HIV and AIDS

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Marching to a better future: World Aids Day in Kabwe, Zambia. Photo: Albert Ngosa

KEY POINTS

- Eswatini, Botswana and Switzerland are the three countries in the world that have been officially recognised as achieving the UNAIDS 95 95 95 targets ahead of 2025.[1]
- Several other SADC member states are on course to achieve 95 95 95. However, Madagascar appears to be moving towards a high prevalence epidemic which is cause for concern.
- The Global AIDS Update, 2022, In Danger, warns that the world is in danger of failing to reach the goal of AIDS no longer being a public health threat by 2030. New infections are not falling fast enough, more people are not being put on ART fast enough and there are still too many deaths as a result of AIDS. Globally, it is estimated that there were still 1,5 million new HIV infections in 2021 compared to a target of reducing new infections to under 370 000 by 2025.[2]
- There are glaring gaps in the treatment for children in much of the world. However, Eswatini has achieved 98% of children on treatment.
- Botswana achieved silver status on eliminating mother to child transmission - the first high burden HIV country in the world to achieve this.
- COVID-19 had a devastating impact on HIV prevention and TB programming around the world, especially on condom programming as well as Voluntary Medical Male Circumcisions. Fast adaptations, particularly introduction of community based approaches, made it possible for HIV treatment to continue.
- TB is the leading cause of death in people living with HIV. South Africa, Tanzania and Malawi achieved a 75% decline in TB related deaths between 2010 and 2020.
- As the rate of new infections in adolescent girls and young women declines the proportion of new infections in key populations - sex workers, men who have sex with men (MSM), people who inject drugs, transgender persons and prisoners, and their sexual partners - are on the rise.

[1] Thornton, J. Botswana HIV Success. www.thelancet.com Vol 400 August 13, 2022 DOI:https://doi.org/10.1016/S0140-6736(22)01523-9 Accessed 15 August, 2022.
[2] UNAIDS. 2022. Global AIDS Update. 2022. In Danger. Geneva, UNAIDS.

Introduction



UNAIDS 2022 Global AIDS Update, *In Danger*, warns that the world is not on track to end AIDS as a public health threat by 2030.[3] New infections have not fallen fast enough in regions such as East and Southern Africa. The rates are even increasing in some regions. As a result of COVID-19 restrictions millions of children were not in school, there was increased GBV and teenage pregnancy, with continued high rates of new infections in adolescent girls. Globally, it is estimated that there were still 1,5 million new HIV infections in 2021 compared to a target of reducing new infections to under 370 000 by 2025. The number of deaths due to HIV is still too high. The rate at which deaths are falling is too slow. Globally the rate of increase of people on ART has slowed. While three quarters of those living with HIV are on ART, at least ten million people are not on ART.

The Update is a critical call for more action, more investment and greater urgency to meet the targets which were set in the Global AIDS strategy, 2021 - 26[4]:



The 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 recognised, empowered, resourced and integrated community led HIV responses for a transformative and sustainable HIV response.

5: People living with HIV, key populations and people at risk of HIV enjoy human rights, equality and dignity, free of stigma and discrimination.

6: Women and girls, men and boys, in all their diversity, practice and promote gender-equitable social norms and gender equality, and work together to end gender-based violence and to mitigate the risk and impact of HIV.

[3] UNAIDS. 2022. Op Cit.
[4] UNAIDS. 2021. End Inequalities and AIDS. Global AIDS Strategy 2021 - 2026. Geneva. UNAIDS.

7: Young people fully empowered and resourced to set new direction for the HIV response and unlock the progress needed to end inequalities and end AIDS.
8: Fully funded and efficient HIV response implemented to achieve the 2025 targets.
9: Systems for health and social protection schemes that support wellness, livelihood, and enabling environments for people living with, at risk of, or affected by HIV to reduce inequalities and allow them to live and thrive.
10: Fully prepared and resilient HIV response that protects people living with, at risk of, and affected by HIV in humanitarian settings and from the adverse impacts of current and future pandemics and other shocks.

The cross-cutting issues include:

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

UNAIDS 2022 Global AIDS Update, In Danger, warns that the world is not on track to end AIDS as a public health threat by 2030

Across SADC all efforts are needed to achieve the goal of 95% of all those living with HIV knowing their status; 95% of all those who know their status being on antiretroviral treatment (ART) and 95% of those on ART becoming virally suppressed. Eswatini and Botswana, have demonstrated the best results. There is much work to continue to maintain these achievements and to reach these goals in all countries and across all sub populations.

The Global Strategy has 3 goals for enablers (referred to as the three tens). These include:

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

Table 5.1 overleaf is based on data from the most recently available UNAIDS estimates. It is important to note that estimates vary slightly from one year to another. In 2022 there were no estimates for Mozambique.

Table 5.1: Key HIV data 2021

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 (%)	1.6	18.6	<0.1	0.7	27.9	20.9	0.4	7.7	1.4	11.5	11.8		18.3	4.5	10.8	11.6
Women who are HIV positive as a % of total	59	61	50	56	59	59	53	58	41	57	59		64	59	60	58
Women aged 15 to 49 HIV prevalence rate	2.1	23.8	<0.1	0.9	36.1	26.1	0.4	9.4	1.2	14.4	15.1		24.5	5.7	13.8	14.4
Men aged 15 to 49 HIV prevalence rate	1.0	13.4	<0.1	0.6	19.4	15.7	0.3	5.7	1.5	8.6	8.4		12.1	3.2	7.7	8.7
Prevalence women/ prevalence men	2,1	1,8	1,0	1,5	1,9	1,7	1,3	1,6	0,8	1,7	1,8		2,0	1,8	1,8	1,7
HIV prevalence among young women (15-24)	0.8	6.6	<0.1	0.3	12.6	8.9	0.1	3.2	0.3		6.1		9.1	1.9	5.0	4.7
HIV prevalence among young men (15-24)	0.3	3.5	<0.1	0.2	4.0	3.9	<0.1	1.8	0.2		2.7		3.0	1.0	2.0	2.6
Prevalence young women/ prevalence young men	2,7	1,9	1,0	1,5	3,2	2,3	1,0	1,8	1,5		2,3		3,0	1,9	2,5	1,8
Sex workers																
HIV prevalence (%)	8	42.2	0.8	7.5	60.8	71.9	5.5	49.9	15		29.9	4.6	62.3	15.4	48.8	45.1
Condom use (%)	71.7	75.7	35.8	73.9	50	62.3	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	29.7	8.4		21.1
Condom use (%)	59.1	77.5	56.2	50.6	79.6	46.4	57.2	85.5	53.1		54,8		71.8			83.4
Prevention																
Proportion of people age 15+ who know their HIV status																
Percent of people living with HIV who know their HIV status	57	94	86	82	93	92	15	93	56	81	90		94	88	91	96
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 (%)	75	>98		61	>98	86	15	93	>98	>95	>98		96	80	97	87
Mother to child transmission rate	15.9	2.2		22.6	3.1	7.9	41.3	7.6	5.3	13.5	4.6		3.5	10.9	7.4	8.7
Knowledge																
Comprehensive knowledge of HIV and AIDS	32.3	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	41	92	61	82	91	81	15	91	26	68	91		74	86	90	91
Women aged 15 and over receiving ART	47	95	58	90	94	85	16	98	19	73	95		78	93	93	94
Men aged 15 and over receiving ART	36	87	67	84	85	76	15	83	31	62	85		68	77	89	91
Children aged 0 to 14 receiving ART	19	69		38	>98	64	7	74	82	64	81		48	60	67	73
Viral Suppression																
Percent of people living with HIV who have suppressed viral loads (73% indicates achievement of 90-90-90 and 86% of 95-95-95)		90			89	79		85	18		84		67	83	87	85

Source: Gender Links computations and UNAIDS data, 2022, https://aidsinfo.unaids.org/ accessed 28 July, 2022.



New HIV infections among young girls and women is worrying.
Photo: Gender Links

Table 5.1 shows:

- HIV prevalence rates in Southern Africa continue to fall slowly, but remain the highest in the world. Eswatini, Lesotho, Botswana, South Africa, Namibia, Zimbabwe, Mozambique, Zambia (which have prevalence rates above 10%) have the highest prevalence rates in the world. Malawi, Equatorial Guinea, Uganda, Tanzania, Kenya and Congo have the next highest HIV prevalence levels.
- In Southern Africa HIV and AIDS is still predominantly a heterosexually driven pandemic, with women comprising the highest proportion of those living with HIV. This is now the case even in Madagascar. In Comoros, Mauritius and Seychelles transmission is mainly within key populations. Small populations in Comoros and Seychelles result in sparse data for these two countries.
- Prevalence in women is generally 1.5 times higher than in men; two times higher in South Africa and 2.1 times higher in Angola. This is indicative of an epidemic that is expanding, as the prevalence increases rapidly in women before it begins to increase in men. The difference is even more marked between young women and young men. Prevalence is 3.2 times higher in young women than young men in Eswatini and three times higher in South Africa. Prevalence is about the same for women and men in Comoros, higher generally in men than women in Mauritius but now higher among young women than young men in Mauritius. This suggests that the epidemic in Mauritius is beginning to move from one that is driven by infections in key populations to one that is expanding in the heterosexual population.
- The percentage of people who know their HIV status is over 90 in Botswana, Eswatini, Lesotho, Malawi, Namibia, South Africa, Zambia and Zimbabwe. It is between 80 and 90 in Comoros, DRC, Mozambique and Tanzania; but as low as 15 in Madagascar and only 56 in Mauritius and 57 in Angola.
- Coverage of adults and children receiving Antiretroviral Therapy (ART) has improved dramatically, but ranges from 15% in Madagascar and 26% in Maurituis to over 90% in Botswana, Eswatini, Malawi, Namibia, Zambia and Zimbabwe. There is a major disparity between coverage of adults on ART and children on ART, with one notable exception being Eswatini where over 98% of children living with HIV are on ART.
- Women are generally much more likely than men to be on ART. The exceptions are Comoros and Mauritius where higher percentages of men living with HIV are on ART.
- Data on viral suppression is not available for all countries. However, for those countries that do have this data, there is good progress. Botswana, Eswatini, Lesotho, Malawi, Namibia, Tanzania, Zambia and Zimbabwe all have suppression rates over 73% which is the target for 90-90-90 coverage.
- Coverage of ART for Prevention of Mother to Child Transmission (PMTCT) is improving rapidly even in post conflict countries such as Angola and DRC. Where coverage is over 95% the transmission rate from mother to child is falling - South Africa's achievement of 3,5% transmission is notable given the size of the South African epidemic. However, transmission rates from mother to child remain unacceptably high in Angola (15.9%), DRC (22.6%) and Madagascar (41.3%) - pointing to the need for continued vigorous efforts to prevent transmission.
- Positive responses among women to the question "a woman has the right to insist on a man using a condom" varies widely, from 17% in Mozambique to 68% in Seychelles. Amongst men there was similar variation of 17% in Namibia to 71% in Zimbabwe.

COVID-19, HIV and AIDS



SADC experienced several waves of COVID between March 2020 and the end of 2021, with extended school closures, times when health services were not accessible and severe economic impact on many millions. Several countries experienced severe levels of illness and mortality resulting from COVID-19. People living with HIV experienced worse outcomes than those who were HIV negative. COVID had a negative impact on prevention, testing and initiation on ARV. Many treatment programmes were able to make quick adaptations to community-based responses to maintain those on treatment.

A shared lesson from both HIV and COVID-19 is that inequalities must be addressed - a pandemic can only be addressed effectively when its impact on all is prioritised. There have been distinct similarities in the impact of both pandemics across socio-economic, gender and other societal fault lines, with the weakest and most marginalised being the most affected:

- More women have been affected by both HIV and COVID in Southern Africa (while men have been more impacted by both in other regions);
- Men have been more hesitant to seek health care and support;
- Women and girls have been responsible for a disproportionate amount of unpaid care work in the home as well as paid formal sector care work;
- Many have been left behind due to stigma and discrimination, and been afraid to access health care, which has worsened both pandemics;
- The better off generally are able to protect themselves better and have suffered less from both pandemics than those from poorer socio economic groups.

Some recommendations that were made to reduce the impact of COVID-19 are very applicable for HIV as well[5]:

a. **Address the different needs of women and girls**, paying attention to the most marginalised.
b. **Recognise and guarantee access to essential health services** particularly SRHR, ante- and post-natal care.
c. **Address the neglected epidemic of gender-based violence against women and girls** Without attention this epidemic has simmered around the world and has soared during lockdowns where relationships have been strained due to poor mental health, security and income and cramped living conditions. This epidemic has contributed to increased spread of HIV.
d. **Stop misuse of criminal and punitive laws**, especially those that criminalize sex work, LGBTQ and drive these people away from services.
e. **Prioritise adolescent girls' and young women's education, health and well-being** Adolescent girls are more likely than boys to drop out completely after school closures and to face early marriage or trafficking. Being in school is an important measure to prevent spread of HIV in adolescent girls and boys.
f. **Value women's work and make unpaid care work everybody's work**: During the COVID-19 crisis unpaid care work has increased tremendously. Even before COVID-19 women did at least two and a half times more unpaid care work than men.

Some of the adaptations to HIV service delivery, which it is suggested should be maintained, post COVID-19 were[6]:

- Virtual support on mobile phones can accelerate ART initiation and facilitate monitoring in both facilities and communities.

[5] UNAIDS. 2020. Six Concrete Measures to Support Women and Girls in All Their Diversity in the Context of the COVID-19 Pandemic. Geneva. UNAIDS.
[6] Grimsrud A et al. Silver linings: how COVID-19 expedited differentiated service delivery for HIV. Journal of the International AIDS Society 2021, 24(S6):e25807 https://doi.org/10.1002/jia2.25807 Accessed 3 March, 2022.

- Differentiated Service Delivery (DSD) for HIV treatment can benefit those recently started on ART and those on second-line regimens - with dispensing happening in the community.
- Extended ART refill durations or Multi month dispensing (for three to six months) should be a new standard of care.
- Expand access to community-based services.
- DSD for HIV is relevant even in more highly resourced settings.
- DSD and telephone communication can also be used for HIV prevention, such as access to PrEP, and for tuberculosis (TB) treatment.

The first year of COVID-19 set TB gains back by more than 10 years

Lessons learnt in the COVID response that may be useful in the HIV response[7] include:

- More effort including push (investment) and pull (advance orders) may help to develop a vaccine for HIV;
- In addition to investing in developing a vaccine there is need to prioritise planning and effort for roll out and distribution of vaccines;
- Clinical trials of vaccines and therapeutics were conducted in shorter than normal time spans, showing that there are adaptations that can be used to shorten times for trials;
- There are adaptations to testing - especially home testing - that can be adopted to improve testing for HIV;
- The energetic and innovative engagement of non-health sectors in the COVID-19 response was critical.

The COVID-19 response highlighted how little has been invested in TB. Governments invested US$104 billion into COVID-19 research developed within 11 months, compared to only $5.5 billion in TB research in ten years. As immunisation has reduced TB in much of the world it is now a disease associated with poverty - poor nutrition, poor and overcrowded living conditions and poor access to good health care. The lower investment in TB research reflects the fact that this disease is of less concern to rich countries. In the first year, COVID-19 resulted in setbacks to the TB programme of over ten years.[8]



Testing in any pandemic is key: GL Eswatini facilitator Thandokuhle Dlamini tests for HIV at Mbabane Clinic. Photo: Gender Links

HIV Prevalence

The HIV prevalence in SADC is generally beginning to decline slowly. However, SADC still has the highest prevalence rates in the world (the only countries with prevalence over 10%). Eswatini and Lesotho have prevalence rates above 20% while six other SADC countries (Zambia, Mozambique, Zimbabwe, Namibia, South Africa and Botswana) have adult prevalence rates which are between 10 and 20%.

[7] The International AIDS Society. 2022. Lessons from the structural innovations catalysed by COVID-19 for the HIV response. Geneva, Switzerland https://www.iasociety.org/sites/default/files/IAS-Lessons-from-COVID-for-HIV_report_2022.pdf accessed 4 August, 2022.

[8] Rangaka, M. Hamada, Y. Abubakar, I. Ending the tuberculosis syndemic: is COVID-19 the (in)convenient scapegoat for poor progress? Lancetresp Vol 10 June 2022. Published Online March 23, 2022 https://doi.org/10.1016/S2213-2600(22)00123-0 Accessed 25 June, 2022.

Figure 5.1 HIV Prevalence in SADC 2021

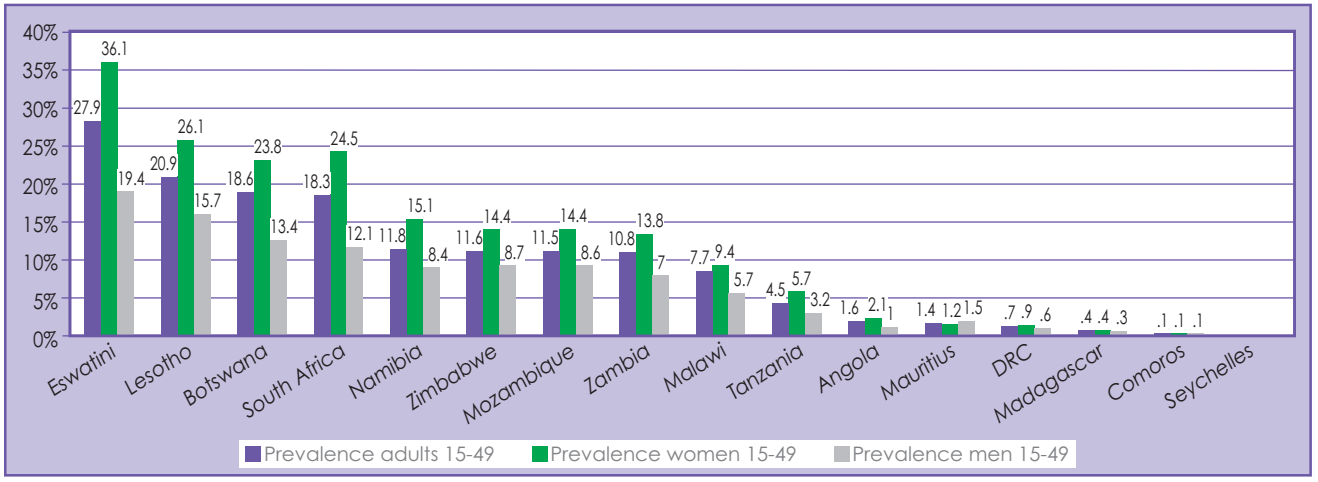


Table 5.2 HIV Prevalence in SADC, 2021

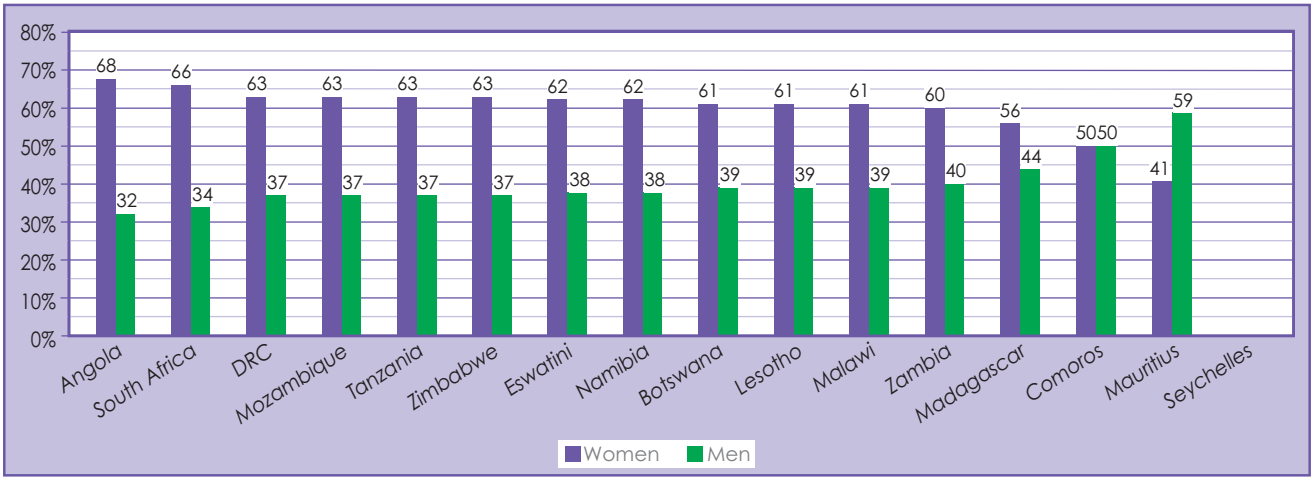
Country	Prevalence Adults 15 - 49	Prevalence Women 15 - 49	Prevalence Men 15 - 49	Prevalence Young women	Prevalence young men	Ratio Young women: young men
Eswatini	27,9	36,1	19,4	12,6	4	3,2
Lesotho	20,9	26,1	15,7	8,9	3,9	2,3
Botswana	18,6	23,8	13,4	6,6	3,5	1,9
South Africa	18,3	24,5	12,1	9,1	3	3,0
Zimbabwe	11,8	15,1	8,4	6,1	2,7	2,3
Namibia	11,6	14,4	8,7	4,7	2,6	1,8
Mozambique	11,5	14,4	8,6	6	3	2,0
Zambia	10,8	13,8	7	5	2	2,5
Malawi	7,7	9,4	5,7	3,2	1,8	1,8
Tanzania	4,5	5,7	3,2	1,9	1	1,9
Angola	1,6	2,1	1	0,8	0,3	2,7
Mauritius	1,4	1,2	1,5	0,3	0,2	1,5
DRC	0,7	0,9	0,6	0,3	0,2	1,5
Madagascar	0,4	0,4	0,3	0,1	0,1	1,0
Comoros	0,1	0,1	0,1	0,1	0,1	1,0
Seychelles						

Source: Compiled from UNAIDS 2022 Data https://aidsinfo.unaids.org/ accessed 30 July, 2022.

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

- Adult prevalence rates range from 0.1% in Comoros to 27.9% in Eswatini (which is slightly higher than in 2021).
- Seychelles, which has a total population of under 100 000 and a very low prevalence rate, has such small total numbers of people living with HIV that percentages are of little value. Thus, very little data is available and Seychelles is missing from much discussion in this chapter. Comoros and Mauritius have higher populations and thus have more data available.
- The island nations have pandemics that have been largely driven by key populations. Most of SADC has a generalised, heterosexual pandemic. The pandemic in Madagascar is becoming generalised and prevalence is now higher in women than in men, where it has been higher in men than women. Prevalence in young women in Mauritius is now higher than in young men though overall prevalence is still higher in men than women.
- The differences in prevalence rates are particularly high for young women as compared to young men. HIV prevalence is three times higher in young women than young men in Eswatini and South Africa and at least double in Angola, Zambia, Lesotho, Zimbabwe, and Mozambique.

Figure 5.2: Proportion of Women and Men Living with HIV in 2021



Source: Gender Links, derived from UNAIDS Data 2022 https://aidsinfo.unaids.org/ accessed 28 July, 2022.

Figure 5.2 shows the proportion of women and men living with HIV across SADC. There are more women living with HIV in most of SADC. The highest proportions are in Angola and South Africa. There are now more women than men living with HIV in Madagascar. Mauritius is the only member state that has more men than women living with HIV.

HIV transition Metrics

The incidence to prevalence ratio comprises 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 three.

Table 5.3 shows that the transition metrics have continued to improve. Data for 2021 indicate that Zimbabwe, Botswana, Malawi, Lesotho, South Africa and Zambia have achieved the tipping point of three and should all experience a decline in the HIV epidemic. Namibia, Eswatini and Tanzania are very close to the tipping point. The only countries which are experiencing increase in the metric are Madagascar and Mauritius. Globally the incidence to prevalence ratio declined to 3.85.

Table 5.3: Transition Metrics - Incidence: Prevalence ratio

Country	2000	2020	2021
Zimbabwe	7,86	1,9	1,75
Botswana	10,74	2,12	1,96
Malawi	10,02	2,13	1,99
Lesotho	12,96	2,79	2,59
South Africa	17,44	3,01	2,83
Zambia	10,6	3,21	2,85
Namibia	13,14	3,07	3,07
Eswatini	14,48	3,4	3,12
Tanzania	9,76	3,57	3,13
DRC	9,66	4,43	3,8
Comoros	15	4,79	4,73
Angola	19,55	5,94	5,41
Mauritius	28,54	5,4	5,63
Madagascar	32,62	15,37	15,81
Mozambique	17,9	4,76	na
Global	11,12	4,05	3,85

Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/

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.

Table 5.4: Most recent HIV and AIDS policy or strategy

Country	Most recent HIV strategy	Year
Mozambique	Plano Estratégico do Nacionale de combate HIV e SIDA - PEN V 2021 - 25	2021
Malawi	Malawi National Strategic Plan for HIV and AIDS 2020-2025	2020
Zimbabwe	Zimbabwe National HIV and AIDS Strategic Plan IV (2021-2025)	2020
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
DRC	Plan Strategique National De La Riposte au VIH/SIDA 2018-2021	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 National Comprehensive Condom Strategy and Operational Plan 2020 - 2025	2017 2020
Namibia	National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 - 2021/22 National HIV Action Plan 2017-2021	2017
Mauritius	Plan Strategique National de Reponse aux Infections Sexuellement Transmissibles et au SIDA a	2017
Madagascar	Madagascar 2013 - 2017	2014
Comoros	National Strategic Plan 2011 - 2015	2011

Source: GL Audit of SRHR Policies and Laws 2020.

Table 5.4 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. There are some plans that should have been reviewed, and others that require review now. The Global Strategy 2021 - 26 will give impetus to policy reviews at country level.

All countries have a strategic HIV and AIDS plan

Table 5.5: 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. Parental consent not required
- No data
- Criminalised. Parental consent required. Testing required for some permits
- 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: UNAIDS. 2022. Global AIDS Update. 2022. In Danger. Geneva, UNAIDS.

Table 5.5 shows that the legal framework in SADC generally fails to protect the rights of key populations such as sex workers and people in same sex relationships. There have been no changes from 2021 in this regard. Though the HIV epidemic in SADC has been largely driven by new infections in adolescents, new infections among key population groups is on the rise. In 2021, the proportion of new infections in different groups in East and Southern Africa consisted of[9]:

- 13% sex workers;
- 3% people who inject drugs;
- 3% gay men and other men who have sex with men;
- 2% transgender women;
- 25% clients of sex workers and sexual partners of all key populations.

One of the goals of the global strategy is three tens for societal enablers. One of these 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 key populations hinders their access to services and will continue to fuel the HIV epidemic. This issue requires attention in the next five years.

[9] UNAIDS. 2022. Op Cit.

Article 27. 3: State Parties shall:
a) Develop gender sensitive strategies to prevent new infections.
BPFA +20 Africa Declaration: (h) Scale up combined preventive HIV/AIDS measures for young women and girls and expand programmes to eliminate mother-to-child transmission;

SADC SRHR Strategy: HIV and AIDS ended as a public health threat by 2030 (SDG 3.3.);
ICPD: 7.32 Information, education and counselling for responsible sexual behaviour and effective prevention of sexually transmitted diseases, including HIV, should become integral components of all reproductive and sexual health services.

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

o Achieve universal access to comprehensive HIV prevention, programmes, treatment, care and support to all women and girls and achieve universal health coverage.
o 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,
o Eliminate mother-to-child transmission and keep mothers alive.
o Provide combination prevention for women and girls for the prevention of new infections, to reverse the spread of HIV and reduce maternal mortality.
o Avail comprehensive data disaggregated by age and sex to inform a targeted response to the gender dimensions of HIV and AIDS.
o Build up national competence and capacity to provide an assessment of the drivers and impact of the epidemic.
o Support action-oriented research on gender and HIV and AIDS, including on female-controlled prevention commodities.

Achieving 95-95-95 by 2025

The Global AIDS Strategy 2021 - 26 puts much focus on those who have not been reached so far. These include adolescents and young women who are at greater risk in SADC of contracting HIV than boys and young men; men in general who are much less likely to access any HIV services than women; children (particularly those aged 5 to 14) and members of key populations. Other disparities are between rural and urban areas, poorer and better off, those with less or more education. The strategy emphasises better understanding of why men are not accessing services, how to reach children and key populations.

The global strategy focuses on reaching those that are not being reached

Table 5.6: Progress towards achieving the 95-95-95 goals in SADC

Country	Progress 95-95-95 Adult women 2021	Progress 95-95-95 Adult men 2021
Zimbabwe	>98 >98 94	95 95 >98
Malawi	98 >98 95	89 92 >98
Botswana	95 >98 >98	93 94 >98
Namibia	95 >98 94	88 96 >98
South Africa	95 >98 92	92 75 95
Eswatini	94 >98 98	91 94 >98
Lesotho	94 90 >98	92 82 92
Zambia	94 >98 97	90 >98 >98
Tanzania	93 >98 98	85 91 >98
DRC	90 >98	84 >98 >98
Comoros	85 68 93	95 71 >98
Mozambique	81 68 55	
Angola	64 73	55 66
Mauritius	40 47 67	67 47 55
Madagascar	17 97	15 97 >98
Global	89 >98 92	82 86 >98

Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed 29 July, 2022.

Table 5.6 shows the progress towards achievement of 95 95 95 for women and men. Many countries in SADC have made great progress, especially for women. These include Zimbabwe, Malawi, Botswana, Namibia, South Africa, Eswatini, Lesotho and Zambia. Madagascar, Mauritius and Angola have lower levels of achievement. There are marked differences in achievements for women and men with percentages of men who have accessed testing, treatment and are adhering to treatment generally lower than those of women. However, in Mauritius and Comoros the percentages of men are higher than of women.

Recognising the need to engage more men, UNAIDS East and Southern Africa developed a Framework for Male Engagement in HIV Testing, Treatment and Prevention which was launched in 2022[10]. The framework is responding to lower levels of testing, initiating ART and adhering to ART in men than in women. The proportion of men that are dying is also higher than that of women. The strategy promotes intentional creation of an enabling environment to encourage men to access health services (structural enablers) and seeks to accelerate action at many levels to reach men and boys with HIV services (programmatic strategies).



Botswana: Three countries have been officially recognised as reaching the 95 95 95 targets already. These are Eswatini and Switzerland in late 2021 and Botswana recently. Madisa Mine, former head of the Botswana National HIV Reference Laboratory presented findings of the fifth Botswana HIV/AIDS Impact Survey (BAIS V), 2021 to the International AIDS Conference in Montreal in late July, 2022. The study included a nationally representative survey of 14,763 adults aged 15 - 64 years old. The results showed 95.1% of people living with HIV (men: 93.0%; women: 96.4%) knew what their status was; 98.0% (men: 97.2%; women: 98.4%) of those aware were on ART, and 97.9% (men: 96.6%; women: 98.6%) of those on ART were virally suppressed. The percentages were lower for young people living with HIV (aged 15 - 24).[11]



HIV and AIDS features strongly in all Botswana campaigns. Photo: Mboy Mswabi

Strong political will is at the heart of this success. Former President Festus Mogae introduced the Masa (New Dawn) programme in 2002 when Botswana had an adult prevalence of 35, 8%. He is credited with setting Botswana on the path to where it can realistically plan to end the AIDS epidemic by 2030. This has been achieved without politicising the HIV response.[12]

All member states need to put much more emphasis on reaching 95 95 95 targets for all sub populations, such as adolescent girls and young women, sex workers and other key populations. The challenges of doing this are illustrated in the media article by Lungelo Ndhlovu, reporting from Zimbabwe:

[10] UNAIDS. 2022. Male engagement in HIV testing, treatment and prevention in eastern and southern Africa - A framework for action. Geneva, UNAIDS.
[11] https://www.unaids.org/en/resources/documents/2022/male-engagement-hiv-testing-treatment-prevention-eastern-southern-africa Accessed 20 June, 2022. Mine, M et al, Botswana achieved the Joint United Nations Programme on HIV/AIDS (UNAIDS) 95-95-95 targets: results from the Fifth Botswana HIV/AIDS Impact Survey (BAIS V), 2021. https://programme.aids2022.org/Abstract/Abstract/?abstractid=12921 Accessed 30 July, 2022
[12] Thornton, J. Botswana HIV Success. www.thelancet.com Vol 400 August 13, 2022 DOI:https://doi.org/10.1016/S0140-6736(22)01523-9 Accessed 15 August, 2022.



New HIV infections among young women worrying

The prevalence of new HIV infections among young girls and women is a cause for concern in Zimbabwe, with 1,705 new HIV infections recorded among females in Bulawayo-Metropolitan province alone, according to the National Aids Council of Zimbabwe (NAC). The HIV prevalence rate among adults in Bulawayo between the ages of 15 and 49 years is 13.77%, higher than the national prevalence of 12.9% which corresponds to approximately 1.23 million adults in Zimbabwe living with HIV in 2020. The 2020 Zimbabwe Population-based HIV Impact Assessment (ZIMPHIA) indicates that HIV prevalence was higher among women (15.3%) than men (10.2%).

Speaking at the signing ceremony for the Fast-Track Cities, a UNAIDS initiative, in Bulawayo recently, city Mayor, Councillor Solomon Mguni, said new infections in women were double the number of infections in men, though infections have declined by about 50% between 2010 and 2020. Prevalence of HIV in key populations and vulnerable communities are also of grave concern. 19 clinics in Bulawayo offer HIV and AIDS integrated programming with a special focus on key populations, as a show of commitment towards HIV programming. The clinics prioritise non-bias in all staff.

Director of Operations, National AIDS Council (NAC), Raymond Yekeye, indicated that although Zimbabwe was moving in the right direction towards ending HIV by 2030, there were still some gaps in achieving the United Nations General Assembly's Political Declaration on Ending AIDS' 90-90-90 targets. Yekeye further indicated that having a generation who has never been exposed to the hard-hitting impact of HIV is a risk in itself. He stated that alcohol and substance abuse, early child marriages, cases of gender based violence also contributed to new infections - particularly during COVID-19.

The Southern African Gender Protocol 2020 Voice and Choice Barometer indicates that though the world missed the UNAIDS 2020 "90-90-90" targets, four of the eight countries which did achieve the targets are in Africa: Eswatini, Botswana, Malawi and Uganda. A further 11 countries globally reached the overall 73% viral suppression target, including Zimbabwe, Lesotho, Namibia and Zambia in SADC; but did not achieve one of the three 90s, the gender protocol indicated.

Sophia Mukasa, the UNAIDS Country Director commended the city of Bulawayo's progress on the HIV response. She welcomed the city on joining 350 other cities and municipalities globally which have joined the Fast-Track Cities Initiative since its inception in 2014. She also spoke of the importance of making sure that all marginalised and vulnerable groups in society had access to healthcare services.

Nothando Hadebe, the Public Relations Officer for the Youth Initiative for Empowering Leadership and Development (YIELD) said the City of Bulawayo should prioritise young people's Sexual and Reproductive Health and Rights (SRHR). YIELD focuses on young people in the age range between 18-24 years and believes that emphasis on SRHR is needed to reduce the prevalence of new infections amongst girls.

"The city of Bulawayo should establish health booths as per wards. In as much as we have Econet booths (for cell phone airtime), health booths are ideal for easy access to SRHR services. In this case, people don't really need to go to the clinics or hospitals where they are tormented," she said.

Source: Ndlovu, Lungelo. 10 February, 2022. New HIV Infections Among Young Women Worrying' GL Sixteen Days of Activism News series[13].

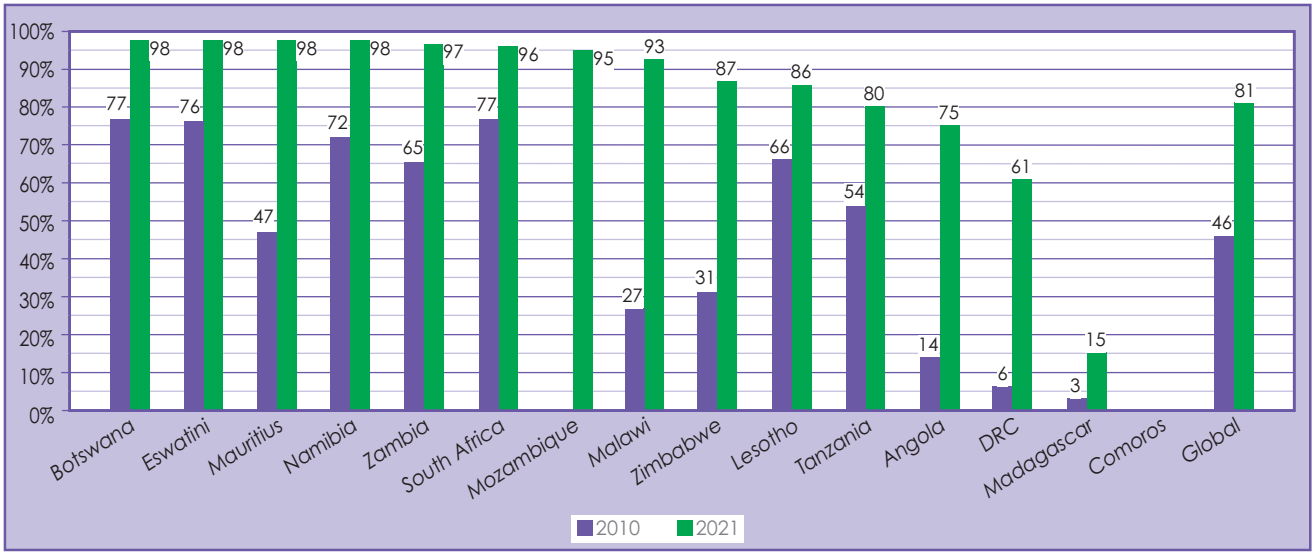
[13] https://genderlinks.org.za/news/zim-new-hiv-infections-among-young-girls-and-women-worrying/

Elimination of Mother to Child Transmission

Recognising that one of the most glaring gaps in the AIDS response has been prevention and access to treatment for children, a Global Alliance to End AIDS in children by 2030 was launched during the 2022 International AIDS Conference. Founding members of the Alliance include UNAIDS, UNICEF, PEPFAR, the Global Fund, the Global Network of People living with HIV. It also includes twelve countries, of which Angola, DRC, Mozambique, South Africa, Tanzania, Zambia, and Zimbabwe are in SADC. The Alliance will focus on four pillars for collective action:[14]

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

Figure 5.3: ART Coverage for Pregnant women 2010 and 2021



Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed 30 July, 2022.

Figure 5.3 reflects tremendous progress between 2010 and 2021 in access to ART for pregnant women living with HIV. Seven member states have achieved at least 95% coverage. Angola and DRC have made marked progress even though their rate of coverage is still only 75% and 61%. Increased effort is needed in Madagascar.

[14] UNAIDS. New global alliance launched to end AIDS in children by 2030. 1 August, 2022. https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2022/august/20220801_new-global-alliance-launched-to-end-AIDS-in-children-by-2030 accessed 2 August, 2022 and UNAIDS. 2022. The Global Alliance to End AIDS in Children. Geneva. UNAIDS.

Table 5.7: Pregnant Women on ART 2010 - 2021, Vertical Transmission

Country	Coverage Pregnant women for PMTCT %		Vertical transmission rate %		No of HIV Exposed Uninfected Children	
	2010	2021	2010	2021	2010	2021
Botswana	77	98	9	2	5700	180000
Eswatini	76	98	12	3	200	140000
Mauritius	47	98	17	5	100	1700
Namibia	72	98	13	5	2100	140000
Zambia	65	97	21	8	27000	640000
South Africa	77	96	13	4	14000	4100000
Mozambique		95		13		
Malawi	27	93	29	8	43000	550000
Zimbabwe	31	87	24	9	76000	780000
Lesotho	66	86	17	8	1000	140000
Tanzania	54	80	22	11	64000	950000
Angola	14	75	32	15	2600	260000
DRC	6	61	39	23	52000	280000
Madagascar	3	15	48	41	100	10000
Comoros						
Total SADC					287800	8171700
Global	46	81	24	12	860000	15900000
SADC as % of Global					33%	51%

Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ Accessed 30 July 2022.

Table 5.7 shows how increased coverage of ART for pregnant women has been accompanied by declining rates of transmission to babies - these are now 5% or lower in five member states. South Africa's achievement of 4% is remarkable in view of the extent of the epidemic in South Africa. Mozambique, Tanzania and Angola are still over 10%, while DRC at 23% and Madagascar at 41% are cause for concern and action.



In December 2021 the World Health Organization announced that **Botswana** was the first country with a high HIV burden to have been certified to have achieved "silver tier" status, on the path to elimination of Mother to Child transmission. This status means the mother-to-child HIV transmission rate is below five percent, more than 90 percent of pregnant women receive antenatal care and antiretroviral treatment, and the HIV case rate is fewer than 500 per 100,000 live births[15].

Table 5.7 also shows that as fewer children are being born infected by HIV, there is a huge increase in the numbers of HIV Exposed but Uninfected (HEU) children. In 1990 SADC accounted for at least 287 800 or 33% of the global total of 860 000, while in 2021 SADC accounts for 8 171 700 or 51% of the global total of 15 900 000 of HIV exposed and uninfected children.

Botswana has been granted silver status on the path to elimination

In 2018,[16] five countries accounted for 50% of the 14·8 million children who were HEU globally: 3·5 million (23·8%) in South Africa, 1·1 million (7·5%) in Uganda, 1·0 million (6·6%) in Mozambique, 910 000 (6·1%) in Tanzania, and 880 000 (6·0%) in Nigeria. Zimbabwe, Malawi and Zambia had between 500 000-850 000 HEU children. While

[15] Mbewa, D. Botswana edges closer to closer to eliminating mother-to-child HIV transmission. December 2, 2021. https://africa.cgtn.com/2021/12/02/botswana-edges-closer-to-closer-to-eliminating-mother-to-child-hiv-transmission/

absolute numbers are lower in other countries, the rate of increase between 1990 and 2021 is very high.

The national prevalence of children that are HEU is highest in Eswatini - 32, 4%; Botswana - 27, 4%, South Africa - 21, 6%, Lesotho - 21, 1% and Namibia - 16, 4%.

Evidence suggests[17]:

- Children that are HEU have poorer development outcomes than those that have not been exposed to HIV.
- Infants who are HEU and also born preterm or small-for-gestational age, or experience nutritional deficits (stunted, wasted or being underweight-for-age), or those cared for by women experiencing mental health challenges are at the highest risk of developmental delays.
- Risk factors for mental health disorders among adolescents who are HEU are similar to those in adolescents and youth living with HIV (AYLHIV). Depression, anxiety, trauma, difficulty in psychosocial adjustment with significant loss of self-esteem, as well as suicidal behaviours have been reported among adolescents and youth who are HEU.
- HEU adolescents are largely invisible, as healthcare systems are not aware of their HIV-exposure status. The multidisciplinary care and support for AYLHIV does not exist for HEU adolescents.
- Research from South Africa has shown that adolescents whose parents/caregivers are living with HIV have poorer school outcomes compared with those from HIV-unaffected households and experience high rates of stigma.
- In a South African study, 57% of adolescent girls living with a parent with advanced HIV, who did not have enough to eat and were physically or emotionally abused, were engaging in transactional sex compared with only 7% of girls living with a parent with advanced HIV but who were not hungry or abused.
- Adolescent mothers living with HIV face challenges with ART adherence during pregnancy, which increases the risk of perinatal HIV transmission.

Prevention

2025 TARGETS AND COMMITMENTS in the 2021 Political Declaration on AIDS

- Reduce new HIV infections to under 370 000 by 2025.
- Ensure that 95% of people at risk of HIV infection, within all epidemiologically relevant groups, age groups and geographic settings, have access to and use appropriate, 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, people who inject drugs, transgender people, people in prisons and other closed settings and all people living with HIV.
- Reduce the number of new HIV infections among adolescent girls and young women to below 50 000.
- Ensure availability of 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.

[16] Slogrove, A, Powis, K, Johnson, L. Stover, J. Mahy, M. Estimates of the global population of children who are HIV-exposed and uninfected, 2000-18: a modelling study. Lancet Glob Health 2020;8: e67-75 Published Online November 29, 2019 https://doi.org/10.1016/S2214-109X(19)30448-6 Accessed 15 March, 2022.
[17] Udedi, E. 2020. Surviving and Thriving HIV-Free: Report of the 4th HIV-Exposed Uninfected Child and Adolescent Workshop. International AIDS Society. Cipher Paediatric HIV Matters. https://www.academia.edu/es/63062420/Surviving_and_Thriving_Hiv_Free_Report_of_the_4TH_Hiv_Exposed_Uninfected_Child_and_Adolescent_Workshop Accessed 15 March, 2022.
[18] UNAIDS. 2021. Global AIDS Update. 2021. Confronting Inequalities Lessons for pandemic responses from 40 years of AIDS.

The Global Prevention Coalition (GPC) for HIV Prevention brings together 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.

Table 5.8 Overall Prevention Score Card for SADC countries in the GPC *(scores 0 to 10)*

Country	AGYW and partners	Sex workers	MSM	PWID	Condoms	VMMC	VMMC	PrEP
Angola	3	3	3				3	
Botswana	6	4	6			2	9	5
DRC	4	2	3	0	2		7	3
Eswatini	7	2	9	6	7	3	10	8
Lesotho	8	5	4			4	8	8
Malawi	4	6	7		6	1	9	4
Mozambique	4	3		0	4	3	7	4
Namibia	5				9	5	9	
South Africa	5	8	5	2	6	4	7	6
Tanzania	2	3	4	5	2	10	8	5
Zambia	3	5		0	3	10	8	8
Zimbabwe	4	6	5		7	3	9	8

KEY Not applicable; Insufficient data; Very low (0-4); Low (5-6); Medium (7); Good

Source: Gender Links compiled from HIV Prevention Score Card 2021.[19]

Table 5.8 shows that prevention programming is not satisfactory. The only aspect of prevention programming that is good is HIV treatment. Scores for programmes on Adolescent Girls and Young women (AGYW) have not changed greatly. Only Lesotho's programme is rated as good.

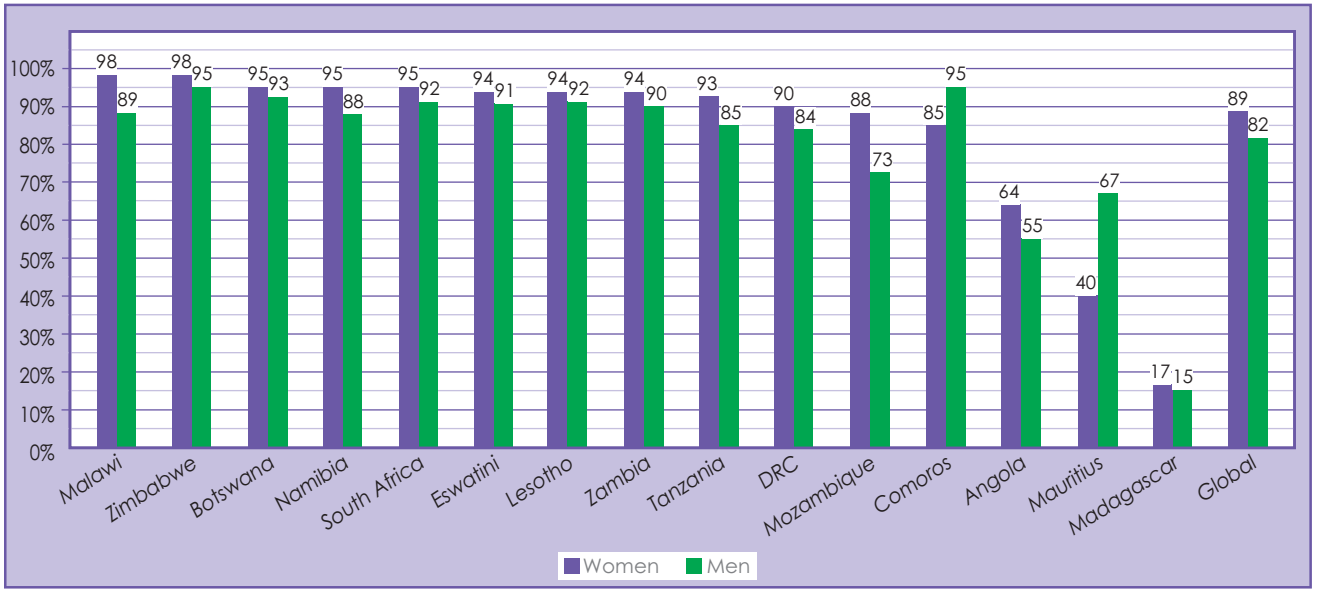
Table 5.8 shows that insufficient attention is being given to prevention programming amongst key populations. Scores for sex worker programming have generally declined, with some increases in Lesotho, Malawi and South Africa. Nine countries reported on programmes for men who have sex with other men, two more than in 2020, with improved scores in Eswatini and Malawi. Prevention programmes which were seriously derailed by COVID-19 - including condom supply and distribution as well as the Voluntary Medical Male Circumcision (VMMC) programmes - are taking time to recover. Six countries had condom programmes rated as good in 2020. In 2021, only Namibia is good and Eswatini medium.

Five key findings from the score card include:

1. New HIV infections are declining in most countries, but too slowly.
2. Major gaps persist in programmes and data on HIV prevention among key populations.
3. Prevention among adolescent girls and young women and their male partners shows increasing effort but insufficient coverage.
4. Access to prevention tools (such as condoms) remains uneven and suffered disruptions.
5. More emphasis and support are needed to improve and consolidate national and implementing partner programme data for analysis at the national level.

[19] Geneva, UNAIDS. Global HIV Prevention Coalition. 2022. Key Findings from 2021 Scorecards of the Global HIV Prevention Coalition. Geneva. UNAIDS. https://www.unaids.org/sites/default/files/media_asset/key-findings-2021-scorecards-global-hiv-prevention-coalition_en.pdf Accessed 30 July, 2022.

Figure 5.4 Women and Men Living with HIV who know their status



Source: Genderlinks compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed 30 July, 2022.

Figure 5.4 shows that the proportion of women who know their HIV status is generally high across SADC. Zimbabwe, Botswana, South Africa Eswatini, Lesotho, and Zambia have achieved over 90% knowledge of HIV status in both women and men. In Malawi, Namibia, Tanzania and DRC over 90% women and 89%, 88%, 85% and 84% respectively of men know their HIV status. Comoros has achieved 95% of men and 85% 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.

Table 5.9 New Infections and HIV incidence, 2021

Country	HIV Incidence			Change in number of people acquiring HIV 2010 - 2020	
	Young people 15 - 24	Adults 15 - 49	Adults 50 & over	Adolescent Girls /Young Women 15-24*	All
Eswatini	10,37	14,88	4,96	-57	-64
Lesotho	6,98	8,1	2,58	-53	-59
South Africa	7,51	6,9	2,79	-48	-45
Botswana	4,96	6,03	1,04	-39	-37
Namibia	5,33	5,16	1,44	-46	-48
Zambia	3,83	4	1,45	+12	-6
Zimbabwe	2,36	2,37	0,63	-65	-66
Malawi	1,69	1,93	0,59	-52	-64
Tanzania	1,36	1,55	0,79	-25	-35
Mauritius	0,66	0,92	0,2		-24
Angola	0,83	0,86	0,25	-16	-26
Madagascar	0,3	0,6	0,12		+159
DRC	0,22	0,26	0,09	-51	-50
Comoros	0,01	0,01	0,01		-30
Mozambique				-20	-33
Global	**0,34**	**0,31**	**0,06**		**-31**

*Data only from Global HIV Prevention Coalition focus countries.

Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed August 5, 2022 and HIV Prevention Scorecard 2021.

Table 5.9 shows that while the epidemic is beginning to slow, incidence or new infections per 1000 population, remain high in much of SADC and especially in Eswatini, Lesotho, South Africa, Botswana, Namibia, Zambia and Zimbabwe. Incidence for adults aged 15 to 49 is higher than for young people aged 15 to 24 in most countries, but it is higher in young people in South Africa and Namibia and very similar in Zimbabwe, Angola and DRC.

Generally, rates of new infections have been going down for young people and overall. But between 2010 and 2020 rates of new infections increased in young people in Zambia. The steep increase in rates of new infections in Madagascar is concerning. There are still new infections in adults over 50, though incidence is much lower than in younger adults, which means that continuous testing is needed.

None of the SADC member states met the target of reducing new infections by 75% between 2010 and 2021. Zimbabwe, Eswatini and Malawi reduced new infections by over 60%. Among SADC member states only Zimbabwe had a 60% decline in new infections among AGYW. Zambia had increased AGYW new infections and Madagascar had increased new infections overall between 2010 and 2021.

Education plus Initiative launched

The Organisation of African First Ladies (OAFLAD) launched the "Education Plus", 2021-2025 initiative in the margins of the 2022 African Union (AU) Mid-Year Summit in Lusaka, Zambia. The initiative focuses on enabling all girls and boys to complete a free, quality secondary education with universal access to comprehensive sexuality education, fulfilment of SRHR, freedom from gender-based and sexual violence, school-to-work transitions, and economic security and empowerment for women. The commitments made through this initiative signals major investment in education as an HIV prevention strategy for adolescent girls. Eswatini, Lesotho, Malawi and South Africa in SADC are amongst the ten initial country members of the programme.



Analysis of HIV incidence in **Botswana**, following a policy change in 1996 to make universal secondary education available, found that each additional year of secondary schooling resulting from the policy change led to an absolute reduction in the cumulative risk of HIV infection of 8.1% (11, 6% for women). The study concluded that increasing access to secondary school could be a cost effective HIV prevention measure in HIV endemic settings[20]. Increased access to education also reduces poverty, improves health outcomes and stimulates social and economic development.



President Hakainde Hichilema of **Zambia** said at the launch, "Education is the greatest equalizer and with appropriate education, everyone is given an opportunity to explore their full potential and be able to participate in the development process. Access to education empowers both girls and boys as it enhances their ability to access decent jobs and other means of production thus alleviating poverty."[21]

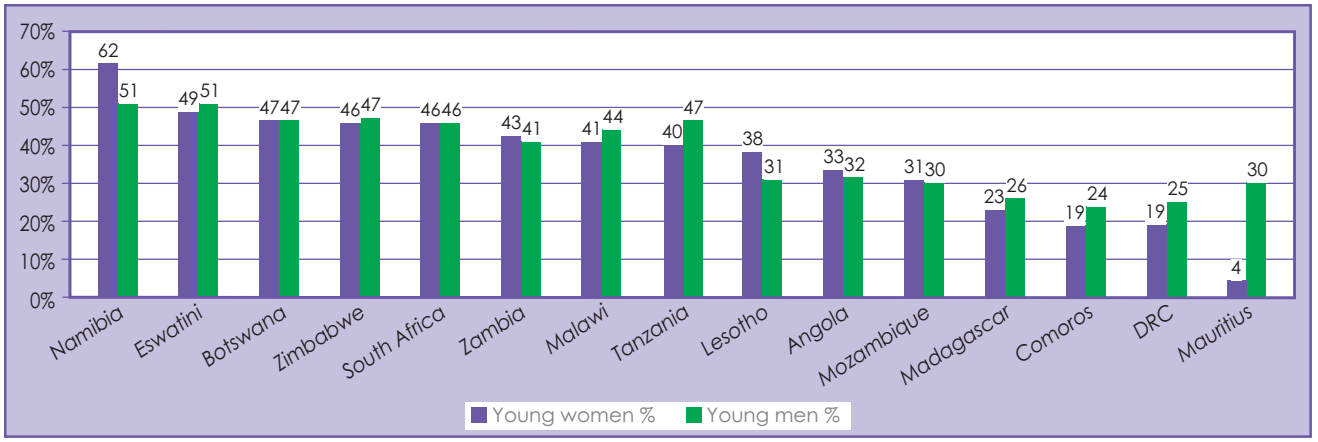
[20] De Neve JW, Fink G, Subramanian SV, Moyo S, Bor J. Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment. Lancet Glob Health. 2015;3(8):e470-e477. Accessed 17 July, 2022.

[21] UNAIDS Press Release. African leaders launch the Education Plus initiative - a huge step forward for girls' education and empowerment in Africa, 18 July, 2022. https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2022/july/20220717_continental-launch-education-plus-initiative accessed 27 July, 2022.

Comprehensive, accurate knowledge of HIV and AIDS

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

Figure 5.5: Knowledge on HIV prevention among young people



Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed 28 July, 2022.

Figure 5.5 illustrates that levels of knowledge about HIV are still well below the goal of 90%, indeed 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 school disruptions as teachers focus on the core curriculum rather than extra-curricular concerns.

Condoms

Condom programming is still one of the most cost effective prevention measures available, though focus on condoms has declined since ARVs became available. It is critical that continued focus is given to both male and female condoms.



Table 5.10: Number of Condoms distributed or sold in 2019/2020

Country	2019	2020	% of condom distribution need met (2020) for selected GPC members
Namibia		34 000 000	100
Eswatini	12 144 576	14 809 730	86
Zimbabwe	94 849 706	82 720 989	67
South Africa	635 981 213	558 190 486	65
Malawi	154 442 236	81 219 283	60
Mozambique	95 715 852	84 273 291	30
Zambia	19 392 644	17 252 787	11
DRC		36 169 500	6
Tanzania	32 664 445	26 828 131	6
Angola	19 782 000		
Botswana	41 148 720	26 932 500	
Comoros	930 007	650 064	
Lesotho	4 018 032		
Madagascar	17 682 860	11 469 917	
Mauritius	975 119		
Seychelles	452 772	223 447	

Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed August 5, 2022 and HIV Prevention Scorecard 2021.

Table 5.10 maps the number of condoms distributed in SADC countries in 2019 and 2020 against the percentage of condom distribution need met in 2020 for selected focus countries. The table shows the impact of COVID-19 production and distribution challenges in reduced numbers of condoms distributed in 2020 in all countries except Eswatini. The GPC and Global Fund created a strategic initiative on condom programming benefited four GPC focus countries, including Malawi, Mozambique and Zambia in SADC, to expand their condom programmes.

The GPC score card rated only Namibia and Eswatini as having good or medium condom distribution.[22]

> Numbers of condoms distributed declined between 2019 and 2020 in all countries except Eswatini

Voluntary Medical Male Circumcision (VMMC)

Voluntary medical male circumcision (VMMC) provides partial lifelong protection against female-to-male HIV transmission. 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). COVID-19 restrictions on access to health facilities had a negative impact on VMMC programmes. As a result several countries only provided less than one third of their targeted VMMCs[23]. However, Tanzania and Zambia achieved 100% of their VMMC targets in 2020. VMMC uptake seems to be higher in urban and higher socio economic groups.[24]

[22] Global HIV Prevention Coalition. 2022, Op Cit.
[23] UNAIDS. 2022. In Danger. Op Cit.
[24] Global HIV Prevention Coalition. 2022. Op Cit.

Pre-Exposure Prophylaxis (PrEP)

PrEP is one of the five prevention pillars in the Prevention Roadmap of the Global HIV Prevention Coalition. PrEP is recommended for discordant couples (where one is positive and the other negative), sex workers, MSM, young women or others at high risk of contracting HIV.

Table 5.11: PrEP Coverage SADC

Country	2017	2018	2019	2020	2021
Botswana		38	1954	2259	5149
Eswatini				9125	
Lesotho	853	7279	35 478		15 749
Malawi			459		10 971
Mauritius		3			19
Mozambique	303	1934		18 513	57 717
Namibia	190				
Seychelles	2	4	26	3	1
South Africa	3189	8184		106 401	346 667
Tanzania					41 335
Zambia		3823		110 714	147 397
Zimbabwe	2714	4982	8351	48 583	7061
Total					632 066

Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed August 5, 2022.

Table 5.11 showing the uptake of PrEP (a daily ARV pill taken as prevention) illustrates that coverage is still relatively low. In 2020 six countries, including South Africa, Zambia and Zimbabwe in SADC, accounted for more than 80% of PrEP users in GPC countries. The GPC rated six countries (including Eswatini, Lesotho, Zambia and Zimbabwe in SADC) as good on their PrEP score, which included regulations, guidelines and coverage. The 632 066 PrEP users in SADC in 2021 is 69% of the global total of 911 825. South Africa alone accounted for 38% of the global total.

The 2022 International AIDS Conference witnessed major progress on providing long-acting injectable cabotegravir (CAB-LA), which is administered by injection once in two months.[25] Key wins included:

- Further evidence of the efficacy of CAB-LA as a prevention method for those at high risk of HIV infection, including cis and trans women and men who have sex with men;
- Guidelines provided by WHO on the use of CAB-LA as a prevention tool. Only the United States has so far approved CAB-LA for PrEP but ViiV, who developed cabotegravir, has submitted applications for its approval to other regulators;
- The announcement of a voluntary licensing agreement between ViiV and the Medicines Patent Pool which will promote production of generic CAB-LA thus making it available to 90 low and middle income and Sub Saharan African countries at a more affordable rate;
- The launch of a coalition led by WHO, Unitaid, UNAIDS and The Global Fund to make CAB-LA more accessible. Until now CAB-LA has only been available in study sites.

As SADC member states have been amongst the early adopters of PrEP, it is anticipated that SADC will benefit from such progress.

[25] IAS. Momentum builds to deliver long-acting PrEP for HIV prevention. 28 July 2022. https://aids2022.org/2022/07/28/momentum-builds-to-deliver-long-acting-prep-for-hiv-prevention/ accessed 30 July, 2022.

Prevention among key populations

Key populations are sex workers, men who have sex with men (MSM), people who inject drugs, transgender persons and prisoners[26]. 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. Key populations face much higher rates of HIV 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 (25%). 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.

Stigma and Discrimination

One of the three ten targets is: Less than 10% of people living with, at risk of and affected by HIV and key populations experience stigma and discrimination

Stigma and discrimination are pervasive amongst people that are living with and affected by HIV. Such stigma is compounded by intersecting forms of stigma related to HIV. Data on stigma and discrimination are sparse although more is being done to try to quantify it. Table 5.13 presents data that has been gathered from Demographic Health Surveillance (DHS) surveys, some UNICEF national Multiple Indicator Cluster Surveys as well as from some country level Behavioural Surveillance surveys. These ask the questions outlined in table 5.12.

Table 5.12: Stigma and Discrimination

Country	I	II	III	IV	V
Angola	31	20,9	34,6		
Botswana					
Comoros					
DRC	49,2				
Eswatini	5,7			34	
Lesotho	13,9			8	8
Madagascar	63,4	58,5	72,2		
Malawi	14,9	8,5	17,6	49	12,9
Mauritius					
Mozambique					
Namibia	13				
Seychelles					
South Africa	12,6	7,5	16,9		
Tanzania					
Zambia	18				
Zimbabwe	26	10,1	28,7	39,3	8,3

[26] UNAIDS. 2022. In Danger. Op Cit.

Where:
I. Percentage of adults (15-49) who responded No to the question: Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?
II. Percentage of adults (15-49) who responded No to the question: Do you think that children living with HIV should be able to attend school with children who are HIV negative?
III. Percentage of adults (15-49) who responded No to both questions
IV. Sex workers: Avoidance of health care because of stigma and discrimination (%)
V. Men who have sex with men: Avoidance of health care because of stigma and discrimination (%)

Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed August 5, 2022.

Table 5.12 underscores the high incidence of stigma and discrimination across SADC. The table also shows how stigma is impacting on access to services for sex workers. For example 49% of sex workers in Malawi avoid health care as a result of stigma. Nearly 13% of men who have sex with men also avoid health services in Malawi due to stigma. The Global Network of People living with HIV (GNP+) is leading in assessing levels of stigma in many countries around the world using the global Stigma Index. A number of SADC countries that have participated in this survey are using the results to advocate for changes in policy and practice to create more enabling and inclusive environments, where people living with HIV in all their diversity are able to access the services that are their right.



The **Eswatini** Stigma Index report, compiled in 2019, found that fewer than 10% of respondents had experienced HIV related stigma and discrimination in the last 12 months. Those that did experience stigma were the object of derogatory remarks which portrayed them as being promiscuous, sick and unproductive. About 4% of the respondents identified as sex workers and half of these reported experiencing stigma and discrimination as a result both of being sex workers as well as due to their HIV status[27]. The report found that significant progress has been made in addressing stigma in Eswatini. The report recommended that Eswatini develop a national strategy to combat stigma and discrimination with a campaign to combat stigma and to promote caring and nurturing families.



In **Zimbabwe** 25% of people living with HIV said that they experience discrimination in health care settings, while 30% experience it in community settings.[27] In Zambia discriminatory attitudes towards people living with HIV are more common in low income and rural communities.

More needs to be done to address stigma at all levels

The Global Partnership for Action to Eliminate all Forms of HIV-Related Stigma and Discrimination (Global Partnership), established in 2018[29], is convened by UNAIDS and receives technical support from a number of civil society partners. To date 31 countries have joined it, including Angola, Botswana, Democratic Republic of the Congo, Lesotho, Mozambique, and South Africa in SADC. The partnership is focusing on addressing stigma in Health care, Education, the workplace, Legal and justice systems as well as communities and emergency and humanitarian settings.

The media article by Keamogetse Motone goes more deeply into how fear of stigma and discrimination make it difficult for people living with HIV to speak openly about their status. This undermines disclosure, including support for adherence to treatment.

[27] Kingdom of Eswatini. 2019. Stigma Index Report. https://www.stigmaindex.org/wp-content/uploads/2022/04/Eswatini-Stigma-Index-Report-2019.pdf accessed 8 August, 2022.
[28] UNAIDS. 2022. In Danger. Op Cit.
[29] UNAIDS website https://www.unaids.org/en/topic/global-partnership-discrimination accessed 6 August, 2022.



Botswana: Discrimination on disclosure of status

Gaborone, 1 December: Despite Botswana's global reputation as a leader on rolling back HIV and AIDS, stigma abounds. Even though disclosure can assist in the battle against HIV and AIDS, it has a dire potential to awaken stigma and discrimination not only against those infected but also against those affected by HIV. This in turn may lead to suicide, cyber bullying, emotional distress, depression and more.

A report by Botswana Network on Ethics, Law and HIV/AIDS (BONELA), noted that disclosure has the potential to de-stigmatise HIV and AIDS by normalising it as a health condition like any other. "Public figures, influencers and celebrities may choose to disclose their HIV status with the view to address stigma associated with HIV/AIDS and this should be celebrated and encouraged," the report said.

Neo Nono Simon is an HIV Advocate at Botswana Networks for People Living with HIV (BONEPWA), who has been living with HIV for 14 years. She said disclosing HIV status is very important. "The benefit of disclosing your HIV status is that you are able to live in peace with your family members. You don't have to hide when it is time for you to take your medication or go for your regular check ups. You will be given the moral support you need," she explained.

According to her, people are generally accepting when people disclose their HIV status. "People still assume that being HIV positive means someone was having many sexual partners.



Botswana's stigma discrimiation hinders disclosure of HIV status.
Photo: Gender Links

Forgetting that people contract HIV in different ways. So before disclosing people should be emotionally ready to be stigmatized. Some will want to discriminate you. It is still hard for people to admit that there are people living with HIV in our midst," she said.

By going public about her HIV status, Neo sought to try and normalise living with HIV. She stated that she is not encouraging people to get infected with HIV but rather trying to change the mind sets of people.

Ditshupo Phiri, a 32 year old man disclosed his HIV status after realising that many people are struggling to accept and adhere. "Accepting yourself is very crucial. If you have done so it is very easy to adhere and that alone can inspire others. If we all do this we will be able to protect others and set a good example to society." He highlighted that when people accept themselves they are simply saying no to more HIV infections.

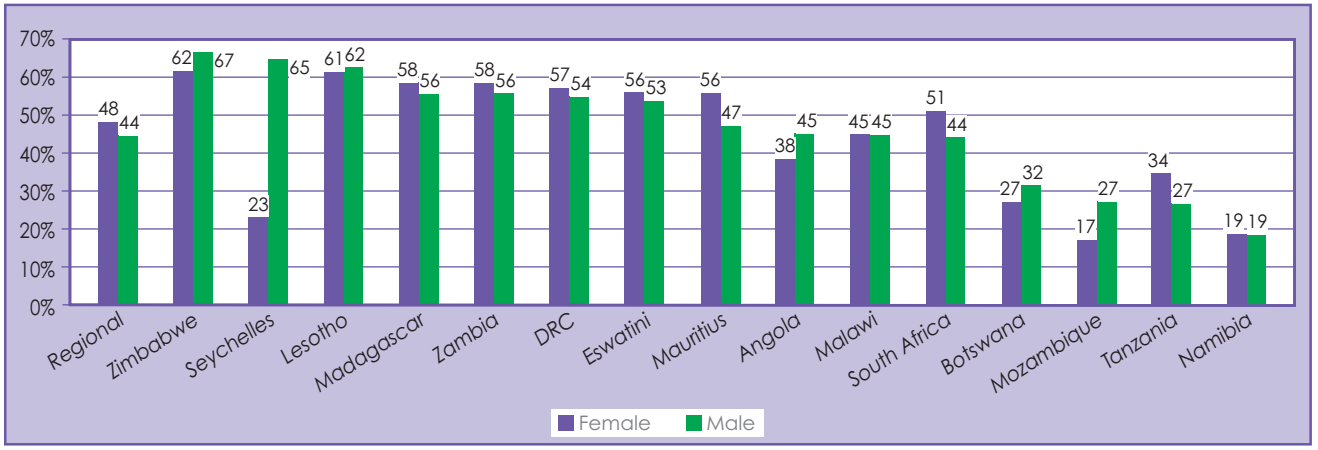
Source: Motone, Keamogetse. January 10, 2022. Bots: Discrimination on Disclosure of Status. GL News Service Sixteen Days of Activism News series[30].

Attitudes

A critical test of HIV and AIDS prevention campaigns is the extent to which the attitudes that fuel this pandemic are changing. Each year Alliance partners administer the Gender Progress Score (GPS) that includes several questions relevant to HIV and AIDS.

[30] https://genderlinks.org.za/news/botswana-stigma-discrimination-hinder-disclosure-of-hiv-status/

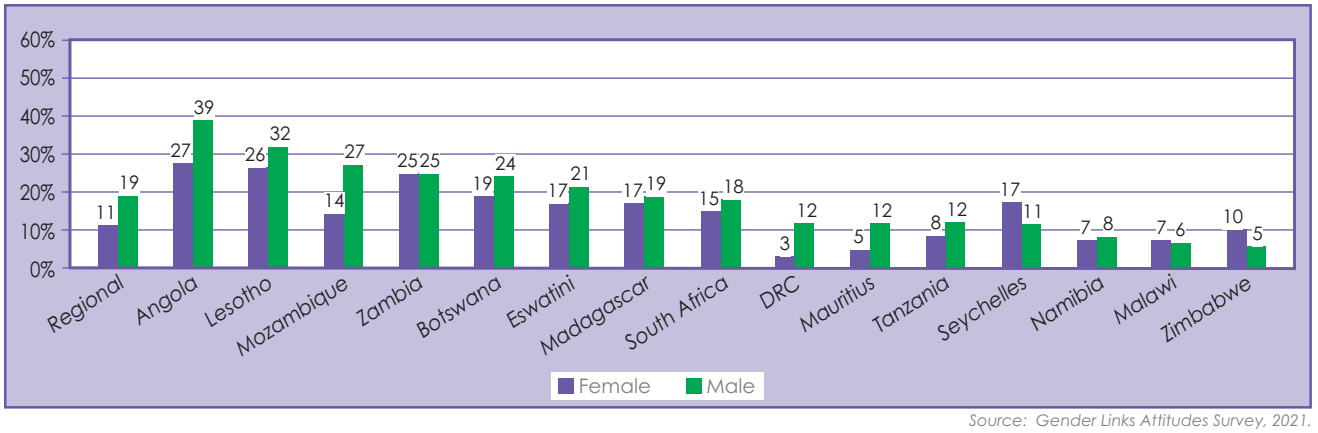
Figure 5.6: A woman can refuse to have sex with her husband



Source: Gender Links Attitudes Survey, 2021.

The attitudes on whether a woman can refuse to have sex with her husband range quite widely. Sixty two percent of female respondents in Zimbabwe strongly agreed with the statement compared to 19% men in Namibia. Overall men and women had similar views. Over 50% of both women and men in Zimbabwe, Lesotho, Madagascar, Zambia, DRC and Eswatini agree with the statement. More females agreed with the statement in South Africa and more men in Angola.

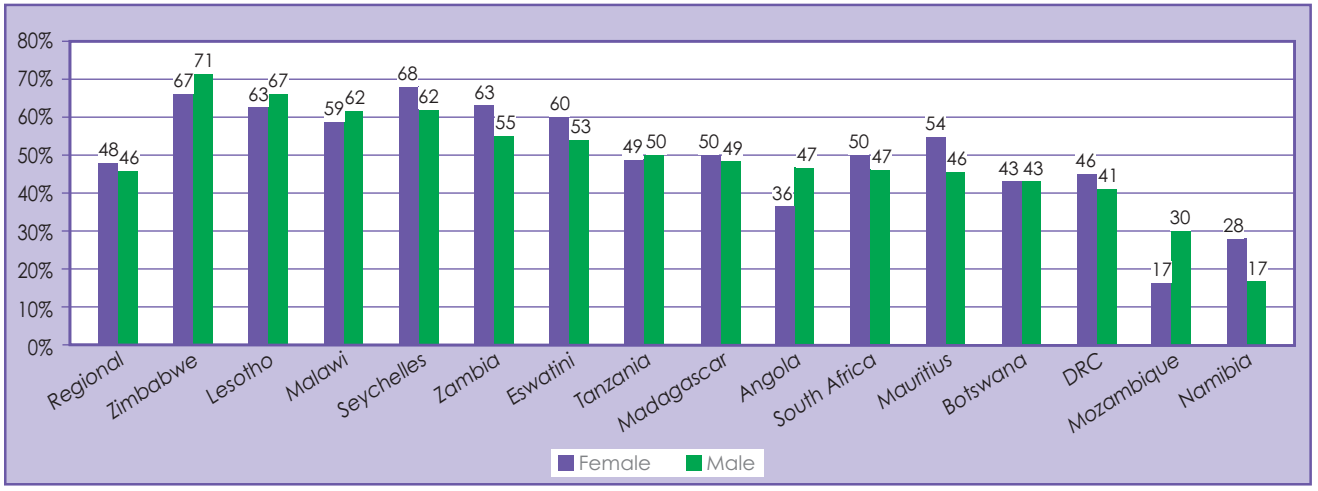
Figure 5.7: Nothing a woman can do if her husband wants to have girlfriends



Source: Gender Links Attitudes Survey, 2021.

A minority of women and men agreed that "there is nothing that a woman can do if her husband wants to have girlfriends", which means that the majority believe that a wife can do something. Across the region, only 11% women and 19% men agreed with this statement. The highest rate of agreement in both females and males is in Angola (27% females and 39% males) and lowest for both is Malawi (7% females and 6% males). Women were generally less likely to agree with the statement than men.

Figure 5.8: A woman can insist on a man using a condom



Source: Gender Links Attitudes Survey, 2021.

Over 50% of female respondents in Zimbabwe, Lesotho, Malawi, Seychelles, Zambia and Eswatini believe that a woman can insist on using a condom. It is disturbing that rates of agreement drop to as low as 17% of female respondents in Mozambique with a regional average of only 48% for women and 46% for men. In Zimbabwe, Lesotho, Malawi, Tanzania, Angola and Mozambique more males than females agree that women have a right to insist on a man using condom. This reflects some changes in attitude, especially at the local level.

Treatment

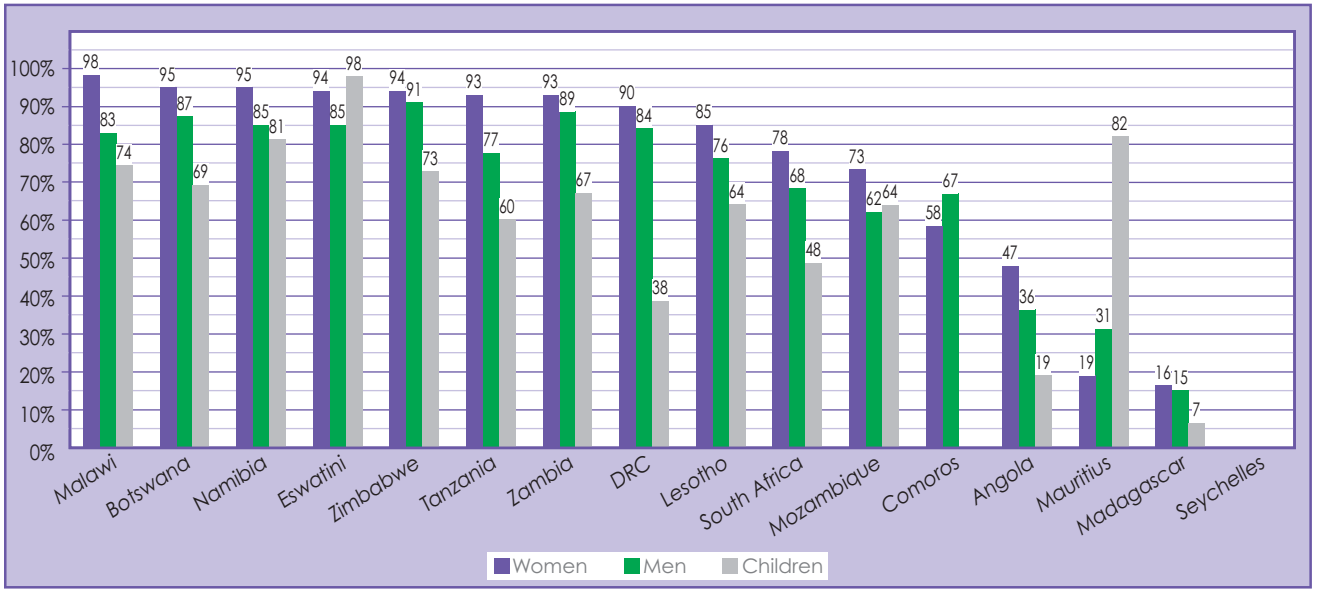
Article 27.3
b) Ensure universal access to HIV and AIDS treatment for infected women, men, girls and boys; and
UNAIDS 95/95/95: Target (2) By 2025, 95% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; Target (3) By 2020, 95% of all people receiving antiretroviral therapy will have viral suppression.

Figure 5.9 overleaf shows the remarkable progress that has been made in expanding access to ART across much of SADC. Countries with lower levels of coverage generally have relatively small epidemics and these are also making progress. Clearly, there is need to accelerate action in Angola, Mauritius and Madagascar. In most countries coverage for women is higher than for men, except in Comoros and Mauritius.



Celebrating successes in the HIV/AIDS Campaign, South Africa.
Photo: Susan Mogari

Figure 5.9: ART Coverage for those living with HIV



Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed August 5, 2022.

Children on Treatment

Figure 5.9 also illustrates the discrepancy between treatment levels for children and those for adults. Even in South Africa, which is making great progress in reducing the levels of new infections in children, only 48% of children living with HIV are on ART.



Working with UNITAID and the Clinton Health Access Initiative (CHAI), **Zimbabwe** is one of six African countries (including Malawi in SADC) that have piloted paediatric dolutegravir.[31] A new formulation, which can be easily dissolved in a small amount of water and has a strawberry flavour that children enjoy, is now available at a reasonable price that was negotiated with producers of generic dolutegravir. The formulation is taken once a day with two other ARVs and has proven to have fewer side effects than other medications. The pilot was conducted at 13 high volume urban and rural health services from May 2021, involving training of doctors, nurses, primary counsellors, pharmacists, and health information officers. COVID-19 restrictions delayed roll out. Community outreach mitigated these delays. Zimbabwe began national roll out to all health facilities in February, 2022. In 2020 Zimbabwe had 79 000 children aged 0-14 living with HIV; 73% on ART.

There is urgent need to prioritise ART for children

Viral suppression

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

[31] Makoni, M. The promise of paediatric dolutegravir in Zimbabwe. The Lancet HIV. 2022, Sept , 9,9:E603-E604. DOI: https://doi.org/10.1016/S2352-3018(22)00223-5

Figure 5.10 People living with HIV who have suppressed viral loads

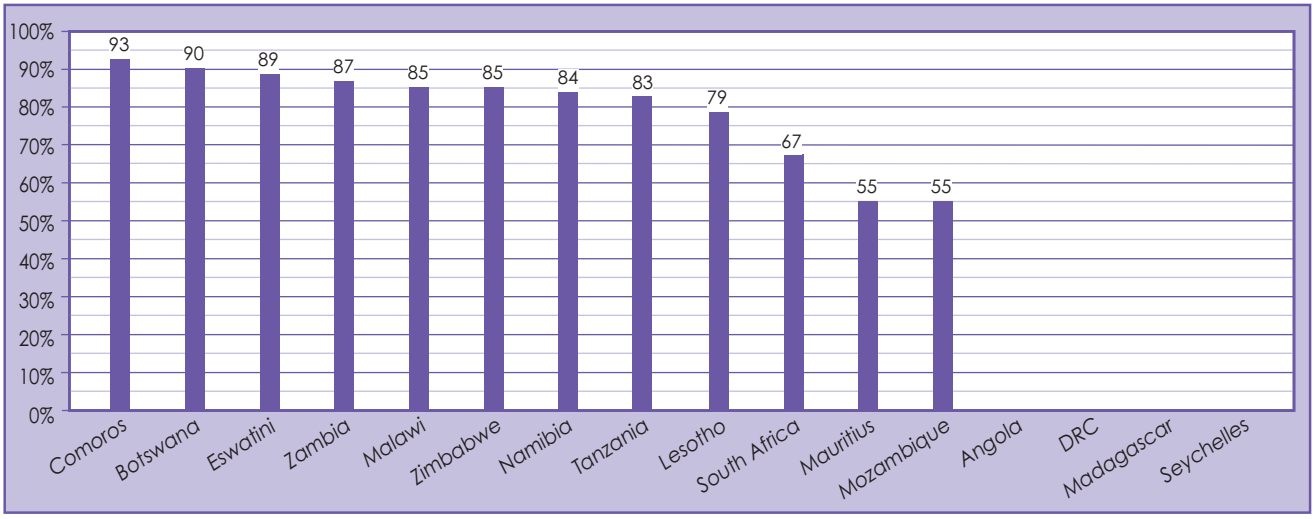


Figure 5.10 shows progress being made towards viral suppression. Data on suppression is not available from Angola, DRC or Madagascar. Mozambique and Mauritius have low rates of suppression. All other countries are making good progress towards this target.

HIV activists in the USA launched the U = U (undetectable equals un-transmittable) campaign in 2016. The campaign highlights that people that are on ART with suppressed viral load cannot transmit the virus through sexual or other contact. The campaign:

- Encourages people that are not aware of their HIV status to be tested;
- Encourages those that are positive to access treatment to protect themselves and their partners;
- Reduces the shame and fear of sexual transmission;
- Helps to challenge stigma at community, clinical and personal levels.[32]

HIV and TB Co-infection

The UN High level meeting on TB in 2016 committed to ending TB, which is both preventable and curable by 2030. TB is still the leading cause of death among people living with HIV. The COVID-19 pandemic had a devastating impact on TB control programmes. In 2020, TB case finding, numbers initiated on treatment and on preventive treatment all declined[33]. Increasing poverty, poorer nutrition and more crowding all increased the chances of spread of TB. Globally, the number of deaths from TB increased for the first time since 2005 and there were an estimated 1·32 million tuberculosis deaths worldwide[34]. TB was the second leading cause of death (to COVID-19) from a single infectious agent. Different models predict that the number of TB cases

[32] UNAIDS. 2020. Community Innovations. Geneva. UNAIDS.
[33] WHO. 2022. Global Tuberculosis report 2021. Geneva. WHO. https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2021 accessed 5 August, 2022.
[34] Dheda, K. et al. Tuberculosis in the time of COVID-19: The intersecting pandemics of tuberculosis and COVID-19: population-level and patient-level impact, clinical presentation, and corrective interventions. Lancet Respir Med 2022; 10: 603-22 Published Online March 23, 2022 https://doi.org/10.1016/S2213-2600(22)00092-3 Accessed 5 July, 2022.

will increase at least until 2025 if urgent action is not taken to bring the levels of new cases back at least to the 2019 levels.

The WHO has defined three High Burden Country (HBC) lists for 2021-2025 - for TB overall, for HIV associated TB and for MDR/rifampicin-resistant TB (MDR/RR-TB). The criteria for the three lists are:

- "the top 20 countries in terms of their estimated absolute number of new (incident) cases in 2019"; plus
- "the 10 countries with the most severe burden in terms of the incidence rate (new cases per 100 000 population in 2019) that are not already in the top 20 and that meet a minimum threshold in terms of their absolute number of cases"[35]. The thresholds are 10 000 new cases per year for TB; and 1000 new cases per year for HIV-associated TB and rifampicin-resistant TB.

A total of 49 countries around the world, including twelve SADC member states, are on at least one of the lists. The twelve and the lists that they are on are illustrated in Table 5.13. DRC, Mozambique, South Africa and Zambia are on all three of the lists, indicating that they have high burdens of TB overall, of HIV associated TB and of MDR/rifampicin-resistant TB.

Table 5.13: SADC Countries in any of the WHO HBC lists of TB for 2021 - 26

Country	TB	TB/HIV	MDR/RR-TB
Angola	■		■
Botswana		■	
DRC	■	■	■
Eswatini		■	
Lesotho	■	■	
Malawi		■	
Mozambique	■	■	■
Namibia	■	■	
South Africa	■	■	■
Tanzania	■	■	
Zambia	■	■	■
Zimbabwe		■	■

KEY ■ Indicates that the country is on this TB list

Source: GenderLinks compiled from WHO. World Tuberculosis Report 2021[36].

These lists provide an indication of the countries that need the greatest support and political commitment to fighting TB.

Table 5.14: TB-related deaths in people living with HIV

Country	2000	2010	2019	2020	Change 2010-2020
South Africa	116000	158000	36000	36000	77%
Tanzania	53000	40000	12000	9800	76%
DRC	24000	18000	9600	9100	49%
Zambia	20000	14000	9500	9100	35%
Mozambique	20000	21000	5600	6100	71%
Zimbabwe	14000	8000	4600	5900	26%
Malawi	13000	18000	4200	4200	77%
Lesotho	4300	7900	3600	3400	57%
Angola	1900	9100	2600	2900	68%
Botswana	3700	2000	1100	1500	25%
Namibia	4500	3800	1300	1300	66%
Eswatini	2400	2300	710	640	72%
Madagascar	36	54	280	290	-437%
Mauritius	7	2	9	9	
Comoros	0	0	0	1	
Seychelles	0	0	0	0	
Total SADC	276843	302156	91099	90240	70%
Global	**680000**	**590000**	**210000**	**210000**	**64%**

Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/ accessed 6 August, 2022.

[35] WHO. 2022. Global Tuberculosis report 2021. Geneva. WHO. Op Cit.
[36] WHO. World Tuberculosis Report 2021. https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2021 accessed 5 August, 2022.

TB Programmes were severely impacted by COVID-19

Table 5.14 compares the number of TB related deaths in people living with HIV in 2000, 2010, 2019 and 2020. The table shows that declining deaths halted in the wake of COVID-19 in 2020. Deaths increased in Mozambique, Zimbabwe, Angola, Botswana and Madagascar; were at very similar levels for South Africa, Malawi and Namibia and continued slow declines in other countries. Only South Africa, Tanzania and Malawi achieved the global target of reducing TB related deaths (between 2010 and 2020) in People Living with HIV by 75% or higher by 2020. Mozambique and Eswatini were between 70 and 75%. SADC overall had a reduction of 70% compared to a global reduction of 64%.



The health authorities of the Western Cape and City of Cape Town in **South Africa** have collaborated with Médecins Sans Frontières (MSF) for some years to improve TB management. In Khayelitsha it is estimated that 200 people are diagnosed with drug resistant TB (DR-TB) every year, making it a global DR-TB hotspot. COVID-19 lock downs increased overcrowding and poorer nutrition: ideal conditions for the spread of TB. Initial responses by the health system, included health education on the signs and symptoms of COVID-19 and TB; integrated screening and testing for COVID-19 and TB and support for clinics to continue TB work. Partners introduced community and family based outreach to provide testing, treatment and prevention services in the households of those diagnosed with TB. This approach enabled even children to be provided with DR TB treatment and care at home.[37]

HIV and Cervical Cancer Co-Infection

A study that pooled data from 24 other studies on Cervical Cancer around the world developed estimates of the global cervical cancer burden associated with HIV.[38] Women living with HIV have a six fold higher risk of developing cervical cancer than women that are HIV negative. Cervical cancer is considered an AIDS defining illness. The study found that 85% of women living with HIV who also have cervical cancer are in East and Southern Africa. While the proportion of women who have cervical cancer that are living with HIV was 5% or less in 122 countries, in ten countries of East and Southern Africa the proportion was over 40%. As shown in Table 5.15 overleaf, eight of these ten countries are in SADC.

It is recommended that as much as possible pre-adolescent girls in high HIV burden countries are vaccinated against the human papilloma virus (HPV) which pre disposes women living with HIV to develop cervical cancer. Further, all women living with HIV should have regular screening for cervical cancer.

Girls in countries with high HIV prevalence should be vaccinated against HPV

[37] Apolisi, I et al. Supporting families with tuberculosis during COVID-19 in Khayelithsa, South Africa. Lancet Respiratory. 2022, June, 10, Published Online March 23, 2022 https://doi.org/10.1016/S2213-2600(22)00121-7 Accessed March 30, 2022.
[38] Stelzle, D. et al. Estimates of the global burden of cervical cancer associated with HIV. Lancet Glob Health. 2021 Feb; 9(2): e161-e169. Published online 2020 Nov 16. doi: 10.1016/S2214-109X(20)30459-9: 10.1016/S2214-109X(20)30459-9 Accessed 6 March, 2022.

Table 5.15: HIV infection and Cervical Cancer

Country	# new cervical cancer cases 2018	Proportion of new cervical cancer patients who are living with HIV (%)	# cervical cancer patients living with HIV (2018)	Population attributable fraction for HIV (%)	# cervical cancer cases attributable to HIV (2018)
Eswatini	380	75,03	284	62,61	237
Lesotho	477	69,3	330	57,85	275
Botswana	333	66,47	221	55,51	184
South Africa	12983	63,35	8223	52,93	6866
Zimbabwe	3186	52,19	1660	43,58	1386
Namibia	2,36	50,22	118	41,9	98
Mozambique	4291	50,21	2151	41,91	1793
Zambia	2994	49,57	1481	41,32	1234
Malawi	4163	43,04	1787	35,94	1492
Tanzania	9772	26,73	2611	22,29	2177
Angola	2949	13,61	401	11,41	335
DRC	5762	6,3	363	5,26	302
Mauritius	120	4,03	5	3,36	4
Madagascar	4353	0,94	41	0,78	34
Comoros	141	0,13	0	0,11	0

Source: Gender links derived from Stelzle, D. et al. Estimates of the global burden of cervical cancer associated with HIV. Lancet Glob Health. 2021 Feb; 9(2).

AIDS related deaths

Table 5.16: AIDS related deaths, 2021

Country	All deaths		Deaths in young people 15 - 24		Deaths in children 0 - 14	
	2004	2021	2004	2021	2003	2021
South Africa	270000	51000	30000	5700	34000	2800
Mozambique		51000		4600		8200
Tanzania	120000	29000	3900	2600	24000	6100
Zimbabwe	130000	20000	4800	2100	22000	2800
Zambia	70000	19000	2900	2500	16000	2400
Angola	10000	15000	500	1000	3500	3600
DRC	56000	14000	1900	1200	12000	4300
Malawi	81000	13000	2600	1400	18000	1500
Botswana	17000	4600	1000	500	2800	200
Lesotho	18000	4500	1000	500	3500	1000
Madagascar	200	2900	100	100	100	1000
Namibia	12000	2900	500	500	2500	500
Eswatini	10000	2600	500	500	2200	200
Comoros	100	100	100	100		
Mauritius						

Source: Gender Links compiled from UNAIDS 2022 data https://aidsinfo.unaids.org/

Table 5.16 compares the number of deaths as a result of AIDS for all people, young people and children between either 2003 or 2004 (the year of highest deaths) and 2021. Globally there were still 650 000 deaths as a result of AIDS in 2021 and the rate of decline has slowed. Overall there has been remarkable progress, though Madagascar and Angola have increasing numbers of deaths, and rates of decline for other countries have been uneven. Noteworthy declines include: in

total deaths in Zimbabwe and Malawi, in deaths in young people in South Africa as well as deaths of children in South Africa, Malawi and Botswana.

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.
Recognise and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.
SADC sponsored UN resolution on Women, Girls and HIV: Recognise women's contribution to the economy and their active participation in caring for people living with HIV and AIDS and recognise, reduce, redistribute and value women's unpaid care and domestic work through the provision of public services, infrastructure.
BPFA +20 Africa declaration: Reduce, recognise and redistribute unpaid care work, which falls disproportionately on women and girls, by investing in infrastructure and time-saving technology and emphasizing shared responsibilities between women and men, girls and boys;

Community Care Givers

Even though the history of the HIV response is rooted in voluntary contributions of community members to provide services when the formal health system could not cope, the Global AIDS Strategy 2021 - 26 targets of HIV services to be community led by 2025 seem ambitious. The targets are:

- 30% of HIV testing and treatment services,
- 80% of HIV prevention services for high-risk populations and
- 60% of programmes to achieve societally enabling environments.

Research shows that peer education is a powerful way of reaching populations who are marginalised and impacted by stigma, such as adolescents and key populations that are led by members of these populations are more accepted by their peers. Further, community led responses are of similar quality to those provided by the formal health sector but are cheaper than external programmes. During COVID-19 restrictions community led initiatives were able to quickly re-organise their service delivery to make sure that clients received their medicines, food and other support.[39]

Reasons given for low levels of support to community led responses include[40]:

- Lack of clear definition of what constitutes a community led programme. A process led by UNAIDS has now defined this as, "…*actions and strategies that seek to improve the health and human rights of their constituencies, that*

[39] UNAIDS. 2022. In Danger.
[40] Ayala G, Sprague L, van der Merwe LL, Thomas RM, Chang J, Arreola S et al. Peer- and community-led responses to HIV: a scoping review. PLoS One. 2021;16(12):e0260555.

are specifically informed and implemented by and for communities themselves and the organisations, groups, and networks that represent them.

Community-led responses are determined by and respond to the needs and aspirations of their constituents. Community-led responses include advocacy, campaigning and holding decision-makers to account; monitoring of policies, practices, and service delivery; participatory research; education and information sharing; service delivery; capacity building, and funding of community-led organizations, groups, and networks. Community-led responses can take place at global, regional, national, subnational, and grassroots levels, and can be implemented virtually or in person. Not all responses that take place in communities are community-led."

- Community led programmes include an emphasis on the meaningful inclusion of people living with HIV, gay and bisexual men, people who use drugs, sex workers, and transgender people in designing, implementing, managing, and evaluating programmes.
- Insufficient evidence of the impact of community led programmes - these programmes seldom have the resources to conduct rigorous research or even to document their impact.
- Poor involvement of communities and those most affected by HIV in the development, implementation or monitoring of programmes that are meant to benefit them.

Community led responses are more effective in engaging whole communities, creating community cohesion to respond to challenges faced and building networks of support for those that are most marginalised. National strategies and processes must include mechanisms for channelling consistent funding to community led responses. Such mechanisms must mitigate the impact of regressive laws and policies, intersecting social stigmatizations, discrimination against groups of people most affected by HIV. They must also support these to manage and account for funds.

National mechanisms should also prioritise:

1. Supporting community led responses to expand their operations in prevention including outreach; HIV testing- with self-testing; STI testing and treatment; comprehensive sexuality education; condom and lubricants distribution; pre- and post-exposure prophylaxis (PrEP and PEP); behavioural interventions; harm reduction, including needle and syringe programmes; peer support; risk reduction counselling; and drop-in centres for those most at risk
2. Supporting community led responses to continue their critical role in treatment access; treatment adherence (which is crucial in a post COVID era of multi month dispensing of ART) and peer support
3. Supporting community led responses which interface with health services to monitor services and make suggestions for improvements; advocate and mobilise community members to access services.

The critical role of the community, community-based organisations and community care-giving in different forms is widely recognised as being crucial in the fight against HIV and AIDS. The new cadres of community caregivers - peer educators and supporters, mentor mothers, and others - are being called upon to play increasingly complex roles to ensure that HIV services continue and expand to reach all people. Recognition, appreciation, support, training and remuneration for this critical work force remains paramount.

[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.

Next steps

The Global AIDS Update has warned the world that we are in Danger. In Danger of failing to eradicate AIDS as a public health threat. This is a clarion call to redouble efforts at prevention, testing, access to ART and adherence to ART. The urgent next steps that are required for SADC to eradicate AIDS as a public health threat by 2030 include:

Redoubling efforts for HIV prevention: including programmes that are delivered at scale and

- Stop ignoring the crisis of HIV sub epidemics in key populations, use human rights based approaches to remove legal and programmatic impediments to members of key populations accessing HIV care;
- Urgently address stigma and discrimination at all levels;
- Mobilise political will at all levels to address the epidemic of GBV that faces girls and women in SADC;
- Continue to focus on prevention of mother to child transmission, especially in children of adolescent and young mothers;



Demonstrating condom use in Mokhotlong, Lesotho, November 2019.
Photo: Ntolo Lekau

- Give more attention to the situation of children and adolescents who were exposed to HIV in utero and are uninfected;
- Embrace traditional approaches such as the Education Plus Initiative with comprehensive sexuality education;
- Be prepared to roll out new technologies such as long acting PrEP swiftly.

Generate new impetus for HIV control in member states where the epidemic is expanding, especially Madagascar.

The search for an effective vaccine still requires investment, even as new therapies and treatments are developed,

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

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

Support and effectively resource community-led responses as the health sector cannot address HIV alone. The need for multi sectoral collaboration is very clear. Health services must collaborate with community initiatives. National mechanisms must find ways to channel support to these initiatives. This might be the opportunity to "build back better" and acknowledge the critical role of the community in HIV prevention, care and support.

Continue domestic resource mobilisation for the HIV response.

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