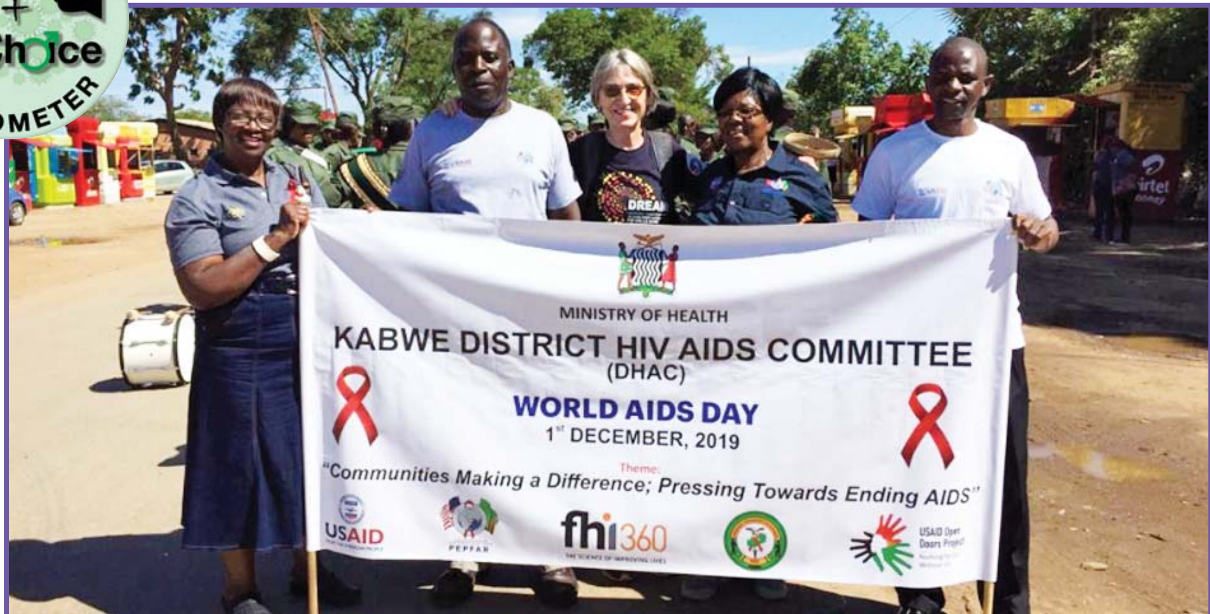
HIV and AIDS 5



Kabwe City Council AIDS committee commemorates World Aids Day, December 2019. Photo: Albert Ngosa

KEY POINTS

- SADC, which has 4.6% of the world's population, is home to 45% of all people living with HIV in the world.
- In 2019 SADC accounted for: 55% of new infections in young women and 35% new infections in young men globally; 48% of people on antiretroviral therapy (ART) and 55% of children on ART globally; 65% of the global number of pregnant women that were on ARTs; 67% of voluntary male circumcisions (VMC) conducted in priority countries; 35% of all acquired immune deficiency syndrome (AIDS)- related deaths, 46% of AIDS related deaths in young people (15 to 24), 37% of AIDS related deaths in children; 50% of TB-related AIDS deaths globally and 52% of all AIDS related deaths that are estimated to have been averted by ART.
- Much progress has been made towards achieving the UNAIDS 2020 targets of 90% awareness of status, 90% access to treatment and 90% suppression of the virus.
- New infections in adolescent girls and young women have been declining steadily and the proportion of new infections in Key populations (sex workers, men who have sex with men, people who inject drugs - who are especially important in the island nations, prisoners) is rising.
- COVID-19 is disrupting Human Immunodeficiency Virus (HIV) services. This could lead to an additional 500, 000 deaths in sub-Saharan Africa by the end of 2021 and regression of the Prevention of Mother to Child Transmission (PMTCT) programme to levels of a decade ago.
- Community care workers have been called into COVID-19 service to support testing and will likely support those that contract COVID-19 and not be hospitalised.

Introduction

Although tremendous progress has been achieved in all aspects of HIV prevention and management, the Southern African Development Community (SADC) is still the epicentre of the HIV epidemic. The global average prevalence is only 0.7% and most regions of the world have prevalence below 1%. Three SADC nations (Eswatini, Lesotho and Botswana) have prevalence above 20%; five more between 10 and 20% (South Africa, Zimbabwe, Mozambique, Namibia and Zambia). There are over 17 million people living with HIV in SADC which is 45% of the global total of 38 million.

In 2014 UNAIDS called on the global community to set ambitious targets for the post 2015 period that would lead to an end of AIDS by 2030. This resulted in the ambitious 90 - 90 - 90 targets which were endorsed by the 2016 high level meeting. The vision of the strategy is **Zero new HIV infections, Zero discrimination and Zero AIDS-related deaths**. The strategy has three overall strategic directions:

- HIV prevention.
- Treatment, care and support.
- Human rights and gender equality for the HIV and AIDS response.

The ten targets of the five-year plan include:

1. 90% of people (children, adolescents and adults) living with HIV know their status, 90% of people living with HIV who know their status are receiving treatment and 90% of people on treatment have suppressed viral loads;
2. Zero new HIV infections among children, and mothers are alive and well;
3. 90% of young people are empowered with the skills, knowledge and capability to protect themselves from HIV;
4. 90% of women and men, especially young people and those in high-prevalence settings, have access to HIV combination prevention and sexual and reproductive health services;
5. 27 million additional men in high-prevalence settings are voluntarily medically circumcised, as part of integrated sexual and reproductive health services for men;
6. 90% of key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants, have access to HIV combination prevention services;
7. 90% of women and girls live free from gender inequality and gender-based violence to mitigate the risk and impact of HIV;
8. 90% of people living with, at risk of and affected by HIV report no discrimination, especially in health, education and workplace settings;
9. Overall financial investments for the AIDS response in low- and middle-income countries reach at least US$ 30 billion, with continued increase from the current levels of domestic public sources;
10. 75% of people living with, at risk of and affected by HIV, who are in need, benefit from HIV-sensitive social protection.

The SDGs do not place as much emphasis on HIV as the MDGs did but do include target 3.3: "By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases." Ending AIDS as

a Public health threat will contribute to good health (SDG 3); reduce inequalities (SDG 10); the achievement of gender equality (SDG 5); promotion of just and inclusive societies (SDG 16). Ending HIV and AIDS is closely linked to revitalised global partnerships (SDG 17), ending poverty (SDG 1) and ensuring quality education (SDG 4).

Table 5.1: Key HIV data 2020

INDICATORS	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
HIV and AIDS Prevalence																
Overall prevalence (%)	1.9	20.7	<0.1	0.8	27	22.8	0.3	8.9	1.2	12.4	11.5		19	4.8	11.5	12.8
Women who are HIV positive as a % of total	65	55	<50	63	60	56	44	55	31	59	62		63	58	59	54
Women aged 15 to 49 HIV prevalence rate	2.6	25.1	<0.1	1.2	35.6	27.9	0.2	10.8	0.8	15.2	14.5		25	6	14	15.4
Men aged 15 to 49 HIV prevalence rate	1.2	16.5	<0.1	0.4	18	17.9	0.3	7	1.7	9.5	8.4		12.9	3.6	8.9	10.1
HIV prevalence among young women (15-24)	1.2	9.3	<0.1	0.5	12.3	10.1	<0.1	4.2	0.2	7.1	4.8		10.2	2.2	5.5	5.9
HIV prevalence among young men (15-24)	0.4	5	<0.1	0.2	4.1	4.5	<0.1	2.1	0.3	2.8	2.7		3.4	1.2	2.6	3.3
Sex workers																
HIV prevalence (%)	8	42.2	0.3	5.7	60.5	71.9	5.5	55	15		40.7	4.6	57.7	15.4	48.8	42.2
Condom use (%)	71.7	75.7	26	69	82.9	62.3	62.8	65	67.2			16	86.1	72.4	78.5	74.9
Men who have sex with men																
HIV prevalence (%)	2	14.8	0	3.3	12.6	32.9	14.9	6.8	17.2			13.2	18.1	8.4		21.1
Condom use (%)	59.1	77.5	56.2	77.4	57.6	46.4	57.2	44	53.1				97.9	13.9		69.2
Prevention																
Proportion of people age 15+ who know their HIV status																
Women age 15+ who know their HIV status	69	95	>95	53	>95	95	18	94	59	86	>95		94	85	93	95
Men age 15+ who know their HIV status	62	91	74	72	>95	92	13	86	73	66	92		91	81	87	86
Condom use at last high risk sex																
Condom use at last high risk sex - women	32	N/A	28	23	54	76	5	50		31	66		61	30	35	67
Condom use at last high risk sex - men	63	N/A	60	31	67	77	13	76		30	80		73	47	56	85
Elimination of mother-to-child transmission																
Coverage of pregnant women who receive ARV for PMTCT (%)	63	>95		45	>95	84	24	>95	>95	>95	>95		>95	92	86	91
Mother to child transmission rate	19	2		25	2	9	35	6	13	14	4		3	11	11	8
Knowledge																
Comprehensive knowledge of HIV and AIDS	32.2	47.2	20	20	50	36	24	42	32	31	58		46	43	42	46
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.	55%	26%		11%	53%	61%	67%	58%	36%	17%	18%	50%	50%	63%	60%	59%
Treatment - Antiretroviral therapy (ART)																
% of those living with HIV who are on ART	27	82	60	53	>95	65	13	79	25	60	85		70	75	85	85
Women aged 15 and over receiving ART	29	93	81	51	>95	71	15	87	25	67	89		75	83	90	89
Men aged 15 and over receiving ART	27	71	44	72	90	57	12	67	25	46	76		63	63	79	80
Children aged 0 to 14 receiving ART	16			28	84	71	9	74	68	63	>95		47	66	76	71

Source: Gender Links computations and UNAIDS data, 2020.

Table 5.1 shows that:

- In Southern Africa HIV and AIDS is still predominantly a heterosexually driven pandemic, with women comprising the highest proportion of those living with HIV and AIDS, except for the islands (Madagascar, Mauritius and Seychelles) where intravenous drug needles are the main means of transmission.
- Women are much more likely than men to be aware of their HIV status.
- Prevention of Mother to Child Transmission (PMTCT) is high but still lacking in poor, post conflict countries such as Angola and DRC, and is not a priority in the islands, since this is not a primary means of transmission.
- The response among women to the question "a woman has the right to insist on a man using a condom" varies widely, from 11% in DRC to 67% in Madagascar.
- Coverage of adults and children receiving Antiretroviral Therapy has improved dramatically, but ranges from 13% in Madagascar to 85% in Namibia, Zambia and Zimbabwe. In all SADC countries (except the islands) women are more likely than men to be on ART.

Many gains have been made in the fight against HIV over more than three decades, and especially in this century. The chapter expands on many of the gains. However, most of these are critically threatened as a result of the COVID-19 crisis, which has impacted on communities across the globe in multiple devastating ways in the first six months of 2020.

Every epidemic thrives on inequalities. *Winnie Byanyima, Executive Director, UNAIDS*

Experts from HIV epidemiology, research, vaccine development, community mobilization have emerged at the forefront of the fight against COVID-19 across the world. Established funding mechanisms such as the Global Fund were swiftly "pivoted" into also addressing COVID-19 needs. Expertise, analytical capacity, laboratories and testing, surveillance and monitoring systems developed through HIV funding are now underpinning COVID-19 responses. Activists and community organisations that have long been active in the HIV arena are leading efforts to support community prevention and management of COVID-19. The Chapter starts with an analysis of COVID-19, HIV and AIDS. The impact is expanded on in each of the main sections - prevalence; prevention; treatment; care and the recommendations at the end.

COVID-19, HIV and AIDS

Although there has been much concern, to date there is limited data on the **impact of HIV on COVID-19 outcomes**. A few small studies from China and Europe appeared to show no correlation.

The report of the largest cohort of people living with HIV to also be impacted by COVID-19 is from the Department of Health in the Western Cape, **South Africa**. This centres on 12,522 COVID-19 public sector patients and 453 deaths. COVID-19 death was associated with being male; increasing age and diabetes, hypertension and chronic kidney disease, as well as previous and current tuberculosis. There was an increased risk of COVID-19 death in people living with HIV compared to HIV negative patients of 2.75. The increased mortality risk does not appear to be related to being on ART, or adhering to ART.[1]

[1] Davies, M and A. Boulle. "Risk of COVID-19 death among people with HIV: a population cohort analysis from the Western Cape province, South Africa". National Institute for Communicable diseases. Vol 18.2. 22 June, 2020. https://www.nicd.ac.za/wp-content/uploads/2020/06/COVID-19-Special-Public-Health-Surveillance-Bulletin-22-June-2020.pdf

There are distinct differences in the impact of COVID-19 across **socio-economic, gender and other societal fault lines**, with the weakest and most marginalised being the most affected. Available data suggests that men experience higher mortality as a result of COVID-19, but women are impacted in numerous other ways. Women and girls experience increased gender based violence, inadequate access to health care, economic insecurity and much increased unpaid and unrecognized care work.

Further, women constitute almost 70% of the health workforce worldwide, but they are mainly employed in lower-level positions with less pay. Women make up around 85% of nurses and midwives, as well as the majority of cleaning, laundry and catering staff, where they are more likely to be exposed to the virus. Some women have less access than men to personal protective equipment (PPE). Women health-care workers report challenges around the use of PPE when they are menstruating, including inadequate flexibility or facilities to manage menstruation with dignity.

As the economic effects of COVID-19 continue to worsen, so too are the social effects on women and girls. HIV programmes are set to be negatively affected due to countries' lack of access to drugs, causing gaps in ART delivery to those already on it, and those still to begin. It is anticipated that the economic turmoil that most people will find themselves in will propel more women into the sex work market where they are likely to experience higher levels of sexual exploitation. This is likely to result in an increase in HIV infections, unwanted pregnancies and Gender Based Violence. Additionally, drug use and abuse will not end, but rather become hidden due to restrictions of lockdowns - making communities unreachable, and exposing people to infection. There are fears of viral rebound occurring in People Living with HIV (PLWHIV) due to inaccessibility of medication for various reasons.

These range from not being able to physically access health facilities to fearing stigma once PLWHIV disclose their statuses to those they live with to explain their needing to access health facilities. Botswana was the first SADC country to introduce universal ART to citizens, a goal which will be reversed. The current reality will affect initiatives such as male circumcision, Pre-exposure prophylaxis (PrEP)[2] and testing drives. Those who were lucky enough to receive ART found it was reduced from a three month supply, to a two month supply to ensure that as many people as possible are able to access treatment in the short term. Due to this negative impact, there is more need than ever to adapt quickly and find solutions to inhibit further negative effects. A multiple stakeholder approach will be more necessary than ever to beat both the HIV and COVID-19 pandemics.[3]

Mum Rose Thamae from Let Us Grow, a community -based HIV and AIDS support group in South Africa, prepares to distribute food parcels in the wake of COVID-19 Photo: Gender Links

[2] Pre-exposure prophylaxis (or PrEP) is when people at risk for HIV take daily medicine to prevent HIV. PrEP can stop HIV from taking hold and spreading throughout your body.

[3] https://genderlinks.org.za/news/botswanas-hiv-response-impacted-by-covid-19/

COVID-19 has affected HIV services in several ways:

- Health resources, including research capacity, are being redirected from HIV to COVID-19 with serious disruptions.
- Lockdowns have introduced barriers to accessing prevention, testing, treatment and care.
- Those most vulnerable to HIV infection are experiencing heightened stigma, persecution and economic hardship. Sex workers, for instance, have not been able to work and seldom qualify for, or are able to access, any social assistance.
- Supply chains have been adversely impacted by COVID-19 disruption to economic endeavour and transport.

Between April and June 2020 the World Health Organisation (WHO) undertook a survey with 144 country offices to determine the extent of disruption of 25 essential health services by COVID-19. Preliminary results of the survey with respect to HIV services were presented at the International AIDS Conference in July 2020, which was held virtually for the first time in its history.

WHO issued guidance to countries on maintaining essential health services, including reducing disruption of HIV services by adopting multi month dispensing (MMD) policies of up to six months' supply of ARVs. To date, 129 countries of the 144 surveyed have adopted such a policy. Twelve percent are providing one-month supply; 6% two months; 63% three months; and only 8% have extended to six months' supply. Unavailability of drugs due to transport problems, delays in the manufacturing process, the need to pay for supplies before they are delivered and other issues have forced some countries to reduce the number of months of supply rather than increase it.

Thirty-six countries who support 45% of the global population that is on ARVs have reported that they have experienced some disruption of supply. In SADC, Malawi and Namibia have increased the number of months' supply, while Botswana has reduced it. Thirty-two of 39 countries in the Africa region have adopted a three months' supply, while seven have adopted six months. Twelve of 19 African countries that reported on their stocks had at least three months' supply of ARVs, while the other seven had less than three months' supply. Supplies to many countries are from India, which barred exports of drugs for about two weeks in March - April. India has subsequently relaxed restrictions. India is currently reeling from the world's third largest COVID-19 outbreak which may have implications for supply of ARVs.

Other services which have also experienced disruption include: PMTCT HIV/ Early Identification Contraceptive/Family planning; Harm reduction needle and syringe exchange for PwID; Hepatitis C treatment; initiation Pre-exposure prophylaxis (PrEP); Enrolment on ARVs; Sexually transmitted infection (STI) services; Hepatitis B testing; Condom provision; Voluntary medical male circumcision (VMMC); Key population services; HIV Viral load monitoring and HIV testing.

HIV service disruptions could add 500000 deaths due to AIDS in Sub Saharan Africa by 2021

Modelling done by UNAIDS shows that if the service disruptions that are being experienced in Sub Saharan Africa continue for the next 6 months this could result in 500,000 additional AIDS-related deaths between 2020 and 2021 and reversal of the gains achieved in PMTCT

programmes to levels experienced ten years ago. Other modelling suggests that just a three-month disruption in Malawi would lead to a 25% increase in the number of infected children.[4]

Some national responses to keep services available are:

Malawi: "Regular communications from Ministry of health - HIV department in the form of circular letters to all service providers, toll free phone lines for consultations and support, flexed criteria for six months dispensation, running HIV clinics every day to reduce congestion, suspension of non-essential HIV services that need frequent visits to the facility.[5]

Namibia: "Implemented intensified MMD for both adults and paediatrics. Decongesting ART facilities, Establishment of a hotline for PLWHIV, community dispensing at existing DSD model sites and primary health care outreach points, Hiring of short term staff to ensure service continuity."

On 19 May, 2020, the Gauteng Department of Health, **South Africa**, reported developing a system to trace 1090 patients that had not collected their TB medication (representing a 1,4% reduction) and 10 950 people living with HIV that had not collected their ARVs (a 19,6% reduction) since the lockdown began on March 27 2020.[6]

Recommendations made by the International AIDS Society and WHO for **continuity of HIV services, including prevention, during COVID-19**[7] are:

- Reduce the frequency and duration of health facility visits.
- Implement extended refills of ARVs.
- Support out of facility pick up points for refills.
- Adapt health facilities to support core COVID-19 control measures.
- Move adherence support to virtual platforms such as Whatsapp and SMS.
- Adjust HIV prevention - to provide messaging through virtual platforms; and provision of prevention materials and testing outside health facilities. This should include, for instance, expanded use of self-testing.
- Assure linkage and ART initiation for those that test positive.
- Continue to test for and treat HIV co infections and co morbidities, including NCDs such as hypertension.
- Ensure that all SRHR services are accessible.
- Ensure that women and girls at higher risk of gender based violence receive support.
- Harness low cost, accessible technologies.

The Global Fund[8] has allowed countries to reprioritise some funds from HIV activities to very urgent demands for COVID-19, such as Personal Protective Equipment (PPE). This process is termed "grant flexibility". All SADC nations, with the exception of Angola, Mauritius and Seychelles, were allowed this flexibility, for a total of $33,895,501 (out of a total of $162,289,024 that was made available). The Global Fund has also made additional funding available for the COVID-19 response. Four SADC countries had been allocated funds from this mechanism by mid-June, 2020. Angola, Eswatini, Namibia and Zimbabwe were allocated $23,305,829 of the $134,959,496 (17%) of the funds awarded.[9]

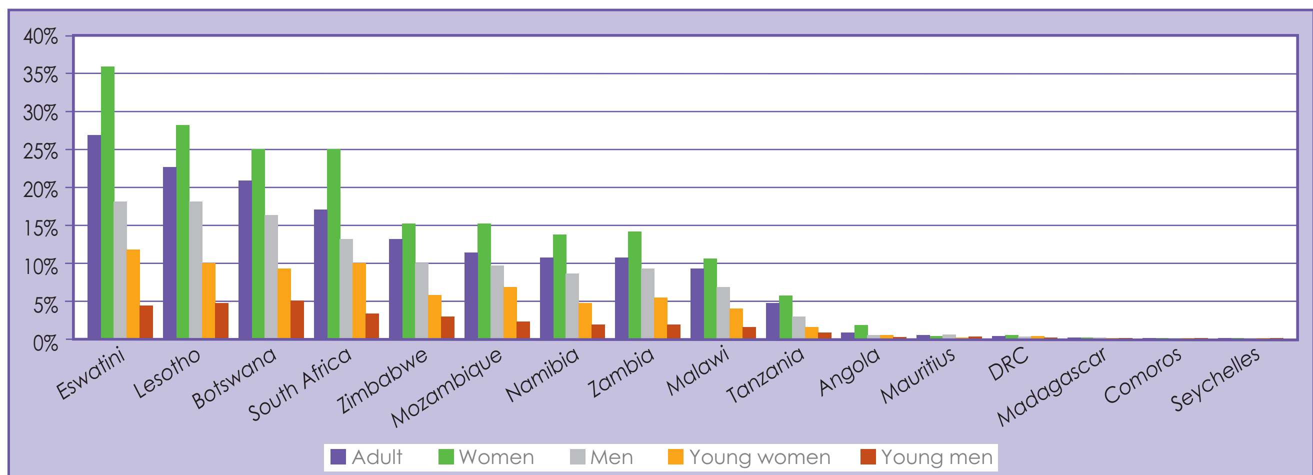
4 UNAIDS. 2020. Progress towards the Start Free, Stay Free, AIDS Free Targets. 2020 report. Geneva UNAIDS.
5 https://www.who.int/docs/default-source/hiv-hq/presentation-disruption-in-services-international-aids-conference-2020.pdf?sfvrsn=d4bf1f87_7 Accessed 11 July, 2020.
6 https://www.timeslive.co.za/news/south-africa/2020-05-19-almost-11000-hiv-positive-patients-in-gauteng-have-skipped-arv-collection-during-lockdown/
7 International AIDS Society. 2020. COVID-19 and HIV: a tale of two pandemics.
8 The Global Fund partnership mobilises and invests more than US$4 billion a year to support the end of AIDS, tuberculosis and malaria as epidemics programs run by local experts in more than 100 countries.
9 Global Fund. 16 June, 2020. Funding Approved for COVID-19 Response. https://www.theglobalfund.org/en/covid-19/

HIV Prevalence

SADC is home to 4.6% of the world's population; and 45% of all people living with HIV in the world

SADC is still the epicentre of the HIV epidemic. In 2019, UNAIDS estimated that at least 17,140,000 people living with HIV were in SADC. This is 45% of the 38 million people living with HIV globally. SADC's total population of 353,940,000 is only 4.6% of the global population.

Figure 5.1: HIV Prevalence in SADC



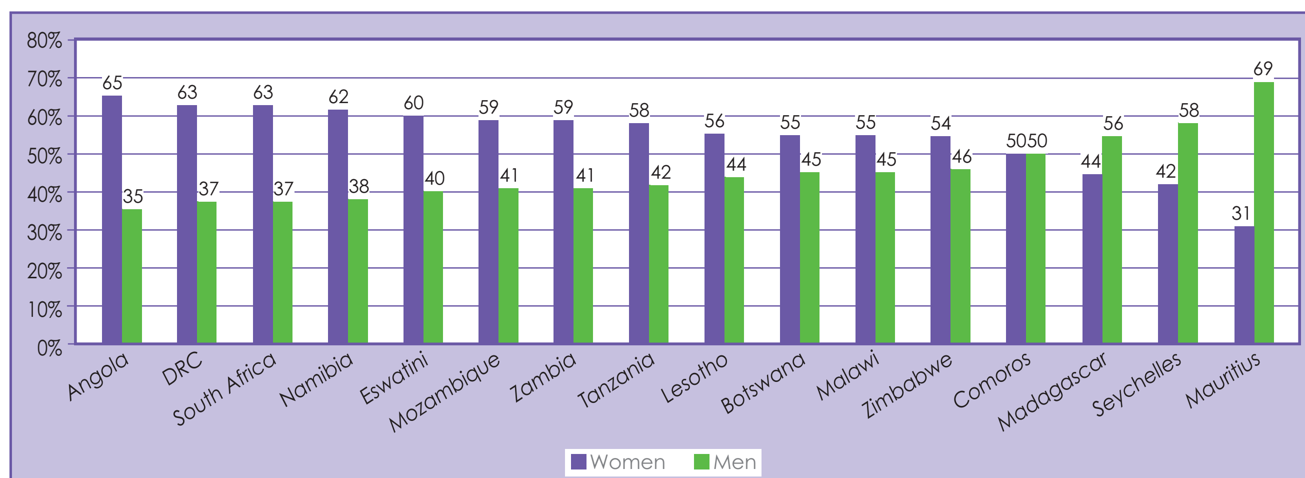
Country	Adult	Women	Men	Young women	Young men	Ratio Young women: young men
Eswatini	27	35,6	18	12,3	4,1	3,00
Lesotho	22,8	27,9	17,9	10,1	4,5	2,24
Botswana	20,7	25,1	16,5	9,3	5	1,86
South Africa	17,3	25	12,9	10,2	3,4	3,00
Zimbabwe	12,8	15,4	10,1	5,9	3,3	1,79
Mozambique	12,4	15,2	9,5	7,1	2,8	2,54
Namibia	11,5	14,5	8,4	4,8	2,7	1,78
Zambia	11,5	14	8,9	5,5	2,6	2,12
Malawi	8,9	10,8	7	4,2	2,1	2,00
Tanzania	4,8	6	3,6	2,2	1,2	1,83
Angola	1,9	2,6	1,2	1,2	0,4	3,00
Mauritius	1,2	0,8	1,7	0,2	0,3	0,67
DRC	0,8	1,2	0,4	0,5	0,2	2,50
Madagascar	0,3	0,2	0,3	0,1	0,1	1,00
Comoros	0,1	0,1	0,1	0,1	0,1	1,00
Seychelles	0,1	0,1	0,1	0,1	0,1	1,00

Compiled from UNAIDS 2020 Data https://aidsinfo.unaids.org/

Figure 5.1 and the data table that informs it shows wide variations in the HIV pandemic across SADC. The data shows that:

- Adult prevalence rates range from 0.1% in Seychelles to 27% in Eswatini. Eight SADC countries (Zambia, Namibia, Mozambique, Zimbabwe, South Africa, Botswana, Lesotho and Eswatini) have adult prevalence rates of higher than 10%.
- Seychelles, which only has a total population of 97,741 and a very low prevalence, 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 of 850,891 and 1,269,670 respectively and thus have more data available
- The island nations have pandemics that are largely driven by injecting drug use while most of SADC has a heterosexual pandemic.
- In all countries except the islands women constitute the majority of those living with HIV. For example in Eswatini, 35.6% of women live with HIV, compared to 18% of men.
- The differences in prevalence rates are particularly high for young women as compared to young men. Figure 5.1 shows that HIV prevalence is three times higher in young women than young men in Eswatini, South Africa and Angola and at least double in Mozambique, DRC, Lesotho, Zambia and Malawi.

Figure 5.2: Proportion of Women and Men Living with HIV



Source: Gender Links, derived from UNAIDS Data 2020 https://aidsinfo.unaids.org/

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

Figure 5.2 shows the proportion of women and men living with HIV across SADC. As expected from the differences in prevalence there are more women living with HIV in most of SADC with marked differences in Angola and DRC, which have newer epidemics as well as South Africa, and Namibia. The differences are less extreme in countries with more mature epidemics.

Table 5.2: Number of people living with HIV, different groups

Country	Total	Children 0 - 14	Adolescents 10 -19	over 50
South Africa	7,500,000	340,000	360,000	1,200,000
Mozambique	2,200,000	150,000	140,000	260,000
Tanzania	1,700,000	93,000	99,000	340,000
Zimbabwe	1,400,000	84,000	85,000	25,000
Zambia	1,200,000	66,000	68,000	230,000
Malawi	1,100,000	65,000	78,000	200,000
DRC	520,000	68,000	47,000	79,000
Botswana	380,000			90,000
Angola	340,000	31,000	22,000	39,000
Lesotho	340,000	12,000	15,000	77,000
Namibia	210,000	10,000	12,000	51,000
Eswatini	200,000	10,000	11,000	32,000
Madagascar	39,000	1,700	900	3,400
Mauritius	11,000	100	150	3,100
Comoros	100			20
SADC Total	**17,140,100**	**930,800**	**938,050**	**2,629,520**
Global Total	**38,000,000**	**1,800,000**	**1,700,000**	**7,900,000**
SADC % of Global	**45%**	**52%**	**55%**	**33%**

Source: Gender Links with data from UNAIDS, 2019.

Table 5.2 shows the total number of people living with HIV in different age categories in SADC, as compared to the global totals. South Africa has the largest HIV epidemic in the world with a total of 7.5 million people living with HIV which is 44% of the SADC total and 20% of the global total number of people living with HIV. Mozambique has 13% and 6% respectively. SADC has even higher proportions of the global burden of HIV in children 0 to 14 years old (52%) and adolescents 10 to 19 years old (55%). While the DRC has only 3% of the SADC total number of people living with HIV, it has 7.3% of SADC's children living with HIV.

SADC has 2,629,520 people over the age of 50 living with HIV (33% of the global total). This is generally a result of wider access to ARVs and more people living longer with HIV. There is growing attention to the issues of older people living with HIV as they are prone to other non-communicable diseases which are more common in older people such as hypertension and diabetes.

SADC accounts for 52% of global population of children living with HIV, 55% of adolescents and 33% of people over 50

Table 5.3: New Infections and HIV incidence

Country	New infections						HIV incidence per 1000 population	
	All	Target 2020	Adults	Women over 15	Men over 15	Children 0-14	Adults 15 - 49	All ages
South Africa	200,000	88,000	190,000	120,000	66,000	10,000	6,9	3,98
Mozambique	130,000	30,000	120,000	69,000	49,000	15,000	8,94	4,68
Tanzania	77,000	14,000	68,000	40,000	29,000	8,600	2,57	1,46
Zambia	51,000	14,000	45,000	26,000	19,000	6,000	6,03	3,17
Zimbabwe	40,000	16,000	34,000	20,000	15,000	5,200	4,87	2,81
Malawi	33,000	11,000	30,000	17,000	13,000	2,500	3,71	1,94
Angola	26,000	5,000	21,000	15,000	6,400	4,600	1,45	0,84
DRC	23,000	3,000	15,000	11,000	3,700	7,700	0,31	0,22
Lesotho	11,000	5,000	10,000	5,600	4,500	1,000	11,35	6,43
Botswana	9,500		9,300	5,100	4,200		8,23	4,78
Namibia	6,900	5,000	6,400	3,900	2,500	400	5,34	3,1
Madagascar	5,900		5,400	2,500	2,900	500	0,4	0,23
Eswatini	4,500	3,000	4,200	2,700	2,500	300	9,77	4,9
Mauritius	750		720	170	550	30	0,96	0,57
Comoros	50		50	20	30		0,01	0,01
TOTAL	**618,600**	**192,000**	**559,070**	**337,990**	**218,280**	**61,830**		
				55%	**35%**			

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

The total number of new infections is declining slowly (from 645,700 in 2018, with 355,900 adult women and 241,500 adult men to 618,600 in 2019; 337,990 women and 218,280 men). SADC's total number of new infections (618,600) is 36% of the global total of 1,700,000 new infections. This is still three times higher than the target for 2020 at global and SADC level which would lead to ending AIDS by 2030. All countries are far off course in terms of meeting targets for reduction in new infections. The largest number of new infections is in South Africa, which comprises 12% of new infections globally while Mozambique contributes 8%. Lesotho, Eswatini, Mozambique and Botswana have the highest incidence rates per 1000 population.

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 3.

Table 5.4: Transition Metrics

Country	2000	2019
Angola	19,68	7,56
Botswana	9,34	2,49
Comoros	22,86	4,65
DRC	9,01	4,37
Eswatini	13,37	2,23
Lesotho	13,33	3,22
Madagascar	20,78	15,14
Malawi	9,75	3,1
Mauritius		
Mozambique	17,9	5,92
Namibia	12,84	3,29
South Africa	16,76	2,63
Tanzania	10,2	4,52
Zambia	9,27	4,08
Zimbabwe	7,12	2,92
Global	**11,32**	**4,37**

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Between 2000 and 2019 the global incidence to prevalence ratio decreased from 11.3% to 4.4%. By 2019, 25 countries reached the 3% milestone, which indicates that they are on the way to ending their AIDS epidemics.[10] As shown in Table 5.4, these include four SADC countries: Botswana, Eswatini, South Africa and Zimbabwe.

Botswana, Eswatini, South Africa and Zimbabwe have reduced new infections sufficiently to be on the way to ending AIDS

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.

[10] UNAIDS. 2020. 2020 AIDS Data Book. Geneva. UNAIDS. https://www.unaids.org/sites/default/files/media_asset/2020_aids-data-book_en.pdf accessed 6 July, 2020.

Table 5.5: Most recent HIV and AIDS policy or strategy

Country	Most recent HIV strategy	Year
Botswana	Third National Strategic Framework for HIV/AIDS 2019 - 2023	2019
Seychelles	Third multi sectoral National Strategic Plan for HIV, AIDS & Viral Hepatitis 2019 - 2023	2019
Eswatini	National Multisector HIV & AIDS Strategic Framework 2018 - 2023	2018
Lesotho	National HIV and AIDS Strategic Plan 2018/19 - 2022/23	2018
South Africa	Let our actions Count: South Africa's National Strategic Plan for HIV, TB and STI's 2017 - 2022	2017
Tanzania	Health Sector HIV & AIDS Strategic Plan 2017 - 2022 (HSHSP IV)	2017
Zambia	National HIV & AIDS Strategic Framework 2017 - 2021	2017
Namibia	National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 - 2021/22	2017
Mauritius	National HIV Action Plan 2017 - 2021, the Republic of Mauritius	2017
Mozambique	Plano Estratégico Nacional de Resposta ao HIV e SIDA 2015 - 2019	2015
Zimbabwe	Extended Zimbabwe National HIV and AIDS Strategic Plan III (ZNASP3) 2015 - 2020	2015
Malawi	National Strategic Plan for HIV and AIDS 2015 - 2020	2015
Angola	Plano Estratégico Nacional de Resposta ao HIV e SIDA 2015 - 2018	2015
DRC	Plan Strategique National de lute contre le VIH et le SIDA 2014 - 2017	2014
Madagascar	National strategic plan in response to sexually transmitted infections and AIDS in Madagascar 2013 - 2017	2013
Comoros	National Strategic Plan 2011 - 2015	2011

Source: GL Audit of SRHR Policies and Laws 2020.

Table 5.5 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. For a region which is at the forefront of fighting HIV an up to date plan for every country is critical. In five of the SADC countries HIV and AIDS policies and strategies are out of date and need to be updated. This is critical in view of the rapid changes in the sector, as well as the "shadow" COVID-19 pandemic threatening many of the gains on HIV and AIDS.

Table 5.6: SADC HIV and AIDS laws scorecard

Country	Criminalising transgender people	Criminalising sex work	Criminalising same sex sexual acts	Drug use/ possession an offence	Parental consent for adolescents HIV test	Spousal consent for married women to access SRHR	Criminalising transmission/ non-disclosure of HIV	Restricted entry/stay of PLHIV	Mandatory HIV test for marriage/ work
Angola	Criminalised	No data	Not criminalised	No data	Criminalised	Not criminalised	Criminalised	(orange)	Not criminalised
Botswana	Not criminalised	Criminalised	Not criminalised	Criminalised	Criminalised	Not criminalised	Criminalised	Not criminalised	Criminalised
Comoros	Not criminalised	Criminalised	Criminalised	Criminalised	Not criminalised	Not criminalised	Not criminalised	Not criminalised	Not criminalised
DRC	Not criminalised	Criminalised	Not criminalised	Not criminalised	Criminalised	No data	Criminalised	Not criminalised	Not criminalised
Eswatini	Not criminalised	Criminalised	Criminalised	Criminalised	Criminalised	Criminalised	Criminalised	Not criminalised	Not criminalised
Lesotho	Not criminalised	Criminalised	Not criminalised	Criminalised	Not criminalised	Not criminalised	Criminalised	Not criminalised	Not criminalised
Madagascar	Not criminalised	Criminalised	Not criminalised	Criminalised	Criminalised	Not criminalised	Criminalised	Not criminalised	Not criminalised
Malawi	Criminalised	Criminalised	Criminalised	Criminalised	Criminalised	Not criminalised	Criminalised	Not criminalised	Criminalised
Mauritius	Not criminalised	Criminalised	Criminalised	Criminalised	Criminalised	Not criminalised	Not criminalised	Criminalised	Criminalised
Mozambique	Not criminalised	Not criminalised	Not criminalised	Criminalised	Not criminalised	Not criminalised	Criminalised	Not criminalised	Not criminalised
Namibia	Not criminalised	Criminalised	Criminalised	Criminalised	Criminalised	Not criminalised	Criminalised	Not criminalised	Not criminalised
Seychelles	Not criminalised	Criminalised	Not criminalised	Criminalised	Not criminalised	Not criminalised	Criminalised	Not criminalised	Not criminalised
South Africa	Not criminalised	Criminalised	Not criminalised	Criminalised	Not criminalised	Not criminalised	Criminalised	Not criminalised	Not criminalised
Tanzania	Not criminalised	Criminalised	Criminalised	Criminalised	Criminalised	Not criminalised	Criminalised	Not criminalised	Criminalised
Zambia	Not criminalised	Criminalised	Criminalised	Criminalised	Criminalised	Not criminalised	Criminalised	Not criminalised	Not criminalised
Zimbabwe	Criminalised	Criminalised	Criminalised	Criminalised	Criminalised	Not criminalised	Criminalised	Not criminalised	Criminalised

KEY Not criminalised · No data · Criminalised

Source: UNAIDS. 2020. Global AIDS Update 2020: Seizing the moment - Tackling entrenched inequalities to end epidemics". https://aids2020.unaids.org/report/

Table 5.6 shows that the legal framework in SADC is generally retrogressive in terms of protecting the rights of members of key populations such as sex workers and people in same sex relationships. There are some notable achievements, such as the decriminalisation of same sex sexual activity in Botswana in 2019 (that may still be appealed by the Attorney General, see Chapter Eight).

Launch of Botswana Relationship Study, Botswana. Photo: Keletso Metsing

Comoros passed a law in 2014 that strengthens the protection for people living with HIV and AIDS. In light of this progressive development, the UNAIDS encouraged, "More countries to follow the bold and inclusive example of the Comoros, ensuring that no one is denied opportunities because of their HIV status."[11]

With the support of civil society, legal action has been taken in **Botswana** to address the discrimination that lesbian, gay, bisexual, transgender and intersex (LGBTI) persons face when seeking health-care services.

In **Eswatini**, standard operating procedures for reducing stigma and discrimination in health-care facilities have been developed to promote key population-friendly services.[12]

The enactment of the Child Care and Protection Act in **Namibia** in January 2019 has allowed the lowering of the age of consent from 16 to 14 years for sexual and reproductive health services and for HIV testing.

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.
UNAIDS 90/90/90: TARGET 1: By 2020, 90% of all people living with HIV will know their HIV status (90% diagnosed)
The SADC-sponsored UN Resolution on women, girls, HIV and AIDS
- Achieve universal access to comprehensive HIV prevention, programmes, treatment, care and support to all women and girls and achieve universal health coverage.
- Enhance the capacity of low- and middle-income countries to provide affordable and effective HIV prevention and treatment products, diagnostics, medicines and commodities and other pharmaceutical products, as well as treatment for opportunistic infections and co-infections, and reduce costs of lifelong chronic care,

[11] Gender Links. Audit of SRHR Policies and Laws. 2020.
[12] Global Health Prevention Coalition. 2020. Implementation of the HIV Prevention 2020 Road Map. Third Progress Report. Geneva, UNAIDS.

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

Although global statistics point to many gaps in reaching the goals to eradicate HIV, there has been much progress in SADC despite diverse economic backgrounds. All the countries who have achieved great progress towards the eradication of HIV over the last decade have shown strong political will and leadership, strong community engagement, reliable and consistent scientific evidence that guides decision making and a focus on rights-based multi-sector approaches to addressing the spread of HIV.

Table 5.7: Progress towards achieving the 90-90-90 goals in SADC

	Progress to 90 90 90 goals All						Progress to 90 90 90 goals Women						Progress to 90 90 90 goals Men					
Goal 1	90 Percent of those living with HIV know their status																	
Goal 2	90 Percent of people who know their status are on ART																	
Goal 3	90 Percent of people on ART achieve viral suppression																	
Year	**2015**			**2019**			**2015**			**2019**			**2015**			**2019**		
Goals	**1**	**2**	**3**	**1**	**2**	**3**	**1**	**2**	**3**	**1**	**2**	**3**	**1**	**2**	**3**	**1**	**2**	**3**
Eswatini	89	76		>95	>95	>95	92	76		>95	>95	>95	90	71		>95	93	>95
Namibia	89	73	>95	95	90	91	93	71	>95	>95	93	93	87	74	>95	92	83	91
Lesotho	84	70		93	71	93	89	71		95	75	93	82	66		92	63	94
Botswana	82	84		92	89	>95	86	91		95	>95	>95	81	75		91	78	>95
South Africa	85	62	86	92	75	92	89	64	87	94	80	92	81	57	86	91	69	92
Zambia	78	87		90	95	90	82	85		93	>95	91	74	87		87	90	90
Zimbabwe	80	80		90	94	86	87	79		95	94	88	76	77		87	92	86
Malawi	78	77	88	90	88	92	86	80	90	94	93	94	74	68	87	86	78	93
Tanzania	65	75		83	90	92	69	81		85	>95	93	62	60		81	78	92
Comoros	34	>95		82	73	86	45	>95		>95	84	84	30	>95		74	60	90
Mozambique	61	62		77	77	75	70	61		86	79	78	50	57		66	70	75
Mauritius				69	37	68				59	42	68				73	34	68
Angola	51	48		62	44		58	46		69	42		50	49		62	44	
DRC	24	>95		54	>95		25	>95		53	>95		30	92		72	>95	
Madagascar				15	90					18	88					13	93	

KEY 90+% 80-89% 70-79% 60-69% Below 59%

Source: Gender Links, with data from UNAIDS Data 2020, https://aidsinfo.unaids.org/, accessed 8 July, 2020.

Table 5.7 shows that:

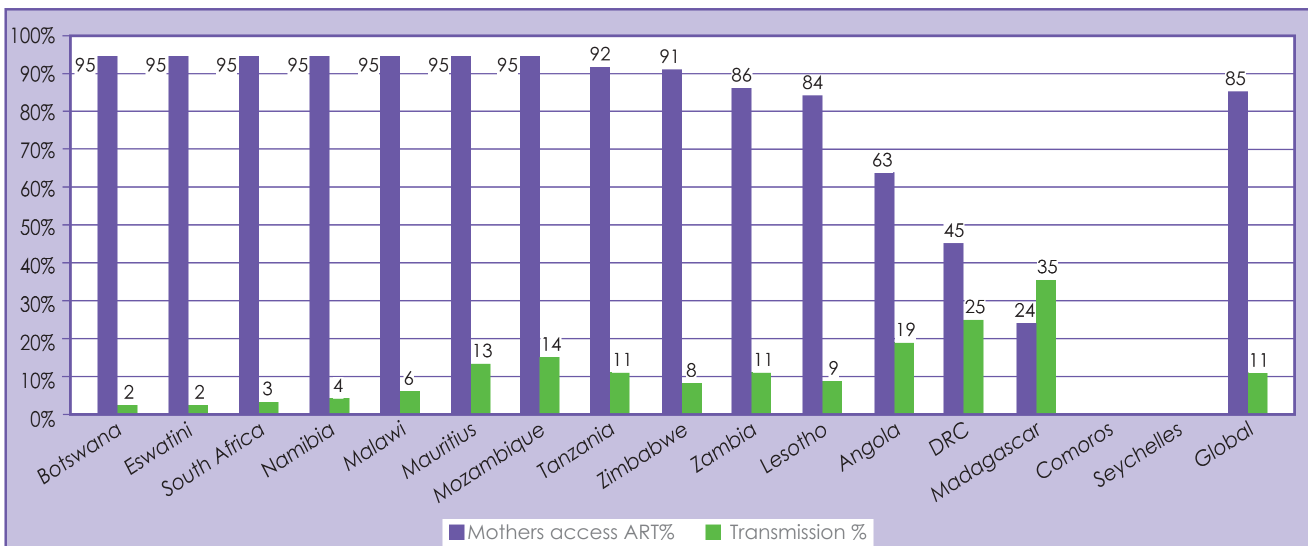
- There has been great progress in SADC towards meeting the 90-90-90 goals between 2015 and 2019, both in terms of collecting data as well as in achieving the goals of testing, access to ARVs and adherence to ARVs to suppress viral load.

- Three SADC countries (Eswatini, Namibia and Zambia) have achieved the UNAIDS 90-90-90 targets (percent people living with HIV who know their status; percent people who know their status who are on ART; and percent people on ART who achieve viral suppression). Eswatini has achieved the 2030 goal of 95 - 95 - 95.
- Six more (Lesotho, Botswana, South Africa, Zimbabwe, Malawi and Tanzania) have achieved two targets.
- Madagascar has a very high testing gap.
- The criminalisation of key populations (Table 5.6) drives many people away from health services and makes it very difficult to reach the levels of testing, access to treatment and adherence that are required for epidemic control.
- Achievement for women is higher than for men in all countries except Mauritius and DRC.

Elimination of Mother to Child Transmission

Twenty-one countries in Africa have been targeted for support to eliminate mother to child transmission of HIV including Angola, Botswana, DRC, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe in SADC. PMTCT programmes targeted: (i) primary prevention of HIV infection of mothers, (ii) access to ARVs for mothers living with HIV and (iii) prevention of transmission after birth and during breastfeeding. Despite remarkable progress in rapidly expanding access to ARVs by pregnant mothers, this has not always resulted in corresponding decline in transmission. Thus, of the 21 focus countries, only eight (of which seven - Botswana, Eswatini, South Africa, Namibia, Malawi, Zimbabwe, Lesotho - are in SADC) have a final transmission rate that is less than 10%.

Figure 5.3: Elimination of Mother to Child Transmission



Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Figure 5.3 reflects tremendous progress, with nine countries having achieved at least 90% coverage of pregnant mothers living with HIV on ART. Ten countries are at the global average or better. Angola, DRC and Madagascar lag far behind, with much higher levels of transmission.

Table 5.8: Number of Pregnant Women on ART 2010 - 2019

Country	Number of pregnant women on ART 2010	Transmission 2010	Number of pregnant women on ART 2019	Transmission 2019	% increase in number of pregnant women on ART 2010 - 2019
South Africa	209,668	16	302,936	3	44%
Tanzania	40,938	18	74,596	11	82%
Zambia	35,494	19	48,342	11	36%
Mozambique	22,344	32	112,282	14	403%
Zimbabwe	21,139	22	57,609	8	173%
Malawi	13,967	28	43,269	6	210%
Botswana	10,999	12	12,728	2	16%
Eswatini	8,295	12	10,433	2	26%
Lesotho	8,047	20	7,589	9	-6%
Namibia	7,695	14	12,522	4	63%
Angola	3,652	31	15,030	19	312%
DRC	2,166	36	13,878	25	541%
Mauritius	64	18	133	13	108%
Madagascar	17	43	339	35	1894%
Comoros					
Seychelles			**19**		
SADC Total	**384,485**		**711,705**		
Global Total	**600,000**	**23**	**1,100,000**	**11**	**83%**
SADC % of global	**64%**		**65%**		

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Table 5.8 shows the actual numbers of pregnant women who accessed ART in 2010 and 2019. There has been a marked increase in the numbers of women accessing ART from a total of 384,485 in 2010 to 711,705 in 2019. The percentage increase is highest in those countries with the lowest rate of coverage (Madagascar, DRC, Mozambique and Angola), indicating an awareness of the need to improve services and action being taken to achieve this. There has also been decline in the overall rate of transmission from mother to child in all countries. The number of pregnant women that accessed ART in SADC is approximately 64% of the global total in both 2010 and 2019.

During 2019, about 150,000 children acquired HIV globally, far more than the global 2020 target of 20,000. Mozambique accounted for 14%; South Africa 9% and Tanzania 8% of children who became HIV positive in 2019. The number of adolescent girls and young women acquiring HIV declined by 19% globally from 350,000 in 2015 to 280,000 in 2019. This is still higher than the target of less than 100,000 by 2020. Three gaps that are contributing to continued transmission are:

1. Women living with HIV did not receive antiretroviral therapy during pregnancy resulting in 38,000 new infections in the focus countries;
2. Women dropped out of antiretroviral therapy either during pregnancy or breastfeeding contributing 29 000 infections.
3. Women acquired HIV while pregnant or breastfeeding, after their initial test result was negative. This added 30,000 infections.

The treatment coverage indicator does not capture whether women were retained on treatment and adherent throughout pregnancy, delivery and breastfeeding. Some countries are beginning to measure viral load suppression at delivery as a more accurate indicator to predict vertical transmission. There is evidence that young women aged 15-24 years have higher viral loads, with a higher risk of vertical transmission.

Programmatically, more attention is being given to:

- Measures to improve adherence during pregnancy and after delivery such as facility and community-based peer support; to support within a woman's network, including male partners to support maternal retention on antiretroviral therapy and to reduce the number of HIV-exposed infants acquiring HIV. Innovations to increase retention in care of both the mother and the baby depend on active follow up until breastfeeding ends, when the child's HIV status can be confirmed.
- Increasing access to viral load testing for pregnant and breastfeeding mothers living with HIV, especially adolescent girls and young women, to enable faster action in response to poor viral load results.
- Reaching 130,000 uninfected women with combination prevention support, such as prevention education, condoms, partner testing (including treatment initiation for those who test positive) and pre-exposure prophylaxis (PrEP). Particular emphasis needs to be placed on young women ages 15-24 years as 43% of those that seroconverted were in this age range. Retesting during pregnancy must be part of the prevention strategy particularly for women most at risk of HIV infection.[13]

Prevention

In 2016, the 26 countries that are contributing the highest number of new infections globally, including ten countries in SADC[14] formed A Global Partnership on Prevention. The Coalition's report in 2019 indicated:

- HIV prevention and leadership structures are being rejuvenated, with new plans.
- HIV related stigma, discrimination and legal barriers stymie efforts to enhance HIV prevention
- Though the critical role of NGOs is recognised, insufficient resources have been invested in community led response.

NGOs play a vital role in the prevention of HIV and AIDS.
Photo: Colleen Lowe Morna

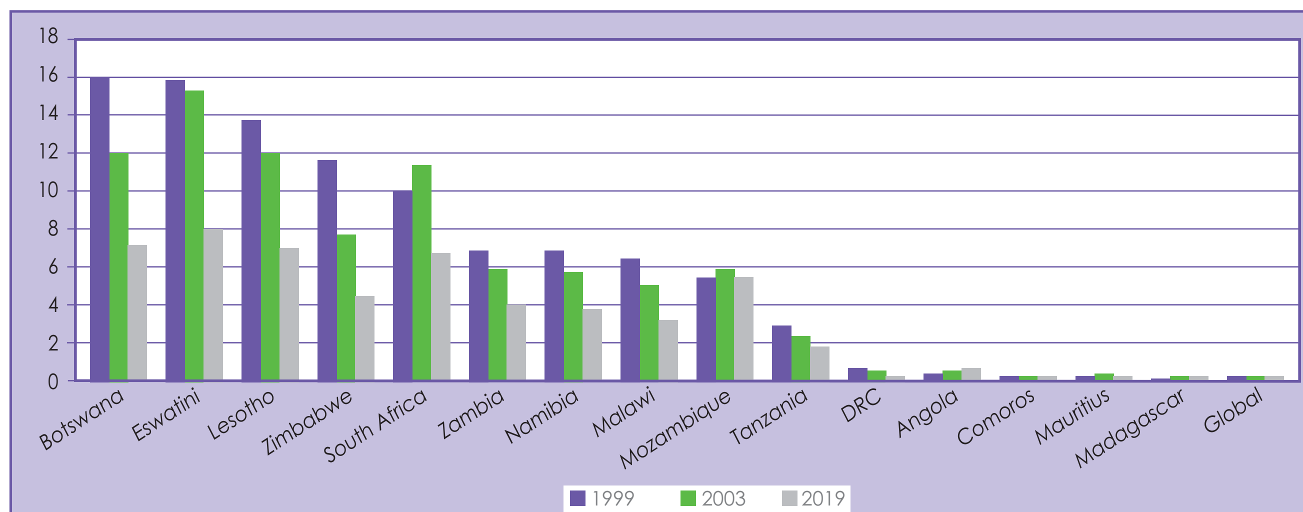
- More emphasis is still needed for the world to achieve prevention targets.[15]

Keeping young women in school prevents HIV

Globally, the HIV pandemic is largely driven by new infections in certain key populations - sex workers, people who use drugs, men who have sex with men, transgender people and prisoners and their partners. Key populations account for 28% of new HIV infections in east and southern Africa with the rest of the population accounting for 72%. The epidemic in east and southern Africa is still mainly driven by new infections in adolescent girls and young women.

[13] UNAIDS. 2020. Progress towards the Start Free, Stay Free, AIDS Free Targets. 2020 report. Geneva UNAIDS.
[14] South Africa, Mozambique, Zambia, Tanzania, Zimbabwe, Malawi, Angola, Lesotho, Namibia and Eswatini
[15] Global HIV Prevention Coalition. 2019. Implementation of the HIV Prevention 2020 Road Map: Third progress report October, 2019. Geneva. UNAIDS.

Figure 5.4: HIV prevalence rates in young people 15 - 24 (1999 - 2019)



Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Prevalence rates in young people have been declining slowly from 1999. Figure 5.4 illustrates the decline from 1999 to 2003 to 2019. Some of the steepest declines are in Botswana (16, 12, 7); Eswatini (16, 15, 8); and Zimbabwe (11, 8, 5). Except for DRC, Angola, Comoros, Mauritius, Madagascar and Seychelles, all the countries in SADC still have HIV prevalence rates in young people aged 15 - 24 that are much higher than the global average (0,4; 0,3; 0,3)

Declining HIV infection rates in young people correlates with an increasing rate of women and girls aged 15 - 24 completing high school. Keeping girls in school increases their chance of using condoms, reducing their chances of contracting HIV. Keeping girls in schools is an important opportunity to teach comprehensive sexuality education and also to increase girls' agency. Cash transfers can keep young people, particularly girls, in school, improve their academic outcomes, increase their use of health services, delay their sexual debut, reduce early marriage and teen pregnancy, and promote safer sexual behaviours. A major concern with the COVID-19 pandemic is the effect that days and months out of school will have on teenage pregnancies as well as HIV and AIDS.

Keeping girls in school is important to reduce HIV transmission

Eswatini a new study has shown that financial incentives to stay in school significantly reduced HIV incidence among adolescent girls and young women, adding to knowledge about the protective value of education for young women and the role of cash transfers and educational incentives in reducing their HIV risk.[16]

[16] Global Health Prevention Coalition. 2020. Implementation of the HIV Prevention 2020 Road Map. Third Progress Report. Geneva, UNAIDS.

Knowledge of HIV status

Figure 5.5: Women and men living with HIV who know their status

Source: Source: UNAIDS Special analysis 2019.

Figure 5.5 shows that six SADC countries (Botswana, Namibia, Malawi, Zimbabwe, Eswatini, and South Africa) have succeeded in expanding coverage of testing to at least 90% of those that are living with HIV, with Lesotho, Zambia, Tanzania and Mozambique not too far behind. This is a particularly noteworthy achievement in South Africa, which has the largest population of people living with HIV of any country in the world. Low coverage of testing in the islands is understandable, due to low prevalence, but is a concern, as testing is one of the most powerful prevention tools.

The Girl Power project in **Malawi** used a youth friendly model that offered HIV testing, family planning and STI services in combination. Adolescent girls using the integrated services were 23% more likely to take an HIV test, 57% more likely to receive condoms, 39% more likely to access hormonal contraception and 16% more likely to use services for STIs.[17]

GL Programme officer Thandokuhle Dlamini taking an HIV test, Eswatini.
Photo: Zethu Shongwe

[17] UNAIDS. 2020. Global AIDS Update 2020: Seizing the moment - Tackling entrenched inequalities to end epidemics". https://aids2020.unaids.org/report/

South Africa: Mobile testing clinics go to the youth

Mossel Bay: HIV testing is a critical first step to both prevention and accessing treatment. Many of those that are most affected, such as youth and males, do not access testing. One strategy to increase access is to bring services to the people, rather than waiting for people to come to access services.

In response to high rates of teenage pregnancy and HIV infections, Mossel Bay municipality has introduced mobile testing clinics for ABC Health Care for Adolescents. The Piet Julies AIDS Action Group and Mossel Bay Taxi Associations combined resources with the Health Department and Mossel Bay Municipality, to enable social change for people who are affected by HIV, TB and STIs due to their higher risk behaviours as well as legal and social issues that increase their vulnerability to health problems. The plan for the initiative taken by the Mossel Bay Municipality and the various stakeholders is to educate communities about HIV, TB, STI's, Road Safety and the Road Traffic Act as well as the National Land Transport Act.

The programme hopes to reduce the rates of new infection and teenage pregnancy by reaching adolescents directly through schools and community facilities. Youth are more likely to use mobile facilities that are specifically for them to avoid discrimination, stigmatisation or judgement when they go to regular health facilities for contraception or HIV treatment. Through regular testing, the programme hopes to identify adolescents already living with HIV and onboard them to ARV treatment

The mobile outreach testing unit targets youth between the ages 12-24. The unit provides many services including HIV testing, prevention, HIV and AIDS education and care in schools and community or outreach centres. The process is:

Mossel Bay Mobile HIV Outreach conduct HIV testing in the community.
Photo courtesy of David Marcus

- A trained nurse conducts a physical examination of the patient.
- The trained health care professional offers contraception advice, options and treatment which includes pregnancy support, male circumcision and referrals for administration of ARVs.
- The administration of ARVs is conducted offsite and includes counselling and referral services.
- In certain circumstances, the trained staff also advise on adoption options for young mothers.

To overcome fears of coming to the come to the mobile clinic, the schools agreed for the project to use the library during breaks. Adolescents can also access the services after school in privacy.

Adolescents take responsibility for their own health and make use of services at the site that is best for their needs (school, health services, or community centre). Teenage pregnancies have decreased from 14% to 10%. STI and HIV infections as well as statutory rape cases have also decreased. Currently two of seven high schools are part of the programme. Mossel Bay is seeking buy-in from the other five.

Source: David Marcus, with Piet Julies AIDS Action Group (PJAAG) Mossel Bay South Africa, submitted the case study for the SADC Protocol@Work Summit application 2019

In all SADC countries (except DRC and Mauritius), knowledge of HIV status is higher among women than men. According to the UNAIDS 2019 report, globally uptake of the three 90s is much higher among women than men: "This is in line with numerous studies showing that men are less likely than women to take HIV tests and to initiate and adhere to HIV treatment, which results in poorer clinical outcomes and a greater likelihood that they will die of AIDS-related causes."[18]

New approaches to men's health-seeking behaviour

There is growing recognition of the need to focus differently on men's health. A supplement of the Journal of the International AIDS Society which focused on this issue in 2020[19] found:

- It is time to move from a narrative that blames men for poor health-seeking behaviour and focuses on men only to improve the health of their partners and children. Engaging men in health services for their own health can provide an entry point for programmes that may also have a positive impact on the health of their families and communities.
- The current system is not working for anyone. All populations (men, adolescent girls and young women key populations) are negatively impacted by prevailing gender norms.
- HIV programmes may be able to drive a larger men's health agenda. Worse outcomes for men compared to women are found in other diseases where mortality is "stagnant or increasing."

Men need to be integral to HIV and AIDS solutions. Photo: Gender Links

Themes which emerged from the articles included in the supplement are:

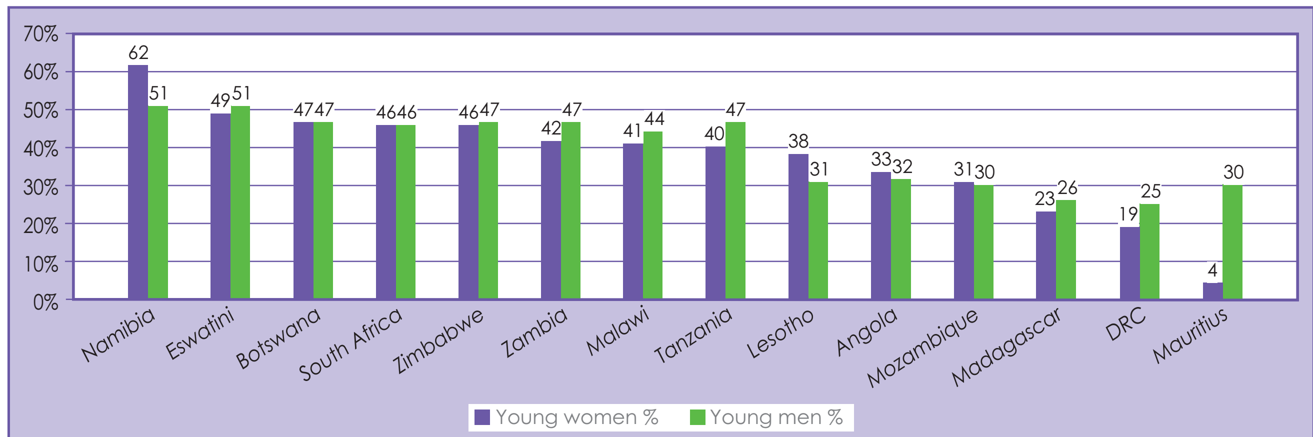
- Health systems are structurally gendered to address women's health needs.
- While there are considerable efforts to reach younger men, there are many "older" men (over 35 years old) who require HIV services.
- Programmes need to be more creative and strategic to access and test men who truly do not know their HIV status. Testing interventions must reach those unaware of their status and corresponding services must be adapted so men start and stay on treatment.
- It is time for a narrative shift away from "men as the problem" to "men as a group that is interested in health and able to be part of the solution" where health systems adapt to meet men where they are.

Comprehensive, accurate knowledge of HIV and AIDS

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

[18] "Communities at the Centre: Defending Rights, Breaking Barriers, Reaching People with HIV Services." UNAIDS Global Update 2019 p85
[19] Grimsrud A et al. Editorial. Journal of the International AIDS Society 2020, 23(S2):e25526 http://onlinelibrary.wiley.com/doi/10.1002/jia2.25526/full | https://doi.org/10.1002/jia2.25526

Figure 5.6: Knowledge on HIV prevention among young people



Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Figure 5.6 illustrates that levels of knowledge about HIV prevention are still very low and the region is still far from the goal of 90%. Knowledge levels are still lower than 50% for both males and females in all countries except Eswatini and Namibia. 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 of out-of-school youth who face significant barriers to accessing information. The case study from Botswana profiles a local initiative to increase awareness in a way that resonates with the youth.

Botswana: Teen Club Games strengthen HIV awareness

Mabutsane: The Teen Club Inter-district Games in 2019 aimed to strengthen HIV talk among youth in an interactive way. Over one hundred adolescents living with HIV from Mabutsane, Moshupa, and Tsabong discussed adhering to treatment and making healthy lifestyle choices, preventing the spread of HIV and the importance of eliminating GBV.

Using role play, the participants had conversations about behaviour that increases the risk of contracting HIV - including alcohol abuse, multiple sexual partners, sleeping with older partners, and neglecting to use condoms. They also engaged in in-depth conversations about the signs of abusive relationships and strategies of how to leave.

Mixed sex teams participated in volleyball, football, and netball, which encouraged teamwork between adolescents from different districts. The “gender bender” approach resulted in boys joining the netball teams or girls joining the football teams. By holding a beauty pageant where both girls and boys could compete, the facilitators and organisers aimed to challenge gender norms and boost confidence and self-esteem in the participants.

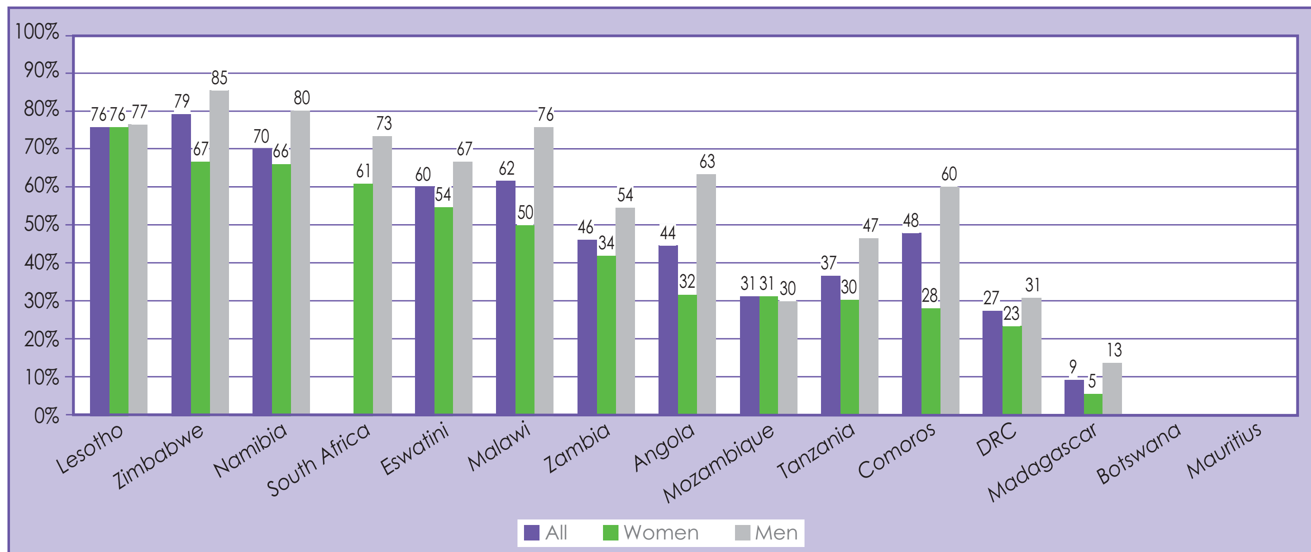
The games were attended, facilitated and managed by four Teen Club facilitators from Moshupa and Tsabong Teen Clubs, 12 from Mabutsane; 4 Peace Corps Volunteers (PCVs) from the respective districts; 20 teen club facilitators from the same districts as well as 40 teens from each of Mabutsane, Moshupa, and Tsabong. PCV's supported facilitators in the development of the programme, competition logistics, and with facilitation techniques.

Source: Botho Tumaeletse; Mabutsane District Health Management Team, SADC Protocol @ Work Summit 2019

Condom use

The attitudes on whether a woman can refuse to have sex with her husband range quite widely with the highest rate of agreement to this statement of 62% of female respondents in Zimbabwe and the lowest rate of 11% of male respondents in Namibia. Overall male and female views are similar in every country. Over 50% of both females and males in Zimbabwe, Seychelles, Zambia, Lesotho and Malawi agree with the statement. South Africa and Angola have significant differences in attitudes between males and females with more females agreeing with the statement in South Africa and more males in Angola.

Figure 5.7: Condom use at last high-risk sex in SADC



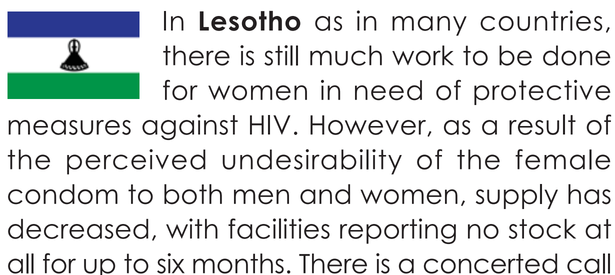
Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Figure 5.7 shows that access to condoms overall ranges from 79% in Zimbabwe to 9% in Madagascar. Lesotho and Mozambique have very similar rates between women and men while all other countries have higher rates of access for men than women.

Condom use has not expanded rapidly enough over the last decade as a result of decreased priority being placed on condom programmes. Active condom promotion in Namibia and Zimbabwe over two decades has led to some of the highest recorded levels of condom use at least for sex with non-regular partners. Condom use by young women has increased in the last decade in Lesotho, Malawi, Mozambique and Zimbabwe but is declining in Zambia and Tanzania.[20]

Demonstration of female condom usage. Photo: Ntolo Lekau

[20] UNAIDS. 2020. Global AIDS Update 2020: Seizing the moment - Tackling entrenched inequalities to end epidemics". https://aids2020.unaids.org/report/



In **Lesotho** as in many countries, there is still much work to be done for women in need of protective measures against HIV. However, as a result of the perceived undesirability of the female condom to both men and women, supply has decreased, with facilities reporting no stock at all for up to six months. There is a concerted call to boost campaigns for female condoms once again, to normalise the use of the condom. However, various factors need to be taken into account. For instance, the female condom is less convenient than the male condom. Awareness needs to be increased for the female condom to help reduce new HIV infections.[21]

Voluntary Medical Male Circumcision (VMMC)

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

Table 5.9: Number of male circumcisions conducted

Country	2015	2016	2017	2018	2019	Total
Tanzania	435,302	548,390	730,435	885,599	799,456	3,399,182
South Africa	485,552	497,186	591,941	572,442	451,636	2,598,757
Zambia	222,481	311,792	483,816	482,183	549,655	2,049,927
Mozambique	198,340	253,079	315,380	311,891	390,589	1,469,279
Zimbabwe	188,732	205,784	301,366	326,012	354,819	1,376,713
Malawi	108,672	129,975	166,350	199,399	114,465	718,861
Namibia	18,549	27,340	30,134	34,942	40,868	151,833
Lesotho	25,966	34,157	25,150	26,448	34,144	145,865
Botswana	15,722	24,042	19,756	24,207	17,123	100,850
Eswatini	12,952	17,374	18,138	14,316	17,360	80,140
TOTAL SADC	**1,712,268**	**2,049,119**	**2,682,466**	**2,877,439**	**2,770,115**	**12,091,407**
Total Priority	**2,623,788**	**2,827,188**	**4,044,740**	**4,135,786**	**4,145,686**	**17,777,188**
SADC as % of all priority	**65%**	**72%**	**66%**	**70%**	**67%**	**68%**

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Table 5.9 shows that health workers conducted 12 million male circumcisions in the ten priority countries of SADC (68% of the total number of circumcisions conducted in the fifteen priority countries). The numbers have not increased dramatically since 2017 leading to the conclusion

[21] https://genderlinks.org.za/news/lesotho-female-condom-low-demand-widens-inequality-gap/
[22] Ensor S et al. Journal of the International AIDS Society 2019, 22(S4):e25299 http://onlinelibrary.wiley.com/doi/10.1002/jia2.25299/full | https://doi.org/10.1002/jia2.25299 "The effectiveness of demand creation interventions for voluntary male medical circumcision for HIV prevention in sub-Saharan Africa: a mixed methods systematic review".

that there is low demand. Achieving the 2020 target of 25 million voluntary male circumcisions by 2020 in the priority countries would involve an enormous expansion of the programme in 2020. This is now impossible as a result of COVID-19.

A number of studies have been conducted on programmes to increase uptake of VMMC. A systematic review[22] examined reports of:
- Financial incentives - direct and lottery.
- Counselling or education for prospective candidates.
- Education and involvement of influencers, and
- Novel information delivery, including SMS to men who have tested HIV negative.

The study found that a range of interventions can increase demand creation and subsequent VMMC uptake. The most acceptable and effective interventions appear to be direct financial incentives, equivalent to two days' wages, food vouchers or conditional cash transfers; and programmes of education or counselling delivered by people who are influential in the community such as religious leaders or have personal experience of VMMC such as coaches in soccer based interventions for youth. Group and individual counselling as well as involving female partners is also effective. All interventions must be appropriate and acceptable in the setting and phase of the programme.

Mathematical modelling suggests that 250, 000 [200,000-330,000] new HIV infections were averted by the end of 2018 (78% among males and 22% among females) in all fifteen priority countries. The future benefits will be larger since VMMC provides lifelong protection. It is estimated that the number of men and boys who have taken up VMMC so far would avert approximately 1.5 million new HIV infections by 2030 and 4.5 million by 2050 if the coverage of other HIV interventions (including antiretroviral therapy) remains constant.[23]

Pre-Exposure Prophylaxis (PrEP)

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

Table 5.10: Number of people accessing PrEP

Country	2017	2018	2019	Total
Botswana		38	1,954	1,992
Lesotho	853	7,279	35,478	43,610
Malawi			459	459
Mauritius		3		3
Mozambique	303	1,934		2,237
Namibia	190			190
Seychelles	2	4	26	32
South Africa	3,189	8,184		11,373
Zambia		3,823		3,823
Zimbabwe	2,714	4,982	8,351	16,047
TOTAL	**7,251**	**26,247**	**46,268**	

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

[23] Global Health Prevention Coalition. 2020. Implementation of the HIV Prevention 2020 Road Map. Third Progress Report. Geneva, UNAIDS.

Table 5.10 shows that countries are gradually adopting PrEP as an additional HIV prevention option for key populations and young people in high-prevalence settings who are at high risk of HIV infection.

A study in **South Africa**, the first country to approve PrEP, shows that providing PrEP through routine family planning services is a promising strategy to reach women in settings with a high burden of HIV. South Africa is planning to expand PrEP services to transgender women who are estimated to have an HIV prevalence rate up to 25%. A study of 213 transgender women from Cape Town, East London, and Johannesburg found only 45% of HIV-negative participants knew about PrEP and only 11% are currently taking PrEP. HIV-negative participants experiencing social and interpersonal hardship such as violence, poverty, discrimination or low community connectedness, reported higher levels of PrEP awareness than HIV-negative transgender women who did not experience these. Barriers to PrEP included taking a daily pill, side-effects, and cost. Poor community connectedness was also a barrier. Participants urged greater education and engagement of transgender women in PrEP implementation.[24]

Eswatini has endorsed PrEP for scale-up at 200 health facilities by the end of 2019 and Namibia is developing a standardized PrEP set of tools (including standard operating procedures and a framework for monitoring and evaluation).[25]

Prevention among key populations

Key populations are sex workers, men who have sex with men (MSM), people who inject drugs, transgender persons, prisoners and migrants. The goal is that 90% of key populations access HIV combination prevention services. As new infections continue to decline in young people, the proportion of new infections from key populations is increasing. 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 (15%). HIV thus spreads into the general population. The paucity of data about the epidemic in key populations is indicative of the low priority that these segments of the population have received so far in the HIV battle in SADC. However, there is growing attention to them and each year more data is available.

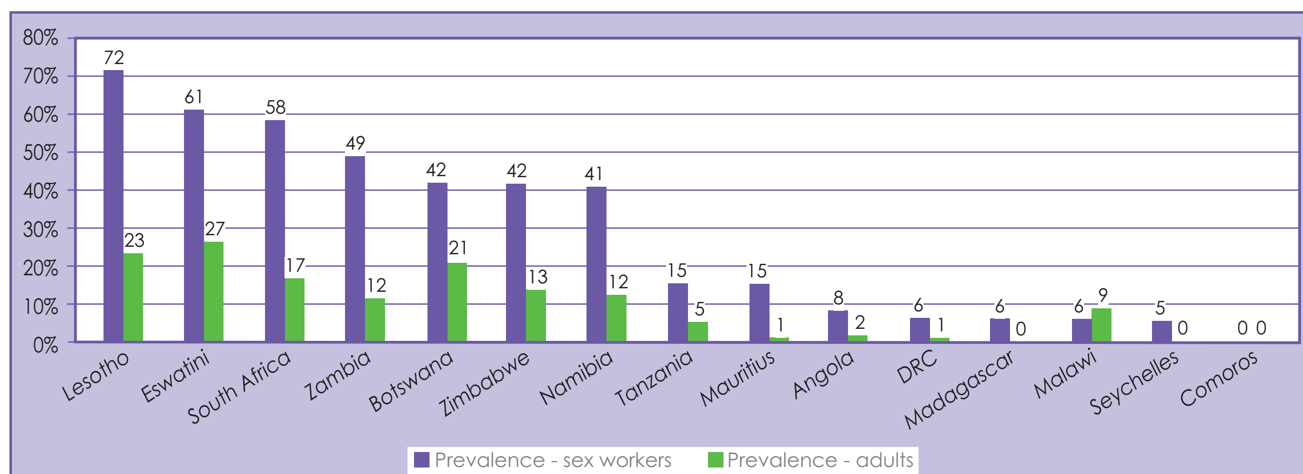
Umguza Rural District Council HIV and STI IEC material, Harare, Zimbabwe.
Photo: Tapiwa Zvaraya

Zimbabwe is intensifying multi-sector efforts to strengthen key population programmes, as outlined in its National Key Populations HIV and AIDS Implementation Plan 2019-2020. Services will include peer education, social networking and digital outreach, with improved health facility services. Actions to address structural barriers include: advocacy for law reforms, sensitization of health-service providers or law enforcement agents, and media campaigns to eliminate stigma and discrimination.[26]

[24] T. Poteat et al. "PrEP awareness and engagement among transgender women in South Africa: a cross-sectional, mixed methods study", The Lancet HIV, 2020. https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(20)30119-3/fulltext accessed 8 July, 2020.
[25] Global Health Prevention Coalition. 2020. Implementation of the HIV Prevention 2020 Road Map. Third Progress Report. Geneva, UNAIDS.
[26] Global Health Prevention Coalition. 2020. Implementation of the HIV Prevention 2020 Road Map. Third Progress Report. Geneva, UNAIDS.

Sex Workers

Figure 5.8: HIV Prevalence among sex workers



Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Sex Work is criminalised across most of SADC, with the exception of Mozambique. Figure 5.8 shows that HIV prevalence is much higher among sex workers than the whole adult population in all countries except Malawi. In the majority of countries it is between two times (Botswana) to 4.2 times as high (Angola and Zambia). In the DRC the rate of infection among sex workers is 7.1 times higher. Among the islands the rate by which prevalence among sex workers is higher than the general population is three times in Comoros; 12.5 times in Mauritius, 18.3 times in Madagascar and 46 times in Seychelles. However, as noted earlier in the chapter the overall HIV prevalence in these countries is low.

Table 5.11: HIV prevention and management among sex workers

Country	Prevalence %	Condom Use %	HIV Prevention %	Testing %	ARV coverage %
Angola	8	71,7		100	42
Botswana	42,2	75,7			87,6
Comoros	0,3	26		100	
DRC	5,7	69			
Eswatini	60,5	82,9			
Lesotho	71,9	62,3		63,8	
Madagascar	5,5	62,8		40,6	
Malawi	5,5	65	68	72,4	80,8
Mauritius	15	67,2		78,9	
Mozambique	No data available				
Namibia	40,7				
Seychelles	4,6	16		98,1	
South Africa	57,7	86,1			23,6
Tanzania	15,4	72,4	20	98,3	
Zambia	48,8	78,5		56,1	85,9
Zimbabwe	42,2	74,9	34,5	80,5	78,2

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Table 5.11 reflects the need for much greater attention to programmes and services for prevention and management of HIV among sex workers throughout SADC. Although some countries appear to have good programmes for testing, with high coverage, this is not translating into condom use or access to ARVs. Disseminating information on HIV among sex workers is important, as reflected in the DRC case study:

DRC: Sex workers have the right to information on HIV

Kinshasa: Female sex workers in the DRC capital face several challenges. Their rights are not respected; they are easily infected with HIV because they are ill informed and they are not protected by law enforcement officials.

Research by *Forum Des Naturalistes* shows that sex workers in Kinshasa charge an average of 3.5 times more for unprotected than protected sex. Sex workers who engage in unprotected sex for extra money are much more likely to live or work in lower socioeconomic areas of Kinshasa. This leads to the conclusion that those who face more socioeconomic challenges are more likely to engage in unprotected sex.

To reduce new HIV infections, awareness programmes encourage young female sex workers to test for HIV. They are provided with testing kits. In the event that they test positive, they are helped to access ARV's. The programme aims to increase legal protection for sex workers rights and their health. The programme is advocating for the regulation of the price of services rendered by sex workers to ensure that they earn a living, and are protected against STI's and HIV infection.

Challenges include difficulties in reaching all communities of sex workers for educational workshops; many women are too far out of the region and travel is difficult. Another threat to the programme is that many sex workers are not willing to miss a day of work as this affects income.

Source: Ngoma Dieu Merci in collaboration with Forum Des Naturalistes. The case study was submitted as part of the SADC Protocol @ Work Summit 2019

As sex worker populations are heterogeneous, health programmes must develop services that reflect the variety and complexity of sex worker needs and behaviours, that are designed in consultation with sex workers. Segmenting sex worker populations according to age, country of origin and place of service delivery, and training healthcare providers accordingly, could help prevent new HIV infections, improve adherence to antiretroviral treatment and increase uptake of SRH services. The Global Fund Key populations programme has supported countries to initiate Pre Exposure Prophylaxis (PreP) programmes with sex workers. Zimbabwe's National Aids Council initiated 1817 sex workers out of a targeted 2200 on PreP during the first quarter of 2020.[27] Stigma is still rife even amongst sex workers.

[27] Gender Links. 2020. Audit of SRHR Laws and Policies in SADC June 2020

Zimbabwe: Stigma bars sex workers from life saving measures[28]

At 17, Andile* a sex worker from Bulawayo has little recourse to medical or legal help due to the nature of her work.

She has turned to sex work at age 13 to enable her siblings to continue with their education. In four years, she has already been exposed to ritual sexual acts, rape, death threats, and unprotected sex for more money. In many cases she has not been given her money; suffered extreme physical abuse and has been held hostage countless times.

She is still unable to access health services. Female police officers often dismiss cases brought by sex workers. This fuels the spread of HIV. Sensitisation drives across Zimbabwe, have focused on training higher-ranking officials. This has not yet trickled down to communities. Stigma keeps young girls such as Andile from accessing critical HIV prevention, reporting their abuse to the police and from being taken seriously by healthcare professionals.

Results of a study conducted by the Centre for Sexual Health and HIV/AIDS Research (CeSHHAR) indicate that the stigmatisation and discrimination of adolescent sex workers at some hospitals and clinics in Zimbabwe is hampering their access to increased HIV/AIDS treatment and care. Presenting the study findings during a Zimbabwe Lawyers for Human Right's health forum for journalists, CeSHHAR programs director, Sibongile Mtetwa, said stigmatisation and discrimination are some of the major barriers to health access faced by sex workers in the country.

Mtetwa revealed that sex workers were also being abused by their clients with the police not doing much to help. Female police officers dismiss adolescent sex workers reports and blame them for spreading HIV/AIDS. This prevents them from approaching health institutions to access treatment and support services.

The 2018 SADC Regional Strategy on HIV prevention and SRHR among Key Populations recognises the abuses of young sex workers and their plight in accessing health care. This has done little to remove the stigma preventing adolescent sex workers from accessing health care services. Efforts by the Ministry of Health to ensure that adolescent sex workers get treatment seems not to be targeting the right people.

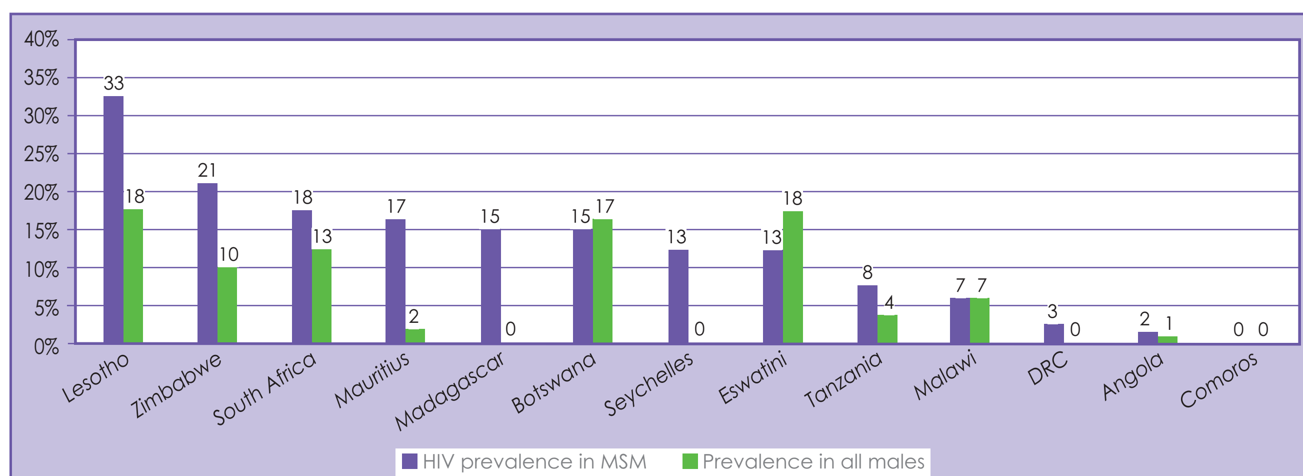
HIV AIDS self-testing booth, Zimbabwe. Photo: Tapiwa Zvaraya

*(*not her real name)*
Source: Hazel Marimbiza, Gender Links News Services

[28] https://genderlinks.org.za/news/zimbabwe-abused-adolescent-sex-workers-ignored/

Men who have Sex with Men (MSM)

Figure 5.9: Men who have sex with men



Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Figure 5.9 reflects much higher HIV prevalence among men who have sex with men (MSM) than in the general population of men in all countries except Botswana and Eswatini. The difference is particularly marked in the island nations of Mauritius, Madagascar and Seychelles.

Table 5.12: Men who have Sex with Men, prevalence and prevention

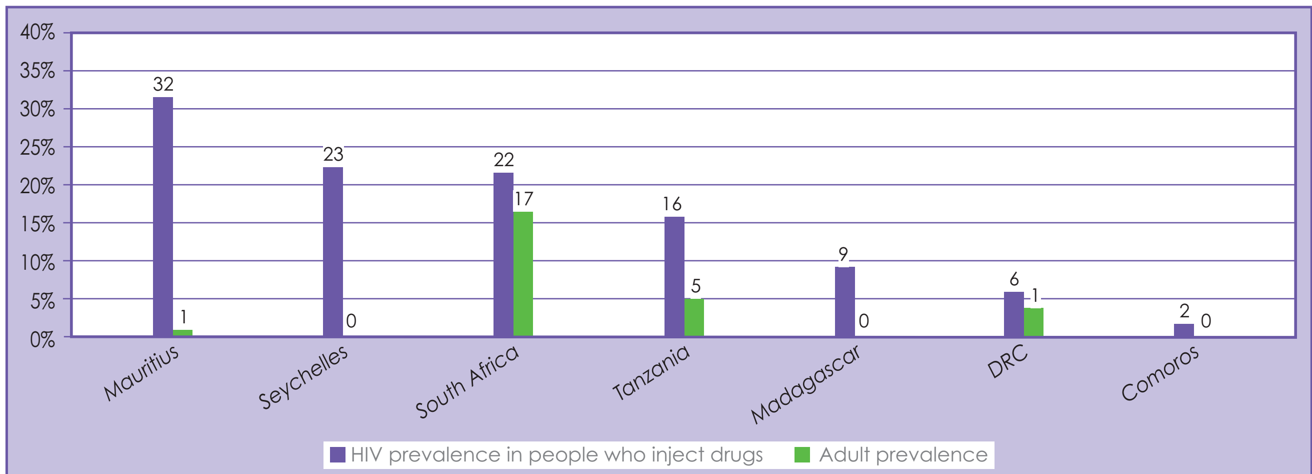
Country	HIV Prevalence in MSM	Testing, Status awareness	Condom Use	ARV coverage
Lesotho	32,9	99,8	59,1	
Zimbabwe	21,1		77,5	
South Africa	18,1	100	56,2	
Mauritius	17,2		77,4	
Madagascar	14,9		57,6	
Botswana	14,8	82,2	46,4	
Seychelles	13,2	19,3	57,2	
Eswatini	12,6		44	85,5
Tanzania	8,4	86,6	53,1	
Malawi	6,8			
DRC	3,3			
Angola	2			
Comoros	0			
Mozambique			13,9	28,1
Namibia		75,7		
Zambia		99,7	69,2	93,7

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Table 5.12 shows significant data gaps on men that have sex with men. Without such data it is not possible to design programmes to address HIV spread in this important key population. In general, condom use is very inadequate.

People who inject drugs

Figure 5.10: HIV Prevalence among people who inject drugs



Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Figure 5.10 shows that people who inject drugs are not a priority for many SADC countries. However, where this group is a priority, HIV prevalence is much higher than it is in the general population. The differences are particularly stark in the island nations (Mauritius, Seychelles, Madagascar and Comoros).

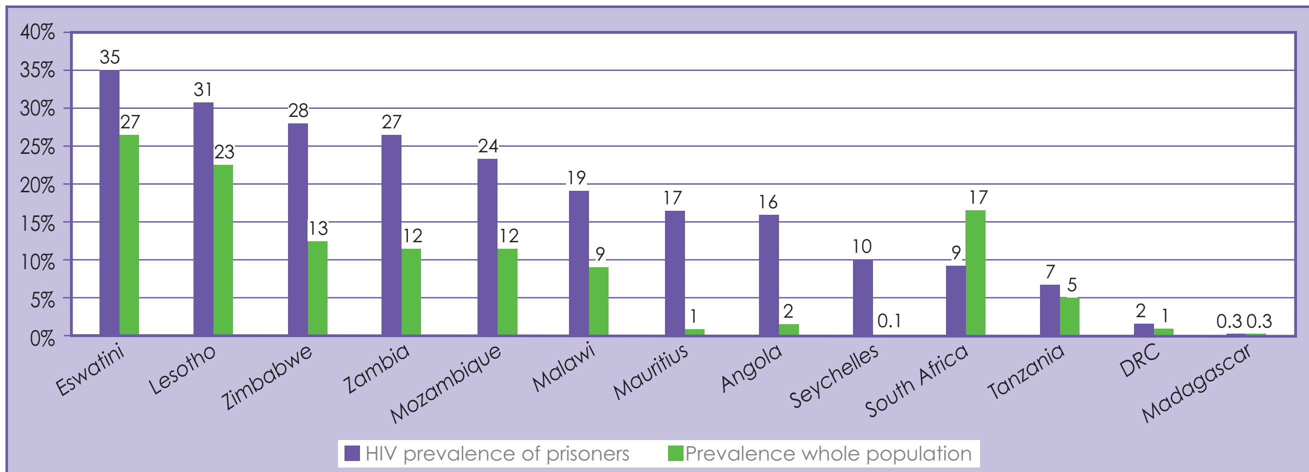
South Africa: Even though people who inject drugs are 22 times more likely to acquire HIV than those that do not, punitive laws, prejudice, stigma and discrimination, and certain donor policies, prevent HIV services from reaching them. To address this, an NGO, TB HIV Care (THC), launched the Step Up project in Cape Town and Durban in 2015. The project offered HIV prevention, testing and linkage to care, harm reduction counselling, and needle-syringe services; and added reporting of human rights violations. With more funding, Step Up now provides TB and STI symptom screening with referrals to health care, opioid substitution therapy (OST), drop-in centres, and psychosocial support and expanded to Port Elizabeth.[29]

The HIV epidemics in Mauritius, Seychelles, Madagascar and Comoros are largely in the people who inject drugs communities

[29] UNAIDS. 2020. Community Innovations. Geneva. UNAIDS.

Prisoners

Figure 5.11: HIV prevalence among prisoners



Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Figure 5.11 shows higher HIV prevalence among prisoners than the general population in all countries for which there is data except South Africa. The differences are particularly marked in countries which have lower prevalence in the general population.

Table 5.13: HIV prevalence, prevention and management for prisoners

Country	HIV prevalence of prisoners	ART Coverage	Condoms distributed to prisoners	Clean needles distributed to prisoners	Prisoners receiving opioid substitution therapy
Eswatini	34,9				
Lesotho	31,4	80,1			
Zimbabwe	28				
Zambia	27,4	100			
Mozambique	24				
Malawi	19	100	1,500,000		
Mauritius	17,3	79,1			342
Angola	15,9	100	1,161,600		
Seychelles	9,9		432		165
South Africa	8,9	98,8	2,436,068		
Tanzania	6,7				
DRC	1,6		4,003		
Madagascar	0,3		7,169		
Comoros			2,304		

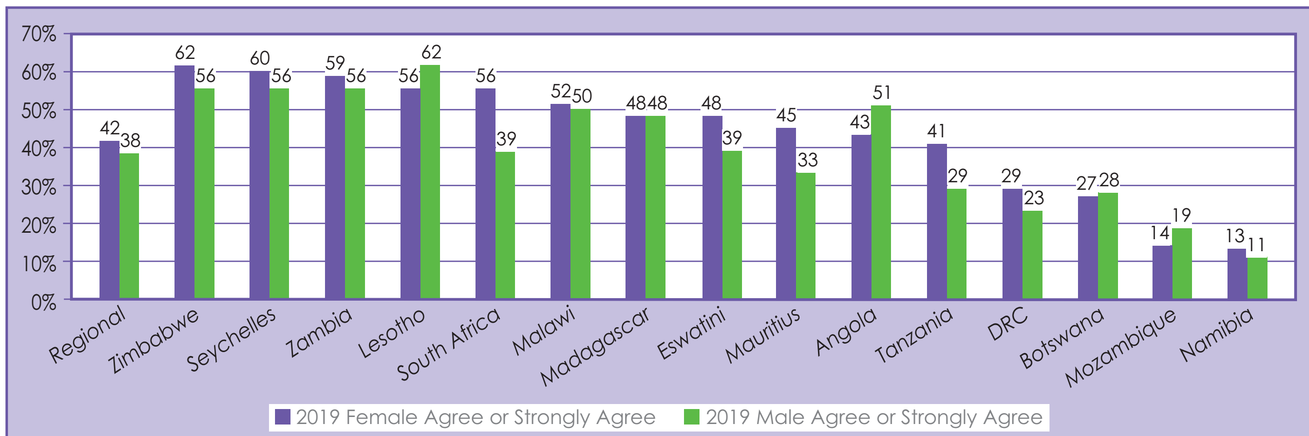
Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Table 5.13 reflects low levels of attention to prevention, testing and access to ARVs for prisoners across SADC: an area of great need. A few countries, notably Lesotho and Namibia, are providing integrated HIV and sexual and reproductive health services to people in prisons and other closed settings.

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 include several questions relevant to HIV and AIDS.

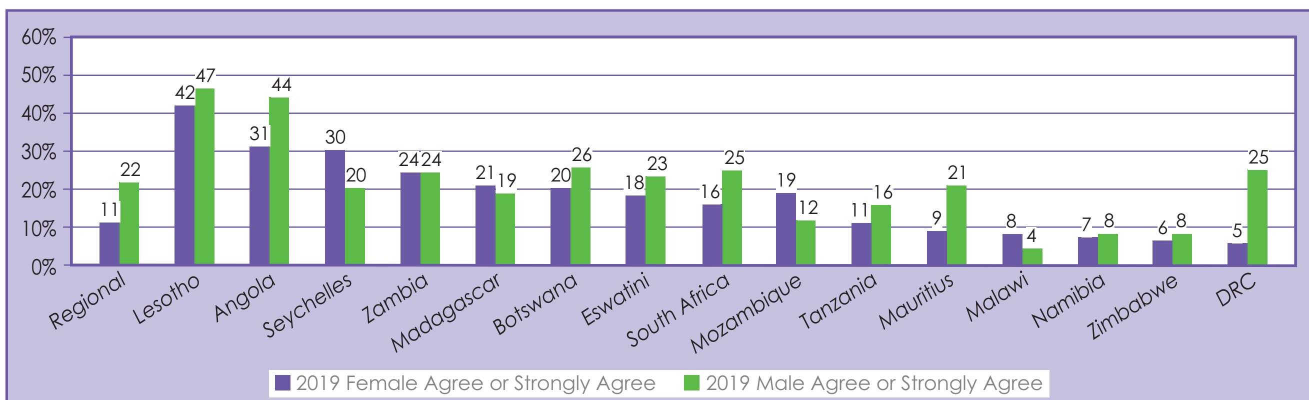
Figure 5.12: A woman can refuse to have sex with her husband



Source: Gender Links Attitude Survey, 2019.

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 11% men in Namibia. Overall men and women had similar views. Over 50% of both women and men in Zimbabwe, Seychelles, Zambia, Lesotho and Malawi agree with the statement. More females agreed with the statement in South Africa and more men in Angola.

Figure 5.13: Nothing a woman can do if her husband wants to have girlfriends



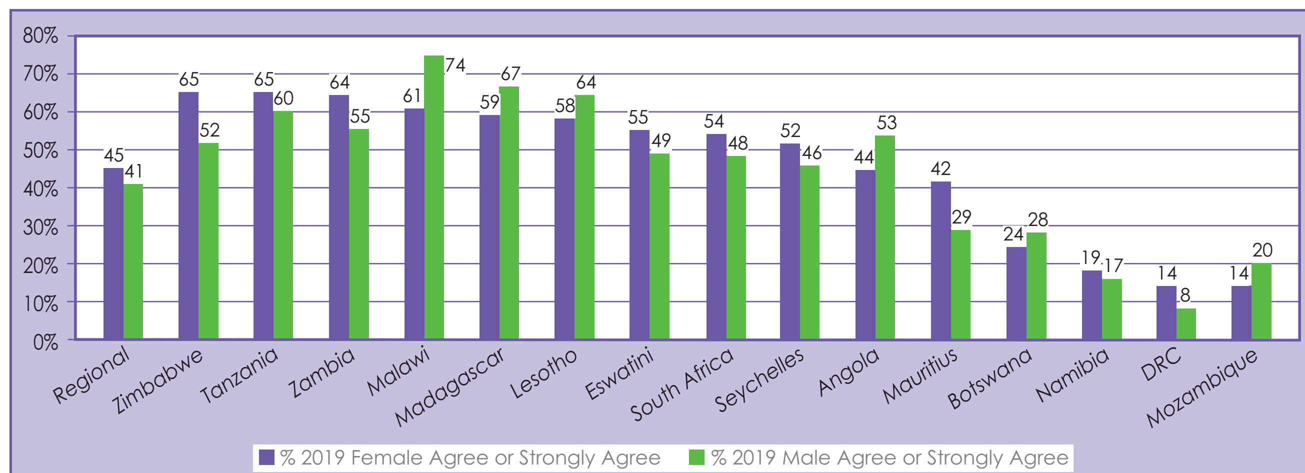
Source: Gender Links Attitude Survey, 2019.

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 they believe that a wife can do something. Across the region, only 19% women and 22% men agreed with this statement. The highest rate

of agreement in both females and males is in Lesotho (42% females and 47% males) and lowest for both is Zimbabwe (6% females and 8% males).

Women were generally less likely to agree with the statement than men.

Figure 5.14: A woman can insist on a man using a condom



Source: Gender Links Attitude Survey, 2019.

Over 50% of female respondents in Zimbabwe, Tanzania, Zambia, Malawi, Madagascar, Lesotho, Eswatini, South Africa and Seychelles believe that a woman can insist on using a condom. It is disturbing that rates of agreement drop to as low as 14% of female respondents in DRC and Mozambique with a regional average of only 45% for women and 41% for men. In Malawi, Madagascar, Lesotho, Angola, Botswana and Mozambique more males than females agree that women have a right to insist on a man using condom. This reflects some change in attitude, especially at the local level.

Search for an HIV Vaccine

To commemorate World HIV Vaccine Day on 18 May, the National Institute of Allergy and Infectious Diseases (NIAID) highlighted the need for continued effort to find safe, effective and durable vaccines for both HIV and COVID-19. So far the search for an HIV vaccine has faced numerous challenges and developed considerable research capacity which is now being used in the race for a COVID-19 vaccine. Over the past decade, three different vaccine approaches have been implemented and two have moved through clinical evaluation to advanced clinical trials, but we do not have a vaccine yet.

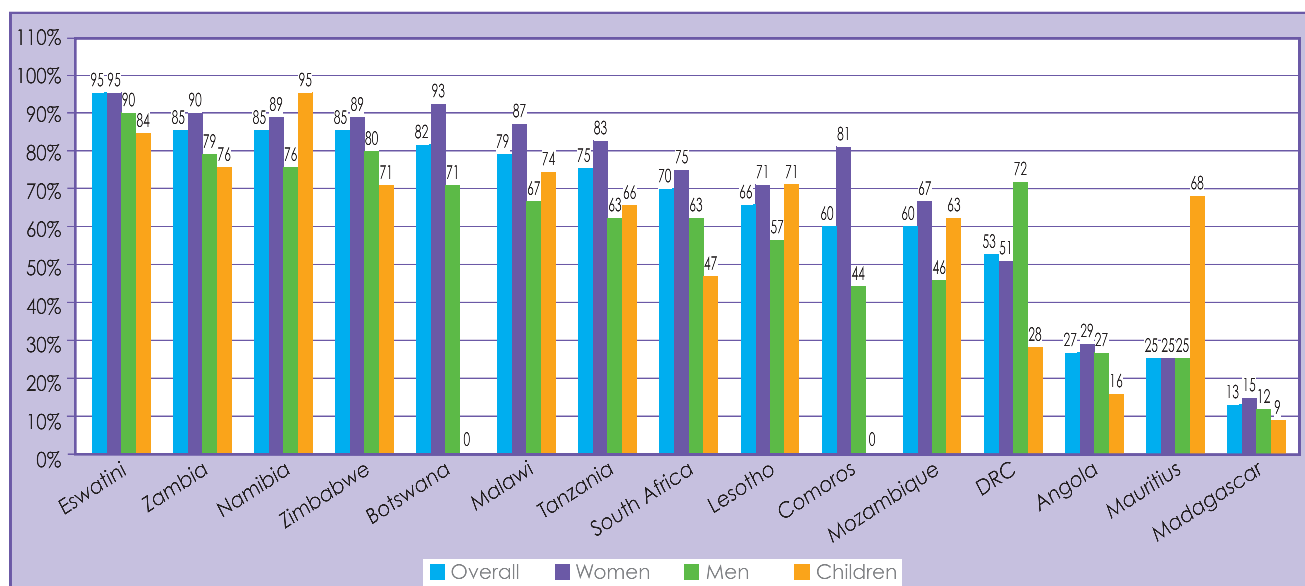
The NIAID concluded: "As we reflect on HIV Vaccine Awareness Day and recent developments in the vaccine field, it is clear that much work remains to be done. Going forward we must continue to engage the community to ensure a shared understanding of our common goals. While we pursue a safe and effective HIV vaccine, we are also seeking ways of improving chemoprophylaxis. We remain optimistic that effective interventions that people will reliably use can be developed and brought to scale."[30]

[30] Dieffenbach CW and Fauci AS Journal of the International AIDS Society 2020, 23:e25506 http://onlinelibrary.wiley.com/doi/10.1002/jia2.25506/full | https://doi.org/10.1002/jia2.25506. The search for an HIV vaccine, the journey continues.

Treatment

Article 27.3
b) Ensure universal access to HIV and AIDS treatment for infected women, men, girls and boys; and
UNAIDS 90/90/90: Target (2) By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; Target (3) By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.

Figure 5.15: ART Coverage for those living with HIV



Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

HIV AIDS test kits in Mutare, Zimbabwe. Photo: Tapiwa Zvaraya

Figure 5.15 shows the incredible progress that has been made in expanding access to ART across most of SADC. Most of the countries with lower levels of coverage have relatively small epidemics. Clearly, there is need to accelerate action in Mozambique, DRC and Angola. In most countries coverage for women is higher than for men, except in the DRC. Across SADC women are more likely to seek health services for HIV. There is still a marked gap between coverage for adults and that for children except in Namibia, Lesotho, Mozambique and Mauritius which have higher coverage for children than adults. Malawi and Tanzania have higher coverage for children than for men, but not higher than all adults.

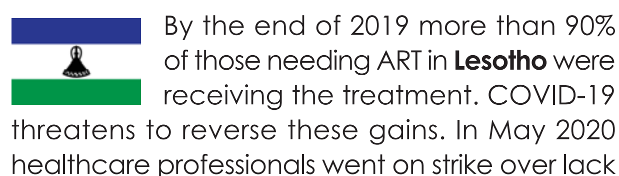
Table 5:15: Number of people living with HIV on treatment

Country	Number of People living with HIV on treatment				
	Total	Adults ≥ 15	Women ≥ 15	Men ≥ 15	Children 0 - 14
South Africa	5,231,809	5,074,479	3,505,194	1,569,285	157,330
Mozambique	1,338,100	1,243,020	873,927	369,093	95,080
Tanzania	1,277,012	1,215,802	818,658	397,144	61,210
Zimbabwe	1,149,191	1,089,366	677,167	412,199	59,825
Zambia	1,064,321	1,014,039	639,498	374,541	50,282
Malawi	832,908	784,948	517,944	267,004	47,960
Botswana	313,850	309,692	197,362	112,330	4,158
DRC	277,592	258,610	169,648	88,962	18,982
Lesotho	220,828	212,536	135,458	77,078	8,292
Eswatini	191,782	183,220	120,417	62,803	8,562
Namibia	177,174	167,005	112,001	55,004	10,169
Angola	93,310	88,197	62,808	25,389	5,113
Madagascar	5,166	5,015	2,685	2,330	151
Mauritius	2,837	2,786	852	1,934	51
Comoros	77	74	43	31	3
Seychelles					
SADC Total	**12,175,957**	**11,648,789**	**7,833,662**	**3,815,127**	**527,168**
Global Total	**25,400,000**				**950,000**
SADC as % of global	**48%**				**55%**

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

Table 5.15 shows that 12,175,957 (48% of the global total of 25,400,000) people who are on ARVs are in SADC. The 527,168 children on treatment in SADC represent 55% of the global total of 950,000. The number of women on treatment (7,833,662) is a 20% increase from 6,543,160 in 2017. At 3,815,127 the number of men on treatment is considerably lower. This is however a 15% increase compared to 2017.

With 5,231,809 people on ART, the **South Africa** ART programme represents 43% of the SADC total and 19% of the global total - by far the largest ART country programme anywhere in the world. Most of the funding for South Africa's programme is domestic.



By the end of 2019 more than 90% of those needing ART in **Lesotho** were receiving the treatment. COVID-19 threatens to reverse these gains. In May 2020 healthcare professionals went on strike over lack of PPE during a 21 day lockdown. During these uncertain times, the Government of Lesotho encouraged people to use HIV Self-Test kits. Those who tested positive were encouraged to proceed to a healthcare facility. Kits are distributed through all major health facilities in the country in partnership with the Ministry of Health.

HIV/AIDS Campaign, South Africa. Photo: Susan Mogari

Viral suppression

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

Table 5.7 on page 15 shows the progress towards viral suppression. Data on suppression is not available from Angola, DRC or Madagascar.

Comoros, 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.[31]

HIV and TB Co-infection

Despite the fact that Tuberculosis (TB) is both preventable and curable, it is the 10th leading cause of death worldwide, the worldwide top infectious killer and the leading cause of death among people living with HIV. The UN High level meeting on TB in 2016 committed to ending TB by 2030. The milestones for achieving the end of TB include a 75% reduction in TB deaths among people living with HIV between 2010 and 2020. In 2018, 10 million people fell ill with TB worldwide and 1.5 million people lost their lives to the disease, including 251,000 people living with HIV. People living with HIV with latent TB are 20 times more likely to develop active TB.

Table 5.16: TB related deaths in people living with HIV

Country	2005	2018
South Africa	102,000	42,000
Tanzania	49,000	16,000
Mozambique	37,000	22,000
DRC	15,000	10,000
Malawi	14,000	7,000
Zambia	14,000	13,000
Zimbabwe	13,000	3,500
Lesotho	8,800	3,300
Namibia	5,600	1,500
Angola	5,200	3,700
Botswana	2,200	1,200
Eswatini	1,700	510
Madagascar	670	380
Comoros	2	0
Mauritius	1	8
Seychelles	0	0
SADC Total	**268,173**	**124,098**
Global Total	**590,000**	**250,000**
SADC as % of Global	**45%**	**50%**

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

[31] UNAIDS. 2020. Community Innovations. Geneva. UNAIDS.

Table 5.16 compares the number of TB related deaths in people living with HIV in 2005 (a year with one of the highest recorded death rates) and 2018. The overall number of deaths has decreased from 268,173 to 124,098 in 2018. The deaths in 2005 comprised 45% of the global number of TB-related deaths in people living with HIV. This figure rose to 50% in 2018. The rate of decline has been uneven. The decline in Zambia, for instance, has been very slow. Namibia, Zimbabwe and Eswatini have witnessed the highest rates of decline. South Africa has the largest TB epidemic amongst people living with HIV in SADC.

More and more technology is being harnessed to support outreach services. An example of this is a digital health platform called One Impact to increase access to TB services and share insights about their quality. The platform is intended as a bridge between health service users and providers. This enables real-time community monitoring of local TB responses. An example of this, One Impact, brings together four apps designed by and for people and communities affected by TB.

- *Get Knowledgeable:* Provides information about TB.
- *Get Access:* Identifies nearby TB health services (such as directly observed treatment [DOTs] centres, hospitals and laboratories), provides relevant information (including opening hours) and sorts services by distance.
- *Get Connected:* Connects you with peer supporters, people who have experienced TB, peer support groups and TB-related social services.
- *Get Involved:* Allows you to report challenges experienced when accessing TB services, such as stigma, services denied or breaches of confidentiality.[32]

AIDS Related Deaths

Table 5.17: AIDS related deaths

Country	All ages		Young people 15-24		Children		Deaths averted
	2005	2019	2006	2019	2005	2019	2019
Angola	7,800	13,000	<500	<1,000	2,900	3,800	8,600
Botswana	11,000	5,000	<1,000	<1,000			13,000
Comoros	<100	<100	<100	<100			<100
DRC	45,000	15,000	2,000	1,400	11,000	5,000	21,000
Eswatini	8,100	2,300	<500	<500	2,200	<200	8,300
Lesotho	18,000	4,800	<1,000	<500	2,900	<1,000	17,000
Madagascar	<500	1,400	<100	<100	<100	<500	<1,000
Malawi	69,000	13,000	2,600	1,700	16,000	1,900	40,000
Mauritius							
Mozambique	69,000	51,000	2,900	4,600	20,000	8,200	79,000
Namibia	9,400	3,000	<500	<500	2,300	<500	7,900
South Africa	280,000	72,000	22,000	6,900	51,000	4,100	360,000
Tanzania	96,000	27,000	3,000	2,300	19,000	5,900	63,000
Zambia	52,000	17,000	2,000	2,100	12,000	3,600	58,000
Zimbabwe	110,000	20,000	3,900	2,300	18,000	3,000	50,000
SADC Total	**775,300**	**244,500**	**38,400**	**21,300**	**157,300**	**35,500**	**725,800**
Global Total	**1,700,000**	**690,000**	**69,000**	**46,000**	**320,000**	**95,000**	**1,400,000**
SADC as % of global	**46%**	**35%**	**56%**	**46%**	**49%**	**37%**	**52%**

Source: Gender Links compiled from UNAIDS 2020 data https://aidsinfo.unaids.org/

[32] UNAIDS. 2020. Community Innovations. Geneva. UNAIDS.

Table 5.17 compares the number of deaths as a result of AIDS for all people, young people and children between either 2005 or 2006 (the year of highest deaths) and 2019. Overall there has been remarkable progress, though Angola has seen increasing numbers of deaths and rates of decline for other countries have been uneven. Noteworthy declines include in total deaths in Zimbabwe; as well as deaths of children in Malawi and South Africa. Deaths in SADC as a percentage of global deaths have declined in all categories. All SADC deaths are now 35% of global total deaths (compared to 46% in 2005). Table 5.17 also shows the estimated number of deaths averted as a result of ART: 725 800 or 52% of the global total in 2019. The largest number of deaths averted is 360,000 in South Africa (49.6% of the SADC total).

Care work

Article 27.3

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

SDG 5.4

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

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

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, and now also against COVID-19. As health centres become more and more difficult to access, "routine" services such as resupply of ART, even HIV testing, will need to move into the community. The new cadres of community caregivers - peer educators, mentor mothers, and others - will be called upon to play increasingly complex roles to ensure that HIV services continue.

However, there is insufficient recognition, appreciation, support, training or remuneration of this critical work force. The Coalition encourages Member States to honour the *2016 Political Declaration on Ending AIDS Commitment* by expanding community-led service delivery to cover at least 30% of all service delivery by 2030. An important area of focus is the involvement of men in care work, as illustrated in the following case study from Namibia:

Namibia: The future starts today

Seth Phillips receives an award during the Namibia SADC Gender Protocol@Work Summit in Windhoek. Photo: Veronika Haimbili

Erongo: Seth Phillips, winner of a 2019 SADC Protocol@Work award, is one of the few male home-based care givers providing support to bed-ridden clients, orphans and vulnerable children.

For the past 15 years Phillips has been a volunteer and agent of change. As a district AIDS coordinator he works in partnership with the Family Care Centre located in Omdel Residential Area. The District Aids Committee is a community- based structure operating under the Office of the Mayor.

Namibia is implementing the National Strategic Framework for HIV and AIDS at the district, national and regional levels. The interventions aim to achieve the following by 2022: new HIV infections reduced by 75%; HIV-related deaths reduced by 75%; Mother to Child Transmission reduced to less than 2%; 100% of newly identified People Living with the HIV enrolled and retained in ART; TB-related mortality reduced; domestic contribution towards the local multi sectoral HIV and AIDS response increased to 80%. The strategy includes providing awareness and services for voluntary medical male circumcision; condom promotion and distribution (targeting all shebeens, bars and businesses in the region).

Involvement of men is key. The Mayor is chairperson of the Erongo Male Forum and advocates for the Men for Change Movement in the region. The forum promotes treatment, care and support (provision of Home- Based Care Activities) as well as HIV Testing Services. Financial disparities and intimate partner violence in relationships often hinder a woman's ability to negotiate condom use and protect herself from HIV. The Henties Bay District AIDS Committee is committed to scaling up efforts to promote gender equality and end violence against women.

Source: Seth Phillips, District AIDS Coordinator with Henties Bay Local Youth Forum, Namibia case study for the SADC Protocol @ Work Summit 2019

More recently, community caregivers are reaching adolescent girls and young women, key populations, men (to encourage VMMC) pregnant women and mothers. The Prevention Coalition notes that "insufficient funding for community-led responses, social and gender inequalities, shrinking civil society space and negative policy environments have tended to stop (community led) successes from reaching full scale and generating the expected impact. More emphasis is needed on including community actors and civil society networks in national dialogues throughout the programme cycle, from the participation of representatives of key affected populations in national programme planning and review bodies, to the establishment and funding of community-led monitoring mechanisms."[33] The case study that follows, from the Limpopo Province of South Africa, illustrates the role played by community-based organisations in providing care services:

[33] Global Health Prevention Coalition. 2020. Implementation of the HIV Prevention 2020 Road Map. Third Progress Report. Geneva, UNAIDS.

South Africa: Making care work count

Mentz, Badimong village: Bulamahlo Home-Based Care next door to the University of Limpopo aims to help all people infected with or affected by HIV. Three years after registration in 2005, the organisation opened a drop-in centre for vulnerable children.

Today, Bulamahlo takes care of 730 orphans, vulnerable children and child-headed families. We make sure these children get good food, uniforms and go to school like all other children. The centre provides sports, arts and culture activities for them. Three satellite centres cater for children that cannot reach the main centre.

Additionally, the organization provides social crime prevention and intervention services, together with prevention, care and support services to people with disabilities. The organisation provides interventions for substance abuse prevention, treatment and rehabilitation. We also help to reduce the incidence of poverty through sustainable livelihood approaches. We provide protection, care and support to older people. While empowering women and people with disabilities we also provide nutrition to ensure healthy lives.

Bulamhlo works with the Child Protection Forum in our community to help keep track of abused women and children. We work with the South African Social Security Agency to help children who do not have access to social grants and food parcels. We work with social workers to provide counselling and assistance to families who need social interventions. The two closest clinics, Evelyn Lekganyane and A. Mamabolo help us in identifying patients who need help in taking their medication and counselling them. Every year we hold campaigns with two local schools Badimong Primary and Mphetsebe High to teach children about speaking out against abuse, the dangers of teenage pregnancy and HIV. The Capricorn District Municipality provides funds for all our campaigns.

Bulamahlo Home Based Care, Limpopo South Africa.
Photo courtesy of Bula Mahlo Home Based Care Centre

Rosina Ngobeni, Bulamahlo Home Based Care, Limpopo South Africa in the SADC Protocol @ Work Summit 2019

There is insufficient recognition, appreciation, support, training or remuneration for care workers

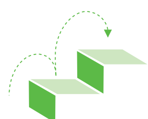
Care workers are integral to the nationwide COVID-19 response

For the last three decades, Southern Africa has been battling the dual threat of HIV and TB. This has resulted in honing sharp community-based skills to prevent, find and treat patients. As COVID-19 hit the nation, government and civil society sought to draw on the decades of learning and skills gained from work with TB and HIV to combat COVID-19. In one such example the Africa Health Research Institute (ARHI) in Durban turned its focus from TB and HIV to redirect its entire staff, including community workers, and mobile clinics to focus on COVID-19.

Care workers, who are part of communities as well as peers, have built trust with the communities over time, so have become essential on the frontlines in screening and identifying possible COVID-19 patients. Under "normal" circumstances, care workers often get infected from their patients. Frontline workers are prone to infection due to lack of protective gear.

It is estimated that 2,500 community health workers throughout South Africa's Kwa Zulu Natal province have lost their lives to TB and related conditions that they acquired or contracted while on the job over the last 10 years. Most of them have been asked to join the COVID-19 tracing programme. Some have vehemently disagreed with the call unless there is sufficient PPE for them, stating that they were afraid to continue working. Care workers emphasise that the need for PPE did not arise with COVID-19. It has existed for years prior as teams have needed masks when handling TB patients but have never received them. The stories are the same across all provinces. There is not enough emphasis placed on care workers' safety.

South Africa's Khayelitsha, Alexandra and Diepsloot high density suburbs introduced COVID testing and contact tracing with over 5,000 fieldworkers deployed for identifying and tracing people who have and may have COVID-19 to mitigate the fast-paced spread through communities. Even with all the planning in place, training for care workers remained minimal and they had to rely on their TB training. Care workers stated that the training they received felt like a crash course. Confusion broke out in many parts regarding the role of care workers, and COVID-19 protocols. Though employed by the Depart-ments of Health or Social Development they do not have access to worker's compensation if they contract any illnesses during the course of their duty, placing them at economic risk, in addition to health risks. Many stakeholders have called for recognition of care work.[34]



Next steps

During the time of COVID-19 UNAIDS recommends action to:

- ***Address the different needs of women and girls***, paying attention to the most marginalized. This includes addressing the specific needs of women and girls living with or affected by HIV, particularly regular access to health care with attention to co morbidities. All policy responses to COVID-19 should incorporate a gender perspective. Issues such as the increased burden on women who spend considerable time collecting water which is so essential to prevent spread of COVID-19 should be recognised.
- ***Recognise and guarantee access to essential health services*** particularly SRHR, ante and postnatal care.
- ***Address the neglected epidemic of gender-based violence against women and girls:*** With-

[34] https://www.spotlightnsp.co.za/2020/04/03/covid-19-discontent-among-chws-on-the-frontlines/

out 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.

- ***Stop misuse of criminal and punitive laws***, especially those that criminalize sex work, LGBTI and drive these people away from services.
- ***Prioritise adolescent girls' and young women's education, health and well-being:*** Approximately 89% of students in the world have been out of school. Adolescent girls are more likely than boys to drop out completely after school closures and to face early marriage or trafficking.
- ***Value women's work and make unpaid care work everybody's work:*** During the COVID-19 crisis unpaid care work has increased tremendously due to school closures, caring for family members that are not well and caring for the elderly. Even before COVID-19 women did at least two and a half times more unpaid care work than men.s

Other recommendations in this chapter include:

- ***Support continuity of HIV services, despite COVID-19 disruptions.*** SADC has achieved so much in the struggle to end AIDS by 2030 that we cannot afford to go backwards by a decade. All effort from donors, to governments to communities must be invested to ensure that services are continued albeit in new formations.
- ***Invest in HIV prevention*** particularly for young people and also for members of key populations. At this time of challenge, we must forge forward.
- ***Invest in community initiatives*** - this might be the opportunity to "build back better" and acknowledge the critical role of the community in HIV prevention, care and support.
- ***Acknowledge gender disparities*** and find innovative solutions to these.

"When we get past this crisis, we will face a choice... we can go back to the world as it was before or deal decisively with those issues that make us all unnecessarily vulnerable to crises."
António Guterres, United Nations Secretary-General

[35] UNAIDS. 2020. Six Concrete Measures to Support Women and Girls in All Their Diversity in the Context of the COVID-19 Pandemic. Geneva. UNAIDS.