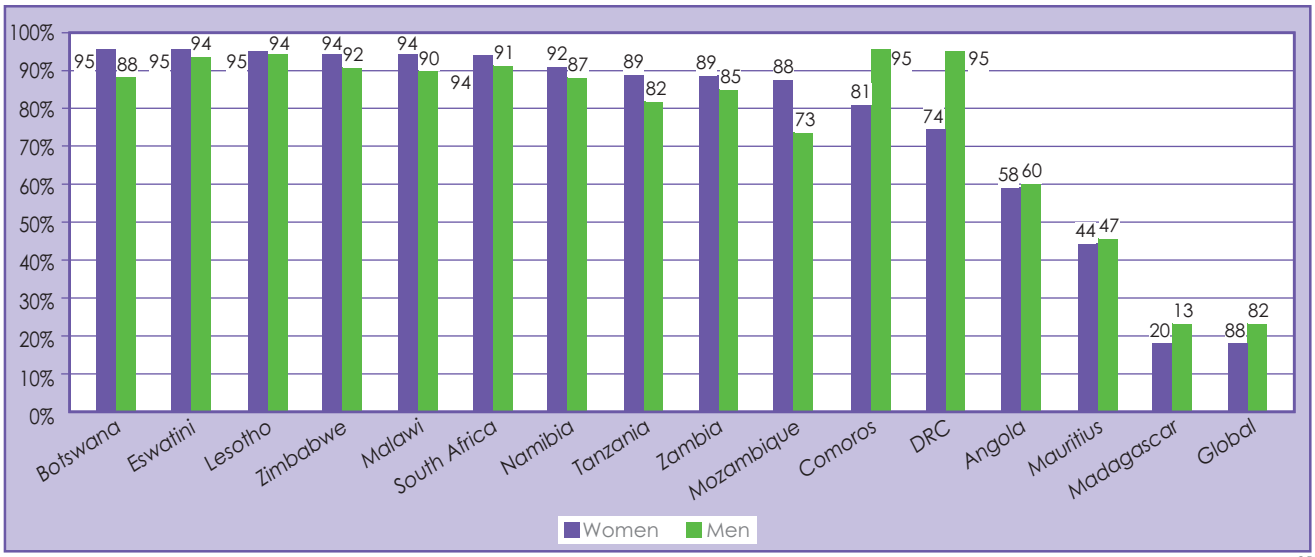
[33] Start Free, Stay Free, AIDS Free Final report on 2020 targets, https://www.unaids.org/en/resources/documents/2021/start-free-stay-free-aids-free-final-report-on-2020-targets, accessed 10 August 2021.

[34] UNAIDS Scorecards and Posters, https://hivpreventioncoalition.unaids.org/global-dashboard-and-country-scorecards/, accessed 10 August 2021.

Table 5.12 indicates that across SADC, a relatively low percentage of young women and men report having multiple sexual partners. This is a promising sign. It also shows wide variation in condom use across the region with low use in both women and men in DRC and Tanzania and much higher use in Eswatini and Lesotho.

Knowledge of HIV status

Figure 5.3: Women and Men Living with HIV who know their status



Source: Compiled from UNAIDS 2021 data.[35]

The extent to which women and men know their HIV status is a key indicator and factor in reducing the rate of new infection. Figure 5.3 shows that the proportion of women who know their HIV status is generally high across SADC. Eswatini, Lesotho, Zimbabwe, Malawi and South Africa have achieved over 90% knowledge of HIV status in both women and men, while Botswana and Namibia have over 90% in women and 88% and 87% respectively of men with knowledge of their HIV status. Comoros and DRC have achieved 95% of men and 81% and 74% respectively of women with knowledge of their HIV status. Testing and knowledge of HIV status is an important first step in prevention of HIV and managing HIV infection. The new strategy upholds the Undetectable = Untransmittable (U = U) principle. This means viral suppression through antiretroviral therapy is a powerful component of combination HIV prevention because people living with HIV with undetectable viral loads will not transmit their infection to others.

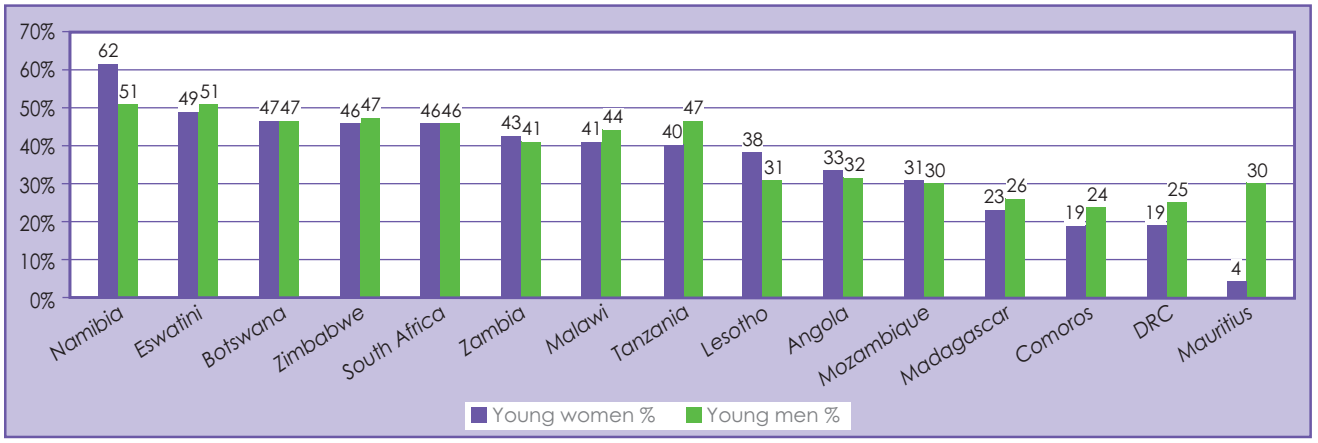
The WHO issued a policy brief in 2021 about improving HIV testing in men. The brief recommends that in high HIV burden settings it is important to test men in both general and key populations while in low burden settings focus should be on men from key populations; men with sexually transmitted infections; men with confirmed or suspected TB; men whose partners have HIV; and men who have HIV-related symptoms or indicator conditions.[36]

[35] https://aidsinfo.unaids.org/
[36] WHO, 2021. Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva, World Health Organization. https://www.who.int/publications/i/item/9789240031593 accessed 2 August 2021.

Comprehensive, accurate knowledge of HIV and AIDS

The goal is to ensure that at least 90% of all young people have comprehensive knowledge of HIV so that they are able to protect themselves from it.

Figure 5.4: Knowledge on HIV prevention among young people



Source: Gender Links compiled from UNAIDS 2021 data https://aidsinfo.unaids.org/

Figure 5.4 illustrates that levels of knowledge about HIV are still well below the goal of 90%. Knowledge levels are still below 50% for both males and females in all countries except Namibia and Eswatini. Poor knowledge contributes to low levels of risk awareness and poor prevention of HIV at a time when we need to redouble our efforts in prevention. New approaches and programmes are necessary to increase access to accurate information particularly in view of COVID-19 when most children are not in school, and when they are, teachers are focusing on the core curriculum rather than issues that are considered to be extra-curricular.

Condoms

Condoms continue to be a crucial component of a combination prevention approach. As consistent condom use in all high risk sex acts has proved difficult to achieve, it is not believed that condoms alone are sufficient. However, increasing access to condoms is a continuing priority.

Table 5.13: Number of Condoms distributed or sold in 2019

Country	Number of condoms distributed
Angola	54 000 000
Botswana	41 148 720
Comoros	930 007
DRC	168 000 000
Eswatini	15 000 000
Lesotho	38 000 000
Madagascar	17 682 860
Malawi	154 442 236
Mauritius	975 119
Mozambique	95 715 852
Namibia	29 000 000
Seychelles	452 772
South Africa	635 981 213
Tanzania	32 664 445
Zambia	62 000 000
Zimbabwe	94 849 706
Total	1 440 842 930

Source: Gender Links compiled from UNAIDS 2021[37] and Country Score cards[38]

[37] UNAIDS Scorecards and Posters, https://hivpreventioncoalition.unaids.org/ global-dashboard-and-country-scorecards/, accessed 10 August 2021.
[38] Ibid

Table 5.13 shows that all countries are distributing condoms and a total of over 1,4 billion condoms were distributed in SADC in 2019.

Table 5.14: Condom availability and use in GPC Priority Countries

Country	Condom use with non-regular partner		Women justified to insist condom use if husband has an STI		No. condoms per man 15 - 64	% condom need met 2019
	Women 15 -49	Men 15 -49	Women 15 -49	Men 15 -49		
Angola	59	74	59	74	8	25
Botswana					53	100
DRC	68	79	68	79	7	25
Eswatini	94	96	94	96	38	77
Lesotho	92	90	92	90	56	100
Malawi	82	88	82	88	20	95
Mozambique	61	72	61	72	15	44
Namibia	93	91	93	91	37	100
South Africa					34	92
Tanzania					2	9
Zambia	73	81	73	81	13	51
Zimbabwe	87	85	87	85	20	83

Source: Compiled from Global dashboard and Country Score cards.[39]

Table 5.14 shows variations in the use of condoms with non-regular partners across different countries, with generally higher utilisation by men than by women. Higher rates of utilisation are generally correlated with higher availability. Five countries (Botswana, Eswatini, Malawi, Namibia and South Africa) are providing at least 90% of need for condoms. Men are as likely as women to agree that a woman is justified to insist on use of a condom if her husband has an STI.

Voluntary Medical Male Circumcision (VMMC)

Voluntary medical male circumcision provides partial lifelong protection against female-to-male HIV transmission. VMMC should be used in combination with wider sexual and reproductive health service provision for boys and men including correct and consistent condom use, STI management, pre-exposure prophylaxis, HIV testing and prompt initiation of antiretroviral therapy. VMMC can have a major impact on HIV epidemics in high-prevalence settings. Ten of the 15 priority countries identified by UNAIDS for intense effort to increase levels of VMMC are in SADC (Botswana, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe).

Voluntary Medical Male Circumcision was seriously disrupted by COVID-19

[39] Ibid

Table 5.15: Number of male circumcisions conducted

Country	2015	2018	2019	2020	Total 2015-20	Difference 2020:2019
Tanzania	435 302	885 599	799 456	539 859	3 939 041	-259 597
South Africa	485 552	572 442	451 636	164 499	2 763 256	-287 137
Zambia	222 481	482 183	549 655	661 796	2 711 723	112 141
Mozambique	198 340	311 891	390 589	113 227	1 582 506	-277 362
Zimbabwe	188 732	326 012	354 819	82 060	1 458 773	-272 759
Malawi	108 672	199 399	114 465	47 316	766 177	-67 149
Namibia	18 549	34 942	40 868	45 880	197 713	5 012
Lesotho	25 966	26 448	34 144	9 802	155 667	-24 342
Botswana	15 722	24 207	17 123	3 171	104 021	-13 952
Eswatini	12 952	14 316	17 360	8 639	88 779	-8 721
Total SADC	1 712 268	2 877 439	2 770 115	1 676 249	13 767 656	

Source: Gender Links compiled from UNAIDS 2021 data https://aidsinfo.unaids.org/

Table 5.15 shows the number of VMMCs conducted in the SADC priority countries in 2020. As a result of COVID-19, VMMC dropped by 40% from 2,770,115 in 2019 to 1,676,249 in 2020. Only Zambia and Namibia in SADC were able to conduct more VMMCs in 2020 than 2019. Adaptations included providing transport, moving services from health facilities, and provision of COVID-19 personal protective equipment to VMMC mobilisers. SADC priority countries conducted a total of about 13.8 million VMMCs from 2015 to 2020: much lower than the target of 25 million for these priority countries. VMMC uptake is higher in urban and higher socio economic groups. Thus, it is necessary to re-strategize to make the service available and to create demand for it in lower socio economic and rural populations.[40]

Pre-Exposure Prophylaxis (PrEP)

PreP is one of the five prevention pillars in the Prevention Roadmap of the Global HIV Prevention Coalition. Prep means taking an ARV every day, before you have contracted HIV, to prevent HIV. PrEP is recommended for discordant couples (where one is positive and the other negative), sex workers, or others at high risk of contracting HIV.



GL programme officer Thandokuhle takes an HIV test at the Mbabane HIV campaign. Photo: Mancoba Vilane

[40] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, available at: https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.

Table 5.16: PrEP Coverage SADC members of GPC

Country	No. who received PreP at least once in last 12 months	
	July 2019	July 2020
South Africa	8 100	43 255
Lesotho	7 300	35 478
Zambia	8 991	23 250
Namibia	5 600	10 583
Zimbabwe	5 000	8 351
Mozambique	2 000	7 434
Eswatini	2 176	5 607
Tanzania	8 000	5 312
Botswana	298	1 954
Malawi	300	459
DRC	356	356
Total SADC members of GPC	48 121	142 039

Source: Gender Links compiled from ARV Based prevention thematic summary.[41]

Table 5.16 shows that countries are gradually adopting PrEP as an additional HIV prevention option. The rate of uptake is not the same, with the number offered PrEP in Tanzania declining between 2019 and 2020, very slow change in DRC and Malawi and fast uptake in countries such as Lesotho, South Africa and Zambia. The total number of people who opted to use PrEP globally in 2020 was only 28% of the 2020 target for PrEP of 3 million in low and middle income countries.

Some of the challenges associated with PrEP are:

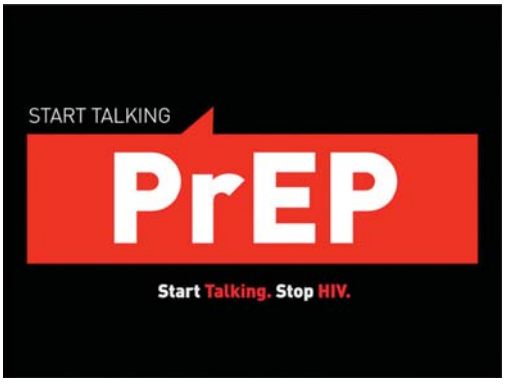
- Low levels of awareness in potential users.
- Self-perceptions of HIV risk.
- Ability to adhere to daily pills.
- Stigma, including from health providers and low levels of support, especially from the male partners of adolescent girls and young women.
- Problems attending clinic appointments.

Some solutions to increase uptake include:

- Building awareness of PrEP in parents.
- Social media to boost knowledge.
- Linking provision of PrEP to youth friendly services for sexually transmitted infections (STIs) and antenatal and postnatal care.
- Consulting with users about adaptations to increase uptake, build into peer networks.

Tests of long-acting injectable cabotegravir show that it reduces HIV infection even more than daily pills for men who have sex with men and for women. Injectable PrEP is administered every two months which is more discreet and easier to adhere to for many. However, it must be delivered by a health provider, there is still need to ensure that break through infections are managed well and the cost of injectable PrEP is still to be determined.

In January 2021, the World Health Organization (WHO) conditionally recommended use of the dapivirine vaginal ring, which has been found to reduce HIV infection by up to 50%, as an additional prevention method for women who are at substantial risk of HIV infection. Additional prevention methods being tested are a monthly PrEP pill, six-monthly injectable PrEP, as well as technologies for preventing both HIV infection and pregnancy.[42]



[41] UNAIDS Scorecards and Posters, https://hivpreventioncoalition.unaids.org/global-dashboard-and-country-scorecards/, accessed July 15, 2021
[42] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, available at: https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.

Prevention among key populations

Key populations include sex workers, men who have sex with men (MSM), people who inject drugs, transgender persons, prisoners and migrants. The goal is that 95% of members of all key populations access HIV combination prevention services and that those that test positive will access treatment, with ongoing support to be virally suppressed.

As new infections continue to decline in young people, the proportion of new infections from key populations is increasing (from 28% in 2019 to 32% in 2020). Key populations have higher HIV prevalence than the general population. Punitive laws and policies, police harassment, stigma and discrimination within health settings all deter members of Key Populations from accessing needed services. The largest proportion of new HIV infections within key populations is found in clients of sex workers and other partners of key populations (18%). HIV thus spreads into the general population. The paucity of data about the epidemic in key populations is indicative of the low priority that members of key populations have received so far in the HIV battle in SADC.

We cannot end AIDS without services to reduce transmission in Key Populations

Table 5.17: Selected data on HIV in Sex Workers

Country	Prevalence women 15 - 49	Prevalence in sex workers	Population size estimate	Condom use	Active Syphilis
Lesotho	26,1	71,9	7500	27	2,7
Eswatini	35	60,8	4000	5,9	
South Africa	24,7	57,7	24000	86,1	32,6
Malawi	10,3	49,9	36100	65	19,6
Zambia	14,1	48,8	126000	78,5	9,4
Botswana	24,8	42,2	6700	75,7	30,3
Zimbabwe	14,7	42,2	45000	43,4	
Namibia	14,7	29,9	4000	42,3	7
Tanzania	6	15,4	155500	72,4	6,4
Mauritius	1	15	6200	67,2	3
Angola	2,3	8	54000	71,7	32,8
DRC	1,1	7,5	350300	73,9	12,1
Madagascar	0,3	5,5	191200	62,8	
Seychelles		4,6	600	16	0,39
Comoros	0,1	0,8	1000	35,8	
Mozambique	14,4		27300		

Source: Gender Links compiled from UNAIDS 2021 data https://aidsinfo.unaids.org/

Table 5.17 show how widespread the pandemic is amongst sex workers in all countries of the region. Except in South Africa, and to a lesser extent in Zambia and Botswana, condom use by sex workers is still generally low and is particularly low in Seychelles, where the risk of HIV may be perceived to be low but is climbing in the sex worker community. The overall prevention score card showed that all GPC countries had programmes for sex workers. None were rated poorly nor were they rated as doing well. As long as sex work is criminalised, as it is in all countries except Mozambique, it is difficult to ensure that sex workers receive adequate services.

A study of sex workers in three urban areas of South Africa found that they were consistently less likely to be aware of their HIV status than other women and also that they were generally less likely to access treatment or be virally suppressed even after they became aware of their status[43]. Sex workers have been particularly hard hit by COVID-19, losing their source of income, without social or any other protection. Sex workers are much more vulnerable to violence and less able to access health services. Young and migrant sex workers are particularly vulnerable.

Table 5.18: HIV Epidemic in Men who Have sex with Men (MSM)

Country	HIV Prevalence Men	HIV Prevalence MSM	Population size estimate	Condom use	Active Syphilis
Lesotho	16	32,9	6100	46,4	5,1
Eswatini	18,2	27,2	2400	79,6	1,2
Zimbabwe	9,1	21,1	23000	69,2	0,4
South Africa	13,5	18,1	309700	71,8	
Mauritius	2,3	17,2	5500	53,1	14,2
Madagascar	0,3	14,9	17000	57,2	6,1
Botswana	15,2	14,8	2600	77,5	3,2
Seychelles		13,2	200		
Malawi	5,7	12,9	42600	79,4	9
Tanzania	3,3	8,4	49700		
Namibia	8,3	7,8	2200	54,8	
DRC	0,4	7,1	194900	50,6	42
Angola	1,3	2	29400	59,1	2
Comoros	0,1	0,4	600	56,2	0,41
Mozambique	8,6		15800		
Zambia	8		6500		12,4

Source: Gender Links compiled from UNAIDS 2021 data https://aidsinfo.unaids.org/

Table 5.18 shows high HIV prevalence in MSM in Seychelles and Mauritius, which otherwise have low rates of prevalence. Prevalence rates are similar to those of other men in countries such as Botswana. Similar to sex workers, MSM often do not access services such as HIV testing and treatment. However, there is data to suggest that when MSM do know their HIV status they are more likely than other men to access and to adhere to treatment[44]. This suggests that more effort should be invested in ensuring that services are available at times and places which are convenient for men, including MSM.

[43] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, available at: https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.
[44] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, available at: https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.

People who inject drugs

Table 5.19: HIV in people who inject drugs

Country	HIV Prevalence	HIV Prevalence in People who inject drugs	Population size estimate	Condom use %	Safe injecting practices %	Active Syphilis
Comoros	0,1	1,8		43,8		
DRC	0,7	3,9	155800	26,5		42
Eswatini	26,8		300			
Madagascar	0,3	8,5	2300	41,8	68,4	
Mauritius	1,7	32,3	11700	45,4	92,2	53,6
Mozambique	11,5		2200			
Seychelles		23	2500	44,1	58,5	
South Africa	19,1	21,8	82500	57,1		
Tanzania	4,7	15,5	36000	29,4	84,2	
Zambia	11,1		26800			

Source: Gender Links compiled from UNAIDS 2021 data.[45]

Table 5.19 shows that the prevalence of HIV in people who inject drugs. Although people who inject drugs are not a large part of the SADC population, it is important that they should be able to access the same services as others. There are very few countries with programmes to promote safe injecting practices. There is evidence that countries are slowly beginning to pay attention at least to this population which may support increased service provision. In the island nations the difference in HIV prevalence between those that inject drugs and the rest of the population is very marked.

Prisoners

Table 5.20: HIV prevalence, prevention and management for prisoners

Country	Population size	HIV Prevalence	ARV coverage %	Condoms distributed
Angola		15,9	100	1161600
Comoros	2304			
DRC	36700	2,5		4003
Eswatini	46800	34,9		
Lesotho	2600	31,4	80,1	
Madagascar		0,3		7169
Malawi	14200	19	100	1500000
Mauritius	2300	17,3	79,1	343
Mozambique		24		
Seychelles	300	4,8		222
South Africa	166400	11,1	98,8	1169999
Tanzania		6,7		
Zambia	20800	27,4	100	
Zimbabwe	20900	28		

Source: Gender Links compiled from UNAIDS 2020 data.[46]

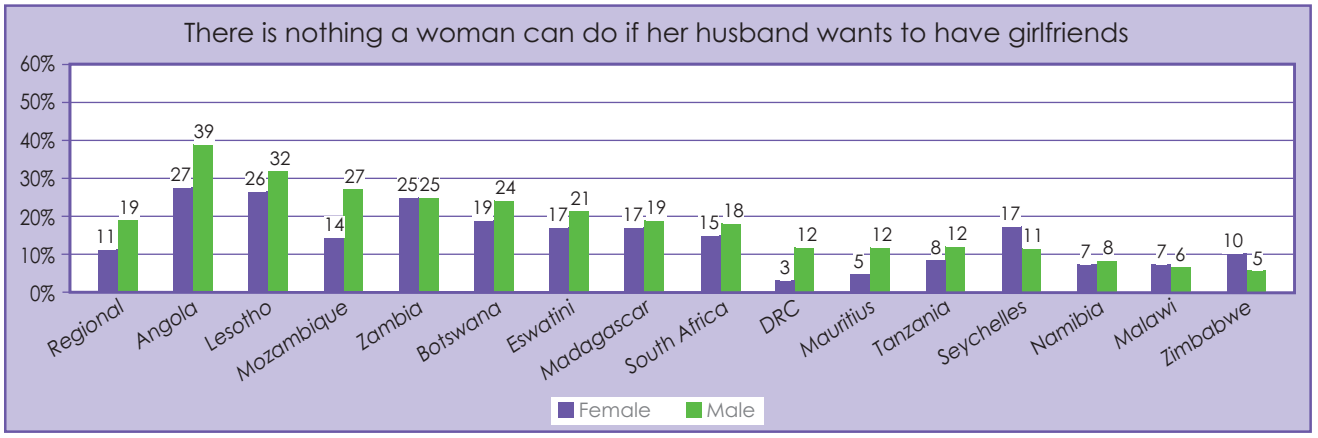
[45] https://aidsinfo.unaids.org/
[46] https://aidsinfo.unaids.org/

Table 5.20 shows that HIV prevalence is generally higher in prison populations than it is in the population at large. While the rates are lower than that of people who inject drugs or other key populations, it is critical that services are expanded to this neglected group. The number of condoms that are being distributed to prisoners is beginning to increase. It is important to link prisoners who have received care while in prison with services in their communities when they are released.

Attitudes

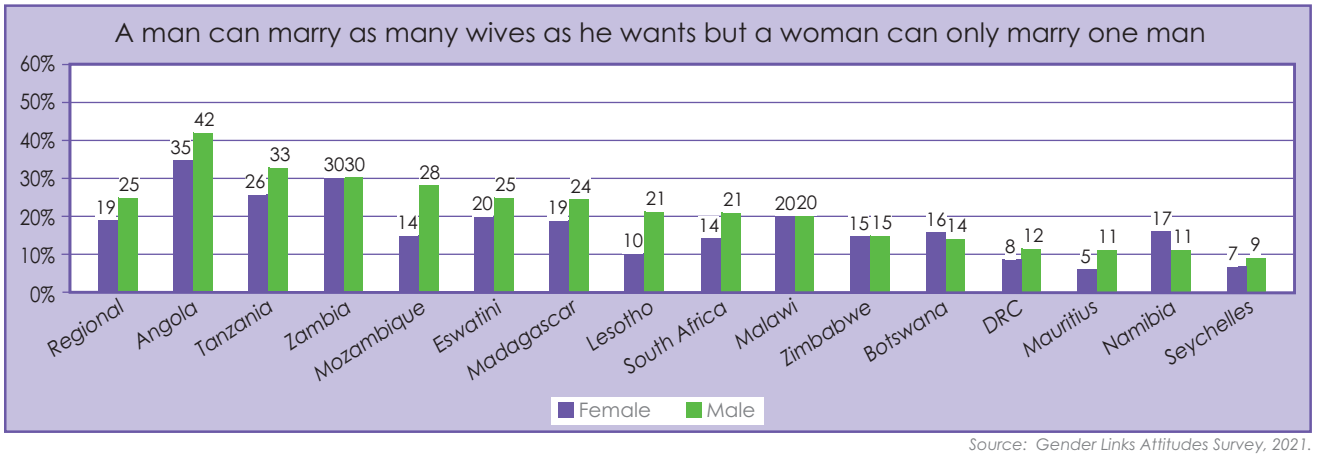
A critical test of HIV and AIDS prevention campaigns is the extent to which the attitudes that fuel this pandemic are changing. Alliance partners administer an attitudes survey. Several of the questions in the survey are pertinent to how successful HIV prevention campaigns will be.

Figure 5.5a: Attitudes on multiple concurrent partners



Source: Gender Links Attitudes Survey, 2021.

Figure 5.5b: Attitudes on polygamous marriages

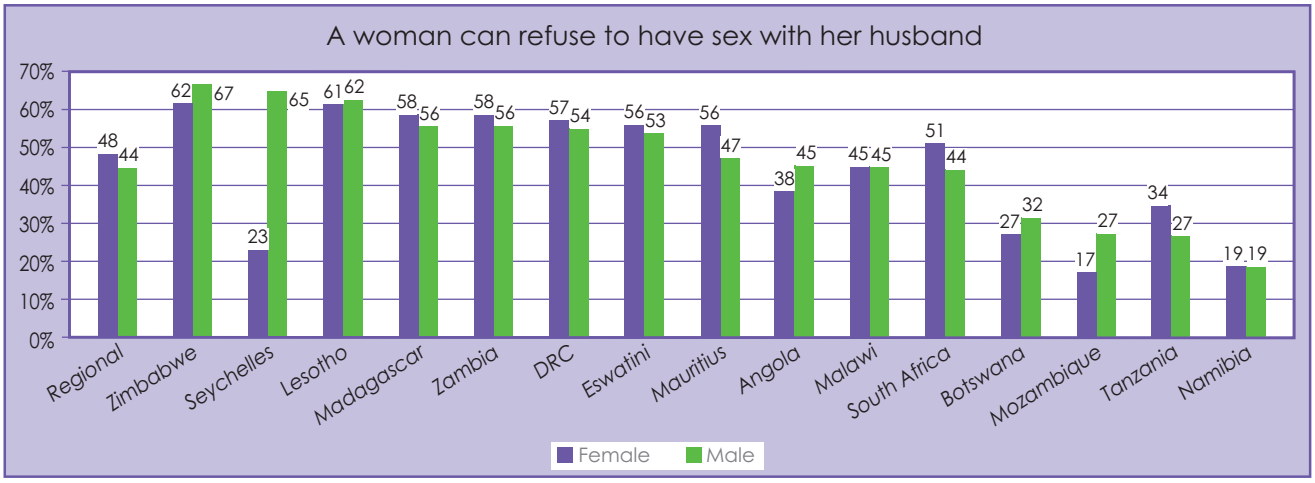


Source: Gender Links Attitudes Survey, 2021.

Figures 5.5a and 5.5b show the results of the Gender Links attitudes survey in respect of the percentage of women and men who agreed with the following statements: "there is nothing a woman can do if her husband wants to have girlfriends" and "a man can marry as many wives as he wants but a woman can only marry one man." Overall, less than 40% of either men or women agreed with these statements. The lowest rates of agreement were found in DRC, Mauritius, Namibia and Zimbabwe. Generally, more people agreed that a man could have more than one wife than agreed that there was nothing that a woman could do if her husband wanted to have many girlfriends, except in Botswana, Lesotho and Seychelles. As multiple concurrent partners have been a critical driver of HIV infection, it is important that attitudes are not accepting of either men or women having several sexual partners concurrently.

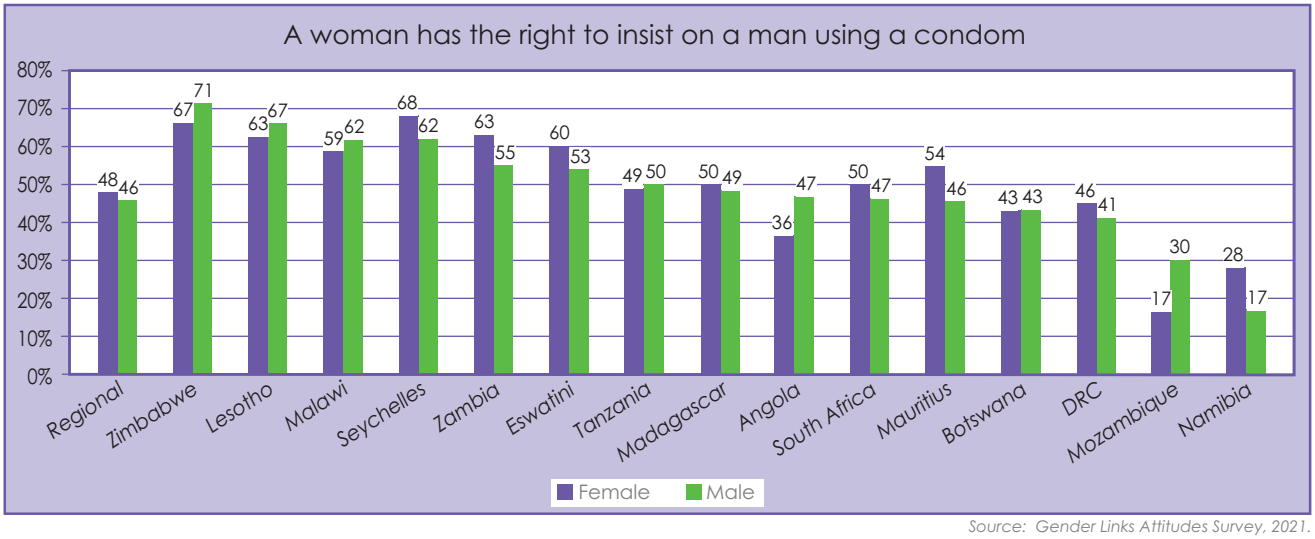
Neither women nor men had attitudes which condoned multiple concurrent partnerships

Figure 5.6a: Attitudes on sex which may not be safe



Source: Gender Links Attitudes Survey, 2021.

Figure 5.6b: Attitudes on the right to insist on condom use



Source: Gender Links Attitudes Survey, 2021.

Figures 5.6a and 5.6b show that regionally just under 50% of both women and men agreed with the statements: "a woman can refuse to have sex with her husband" and "a woman has the right to insist on a man using a condom". This indicates that women are generally not held as having power to negotiate or even to refuse sex if they consider that it may not be safe. Zimbabwe, Zambia, Seychelles and Lesotho had the highest proportions who agreed with both statements (except women in Seychelles, where a very small proportion agree that a woman can insist on condoms). This is clearly an area for greater advocacy and awareness raising across the region and especially in programmes addressing adolescent girls.

Female Genital Schistosomiasis - a missing link in HIV Prevention

Schistosomiasis is wide spread in tropical and sub-tropical regions of the world, especially in poor, rural communities in Africa who rely on open sources of water for cooking and bathing. As many as 56 million women in Africa are affected by female genital schistosomiasis (FGS) which is caused by schistosome eggs being trapped in the female genital tract. Untreated FGS can be mistaken as cervical cancer. Studies in Mozambique, Tanzania and Zimbabwe have shown that women with FGS have a three to four times greater risk of contracting HIV. In Zambia a study has linked schistosomiasis with increased risk of HIV in both women and men. Adolescent girls with FGS have a higher proportion of HIV receptors in their genital tissue.

FGS also causes lesions or tears in the cervix and vaginal mucosa of young women which also increases the chances of HIV transmission. Adolescents often contract FGS before their sexual debut. An important but neglected aspect of HIV prevention should be treatment for FGS in adolescent girls and older women. Raising awareness and skills of health providers to do this is a critical need.[47]

Women and health providers need to be aware of Female Genital Schistosomiasis

Treatment

Article 27.3

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

HIV infection will receive sustained antiretroviral therapy; Target (3) By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression

[47] UNAIDS (2019) No more neglect - Female genital schistosomiasis and HIV - Integrating sexual and reproductive health interventions to improve women's lives, https://www.unaids.org/en/resources/documents/2019/female_genital_schistosomiasis_and_hiv, accessed 2 August 2021.

Table 5:21: Number of people living with HIV on treatment

Country	2020				2010
	Women	Men	Children	Total	Total
South Africa	3 765 437	1 685 797	148 430	5 599 664	1 343 661
Tanzania	914 260	446 985	61 537	1 422 782	244 225
Mozambique	884 187	435 631	83 082	1 402 900	218 991
Zimbabwe	692 386	436 046	56 469	1 184 901	363 261
Zambia	710 457	421 071	47 503	1 179 031	349 076
Malawi	531 872	275 471	45 689	853 032	250 953
DRC	230 284	124 664	21 669	376 617	43 790
Botswana	203 292	116 977	4 662	324 931	159 350
Lesotho	146 626	79 104	7 254	232 984	94 287
Eswatini	127 558	67 816	8 912	204 286	60 757
Namibia	117 164	58 242	6 290	181 696	77 453
Angola	76 732	28 495	5 961	111 188	22 036
Madagascar	3 099	2 632	154	5 885	266
Mauritius	871	2 020	45	2 936	654
Comoros	46	34		80	17
Seychelles					
Total SADC	8 404 271	4 180 985	497 657	13 082 913	3 228 777
Global				27 500 000	7 800 000
SADC as percentage of Global				**48%**	**41%**

Source: Gender Links compiled from UNAIDS 2021 data https://aidsinfo.unaids.org/

South Africa accounted for 20% of those on ART globally in 2020

Table 5.21 shows the progress that has been achieved in expanding access to treatment in SADC for all groups and in comparison to the numbers that were accessing treatment in 2010. Globally, the numbers of people on treatment has tripled over the decade from 7.8 million in 2010 to 27.5 million in 2020. The increase in SADC in the same time period has been fourfold from 3,228,777 to 13,083,913. SADC accounted for 41% of the global population on treatment in 2010 and 48% in 2020. South Africa accounted for 20% of all people in the world who were on ART in 2020. The numbers in all countries that are on treatment have increased with the greatest rates of increase being in those countries which began from a low total number - Madagascar, DRC - and significant increases in Mozambique and Tanzania.

The remarkable success that has been achieved is partly a result of sustained advocacy for access to cheaper, generic ART against fierce resistance from multinational pharmaceutical companies and developed countries. Civil society played a crucial role in this advocacy, led by organisations such as the Treatment Action Campaign in South Africa. The result has been increased production of much cheaper generic drugs and fall in the cost of ART per patient per year from US$ 10,000 in 1990 to under US$100 now.[48]

[48] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.

Viral suppression

UNAIDS TARGET 3: 90% of all people receiving antiretroviral therapy will have viral suppression.

As shown in Table 5.7 viral suppression overall reached the target of 73% or better in Eswatini, Botswana, Malawi, Zimbabwe, Namibia, Lesotho and Zambia.

Results from across Sub Saharan Africa have shown that support to continue in care is very critical. 19% of over 500 000 patients who initiated ART in 2009 were found to have dropped out by 2014.[49] People that have been found to be more likely to disengage from care include men, those who are unemployed, with less education, who have more advanced HIV illness, or poorer adherence to daily medication, who have not disclosed their HIV status or who live far from a health facility. Men are at greater risk of dying while on ART than women, partly because they are often diagnosed later and therefore start ART late.

Factors that can improve adherence include friendly, supportive health services; lack of stigma; emotional, practical and financial support. It is recommended that adolescent services should include peer support, be available at times which allow adolescents' schooling to continue without disruption and be responsive to adolescents' specific concerns[50].



South Africa: The Coach Mpilo programme is a peer support programme designed to engage men more effectively, based on research that found that men often have deep fears, associate HIV with abandonment and loss, and find health facilities to be more judgemental than supportive. The programme involves community based male peers that are living with HIV helping other men who have been diagnosed with HIV to overcome isolation and despair. The peers (or coaches) foster positive attitudes and confidence about HIV treatment, which improves treatment outcomes. In the seven-month long pilot phase of the programme, treatment uptake was 94% of newly diagnosed men, with 95% of participants retained on HIV treatment. Though 16% of participants interrupted treatment at least once, more than 80% of these were brought back onto treatment[51].

HIV and TB co-infection

Tuberculosis (TB) is both preventable and curable. However, without treatment, a person living with HIV who has TB is likely to die. Thus, the WHO has recommended, from 2010, that everyone with TB who is also living with HIV should be initiated on ART regardless of CD4 count and, in 2021, that ART be initiated as soon as possible. WHO has also recommended, since 2012, that

[49] Haas AD, et al. Retention and mortality on antiretroviral therapy in sub-Saharan Africa: collaborative analyses of HIV treatment programmes. J Int AIDS Soc. 2018;21: e25084. https://pubmed.ncbi.nlm.nih.gov/29479867/, accessed 5 August, 2021.
[50] WHO, 2021. Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva, World Health Organization. https://www.who.int/publications/i/item/9789240031593, accessed 2 August, 2021.
[51] UNAIDS. 2021. Global AIDS Update. 2021. Confronting Inequalities Lessons for pandemic responses from 40 years of AIDS. Geneva, UNAIDS.

all people that test positive for HIV should also be screened for TB and receive "optimal TB care" which is:

- Those without symptoms of TB (cough, coughing up blood, fever, night sweats, weight loss, chest pain, shortness of breath or fatigue) should be given TB preventive treatment.
- Those with symptoms should be investigated for TB disease.
- If they have TB disease, they should start TB treatment immediately.
- If not, they should start TB preventive treatment.

Table 5.22: Number of TB related AIDS deaths

Country	2019	2019	2019	% change 2010-2019
South Africa	116000	158000	36000	77%
Tanzania	53000	40000	12000	70%
DRC	24000	18000	9600	47%
Mozambique	20000	21000	5600	73%
Zambia	20000	14000	9500	32%
Zimbabwe	14000	8000	4600	43%
Malawi	13000	18000	4200	77%
Namibia	4500	3800	1300	66%
Lesotho	4300	7900	3600	54%
Botswana	3700	2000	1100	45%
Eswatini	2400	2300	710	69%
Angola	1900	9100	2600	71%
Madagascar	36	54	280	-419%
Mauritius	11	2	8	
Comoros	0	0	0	
Seychelles	0	0	0	
SADC Total	276847	302156	91098	
Global Total	680000	570000	210000	
SADC as % global	**41%**	**53%**	**43%**	

Source: Compiled from UNAIDS 2021 data.[52]

In 2016, the United Nations set a global target to reduce TB deaths among people living with HIV by 75% between 2010 and 2020. Table 5.22 traces the number of TB related deaths in people living with HIV in SADC from 2000 to 2010 to 2019. By 2019, nine countries, including South Africa and Malawi, had achieved or exceeded the target ahead of schedule. In 2010 South Africa accounted for 28% of all TB deaths in the world among people living with HIV. Tanzania, Mozambique and Angola had achieved over 70% decline in deaths between 2010 and 2019. Madagascar still has increasing mortality, which is concerning, even as the absolute numbers are still relatively small. The 2021 Political Declaration on AIDS has set a target of 80% reduction in TB related deaths compared to 2010 by 2025.

The 2018 UN Political Declaration to End TB set a target of 6 million people living with HIV receiving TB preventive treatment, which reduces their risk of falling ill and reduces the risk of death by about 40%, by 2022. In 2018 and 2019, 5.3 million people living with HIV received TB preventive treatment (which is 88% achievement of the target). More than half of the 3.5 million people living with HIV who received TB preventive treatment in 2019 were in India, South Africa and Tanzania. The 2021 Political Declaration on AIDS target is at least 90% of people living with HIV receiving preventive treatment for tuberculosis by 2025[53].

Despite the gains, it is estimated that in 2019, only 49% of the estimated 815 000 people living

[52] https://aidsinfo.unaids.org/
[53] 2021 UNAIDS Global AIDS Update, Confronting inequalities Lessons for pandemic responses from 40 years of AIDS, https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 10 August 2021.

with HIV who also have TB disease were receiving both HIV and TB treatment. There are many gaps in screening, testing and treatment for both HIV and TB. Programmes need to find new ways of integrating care for both, as well as COVID, at community level[54].

Cervical Cancer

Cervical cancer is the fourth most commonly found cancer in women worldwide, with over 500,000 new cases and 311,365 deaths in 2018 globally. Women living with HIV are more likely to contract human papillomavirus (HPV) infection, which causes cervical cancer, than other women and less likely to clear the infection. HIV increases both the risk of cervical cancer as well as recurrence after treatment.

Cervical cancer is the most common cancer found in women living with HIV, who have a five to seven times greater risk of contracting it than other women. It is considered an AIDS defining condition. In 2018 it is estimated that 33,000 new cases of cervical cancer occurred in women living with HIV, of which 9,200 cases were in Southern Africa and 14,000 in East Africa (or 70% of all cases of cervical cancer in women living with HIV globally).

Care work

Article 27.3
a) 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 care givers as well as support for care givers as well as support of people for people living with AIDS.

SDG 5.4
Recognize 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.

Global AIDS Strategy 2021 - 2026:
Strategy 4
Fully recognized, empowered, resourced and integrated community led HIV responses for a transformative and sustainable HIV response

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 recognize, reduce, redistribute and value women's unpaid care and domestic work through the provision of public services, infrastructure.

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

[54] Tuberculosis deaths among people living with HIV are declining globally, but worrying gaps in TB care persist, https://www.unaids.org/en/resources/presscentre/featurestories/2021/march/20210324_tuberculosis-deaths-people-living-with-hiv, accessed 10 August 2021.

The Global AIDS Strategy High-level 2025 targets and commitments for achievement of Result Area 4 (Fully recognized, empowered, resourced and integrated community-led HIV responses for a transformative and sustainable HIV response) are:

- 30% of testing and treatment services to be delivered by community-led organizations.
- 80% of service delivery for HIV prevention programmes for key populations and women to be delivered by community-, key population- and women-led organizations.
- 60% of the programmes support the achievement of societal enablers to be delivered by community-led organizations.
- Less than 10% of countries have punitive legal and policy environments that lead to the denial or limitation of access to services.
- Less than 10% of people living with HIV and key populations experience stigma and discrimination.
- Less than 10% of women, girls, people living with HIV and key populations experience gender-based inequalities and all forms of gender-based violence.[55]

Community based organizations and community caregivers, including peer supporters from affected populations, have long been recognized as vital in the HIV response, but have seldom received the support, training, materials and funding that they deserve.

The COVID-19 response has highlighted the urgent need for more attention and support to community based responses as many services are moved out of health facilities and into the community. Many countries, for instance, rapidly expanded multi-month dispensing of ART so that people living with HIV only come to health facilities once in three to six months. Other adaptations were more community based re-supply of ARVs.

COVID-19 response has highlighted the urgent need for more attention and support to community based responses

Such moves must be accompanied by increased community based support and follow up to ensure that all are adhering to their treatment. Based on evidence of growing numbers that are disengaging from care, the WHO's updated guidelines include a recommendation to trace people who have disengaged from care and provide support for re-engagement.[56]

Other services that have been disrupted by COVID-19, especially testing, need to urgently be supplemented by community based models which can reach people at times and places which are convenient to them. This is particularly important for reaching hard to reach populations and those most impacted by stigma. Where community testing is accompanied by community based initiation of ART it is critical that this includes sufficient support and counselling, with follow up. As illustrated in the case study that follows, local councils have a critical role to play:

[55] End Inequalities. End AIDS. Global AIDS Strategy 2021-2026, https://www.unaids.org/en/Global-AIDS-Strategy-2021-2026, accessed 2 July 2021.
[56] WHO, 2021. Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva, World Health Organization. https://www.who.int/publications/i/item/9789240031593 accessed 2 August, 2021.



Henties Bay District Aids Committee



The Henties Bay District Committee was established in 2004 in the coastal town of Henties Bay, Namibia. This is a sub-committee of the Arandis Constituency HIV and AIDS Coordinating Committee, which has 16 active stakeholders to date and is guided by the National Strategic Framework for HIV and AIDS response in Namibia.

The committee aims to reduce new HIV infections, reduce HIV related deaths, eliminate MTCT, support newly identified PLHIV and help them to stay enrolled and retained on ARV treatment. In addition, the committee contributes to resource mobilisation.

The committee focuses on social behaviour change awareness campaigns. As part of this, the committee conducts HIV testing and counselling, VMMC awareness drives, condom programming, HIV and TB defaulter tracing and adherence counselling. The committee also commemorates World TB Day and World AIDS day.

Partners in the committee include the office of the mayor, Henties Bay Clinic, Henties Bay Municipality, UNAM, Henties Bay Women's Association, Henties Bay Local Youth Forum and strategic partners who assist in rolling out the activities. To date, on a budget of N$60,000, the committee has managed to directly assist 100 beneficiaries, 75 of whom are women. The committee has also indirectly benefited 60 people through their networks and another 16 online.

Despite a lack of financial resources, the network continues to press forward with their plans, reviews and initiatives. To date, they have managed to assist the Henties Bay Women's Association to register as a welfare organisation with 75 women registered. The committee is committed to ensuring that residents across the community are protected from HIV and other sexually transmitted diseases and continuing to coordinate HIV prevention programming.

Source: Phillips, Seth. SADC Protocol@Work Summit 2019. Action and Youth Category - SRHR. Henties Bay District AIDS Committee

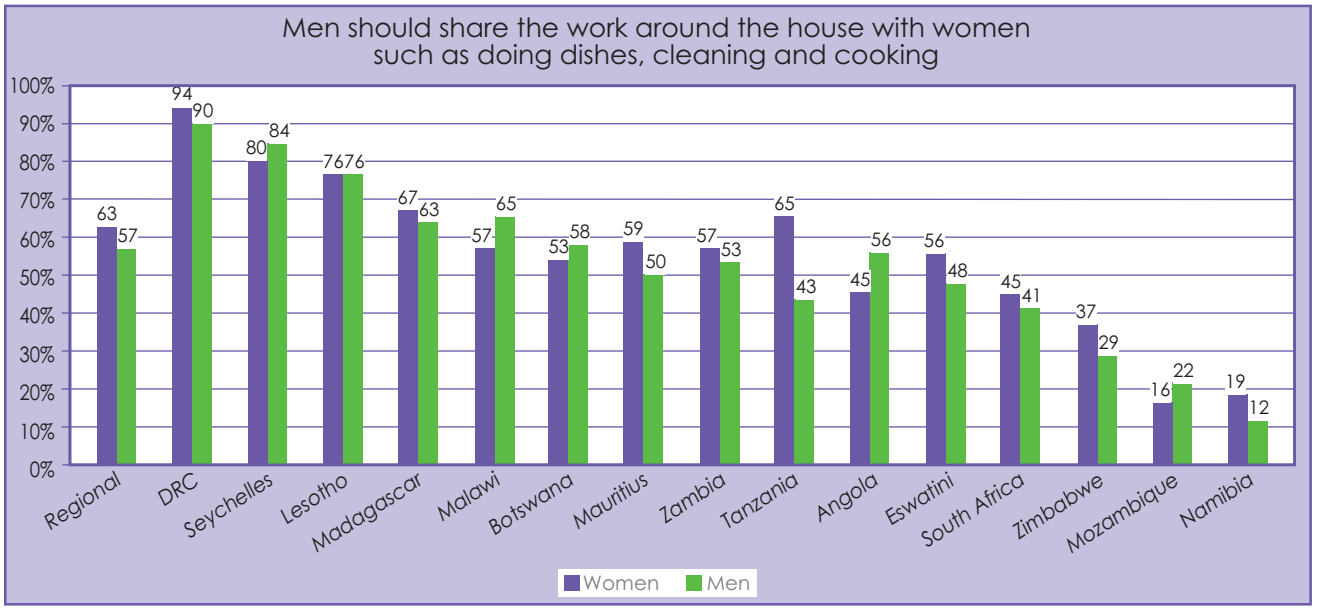
The WHO Guidelines recognise that peer support models can support adherence as more than 15% of all those on ART report that depression is a barrier to adherence, while adults and adolescents often report alcohol and substance misuse as barriers. Adolescents also face specific challenges such as peer pressure, inconsistent daily routines and the pressure to conform. Community programmes that engage caregivers of children and adolescents living with HIV are also important.

The WHO guidelines on task sharing include dispensing of ART between clinical visits by

trained and supervised community health workers. WHO further recommends that all health-care workers, including community health workers, should be appropriately trained, remunerated and supervised, as programme experience indicates that sustaining health services based on volunteerism alone is difficult[57]. This recommendation echoes what the Alliance has consistently called for over many years: all community caregivers (peer supporters, community health workers etc.) need good quality training, support and mentorship, provision of materials (including personal protective equipment against COVID-19 or any other infection) and to be remunerated.

The Gender Links Attitudes Survey included a question on whether men should share the housework with women.

Figure 5.7: Men sharing in care work



Source: Gender Links Attitudes Survey, 2021.

Figure 5.7 illustrates the attitudes regarding whether men should share work around the house with women. Sixty three percent women and 57% men agreed or strongly agreed with the statement. However, the response varied widely by country. The most positive responses came from DRC and the lowest from Namibia and Mozambique. Overall, responses between women and men were quite similar in each country, with the highest difference in Tanzania where 65% of women and only 43% of men responded positively.

Mental Health and Psychosocial Support

Research commissioned by United for Global Mental Health (UGMH), and conducted by Dr José Manuel Roche analysed the impact of integrating mental health and psychosocial services into HIV and TB programmes. The research found that by 2030:

- The rate of reduction in infection rate can be increased by 10-17% for HIV and 13-20% for TB.
- Up to 924,000 HIV infections could be avoided.
- Up to 14 million TB infections can be avoided.
- Integrating mental health treatment does not need to be expensive and it is cost-effective.

[57] WHO, 2021. Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva, World Health Organization. https://www.who.int/publications/i/item/9789240031593, accessed 2 August, 2021.

There is a strong and bidirectional relationship between HIV/TB and poor mental health. On one hand, poor mental health is a risk factor for contracting both HIV and TB, while those with poor mental health are less likely to seek testing, treatment or adhere to treatment for either HIV or TB. On the other, living with HIV and/or TB is a risk factor for decline in mental health, especially if it is compounded by the stress of stigma and discrimination.

UGMH advocate for increased investment in mental health and psychosocial support within HIV and TB programmes. It is estimated that every US$1 invested in psychosocial support and mental health within HIV and TB programmes provides savings of $6,40 and $43 respectively by reducing community transmission and drug resistance, as well as social and economic costs to individuals and households.[58]

The new WHO HIV guidelines recommend psychosocial interventions for adolescents living with HIV to increase retention in care, improve adherence to treatment and reduce viral load. Interventions targeting the young people should be accompanied by interventions to expand their social network and targeting their families. The guidelines also recommend support and treatment for those with depression and anxiety, or who use alcohol and substances, as these result in poor adherence.[59]

The COURRAGE to change

The COURRAGE project being undertaken by Phola is a story-telling intervention or narrative based methodology that is designed for vulnerable women. These include women living with HIV and AIDS, sex workers, survivors of violence and abuse, women living with disabilities, young mothers, adolescent girls and other vulnerable groups. COURRAGE allows women to;

- Take steps to change their life circumstances and challenge inequalities in their personal, work and social lives.
- Understand factors that contribute to their psychosocial distress, find healing through drawing strength and lessons from group members and separate from shame, guilt, self-hate and blame that is associated with experiences of abuse, hardships, and GBV.
- Take collective action to address economic challenges, isolation, and other issues that impact their lives in their communities.
- Have control over their health, bodies, decisions, choices, resources and thoughts.



Grandaunts of the COURRAGE Programme. Photo: Colleen Lowe Morna

The current programme offers up to 13 workshop sessions where women come together and benefit from their collective story-telling and power. On completion of the programme, they are all welcomed as part of the Phola community structures, which provide ongoing support. The programme results in reduced anxiety, depression and stress as measured by the PHQ-9 test, which tests for levels of depression. When participants have high PHQ-

[58] United for Global Mental Health. 2021. Bending the curve: The impact of integrating mental health services on HIV and TB outcomes. https://unitedgmh.org/sites/default/files/2021-06/The%20impact%20of%20integrating%20mental%20health%20services%20on%20HIV%20&%20TB%C6%92%20%281%29.pdf, accessed 1 July 2021.
[59] WHO, 2021. Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva, World Health Organization. https://www.who.int/publications/i/item/9789240031593, accessed 2 August 2021.

9 scores, facilitators work on improving mental health.

COVID-19 has put strain on the programme as venues for gatherings are closed. Some participants have dropped out of the programme altogether, which slows progress. Some women choose to work and make money during the uncertainty of job loss, rather than come for sessions. The Phola team offered catch up sessions and arranged transport for them to attend training in the Phola offices. Phola plans to extend the training to boys, under another banner - OUTTRAGED, which is similar to COURRAGE.

Phola has partnerships with multiple entities, such as Tosunga Baninga, 1 in 9, Treatment Action Campaign, Cosmo Women's Campaign, Cosmo Women's Forum and Following Jesus Church. COURRAGE aims to reach 250 vulnerable women and girls annually. So far the programme has reached 91 women and 22 men.



Phola receives award at the Women Voice & Leadership South Africa (WVLSA) Learning and Sharing Summit, 2021. Photo: Gender Links

Source: WVL SA Learning and Sharing Summit. 2021

Next steps

The world has adopted an ambitious new plan to end inequalities resulting from gender, sexual orientation, age, economic status, or geographical location, to end AIDS. Individuals, communities, governments and the whole region must invest all necessary resources to achieve these goals as we move towards the final effort to end AIDS by 2030. Some necessary immediate steps are:

- **Continued focus on the needs of women and girls, especially adolescent girls and young women**, including making all possible efforts to ensure that girls are able to resume their education following prolonged school closures during the COVID-19 lockdowns;
- **Continued focus on the epidemic of gender based violence against women and girls** with continued efforts at community level to make families and communities safe for girls and women;
- **Decriminalise sex work, same sex sexual acts and injecting drug use** as such laws only serve to drive people away from services which they desperately need. Unless SADC is able to tackle the HIV epidemic in sex workers, the LGBTIQ population and other key populations, it will not be possible to end AIDS by 2030.
- **Continue to invest in HIV prevention** for all people
- **Invest more in community interventions** to strengthen community capacity to address HIV and COVID-19 and support those that are affected, without stigma.
- **Recognise and value the contribution of women's work and unpaid care work** especially as more and more HIV services are moved from health facilities into communities. Those that provide care work must be trained, supported, provided with materials and remunerated. Community caregivers should be prioritised for vaccination against COVID-19.

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