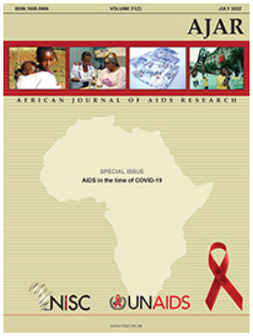

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Research Article

A pandemic of inequality: reflections on AIDS and COVID-19 in the southern African context

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In 2020, COVID-19 started spreading from Wuhan in China to the USA, the UK and Europe and then to the rest of the world. In Africa, the first case of COVID-19 was reported in Egypt on 14 February, while South Africa's first case was identified on 5 March. On 11 March, the World Health Organization declared a pandemic. At the time, it was said that COVID-19 would become the great equaliser because the virus made no distinction between first and third world countries, between the rich and the poor, and nor was it influenced by gender, sexual orientation or race. When someone contracted SARS-CoV-2, no guarantee could be given that the patient would survive, regardless of who they were or their status in the community.

This stood in contrast to the early experience of AIDS before antiretrovirals existed and when HIV was spreading like wildfire in sub-Saharan Africa and other countries with low or lower-middle-income status. It seemed as if these countries were doubly cursed — by poverty and the AIDS pandemic that was causing as many as 6 000 mortalities per day in sub-Saharan Africa. This led to the South African president at the time, Thabo Mbeki, to assert that poverty was an even greater problem than HIV and AIDS.

It did not take long to see that COVID-19 was not the anticipated equaliser. As lockdowns were enforced within most countries across the globe and resulting in economic slumps, differences between rich and poorer countries and their respective citizens were thrown into sharp relief once again. This article reports how both AIDS and COVID-19 adversely affected women, the impoverished and those without access to sustainable souces of food and medicine.

Keywords: inequality, pandemics, sustainable development goals

This article is part of a special issue on *AIDS in the time of COVID-19*

Introduction

On 5 June 1981, an article in the *Morbidity and Mortality Weekly Report* announced an increase in *pneumocystis carinii pneumonia*, a rare lung infection. The patients were all male, had been treated in three different hospitals in Los Angeles, and were active homosexuals (Gottlieb, et al., 1981, p. 1). Preliminary observations led to the assumption that this disease was restricted to homosexual men (Altman, 1981). Later reports, however, indicated that the disease was also spreading among intravenous drug users. Furthermore, it became clear that the disease was being spread through blood transfusions and heterosexual intercourse. The conclusion was that nobody was exempt from possible infection with what then became known as the human immunodeficiency virus (HIV) which causes acquired immune deficiency syndrome, better known as AIDS (Maartens, 2012, p. 11).

In 1983, Margaret Heckler, secretary for the United States Health and Human Services predicted that a vaccine would be ready by no later than 1986 and concluded by saying, "Yet another terrible disease is about to yield to patience, persistence and outright genius" (Smith, 2009).[1]

At the 11th International Conference on AIDS in Vancouver (July 1996), there was great excitement and anticipation about treatment with combination antiretroviral therapies (ART). Some scientists even declared that "[a]ggressive treatment with multiple drugs can convert deadly AIDS into a chronic, manageable disorder like diabetes" (Maugh, 1996). A few critical voices, largely ignored, mentioned that the drugs, which could cost up to $16 000 per year, were too expensive for many Americans and most of the rest of the world. The South African health minister at the time, Nkosazana Zuma, warned that "most people infected with HIV live in Africa, where therapies involving combinations of expensive antiviral drugs are out of the question" (Black History Month, 2015). In time, however, the cost of antiretrovirals (ARVs) fell dramatically and treatment was being rolled out worldwide with the support of donors by the early 2000s.

On 31 December 2019, the World Health Organization (WHO) was informed of cases of pneumonia occurring in

Wuhan, China. A month later, the emergency committee convened by the WHO director-general declared a public health emergency of international concern and said, "…it is still possible to interrupt virus spread, provided that countries put in place strong measures to detect disease early, isolate and treat cases, trace contacts, and promote social distancing measures commensurate with the risk" (WHO, 2020a). A coronavirus was identified as the cause of the infections and, on 11 February 2020, the WHO announced that COVID-19 would be the official name of the disease caused by the novel virus named severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2; WHO, 2020b). On 11 March 2020, the director-general of the WHO announced that COVID-19 had spread to 114 countries, with more than 118 000 cases identified and 4 291 related mortalities (WHO, 2002c). With the expectation that these numbers would continue to rise, COVID-19 was declared a pandemic.

At the time, it seemed that the entire world was similarly affected. International borders were closed and strict lockdown measures were announced, while masking, hand sanitising, and physical distancing regulations created the impression that people everywhere were affected in the same way. SARS-CoV-2 was even portrayed as the great equaliser because no one was immune against infection (Galasso, 2020, p. 376) — but it soon emerged that this was not the case. In his statement announcing COVID-19 as a pandemic, the WHO director-general acknowledged that not all countries were facing the same challenges; some were struggling with a lack of capacity, some with a lack of resources, and some with a lack of resolve (WHO, 2020c).

Both the AIDS and the COVID-19 pandemics affected the marginalised most adversely. In Southern Africa (the focus of this article), HIV spread at a disproportionate rate, with younger women — especially from early adolescence — being at much greater risk of infection than males. In the case of COVID-19, people over the age of 65 as well as those with comorbidities and a compromised immune system, were at greater risk of severe illness and death.

In this article, I examine the inequalities exacerbated by the two pandemics, to determine whether there is a correlation between those struck hardest by AIDS and those struck hardest by COVID-19.

Methodology

Although the conclusions drawn in this article are universal in that inequality is experienced not only within poorer countries but also among certain communities within richer countries, it was decided to concentrate on two countries — South Africa (where the author resides) and Eswatini (where the author has had more than 30 years of experience working among people living with HIV and AIDS [PLWHA]). South Africa has the highest number of PLWHA in the world,while Eswatini has the highest HIV-infection rate (World Population Review, 2022). The article draws on published sources as well as data collected since 2008 from about 1 500 home-based caregivers associated with Shiselweni Home-Based Care, an NGO in Eswatini.

Inequality amid global pandemics

UNAIDS made a case for strong action to be taken against inequalities to bring an end to AIDS, COVID-19 and future pandemics (UNAIDS, 2021). Goal 10 of the United Nations' Sustainable Development Goals (SDGs) was aimed at reducing inequality within and among countries (United Nations, 2020). The UN agreed in 2021 "to address inequalities, to close gaps in HIV-service access by 2025 and to get on track to the global goal of ending AIDS by 2030" (UNAIDS, 2021, p. 5). These inequalities include, but are not limited to, gender, age, poverty, food insecurity and access to medical services.

When COVID-19 was declared a pandemic, it soon became clear that not everyone was equally at risk. People older than 65, those with comorbidities, as well as those who were immunocompromised or have weakened immune systems, had a higher risk of severe illness, hospitalisation and death (DC, 2020). As early as April 2020, Emily Wong of the Africa Health Research Institute at the University of KwaZulu-Natal had warned that "HIV infection may also affect SARS-CoV-2 infection and COVID-19 severity" (*Medical Brief*, 2020). With initial news reports of countries, especially in Europe, running out of hospital beds and intensive care facilities to treat those with severe COVID-19 (Horowitz, 2020; Carreño & Rodríguez, 2020), the obvious question was: What would happen in poorer countries with fewer medical personnel, fewer hospitals, fewer ICU beds, fewer ventilators and less access to oxygen and basic medical care?

Gender and age

HIV and AIDS

Three in five new HIV infections in people aged 15–24 years occurred among women in 2017 (UNAIDS, 2019). Almost 30 per cent of all new HIV infections occur among adolescent girls and women aged 15–24 and they seroconvert five to seven years earlier than their male counterparts (Dellar et al., 2015, p. 64). The high incidence of HIV among this cohort is caused mostly by sexual relations with older males, sometimes voluntarily but often transactional, a practice frequently driven by desperation from extreme poverty. Research done by Human Rights Watch in several African countries has shown that child marriages and early pregnancies increase significantly during crises such as pandemics (UNAIDS, 2020, p. 145). Globally, more than one in three women have been physically or sexually violated either by an intimate partner or by a non-partner, making these victims 50 per cent more likely to be infected with HIV (UNAIDS, 2014, p. 3; Health & Development Information Team, n.d., p. 2). These are also often the people who lack the knowledge or power to negotiate safe sex. "Of the 38 million sexually active adolescent girls aged 15 to 19 years globally, more than half are not using contraceptives" (UNAIDS, 2020, p. 24).

While women are more likely to access HIV testing and ART than men, the lower number of men who know their HIV status and are willing to adhere to ART contributes to the higher number of new HIV infections among women, especially in sub-Saharan Africa (UNAIDS, 2020, p. 25). The

age group most susceptible to infection — ages 15 to 65 years — also correlates with the group that would normally be the most productive in the labour market, thereby leading to further impoverishment of affected households (Whiteside & Whalley, 2007, p. v; 14; 41).

The plight of orphaned or vulnerable children — often referred to as the fourth wave of the AIDS pandemic — cannot be ignored. A person below the age of 17 who has lost one or both parents is considered to be an orphan (Maartens, 2012, p. 19). Eswatini had about 130 000 orphaned or vulnerable children in 2007 (Whiteside & Whalley, 2007, p. v) – more than 10 per cent of the country's total population. In 2019 it was reported that a staggering 58 per cent of the kingdom's children were orphans or vulnerable due largely to the impact of HIV and AIDS; that one in four children had lost one or both parents; and at least 38 per cent of rural households cared for at least one orphan (Altorio, 2019).

COVID-19

From the start of the COVID-19 pandemic, it was clear that age played a significant role in morbidity and mortality from the virus (*The Economist*, 2020). These findings were confirmed by further research indicating that adults aged over 65 years represented 80 per cent of hospitalisations due to COVID-19 and that this cohort had a 23-fold greater chance of dying than those under the age of 65 (Mueller et al., 2020).

Although SARS-CoV-2 has no gender bias, early research indicated that more men than women were suffering from severe symptoms and were dying (Wenham et al., 2020). However, women once again found themselves in a more disadvantaged position, as during the AIDS pandemic. Most caregivers are women, both at home and in communities. Due to their higher exposure to people with SARS-CoV-2, these women had an increased risk of being infected themselves. Almost 9 300 healthcare workers in the USA had been infected with the virus by early April 2020, of which 73 per cent were women. The same pattern emerged in other countries: in Spain, 75.5 per cent of more than 28 000 healthcare workers infected were women; in Italy, 69 per cent of 20 800 infected healthcare workers were female (UN Women, 2020a).

COVID-19 has exacerbated existing gender inequalities, especially in countries where women form the backbone of the informal economy. In many cases, female migrant workers had to return to their home countries due to lockdown measures in the countries where they were working, thereby losing the ability to make a sustainable income. In sectors and jobs which were hardest hit by COVID-19 — manufacturing, textile and garments, care services, and hospitality and tourism industries — the workforce consists largely of women who found themselves without any income. The same applies to women employed as domestic workers and daily wage workers (UN Women, 2020b, pp. 6–7; Nanda, 2021, pp. 114–115). Worldwide, women are bearing the brunt of the economic crisis caused by the COVID-19 pandemic.

Wuhan, where SARS-CoV-2 is believed to have been first detected, went into lockdown on 23 January 2020. The lockdown regulations included the banning of gatherings, thereby forcing most people to remain inside their homes. These measures were replicated in countries across the world and, by the end of March 2020, more than a fifth of the world's population was living under strict lockdown regulations (Van Wyngaard & Whiteside, 2021, p. 119). Reducing interpersonal contacts and maintaining physical distance between people were considered to be effective ways to slow down the spread of the virus, thereby "flattening the curve" and enabling healthcare systems to better cope with increased cases.

Although these lockdown measures were partially successful, an unintended outcome was the increase in domestic violence, with women mostly on the receiving end. Shortly after South Africa introduced lockdown measures, Phumzile Mlambo-Ngcuka, former deputy president of South Africa and former executive director of UN Women, said:

> Confinement is fostering the tension and strain created by security, health, and money worries. And it is increasing isolation for women with violent partners, separating them from the people and resources that can best help them. It's a perfect storm for controlling, violent behaviour behind closed doors. And in parallel, as health systems are stretching to breaking point, domestic violence shelters are also reaching capacity, a service deficit made worse when centres are repurposed for additional COVID-response.

She added that women needed to not only survive the pandemic but also to emerge as a powerful force of recovery (Mlambo-Ngcuka, 2020, April 6).

Poverty[2]

HIV and AIDS

The general population of the USA has not been impacted by the AIDS pandemic as has happened in sub-Saharan Africa. Nevertheless, the Centers for Disease Control and Prevention (CDC) has found that the HIV-prevalence rate among Americans living in poverty is twenty times greater than the prevalence among all heterosexuals in the USA (Denning & DiNenno, 2019). However, despite the strong correlation between poverty and AIDS, causality cannot be inferred, as indicated by Tladi (2006, p. 380), as well as Gillespie et al. (2007, p. 15): "In summary, when examining the interplay between wealth or poverty and HIV transmission, there is no simple explanation, no magic bullet. AIDS cannot accurately be termed a 'disease of poverty'."

Still, the connection between poverty and AIDS cannot be denied. Based on data analysed from 16 sub-Saharan countries, Fox (2012, p. 477) concluded that while poverty as such does not lead to a higher risk for HIV infection, inequality or "relative deprivation" does play a greater role in the growing HIV-infection rate, concluding: "Inequality trumps wealth: living in a region with greater inequality in wealth was significantly associated with increased individual risk of HIV infection" (p. 459). Mufune (2015, p. 14) argues that poverty is often also the cause of a feeling of insecurity and low self-esteem in men who see themselves as the breadwinners and, in failing to fulfil this role, may revert to intimate partner violence (p. 22), which presents a high risk of HIV-infection for the female partners (Be in the Know, 2022). A sense of powerlessness (often a result of poverty)

was identified among many mineworkers in South Africa as a factor that leads to risky sexual practices (Campbell, 1997, p. 277).

COVID-19

The World Bank reported in October 2021 that the global economy was starting to recover from the economic ravages of the COVID-19 pandemic, but this was not experienced equally (Yonzan et al., 2021). Poorer countries face a deeper and longer-lasting crisis that is reversing recent downward trends in inequality. About 97 million more people are living on less than USD 1.90 per day since the pandemic, resulting in the loss of about three to four years of progress toward ending extreme poverty (Sánchez-Páramo et al., 2021).

According to the World Bank Group's *Global Economic Prospects*, the recovery from the recession brought on by the COVID-19 pandemic is uneven, "leaving behind some of the poorest countries", and adding that "(l)ower-income population groups have been hurt disproportionately, and the pandemic has raised extreme poverty rates" (World Bank Group, 2022, p. 157). According to the International Monetary Fund (Kharas & Dooley, 2021), by 2026, 33 developing countries will still have per capita income levels lower than what they were in 2019. Fifteen of these countries are in sub-Saharan Africa.

Children across the globe suffered tremendously when schools were closed in an attempt to prevent the virus from spreading. In many countries, more than 200 school days — more than a year's education – had been lost by the end of 2021. In São Paulo, where educators measure the state of learning continuously, it was found that students had learned 27 per cent less than under normal circumstances (Gill & Saavedra, 2022). The World Bank believes that a hybrid learning system — combining in-person and remote instruction through the use of digital technology – is here to stay. Once again, however, not all will be able to benefit from such learning innovations:

> [M]ore than half the households in 30 African countries don't even have electricity. For just too many children in the world, conditions at home are not conducive for learning, too many do not have Internet access, a decent device, or money to pay for data or books, and a space to study at home. And education is inherently a social endeavor: it requires incessant interaction. This means brick-and-mortar schools, which must open and be made safe for students and teachers. Investments are needed. Quite often there is money available for this and there is no dearth of guidelines from international agencies on how to reopen schools safely. What is generally missing in many countries is a national sense of urgency (Gill & Saavedra, 2022).

Food insecurity

HIV and AIDS

Food insecurity is closely related to the problem of poverty. The lack of regular access to a sufficient quantity of food has a direct impact on an individual's ability to survive AIDS. HIV by definition causes immunodeficiency in a human; therefore, it is paramount that the immune system of someone who is HIV-positive be built up, including by following a healthy diet. Food insecurity, usually a direct result of poverty, makes it impossible to choose what food to eat, leading to deteriorating health. The AIDS pandemic has also contributed greatly to the problem of food insecurity, as De Waal and Whiteside (2003, p. 1234) argue:

> Our hypothesis is that the HIV/AIDS epidemic in southern Africa accounts for why many households are facing food shortages and explains the grim trajectory of limited recovery. Four factors are new: (1) household-level labour shortages are attributable to adult morbidity and mortality, as is the rise in numbers of dependants; (2) loss of assets and skills result from increased adult mortality; (3) the burden of care is large for sick adults and children orphaned by AIDS; and (4) vicious interactions exist between malnutrition and HIV.

While a healthy and nutritious diet is essential to enable the body to fight disease, food insecurity poses another challenge when a person commences ART. In the early days of ART, some drugs had to be taken with food. People without access to regular meals had to choose between taking the drugs on an empty stomach, resulting in severe discomfort and pain, or defaulting on their prescribed medication regime.

During a research project undertaken in the Shiselweni district of Eswatini (known as Swaziland at the time), 38 per cent of the 296 participants indicated that they had defaulted on their medication regime at least once due to a lack of food (Van Wyngaard et al., 2017, p. 604), which posed serious health risks for PLWHA (Ndubuka, Lim, Van der Wal, & Ehlers, 2016, pp. 1–2).

Newer ARVs, by contrast, have the advantage that they can be taken on an empty stomach. As a direct result of the aforementioned research project in Eswatini, Médecins Sans Frontières held a conference in October 2016 where attendees were given the assurance that they could take their ARVs, even on an empty stomach, without suffering any negative consequences (Zabsonre, 2016).

COVID-19

When Eswatini followed the example of its neighbour, South Africa, and announced a partial lockdown from 27 March 2020 — closing borders, banning non-essential travel within the country and restricting gatherings (GardaWorld, 2020) — the distribution of food was severely affected. Shortly after announcing the lockdown regulations, the South African government published a communique to prevent companies from unreasonably increasing the prices of basic foods and consumer items, imposing severe penalties where these regulations were ignored (GCIS, 2020). In Eswatini, however, this was not the case. Unable to travel to larger towns or across the border to South Africa to buy staple food such as maize meal, the Swazi public in rural areas had to rely on unscrupulous store owners who raised their prices, knowing that people had no choice other than to buy the food from them.[3] Furthermore, all schools and neighbourhood care points, where thousands of children received meals, were ordered to close. After the Eswatini government realised the implications of this decision, these

centres were allowed to re-open, but had to cope with higher food prices.[4]

Shiselweni Home-Based Care is a faith-based organisation situated in the southern district of Eswatini, delivering home-based care through a network of 1 500 trained community members to 5 845 clients. Of these clients, 1 058 (18%) have been diagnosed with hypertension while 585 (10%) suffer from diabetes. Hypertension and diabetes are specific risk factors for death from COVID-19 (Patel, et al., 2020, p. 110).

In a research project conducted among five different population groups in Uganda, South Africa, Tanzania and Nigeria, more than 25% of those interviewed were found to suffer from hypertension, of whom only 50% were aware of their condition (Guwatudde, et al., 2015, p. 1;4). According to Kibirige et al. (2019, p. 1), "the prevalence of diabetes mellitus (DM) has reached epidemic levels especially in low- and middle-income countries" (2019, p. 1). They projected an increase of 48% by 2045.

Food insecurity (associated with poverty) is a leading cause of both these conditions (Marmot, et al., 2010, p. 159) and results in more people who are at risk of serious illness or death due to COVID-19.

Access to medical services

HIV and AIDS

The difference between poverty-stricken and more affluent societies is harshly illuminated when observed through the lens of access to medical services. Maartens found in 2012 that in Eswatini there were 15 doctors per 100 000 of the population, compared to the USA where there were 230 doctors for the same number of people (p. 18). In poorer countries, people are dependent on public health systems, which were not only inadequate but also overburdened as HIV infections increased (Whiteside & Whalley, 2007, p. 8). Van Wyngaard (2014) observed that "terminally ill people are hospitalised until they are stabilised and then often sent home where they die. Whilst in hospital, most patients ask family members or friends to remain with them to feed and wash them, as the understaffed hospitals cannot provide in these basic needs" (p. 4).

With antiretroviral drugs, things changed as certain death was transformed "into a chronic, manageable condition" (Mufune, 2015, p. 4). However, as Mufune rightly indicates, this transformation did not come easily. Combination ART, costing as much as USD 16 000 annually initially, was out of reach for all but the most wealthy. As these drugs became more affordable, the next stumbling block was the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), accepted by the World Trade Organization (WTO) in 1994 and requiring all member states to introduce twenty-year patents in all fields of technology, including pharmaceutical products (Hoen et al., 2011, pp. 2–3).[5] In November 2001, the WTO ministerial conference adopted the Doha Declaration on TRIPS and Public Health, which made it clear that the TRIPS agreement "can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all" (Hoen et al., p. 5).

By 2008, 95 per cent of all ARVs funded by donors were generics, of which most were manufactured in India. In South Africa, the initial inaccessibility of ARVs due to their high cost as well as the reluctance of the government under former president Thabo Mbeki to approve their distribution, led to 3.8 million person-years being lost between 2000 and 2005, while 35 000 babies were born with HIV due to the failure to implement a mother-to-child transmission prophylaxis programme (Chigwedere et al., 2008, pp. 412–413).

COVID-19

Of the 5 845 clients in Shiselweni Home-Based Care's programme, about half are HIV-positive. Since 2008, the organisation has kept accurate records of all its clients, including the number that had died. Since 2008, the number of clients who died declined annually (Root et al., 2015, p. 269). In 2018, a total of 99 clients died and in 2019 this number decreased to 91. However, in 2020 the number of mortalities rose to 144, of whom 14 were positively identified as having died of COVID-19. In 2021, the number of mortalities among the clients rose to 162, of whom 74 had been diagnosed with COVID-19. Over the same period, 13 caregivers also died due to COVID-related illness. Thus, out of 7 345 caregivers and clients, at least 101 (1.4%) had died due to COVID-19 in the twenty months from May 2020 to December 2021.

In Eswatini, dire circumstances in public hospitals, such as those found at the height of the AIDS pandemic, have remained much the same. By 2016, the number of doctors available for the population had decreased to eight per 100 000 people (*Index Mundi*, 2019); in the entire country, there are only 2 573 hospital beds and a mere 23 critical care beds (Ayebale et al., 2020). This is the scenario across most of Africa, where only six countries have more than two critical care beds per 100 000 of the population, in contrast with Europe, where there are, on average, fourteen times more critical care beds.[6]

A direct result of the COVID pandemic was that the provision of HIV services, including supplying ARVs, was greatly disrupted. After the first lockdown was announced in South Africa, 13 per cent of PLWHA said that they did not have access to their chronic medication and, by May 2020, only 30 to 50 per cent of patients were collecting their medication (Jewell, et al., 2020, pp. e629–e630). This led to an increase in mortality risk, where "[a] 6-month interruption in ART supplies for 50% of people would be expected to lead to an approximately 1.63 times (range 1.39–1.87) increase in HIV-related deaths over one year" (p. e638).

Soon after SARS-CoV-2 was identified, the race was on to manufacture a vaccine against infection with the virus. Twelve months after the virus had first been identified, the Pfizer vaccine received emergency use authorisation from the Food and Drug Administration on 11 December 2020 (Solis-Moreira, 2021). However, the distribution of vaccines happened in an inequitable manner, with some wealthy nations hoarding enough vaccine supplies to vaccinate their entire population more than twice, while low- to middle-income countries had to make do with insufficient doses (International Rescue Committee, 2021). "Out of more than nine billion vaccines doses produced, Africa [had] only

received approximately 540 million (about 6 per cent of all COVID vaccines, despite having 17 percent of the world's population)" by January 2022 (Sidibé, 2022).

Highlighting the inequities in vaccine distribution, Pilkington et al. (2022, p. 2) noted:

> • Within the first year of distribution of vaccines against COVID-19, high-income countries (HICs) have achieved vaccination rates of 75–80%, while low-income countries (LICs) have vaccinated <10%.
> • The pharmaceutical industry did not develop these vaccines alone, with billions of dollars of public funding being instrumental in their discovery and development. However, private companies who hold [intellectual property] currently control manufacturing, distribution, and pricing.
> • The current model of global vaccine distribution is based on financial competition for limited vaccine supplies, resulting in HICs getting first access to vaccines, with LICs being forced to rely on voluntary donations through schemes like COVAX [COVID-19 Vaccines Global Access initiative].

On 12 March 2022, it was reported that Prince Harry and Duchess Meghan had pledged their support for The People's Vaccine Alliance through which more than 130 world leaders, scientists, faith leaders, humanitarians and others advocated for an end to vaccine monopolies, speaking out against the European Union, the UK and Switzerland for blocking the "lifting of intellectual property rules which would enable the redistribution and scale-up of COVID-19 vaccines, test and treatment manufacturing in the global south" (McKay, 2022). The open letter[7] stated that it is possible to bring an end to the pandemic and to ensure that everyone is protected:

> This is possible, thanks to the incredible advances of science and the public investment of governments around the world. However, the cruel reality is that self-defeating nationalism, pharmaceutical monopolies and inequality stand in our way. We did not need to reach the milestones of two years and an estimated twenty million deaths from COVID-19. This was avoidable.

Addressing the inequalities

The United Nations adopted 17 Sustainable Development Goals (SDGs) in 2015. These SDGs shared a vision of a life of dignity for all. Both the AIDS and the COVID-19 pandemics accentuated the inequalities between countries as well as between different communities within countries. From 2015 to 2019, great progress was made towards the SDGs. However, the COVID-19 pandemic led to a regress in some of these goals, notably, with the first rise in extreme poverty in a generation, an increase in world hunger, a shortened life expectancy, an increase in gender-based violence and reversals in reducing income inequality (United Nations, 2021).

In the foreword to the *2021 Sustainable Development Goals Report* (p. 4), the Secretary-General of the United Nations, António Guterres, stated:

> The global community is at a critical moment in its pursuit of the Sustainable Development Goals (SDGs). More than a year into the global pandemic, millions of lives have been lost, the human and economic toll has been unprecedented, and recovery efforts so far have been uneven, inequitable and insufficiently geared towards achieving sustainable development. The current crisis is threatening decades of development gains, further delaying the urgent transition to greener, more inclusive economies, and throwing progress on the SDGs even further off track.

A letter from the group of 13 agencies supporting The Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP) — while acknowledging the widening inequities caused by COVID-19 — called on countries to "deepen and scale collaboration" through (1) joint planning; (2) joint monitoring; (3) joint promotion of equity; and (4) joint alignment with other processes (SDG3 GAP Principals, 2022).

South Africa's president, Cyril Ramaphosa, announced on 21 April 2020 that financial assistance would be given to various recipients in South Africa, including medium, small and micro-sized businesses, as well as a special coronavirus grant to relieve the plight of those most desperately affected by the pandemic (Ramaphosa, 2020, p. 3). This grant was specifically aimed at addressing poverty and food insecurity among the most vulnerable people in the country.

However, governments need support from corporates to effectively address the inequalities deepened by COVID-19. In a *Fortune Daily* article, a call was made (Dunn & Tavarez, 2021) for the world to:

> Reimagine capitalism and for companies to embrace stakeholder capitalism… to tackle some of the biggest challenges the world has faced — the climate crisis, growing inequality and wealth disparity, inequitable access to health care, and long-rooted systemic racism and bias.

Fortune's Change the World list encouraged exactly this by honouring companies "that use the creative tools of capitalism — including the profit motive — to address society's unmet needs" (*Fortune*, 2021a). When compiling the 2021 list, it was observed that many honourees were making notable progress reversing the neglect of some societal needs, as magnified by the pandemic, by investing in the long-term health of their businesses through supporting those on the lower rungs of the global economic ladder.

One example from South Africa was the telecommunications group Mobile Telephone Networks (MTN) — number 34 on Fortune's global 2021 list — making use of their "creative tools of capitalism" to ensure that people could be vaccinated (*Fortune*, 2021b):

> At a time when rich countries had bought up most of the global supply of COVID vaccines, telecom giant MTN paid $25 million to secure 7 million doses for countries such as Malawi, Ghana, Nigeria, and South Sudan — helping provide essential protection for health workers. MTN has also partnered with the Africa CDC to send SMS messages to spread the word about anti-COVID measures to far-flung communities.

Conclusion

COVID-19 will not be the last pandemic to spread across the world. During pandemics, the marginalised, specifically, are vulnerable. This was true for AIDS as well as for COVID-19. Although HIV and SARS-CoV-2 are two completely different viruses, there is a similarity in that inequality, both across country borders as well as within countries, can and does exacerbate the effects of both these viruses.

- Progress made towards the SDGs was greatly reversed by the COVID-19 pandemic. However, gender and other forms of inequality, poverty, food insecurity, gender-based violence and poor access to medical services were not initiated by either the AIDS or the COVID pandemics, which merely brought these inequalities back into the spotlight. Should the world be faced with a new pandemic, or should SARS-CoV-2 mutate into a new variant more deadly than the delta variant, then the world must be better prepared to address these inequalities.
- Pursuing the SDGs, specifically those that address inequalities between different groups of people — ending poverty (SDG 1), achieving food security (SDG 2), ensuring healthy lives for all (SDG 3), achieving gender equality and empowering women and girls (SDG 5) and reducing inequality within and among countries (SDG 10) — must be fast-tracked.
- Gender-based violence must be addressed as a matter of high priority. Although this is the objective of SDG 5 and certainly justifies a spot on the world agenda, boys and men need to be educated to ensure that they do not resort to gender-based violence when they become angry or frustrated.
- The challenges of poverty and food insecurity cannot be addressed by any one entity alone. Concerted efforts are required from governments, corporates, smaller companies, NGOs and individuals to address inequalities in income. One is reminded of Mother Teresa's famous motto: "Live simply so others may simply live." Inequality or "relative deprivation" (Fox, 2012, p. 477) should no longer be considered the norm.
- The struggle to make ARVs accessible to all PLWHA and to allow the manufacture of generics was long and hard. Presently, the manufacture of generic COVID-19 vaccines is still prohibited under IP laws. It should not have been necessary to fight the same battle as with ARVs to make COVID vaccines available to all on an equal basis. The priority must be to ensure that everybody anywhere in the world will have access to the necessary medication during a pandemic, and we should not need to debate whether pharmaceutical companies may produce generic vaccines.
- The aforementioned letter from the SDG3 GAP principals emphasised the imperative to "leave no one behind", which requires greater collaboration between various stakeholders to support countries' response efforts towards health. This requires a joint effort to help countries recover and to ensure that all will be better prepared for future pandemics.

For now, all other things being equal, things are not equal. We are all in the same storm, but certainly not in the same boat.[8]

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Notes

1 Ironically, the sub-title of this article reads, "Over the past 25 years, HIV/AIDS has gone from a death sentence to – *at least in the developed world* – a manageable, if not curable, illness" (my italics).

2 In 1992, Richard Wilkinson published an article in the *British Medical Journal* in which he indicated that income distribution had a direct influence on life expectancy. He further elaborated on his thesis in two subsequent publications (1996; 2000) in which he focussed on the connection between income inequality, social hierarchy, social anxiety and health. The theory that income inequality has a direct bearing on health, was confirmed in an article in *Lancet* (Lynch, et al., 2001). Wilkinson's view was not accepted without criticism. Johan Mackenbach (2002) considered it too restricted in the number and type of countries included, based on research published ten years previously. In South Africa, COVID-19 highlighted existing income-related health inequalities, where it was found that race, hunger, income and employment all played a role in determining how people could respond to the pandemic (Nwosu & Oyenubi, 2021).

3 In a personal interview with some of the residents in the Nsalitje area of Eswatini, it was found that, before the COVID-19 pandemic, a 50 kg bag of maize cost 350 emalangeni (≈USD 22) in local stores, while the cost in the neighbouring Pongola area of South Africa was only E290. When the borders to South Africa were closed under lockdown, the price of 50 kg of maize kept rising in Eswatini and, by the beginning of 2022, the price was as high as E460.

4 In a conversation with Mduduzi Lukhele, manager of a feeding programme in Eswatini that provides meals to about 500 children daily, it was pointed out that the cost of basic food used for these meals had increased by 33 per cent after COVID-19.

5 One of the unforeseen consequences of this agreement was that patented ARVs remained too expensive for most developing countries. Azidothymidine (AZT), an antiretroviral made by Glaxo-Wellcome, cost USD 240 a month in South Africa, whereas a generic version made in India cost only USD 48 (Bond, 1999, p. 767). In 1999, there was a call to "humanize the trade agreements" and to "accelerate the production and availability of low-cost generic medicines for HIV, without risk of trade retaliation" at the WTO Ministerial Conference in Seattle (Hoen, Berger, Calmy, & Moon, 2011, p. 3). At the International AIDS Conference held in Durban in 2000, the Treatment Action Campaign organised a global march for treatment, increasing pressure on the pharmaceutical industry to make ARVs more affordable for developing countries.

6 It was reported by South Africa's Minister of Health that by May 2022 the country had one doctor per 3 198 patients (*Businesstech*, 2022), which amounts to 31 doctors per 100 000 patients (Clarke, 2022).

7 https://peoplesvaccine.org/wp-content/uploads/2022/03/Vaccine-Open-Letter-March-2022.pdf

8 https://www.secc.sydney/we-are-not-in-the-same-boat-a-poem-about-covid-19/

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References

Altman, L. (1981, July 3). Rare cancer seen in 41 homosexuals. *The New York Times*. https://www.nytimes.com/1981/07/03/us/rare-cancer-seen-in-41-homosexuals.html

Altorio, C. (2019, November 29). *In the country of orphans*. World Food Programme. https://www.wfp.org/stories/country-orphans

Ayebale, E., Kassebaum, N., Roche, A., & Biccard, B. (2020). Africa's critical care capacity before COVID-19.*Southern African Journal of Anaesthesia and Analgesia,26*(3), 162–164. https://doi.org/10.36303/SAJAA.2020.26.3.2431

Be in the Know. (2022, March 11). *Gender inequality and HIV.* https://www.beintheknow.org/understanding-hiv-epidemic/context/gender-inequality-and-hiv

Bond, P. (1999). Globalization, pharmaceutical pricing, and South African health policy: Managing confrontation with U.S. firms and politicians. *International Journal of Health Services, 29*(4), 765–792. https://doi.org/10.2190/4MA6-53E3-LE1X-C1YY

Businesstech. (2022, May 12). South African Medical Association sends warning to government over doctors and other professionals. https://businesstech.co.za/news/government/585748/south-african-medical-association-sends-warning-to-government-over-doctors-and-other-professionals/

Campbell, C. (1997, July). Migrancy, masculine identities and AIDS: The psychosocial context of HIV transmission on the South African gold mines. *Social Science & Medicine, 45*(2), 273–281. https://doi.org/10.1016/S0277-9536(96)00343-7

Carreño, B., & Rodríguez, E. (2020, March 11). Madrid records new jump in coronavirus cases, faces hospital bed crunch. *Reuters*. https://www.reuters.com/article/us-health-coronavirus-spain-madrid-idUKKBN20Y1KK

Centers for Disease Control and Protection (CDC). (2020). *If you are immunocompromised, protect yourself from COVID-19*. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/immunocompromised.html#:~:text=People%20with%20weakened%20immune%20systems,more%20about%20this%20new%20virus

Chigwedere, P., Seage, G., Gruskin, S., Lee, T., & Essex, M. (2008). Estimating the Lost Benefits of Antiretroviral Drug Use in South Africa. *Journal of Acquired Immune Deficiency Syndromes, 49*(4), 410–415. https://doi.org/10.1097/QAI.0b013e31818a6cd5

Clarke, M. (2022, May 9). *Critical shortage of doctors in SA – less than 1 doctor for every 1 000 patients.* Democratic Alliance. https://www.da.org.za/2022/05/critical-shortage-of-doctors-in-sa-less-than-1-doctor-for-every-1-000-patients

De Waal, A., & Whiteside, A. (2003, October 11). New variant famine: AIDS and food crisis in southern Africa. *Lancet, 362*(9391), 1234–1237. https://doi.org/10.1016/S0140-6736(03)14548-5

Dellar, R., Dlamini, S., & Karim, Q. (2015, February 26). Adolescent girls and young women: key populations for HIV epidemic control. *Journal of the International AIDS Society, 18*(S1), 64–70. https://doi.org/10.7448/IAS.18.2.19408

Denning, P., & DiNenno, E. (2019). *communities in crisis: is there a generalized HIV epidemic in impoverished urban areas of the United States?* Centers for Disease Control and Prevention. https://www.cdc.gov/hiv/group/poverty.html

Dunn, A., & Tavarez, V. (2021, October 11). Change the world: To reimagine capitalism, we need to reimagine power. *Fortune Daily.* https://fortune.com/2021/10/11/change-the-world-reimagine-capitalism-reimagine-power/

Black History Month. (2015, September 25). *The history of AIDS in Africa*. https://www.blackhistorymonth.org.uk/article/section/real-stories/the-history-of-aids-in-africa/

Fortune. (2021a). *Change the World*. https://fortune.com/change-the-world/2021/

Fortune. (2021b). *Change the World: MTN*. Retrieved March 29, 2022, from Fortune: https://fortune.com/company/mtn/change-the-world/

Fox, A. (2012, July). The HIV-poverty thesis re-examined: Poverty, wealth or inequality as a social determinant of HIV infection in sub-Saharan Africa? *Journal of Biosocial Science, 44*(4), 459–480. https://doi.org/10.1017/S0021932011000745

Galasso, V. (2020, December 4). COVID: Not a great equalizer. *CESifo Economic Studies, 66*(4), 376–393. https://doi.org/10.1093/cesifo/ifaa019

GardaWorld. (2020). *Eswatini: Partial lockdown comes into effect March 27*. https://www.garda.com/crisis24/news-alerts/326956/eswatini-partial-lockdown-comes-into-effect-march-27-update-1

Gill, I., & Saavedra, J. (2022, February 1). We are losing a generation: The devastating impacts of COVID-19. *World Bank Blogs*. The World Bank. https://blogs.worldbank.org/voices/we-are-losing-generation-devastating-impacts-covid-19

Gillespie, S., Kadiyala, S., & Greener, R. (2007, November). Is poverty or wealth driving HIV transmission? *AIDS (London, England), 21*(S7), 5–16. https://doi.org/10.1097/01.aids.0000300531.74730.72

Gottlieb, M., Schanker, H., Fan, P., Saxon, A., Weisman, J., & Pozalski, I. (1981, June 5). *Pneumocystis* Pneumonia — Los Angeles. *Morbidity and Mortality Weekly Report, 30*(21), 1–3. https://www.cdc.gov/mmwr/preview/mmwrhtml/june_5.htm

Government Communication and Information System (GCIS). (2020). *Government Communications*. Retrieved March 22, 2022, from Coronavirus lockdown: Regulations on price increase protection fact sheet: https://www.gov.za/sites/default/files/gcis_documents/20200418_Regulations%20on%20Price%20Increase%20Protection%20Fact%20Sheet.pdf

Guwatudde, D., Nankya-Mutyoba, J., Kalyesubula, R., Laurence, C., Adebamowo, C., Ajayi, I., Bajunirwe, F., Njelekela, M., Chiwanga, F. S., Reid, T., Volmink, J., Adami, H.-O., Holmes, M. D., & Dalal, S. (2015). The burden of hypertension in sub-Saharan Africa: A four-country cross sectional study. *BMC Public Health, 15*(1211), 1–8. https://doi.org/10.1186/s12889-015-2546-z

Health & Development Information Team. (n.d.). *The links between violence against women and HIV and AIDS*. https://www.hivpolicy.org/Library/HPP001388.pdf

Hoen, E., Berger, J., Calmy, A., & Moon, S. (2011). Driving a decade of change: HIV/AIDS, patents and access to medicines for all. *Journal of the International AIDS Society, 14*, 1–12. https://doi.org/10.1186/1758-2652-14-15

Horowitz, J. (2020, March 12). Italy's health care system groans under Coronavirus — a warning to the world. *The New York Times*. https://www.nytimes.com/2020/03/12/world/europe/12italy-coronavirus-health-care.html

Index Mundi. (2019). Eswatini — Physicians (per 1,000 people). https://www.indexmundi.com/facts/eswatini/indicator/SH.MED.PHYS.ZS#:~:text=Physicians%20(per%201%2C000%20people)%20in,was%200.080%20as%20of%202016

International Rescue Committee. (2021). *The only way to stop COVID-19? Vaccines for all*. https://www.rescue.org/article/only-way-stop-covid-19-vaccines-all

Jewell, B., Mudimu, E., Stover, J., Ten Brink, D., Phillips, A., Smith, J., Martin-Hughes, R., Teng, Y., Glaubius, R., Mahiane, S. G., Bansi-Matharu, L., Taramusi, I., Chagoma, N., Morrison, M., Doherty, M., Marsh, K., Bershteyn, A., Hallett, T. B., & Kelly, S. (2020, August 6). Potential effects of disruption to HIV programmes in sub-Saharan Africa caused by COVID-19: Results from multiple mathematical models. *The Lancet HIV, 7*(9), e629–e640. https://doi.org/10.1016/S2352-3018(20)30211-3

Kharas, H., & Dooley, M. (2021, June 2). Long-run impacts of COVID-19 on extreme poverty. *Future Development* [Blog]. Brookings Institute. https://www.brookings.edu/blog/future-development/2021/06/02/long-run-impacts-of-covid-19-on-extreme-poverty/

Kibirige, D., Lumu, W., Jones, A., Smeeth, L., Hattersley, A., & Nyirenda, M. (2019). Understanding the manifestation of diabetes in sub Saharan Africa to inform therapeutic approaches and preventive strategies: A narrative review. *Clinical Diabetes and Endocrinology, 5*(2), 1–8. https://doi.org/10.1186/s40842-019-0077-8

Lynch, J., Smith, G., Hillemeier, M., Shaw, M., Raghunathan, T., & Kaplan, G. (2001, July 21). Income inequality, the psychosocial environment, and health: Comparisons of wealthy nations. *Lancet, 358*(9277), 194–200. https://doi.org/10.1016/S0140-6736(01)05407-1

Maartens, M. (2012). Using Shiselweni reformed home-based care as model for the church's involvement in the community. MA thesis, University of Pretoria.

Mackenbach, J. (2002, June). Mind the gap—Hierarchies, health and human evolution. *International Journal of Epidemiology, 31*(3), 684. https://doi.org/10.1093/ije/31.3.684

Marmot, M., Atkinson, T., Bell, J., Black, C., Broadfoot, P., Cumberlege, J., Diamond, I., Gilmore, I., Ham, C., Meacher, M., & Mulgan, G. (2010). *Fair society, healthy lives: strategic review of health inequalities in England post-2010*. The Marmot Review. https://www.parliament.uk/globalassets/documents/fair-society-healthy-lives-full-report.pdf

Maugh, I. I. T. (1996, July 12). Studies of combined HIV drugs promising. *Los Angeles Times*. https://www.latimes.com/archives/la-xpm-1996-07-12-mn-23350-story.html

McKay, B. (2022, March 12). Meghan Markle and Prince Harry sign open letter calling out vaccine inequity. *Channel24* https://www.news24.com/channel/gossip/royal-news/meghan-markle-and-prince-harry-sign-open-letter-calling-out-vaccine-inequity-20220312

Medical Brief. (2020, April 1). When three epidemics collide: TB, HIV and COVID-19 in South Africa. https://www.medicalbrief.co.za/archives/when-three-epidemics-collide-tb-hiv-and-covid-19-in-south-africa/

Mlambo-Ngcuka, P. (2020, April 6). *Violence against women and girls: the shadow pandemic*. UN Women. https://www.unwomen.org/en/news/stories/2020/4/statement-ed-phumzile-violence-against-women-during-pandemic

Mueller, A., McNamara, M., & Sinclair, D. (2020). Why does COVID-19 disproportionately affect older people? *Aging (Albany NY), 12*(10), 9959–9981. https://doi.org/10.18632/aging.103344

Mufune, P. (2015, February). Poverty and HIV/AIDS in Africa: Specifying the connections. *Social Theory & Health, 13*(1), 1–29. https://doi.org/10.1057/sth.2014.14

Nanda, S. (2021). Inequalities and COVID-19. In J. Ryan (Ed.), *COVID-19* (Vol. I, pp. 109–123). Routledge.

Ndubuka, N., Lim, H., Van der Wal, D., & Ehlers, V. (2016, October 31). Health-related quality of life of antiretroviral treatment defaulters in Botswana. *Southern African Journal of HIV Medicine, 17*(1), 1–6. https://doi.org/10.4102/sajhivmed.v17i1.475

Nwosu, C., & Oyenubi, A. (2021). Income-related health inequalities associated with the coronavirus pandemic in South Africa: A decomposition analysis. *International Journal for Equity in Health, 20*, 1–12. https://doi.org/10.1186/s12939-020-01361-7

Patel, J., Nielsen, F., Badiani, A., Assi, S., Unadkat, V., Patel, B., Ravindrane, R., & Wardle, H. (2020). Poverty, inequality and COVID-19: The forgotten vulnerable. *Public Health, 183*, 110–111. https://doi.org/10.1016/j.puhe.2020.05.006

Pilkington, V., Keestra, S., & Hill, A. (2022, March 7). Global COVID-19 Vaccine Inequity: Failures in the First Year of Distribution and Potential Solutions for the Future. *Frontiers in Public Health, 10*(821117), 1–8. https://doi.org/10.3389/fpubh.2022.821117

Ramaphosa, C. (2020). *Statement by President Cyril Ramaphosa on further economic and social measures in response the COVID-19 epidemic.* Union Buildings, Tshwane. http://www.dirco.gov.za/docs/speeches/2020/cram0421.pdf

Root, R., Van Wyngaard, A., & Whiteside, A. (2015). Reckoning HIV/AIDS care: A longitudinal study of community home-based caregivers and clients in Swaziland. *African Journal of AIDS Research, 14*(3), 265–274. https://doi.org/10.2989/16085906.2015.1059864

Sánchez-Páramo, C., Hill, R., Gerszon Mahler, D., Narayan, A., & Yonzan, N. (2021, October 7). *COVID-19 leaves a legacy of rising poverty and widening inequality*. The World Bank Blog. https://blogs.worldbank.org/developmenttalk/covid-19-leaves-legacy-rising-poverty-and-widening-inequality#:~:text=About%2097%20million%20more%20people,estimated%20to%20have%20been%20lost

SDG3 GAP Principals. (2022, January). Letter from SDG3 GAP principals to country-facing teams. https://cdn.who.int/media/docs/default-source/global-action-plan/joint-letter-sdg3-gap-principals-to-country-teams.pdf?sfvrsn=e0f4fc61_7&download=true

Sidibé, M. (2022, January 24). *Vaccine inequity: Ensuring Africa is not left out*. Brookings Institute. https://www.brookings.edu/blog/africa-in-focus/2022/01/24/vaccine-inequity-ensuring-africa-is-not-left-out/

Smith, M. (2009, December 23). HIV/AIDS — Much progress, no cure. *Medpage Today*. https://www.medpagetoday.com/hivaids/hivaids/17665

Solis-Moreira, J. (2021, November 13). How did we develop a COVID-19 vaccine so quickly? *Medical News Today*. https://www.medicalnewstoday.com/articles/how-did-we-develop-a-covid-19-vaccine-so-quickly

The Economist. (2020). The COVID-19 pandemic is worse than official figures show. https://www.economist.com/briefing/2020/09/26/the-covid-19-pandemic-is-worse-than-official-figures-show?fsrc=newsletter&utm_campaign=the-economist-today&utm_medium=newsletter&utm_source=salesforce-marketing-cloud&utm_term=2020-09-24&utm_content=article-li

Tladi, L. (2006, February 28). Poverty and HIV/AIDS in South Africa: an empirical contribution. *Journal of Social Aspects of HIV/AIDS, 3*(1), 369–381. https://doi.org/10.1080/17290376.2006.9724863

UN Women. (2020a, June 26). *COVID-19: Emerging gender data and why it matters*. https://data.unwomen.org/resources/covid-19-emerging-gender-data-and-why-it-matters

UN Women. (2020b). *The first 100 days of the COVID-19 outbreak in Asia and the Pacific: a gender lens*. https://asiapacific.unwomen.org/sites/default/files/Field%20Office%20ESEAsia/Docs/Publications/2020/04/ap_First_100-Days_COVID-19-r02.pdf

UNAIDS. (2014). *Unite with women – unite against violence and HIV*. https://www.unaids.org/sites/default/files/media_asset/JC2602_UniteWithWomen_en_0.pdf

UNAIDS. (2019). *Women and HIV*. https://www.unaids.org/sites/default/files/media_asset/2019_women-and-hiv_en.pdf

UNAIDS. (2020). *Seizing the moment: tackling entrenched inequalities to end epidemics*. https://www.unaids.org/sites/default/files/media_asset/2020_global-aids-report_en.pdf

UNAIDS. (2021). *Unequal, unprepared, under threat: why bold action against inequalities is needed to end AIDS, stop COVID-19 and prepare for future pandemics.* https://www.unaids.org/sites/default/files/media_asset/2021_WAD_report_en.pdf

United Nations. (2020). *Goal 10: Reduce inequality within and among countries*. https://www.un.org/sustainabledevelopment/inequality/

United Nations. (2021). *The Sustainable Development Goals Report: 2021*. https://unstats.un.org/sdgs/report/2021/The-Sustainable-Development-Goals-Report-2021.pdf

Van Wyngaard, A. (2014, April 16). Manifesting the grace of God to those with HIV or AIDS. *Verbum et ecclesia, 35*(1), 1–7. https://doi.org/10.4102/ve.v35i1.780

Van Wyngaard, A., & Whiteside, A. (2021). AIDS and COVID-19 in southern Africa. *African Journal of AIDS Research, 20*(2), 117–124. https://doi.org/10.2989/16085906.2021.1948877

Van Wyngaard, A., Root, R., & Whiteside, A. (2017). Food insecurity and ART adherence in Swaziland: The case for coordinated faith-based and multi-sectoral action. *Development in Practice, 27*(5), 599–609. https://doi.org/10.1080/09614524.2017.1327026

Wenham, C., Smith, J., & Morgan, R. (2020, March 6). COVID-19: The gendered impacts of the outbreak. *Lancet, 395*, 846–848. https://doi.org/10.1016/S0140-6736(20)30526-2

Whiteside, A., & Whalley, A. (2007). *National Emergency Response Council on HIV/AIDS*. http://shbcare.org/docs/Reviewing_Emergencies_For_Swaziland_Report.pdf

WHO. (2020a, January 30). *Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV).* https://www.who.int/news/item/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov)

WHO. (2020b, 11 February). *Naming the coronavirus disease (COVID-19) and the virus that causes it.*https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it

WHO. (2020c, 11 March).*WHO Director-General's opening remarks at the media briefing on COVID-19.*https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020

Wilkinson, R. (1992, January 18). Income distribution and life expectancy.*British Medical Journal,304*, 165–168. https://doi.org/10.1136/bmj.304.6820.165

Wilkinson, R. (1996). *Unhealthy societies - The afflictions of inequality*. Routledge.

Wilkinson, R. (2000). *Darwinism today: Mind the gap*. Weidenfeld and Nicolson.

World Bank Group. (2022).*Global Economic Prospects.* https://openknowledge.worldbank.org/bitstream/handle/10986/36519/9781464817601.pdf

World Population Review. (2022). HIV rates by country 2022. https://worldpopulationreview.com/country-rankings/hiv-rates-by-country

Yonzan, N., Lakner, C., & Mahler, G. (2021, October 7). Is COVID-19 increasing global inequality? World Bank Blogs. https://blogs.worldbank.org/opendata/covid-19-increasing-global-inequality

Zabsonre, I. (2016). ARVs and food. MSF and Medical Research Council Meeting on HIV. Nhlangano, Swaziland

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