Towards ending AIDS in Eastern and Southern Africa Region: Leaving no one behind

A focus on sex workers, men who have sex with men, people who inject drugs and transgender people
Introduction

The Sustainable Development Goals (SDGs) pledge all countries to take immediate action to end the AIDS epidemic by 2030. Nowhere is the quest to end AIDS more pressing than in Eastern and Southern Africa, which in 2015 accounted for 6.2% of the world’s population (1) but for 51% of all people living with HIV globally and for 46% of new HIV infections (2).

The 2016 Political Declaration on HIV and AIDS1, which provides a roadmap for ending AIDS as a public health threat by 2030, calls for “urgent action over the next five years to ensure that no one is left behind in the AIDS response” (3). Although historic progress has been made in Eastern and Southern Africa – as annual new HIV infections in Eastern and Southern Africa declined by 52% from 1997 to 2015, while AIDS-related deaths have fallen by more than 60% since 2005 (2) – most of this progress occurred prior to 2010. While new HIV infections among children have sharply fallen in recent years, progress in reducing new infections among adults in the region has stalled since 2010 (1). Indeed, in several countries – including Eritrea, Kenya, Madagascar, South Africa and South Sudan – new infections among adults have actually risen over the first half of this decade (1).

Key Messages

The tools now exist to end AIDS as a public health threat in Eastern and Southern Africa by 2030.

AIDS in the region cannot be ended without ensuring that no population is left behind.

Among four populations – sex workers, men who have sex with men, people who inject drugs and transgender people – HIV risks are much higher than in the general population but access to services is often far lower.

Efforts to address the needs of these four populations suffer from inadequate political will, widespread stigma and discrimination, under-resourced community capacity, and punitive laws that deter service uptake.

Each of the four populations highlighted here has unique HIV-related needs and confronts specific barriers to service access, underscoring the importance of tailoring programmatic and policy responses for each of the populations.

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1 Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030, 70th Session of the United Nations General Assembly, 2016, A/70/L.52.
Towards the goal of ending AIDS by 2030, countries in Eastern and Southern Africa joined with other United Nations Member States in the 2016 Declaration to pledge action to reduce the annual number of new HIV infections and AIDS-related deaths globally to 500,000 by 2020. To contribute to attainment of these ambitious targets, countries in Eastern and Southern Africa have pledged to reach populations that are being left behind, including sex workers, men who have sex with men, people who inject drugs and transgender people (4). Although each of these groups experiences HIV risks that are notably greater than the general population, they are highly stigmatized and often least likely to receive life-saving HIV prevention and treatment services. In 2014, these groups, along with their sex partners accounted for 20% of new HIV infections in Eastern and Southern Africa (1).

A review of available evidence

This brief summarizes findings of Regional synthesis of the HIV epidemic among sex workers, men who have sex with men, people who inject drugs and transgender people, a comprehensive regional review of available data on these four populations in 18 countries in Southern and Eastern Africa (Angola, Botswana, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, South Africa, South Sudan, Swaziland, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe). The research exercise was commissioned by the UNAIDS Regional Support Team for Eastern and Southern Africa and the World Bank, and undertaken by a research team from the Université Laval (Québec, Canada). The project included an extensive review of published and grey data and scientific research, key informant interviews, and more in-depth country visits to Kenya and Namibia. Data triangulation was used to verify standardized information collected on each populations, and two peer reviews were organized through UNAIDS country offices.

Drawing from the findings of a comprehensive assessment and synthesis of available research regarding these four populations (see text box), the brief summarizes key findings of this research project in five strategic areas – strategic information, service scale-up, community mobilization and engagement, enabling environment, and resources and investments. For gaps in each of these strategic areas, priority recommendations are described, providing an action blueprint to fulfil the spirit of the SDGs and 2016 Political Declaration on HIV and AIDS by ensuring that national responses reach those in greatest need as part of fast tracking the AIDS response. With the aim of supporting countries in fast tracking their AIDS response, this brief aims to be useful for national decision-makers, affected communities, international donors and other stakeholders in the AIDS response.
Basic facts about these four populations

This brief focuses on four specific populations – sex workers, men who have sex with men, people who inject drugs and transgender people -- because all are highly stigmatized and none has yet to receive sufficient attention from national AIDS responses in the region. These four are not mutually exclusive; for example, men who have sex with men may sometimes work as sex workers or inject drugs. (According to a 2011 study of men who have sex with men in Malawi, for example, 12.2% reported having injected drugs in the previous six months, while a separate survey of sex workers in Namibia found that 3.3% identified as transgender.) Those belonging to multiple key populations are likely to experience especially high risks of HIV acquisition. Information regarding HIV among these is widely variable across Eastern and Southern Africa, and particularly scarce with respect to transgender people.

A status report : HIV and four populations in Eastern and Southern Africa

To end the AIDS epidemic, HIV transmission among the four populations must be dramatically lowered. In 2014, these populations, along with their sex partners, accounted for an estimated 36% of new HIV infections globally (5). On average, these populations are 5-49 times more likely to be living with HIV than the general population (1). Members of these four populations often confront exceptionally high HIV risks at a very early age (5).

As each of these populations confronts unique barriers to essential services, customised approaches are needed to address their needs and improve health outcomes. To facilitate uptake of approaches tailored for each population’s needs, international partners have developed specific tools for programmatic implementation for sex workers (6) and men who have sex with men (7), and work is underway to finalize a similar implementation tool for programming for people who inject drugs.
HIV and the four populations: Key facts

HIV among female sex workers and their clients has the greatest impact on the regional epidemic among the four groups.

HIV prevalence among men who have sex with men ranges from 3.8% to 36% in Eastern and Southern Africa, and transmission within this population accounts for 6% of new HIV infections.

Limited data indicate that HIV prevalence is extremely high among people who inject drugs, although the extent of injecting drug use across the region is poorly documented.

Little information is available regarding the HIV burden among transgender people in the region, although globally transgender women are 49 times more likely to be living with HIV than the general population.

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Sex workers and their clients

In the region most heavily affected by HIV worldwide, female sex workers have the highest HIV prevalence of any population. In seven countries (Botswana, Lesotho, Malawi, Namibia, Rwanda, South Africa and Zimbabwe), more than half of female sex workers are living with HIV. Although female sex workers are heavily affected by HIV in every country in the region, the HIV burden in this population varies, with HIV prevalence among female sex workers ranging from 1.3% in Madagascar to more than 70% in Lesotho and Namibia. In Johannesburg, South Africa, an estimated 72% of sex workers were HIV-positive in 2013-2014 (8). In all countries, HIV prevalence among female sex workers is notably higher than in the general adult population.

Of these four populations, HIV among sex workers has historically had the largest impact on the regional epidemic. While the number of new HIV infections among sex workers in Eastern and Southern Africa in 2014 was lower than among men who have sex with men (1), these figures do not take account of the substantial but un-quantified number of clients of sex workers who are exposed to HIV.

Men who have sex with men

HIV prevalence among men who have sex with men varies from 3.8% in Angola to 36% in South Africa. One in three men who have sex with men is living with HIV, and roughly one in five in Kenya, United Republic of Tanzania, Malawi and Mauritius (1). In 2014, an estimated 6% of all new HIV infections in Eastern and Southern Africa occurred among men who have sex with men (1).

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2 It is estimated that at least 90% of sex workers are female, although selling sex is also common among men who have sex with men and transgender people in the region. The overwhelming bulk of available evidence in the region concerns female sex workers.
The likelihood of HIV transmission during anal intercourse, especially to the receptive partner, is a key reason why HIV prevalence is so high among men who have sex with men. According to available epidemiological data, an HIV-uninfected person is 17 times more likely to contract HIV from an infected partner during receptive anal intercourse than during receptive vaginal intercourse (9).

**People who inject drugs**

Use of contaminated drug injecting equipment is a highly efficient means of HIV transmission; per-exposure risks of transmission during in injecting drug use is nearly 8 times greater than during receptive penile-vaginal intercourse (9). In the absence of safe injecting practices, the rapid spread of HIV within networks of injecting drug users is common once the virus is introduced.

Relatively little information is available regarding the extent of injecting drug use in the region and the HIV burden in this population, although the limited data available suggests that HIV prevalence is extremely high among people who inject drugs. In both Kenya and Mauritius, nearly half of adults who inject drugs have become infected with HIV (1). The United Republic of Tanzania estimated in 2014 that 20,000 to 42,500 people on the mainland injected drugs and that 36% of these individuals were living with HIV. In Mauritius, it is estimated that 44% of new HIV infections occur among people who inject drugs, with an additional 8% among the sex partners of people who inject drugs. Regionally, it is estimated that people who inject drugs accounted for 2% of new HIV infections in 2014 (1).

**Transgender people**

Of the four groups, information in Eastern and Southern Africa is most limited with respect to transgender people. No country in the region has in place evidence of HIV prevalence among transgender people, although nearby Democratic Republic of Congo estimated that 15% of transwomen were living with HIV in 2015 (10). What is unmistakable is that transgender people are heavily affected by HIV, as globally transgender women are 49 times more likely to be living with HIV than other adults of reproductive age (11).

**Key actions: to address the urgent HIV needs of four populations**

Inadequate attention to the needs of these four populations has enabled HIV within these groups to worsen and potentially undermines hopes for ending the AIDS epidemic in Eastern and Southern Africa. Urgent action is needed to close gaps in five key areas of the response for key populations.

**Strategic information**

Public health efforts are only as sound as the evidence on which they are based. Proven prevention and treatment initiatives must be strategically focused on the populations
and settings in greatest need, and these programmes need to be tailored to address the specific needs and circumstances of each target population. For groups at heightened risk of HIV acquisition, countries need timely, robust and reliable data on the size of each population, the burden of HIV (including prevalence and incidence), the prevalence and nature of behaviours that increase HIV risk and vulnerability, coverage of key HIV prevention and treatment services, and social and structural factors that affect HIV risk and utilization of key services. National household surveys have long provided critical strategic information on HIV prevalence, sexual risk behaviours, HIV testing and the like in general populations in Eastern and Southern Africa, but these national surveys yield no meaningful information regarding the four populations addressed here.

As sex work has long been recognized as an important factor in national epidemics in the region, strategic information is most plentiful regarding this population than for the other three. All 18 countries report some form of strategic information regarding sex workers. Slightly fewer (15) report strategic information regarding men who have sex with men, and 6 collect strategic data on people who inject drugs. No country in Eastern and Southern Africa reports strategic information regarding transgender people.

Understanding the size and HIV prevalence for each key population is critical for service planning and estimating service coverage. According to Global AIDS Response Reporting by countries in Eastern and Southern Africa, at least 13 countries have estimated the number of sex workers in their country; at least 11 have size estimations for men who have sex with men; at least four for people who inject drugs; and no country has estimated the number of transgender people. Existing methods for size estimation – including modes-of-transmission modelling, integrated bio-behavioural surveys and triangulation of multiple data sources – can sometimes be costly, and each method has its strengths and limitations. For example, different countries or research teams often use different methodologies for size estimation, and the limited extent of available data may necessitate triangulation of data sources. Community mapping is a low-cost technique for estimating the size of key populations, using community experts who work closely with researchers. To increase the reliability of size estimations, using more than one research method may be needed.

A number of countries have used integrated bio-behavioural surveys\(^3\) to generate useful strategic information on HIV risk behaviours, HIV burden, service utilization and experience of HIV stigma or discrimination among sex workers and men who have sex with men; this tool has not yet been used to gather data in the region on people who inject drugs or transgender people. Most countries in the region (12 of 18) have submitted data through the Global AIDS Response Reporting (GARPR) system regarding HIV testing among sex workers and men who have sex with men, but fewer (6 of 18) have submitted data with respect to condom use for these populations \(^2\). Only four countries (Kenya, Madagascar, Mauritius and the United Republic of Tanzania) provided GARPR data regarding HIV testing, condom use and safe injecting practices among people who inject drugs \(^2\).

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\(^3\) Integrated bio-behavioural surveys rely on information provided by participants in face-to-face interviews and focus groups.
Strategic Information: Key actions

Estimate the size of each of the four populations, including through community mapping and other methods.

Use the Global AIDS Monitoring system (formerly GARPR) to collect and report comprehensive strategic information on each population.

Ensure that strategic information regarding the four populations is disaggregated by age and sex.

Capture key trends through repeated integrated bio-behavioural surveys.

Ensure that surveys of the four populations are large and diverse enough to capture reliable, nationally representative data.

Standardize data collection methods for estimating population size and tracking behavioural patterns.

Use the most recent strategic information to inform programme planning, implementation and service delivery for the four populations.

Ensure community engagement and participation in all aspects of the collection of strategic information.

Ensure broad national ownership (including government and communities) of strategic information on these populations, including through timely and widespread data dissemination.

Develop evidence-informed, audience-specific advocacy packages to build support for sound national responses to HIV among these four populations.
Scale-up of essential HIV services

These four populations in Eastern and Southern Africa largely lack access to the prevention and treatment services that are essential to ending the AIDS epidemic. To effectively address the exceptionally high HIV burden among key populations, the World Health Organization recommends the provision of comprehensive HIV services, including condom and lubricant programming, harm reduction interventions for substance use, behavioural interventions, routine HIV testing services, HIV treatment and care (including management of co-morbidities), pre-exposure antiretroviral prophylaxis (PrEP) and sexual and reproductive health interventions (12).

The most recent HIV strategic plans and multisectoral frameworks in the region address female sex workers as a priority population in all 18 countries, men who have sex with men in 17 countries, and people who inject drugs in 6 countries. As part of their national HIV coordinating structure, some countries, such as Kenya and Namibia, have created technical working groups for populations that are nationally recognized as priority populations. Some countries, such as Rwanda, have enjoyed notable success in implementing policy and programming for sex workers and men who have sex with men, and five countries (Kenya, Madagascar, Mauritius, South Africa and the United Republic of Tanzania) have focused programmes for people who inject drugs. To date, national efforts have largely overlooked transgender people.

Progress has clearly been made in a number of countries towards policy and programmatic implementation for these populations. However, according to national GARPR reports, critical gaps remain with respect to service access for these groups\textsuperscript{4}. While extremely high rates of condom use are reported among sex workers (as high as 92% in Kenya), 30% or more of sex workers surveyed said they did not use a condom the last time they had sex in at least 3 countries (Lesotho, Uganda, United Republic of Tanzania) (2). Reported rates of condom use are generally lower among men who have sex with men (from 14% in the United Republic of Tanzania to 98% in Rwanda, 9 countries reporting) and among people who inject drugs (from 29% in United Republic of Tanzania to 70% in Kenya, 4 countries reporting). Coverage data are not readily available with respect to other prevention services; in the case of PrEP, coverage is undoubtedly minimal among the four groups, as only 6 countries in the region had approved PrEP as of early 2017 (13) and globally the world had achieved only about 2% of the 2020 PrEP uptake target as of 2015 (1). In the 4 countries reporting GARPR data regarding people who inject drugs, the proportion of people who inject drugs who used safe practices the last time they injected exceeded 80% in each country (2).

\textsuperscript{4} GARPR data cited are the most recent among country reports in 2013-2015.
The four populations also confront considerable barriers to accessing essential services across the HIV treatment cascade. The proportion of people receiving HIV testing services in the last 12 months ranged from 43% (United Republic of Tanzania) to 95% (Malawi) among sex workers (15 countries reporting), and from 14% (Lesotho) to 91% (Angola) among men who have sex with men (8 countries). Although treatment coverage and rates of viral suppression are not available for each of the four populations in most countries, UNAIDS reports that these groups are often less likely to obtain treatment services than people living with HIV generally or to achieve viral suppression (1). Among the four populations, stigma and discrimination often deter individuals from seeking the services they need; in Swaziland, for example, nearly 1 in 4 sex workers said they were afraid to access health services in 2014-2015, and more than 1 in 5 reported that they actively avoid seeking HIV services. In Cape Town, Gaborone, Windhoek and other settings in the region, surveys found that roughly 1 in 5 men who have sex with men reported that they feared seeking health services due to the stigma associated with homosexuality.

Some governments have resisted supporting dedicated services for one or more of these four populations on the mistaken belief that such services encourage behaviours that are illegal or highly stigmatized. In early 2017, programmes providing services specifically for men who have sex with men and other key populations were discontinued in the United Republic of Tanzania. Such approaches often fail to recognize that these populations exist and are at high risk of HIV infection, regardless of whether services are tailored to their needs. By scaling up services that are shaped by and customized for the four populations, countries more effectively address the shared public health effort to move towards ending the AIDS epidemic.
Scale-up of essential services: Key actions

Acknowledge each of the four populations in national HIV strategic plans, frameworks and strategies.

Establish national technical working groups for these populations.

Scale up comprehensive programmes for the four populations, in accordance with best evidence and international normative guidance.

Meanfully engage each of the four populations to develop and deliver customized, peer-led, community-based services.

Develop targeted and coordinated programmes at both national and sub-national levels that ensure access to HIV and TB services for each of the four populations.

Set specific service delivery targets for each of the four populations, and use monitoring and evaluation to track progress towards these goals.

Undertake service gap and bottleneck analyses for each population, specifically identifying key actors at sub-national level responsible for closing gaps and strengthening programme implementation.

Build strong human resources to support programme implementation for each population.

Sensitize health care providers to meet the needs of these populations.

Ensure that targeted programmes reach incarcerated populations.
Community mobilization and engagement

One of the signature features of the AIDS response has been the extraordinary role that communities themselves have played and continue to play – in advocating for change, mobilizing communities, generating demand, delivering services, and holding decision-makers accountable for results (14). Across Eastern and Southern Africa, communities continue to serve as pathfinders in the response, generating innovations that have sharply improved service access, retention in care and rates of viral suppression (15). The UNAIDS Fast-Track approach to end AIDS recognizes that communities will need to play an even more central role if we are to end the epidemic, as funding for community mobilization efforts must markedly increase and the share of services delivered through community-led initiatives must rise from 5% currently to 30% by 2030 (16).

Community engagement is especially critical to address epidemics among these four populations, who are highly stigmatized and marginalized. In all 18 countries in Eastern and Southern Africa, community-based services exist to address one or more of the four populations.

In many parts of the region, community networks of sex workers are especially robust. In South Africa, for example, the Red Umbrella National Sex Worker Programme delivers a combination prevention package to sex workers through 18 implementing partners in nine provinces, taking steps to sensitize stakeholders to reduce sex workers’ barriers to service access. In Kenya, the Sex Workers Outreach Project provides client-friendly, accessible HIV and STI care and services to both male and female sex workers. Many national and local sex worker projects are affiliated with the African Sex Workers Alliance, a pan-African coalition of sex worker networks. A similar regional body also exists for men who have sex with men – African Men for Sexual Health and Rights – and national and local networks are emerging to address the health needs of men who have sex with men and, in some case, transgender people.

However, the current degree of community mobilization among these populations, while encouraging, is wholly insufficient to address the immense HIV challenge facing these groups. None of the 18 countries, for example, has made meaningful investments in community mobilization among the four groups (1). Due to the failure of countries to invest adequate resources, existing networks among the four populations tend to be badly under-funded and lacking ample capacity to deliver services, undertake needed advocacy and fulfil their watchdog role. With a few notable exceptions, networks and organizations are not adequately engaged in decision-making that affects them or in the collection and use of strategic information, reducing the relevance and impact of national HIV efforts for the four populations and diminishing their ability to mobilize national funding for capacity-building, operations and service delivery. Clearly, if the region hopes to write the final chapter of the AIDS epidemic, countries will need to invest in building community capacity within these four populations.
Community mobilization and engagement: Key actions

Actively support formation of national community networks for each of the populations and/or enable a common national platform for the four communities to work together.

Ensure strong financial and human resource investment by national governments and development partners to build strong, sustainable community networks.

Leverage strengthened community engagement to develop and support community-developed and –delivered prevention, treatment and support services.

Include and engage community representatives from all four populations in decision-making bodies.

Build the capacity of community networks to mobilize resources.

Ensure systematic engagement of community representatives in the collection, analysis and dissemination of strategic information.

Empower community representatives to advocate with political, community and religious leaders for a sound, non-stigmatizing, non-discriminatory response to HIV and other health challenges faced by the four populations.

Enabling environment for service uptake

Laws and policies in Eastern and Southern Africa need to support and catalyse, rather than undermine, sound, human rights-based responses for the four populations. All 18 countries in Eastern and Southern Africa have formally endorsed various international human rights accords, and all have national HIV strategies or other laws that enshrine human rights in national approaches. However, the gap between aspirations and reality is notable with respect to the human rights of these four populations. All or some aspects of sex work are criminalized in 17 of 18 countries (all but Madagascar), and 14 of 18 countries criminalize same-sex sexual practices. Injecting drug use is penalized in all 18 countries.

Across the region, these punitive laws often authorize extreme penalties. In all cases, they help create a climate that encourages stigmatization, ostracism and violence. In Uganda, the law authorizes imposition of the death penalty against persons convicted of sexual relations with a member of the same sex. Laws criminalizing behaviours among the four populations foster harassment and violence of these groups by law enforcement agencies, and also encourage health care workers and other service providers to discriminate against members of these populations without fear of punishment.
Sex workers and men who have sex with men in Eastern and Southern Africa report encountering substantial challenges when they seek legal redress for violations of their human rights.

Despite these challenges, recent years also provide convincing evidence from the region that concerted, sustained efforts can improve the human rights climate for the four populations. In Botswana, there is now more open and visible public discourse on homosexuality. Following a similar opening of public discussion regarding homosexuality, Mozambique repealed legislation criminalizing homosexuality. Lessons from these experiences need to be taken on board in order to allow the region to more closely link the rhetoric on human rights with lived reality of the four populations.

Enabling environment for service uptake: Key action

Advocate for legal reform.

Implement programmes to reduce stigma, discrimination and human rights violations by law enforcement agents and the judiciary.

Create and strengthen legal, health and welfare support groups for the four populations.

Build legal literacy among the four populations.

Challenge stigma and discrimination against the four populations.

Build the capacity of local, national and regional networks of the four populations.

Exchange and disseminate promising human rights practices.

Intensify efforts to ensure equity (including gender equity) at all levels.

Investments

Although many countries in the region have increased domestic investments in the AIDS response, analysis of these investments underscores the reality that the four populations are being left behind. As Table 1 indicates, with very few exceptions, the proportion of HIV spending focused on the four populations is extremely low.
<table>
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<th>Financial allocation</th>
<th>Countries (and year of national AIDS spending assessments where data are found)</th>
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| Sex workers/female sex workers (and clients) | Kenya: 0.16% (NASA - 2014, 2009/2010 to 2011/2012)  
Lesotho: 0.27% (NASA - 2009/2010)  
Malawi: 0.36% (NASA - 2013/2011/2012)  
Mauritius: 2.6% (NASA - 2012/2010)  
Mozambique: 0.4% (NASA - 2014)  
South Sudan: 0.6% (NASA - 2014/2010-2012)  
Zambia: amount not specified (NASA - 2014/2012)  
Zimbabwe: 0.1% (NASA/2014/2011/2012) |
| Men who have sex with men | Lesotho: 0.02% (NASA - 2009/2010)  
Malawi: 0.04% (NASA 2011/2012/2013)  
Mauritius: 1.9% (NASA 2012/2010)  
Mozambique: 0.1% (NASA - 2014) |
| People who inject drugs | Kenya: 0.01% (NASA - 2014/2009/2010 to 2011/2012)  
Lesotho: 0.002% (NASA - 2009/2010)  
(Refers to medical injection)  
Mauritius: 30.5% (NASA - 2012/2010)  
Mozambique: 0.3% (NASA - 2014)  
Zimbabwe: US$15,000.00 (NASA - 2014/2011/2012) |
| Specified for “key populations” but without indicating individual allocation per population | Kenya: 0.03% (2009/2010 to 2011/2012)  
Madagascar: 9.3%: female sex workers, men who have sex with men and people who inject drugs (GARPR 2014/2013)  
Mozambique: 0.5% (NASA 2014)  
Namibia: 4.04% for female sex workers, men who have sex with men, people who inject drugs (NASA - 2014/2013)  
Uganda: 0.1% (NASA - 2012/2009/2010) |
| No specific information provided | Angola, Botswana, Ethiopia, Rwanda, South Africa, Swaziland, the United Republic of Tanzania |
National spending reports should be interpreted with some caution. There is often a considerable lag between when actual expenditures occur and when national AIDS spending reports are released. Given the multiple sources of funding for HIV programmes and the predominance of international assistance in most national responses in Eastern and Southern Africa, it is conceivable that reports do not fully capture total spending. In addition, even where countries accurate capture the totality of HIV spending, expenditures may not always be accurately coded to reflect the nature of such spending. In the case of people who inject drugs, the allocation of a substantial share of HIV spending for harm reduction programmes may not be warranted, especially in landlocked countries where importation of opioids is more difficult.

However, even with these caveats, it is clear that countries in Eastern and Southern Africa are largely failing to allocate the investments warranted to address the serious HIV epidemics among the four populations. Only if both countries and international donors substantially increase resources for HIV prevention and treatment among key populations will it be possible to reverse epidemics in these groups.

Investments: Key actions

Demonstrate strong political commitment to ensure strategic investments to address the HIV-related needs of the four populations.

Ensure sufficient investments to generate and use strategic information for the four populations.

Ensure that investments are sufficient to bring comprehensive HIV responses to scale for priority populations in each country.

Invest adequately in community mobilization, empowerment and capacity building for each of the four populations.

Increase domestic funding as a proportion of total AIDS investments for the four populations.

Ensure adequate and timely tracking and reporting by national government on expenditures for each of the four populations.
Conclusion

After more than three decades during which HIV ravaged countries in Eastern and Southern Africa – reversing development gains that took decades to achieve – the end of AIDS is now in sight. But ending AIDS will not happen if efforts are not redoubled to ensure that no population is left behind.

Meeting the HIV-related needs of these four populations is the right thing to do and is the only approach consistent with the spirit and letter of the SDGs. It is also the smart thing to do, as reaching global, regional and national AIDS goals will only be possible if national responses meet the HIV challenge in the communities most heavily affected.
References


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