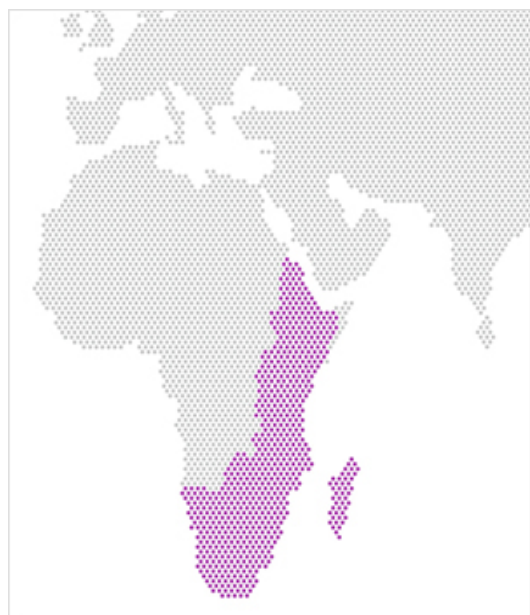


HIV and AIDS in East and Southern Africa regional overview



East and Southern Africa (2017)

19.6m people living with HIV

6.8% adult HIV prevalence (ages 15-49)

800,000 new HIV infections

380,000 AIDS-related deaths

66% adults on antiretroviral treatment*

59% children on antiretroviral treatment*

*All adults/children living with HIV

Source: UNAIDS Data 2018

KEY POINTS

- East and Southern Africa is the region most affected by HIV in the world and is home to the largest number of people living with HIV.
- The HIV epidemic in this region is generalised but young women, men who have sex with men, transgender people, sex workers, prisoners and people who inject drugs are at an increased vulnerability to infection.
- Improved availability of provider-initiated and community-based HIV testing services now means three out of four people living with HIV are aware of their status.
- The number of people living with HIV in East and Southern Africa continues to increase, but access to antiretroviral treatment is increasing as well.
- Although laws and cultural traditions vary between Eastern and Southern African countries, there are a number of ingrained cultural, structural and legal barriers that act as barriers to HIV prevention.

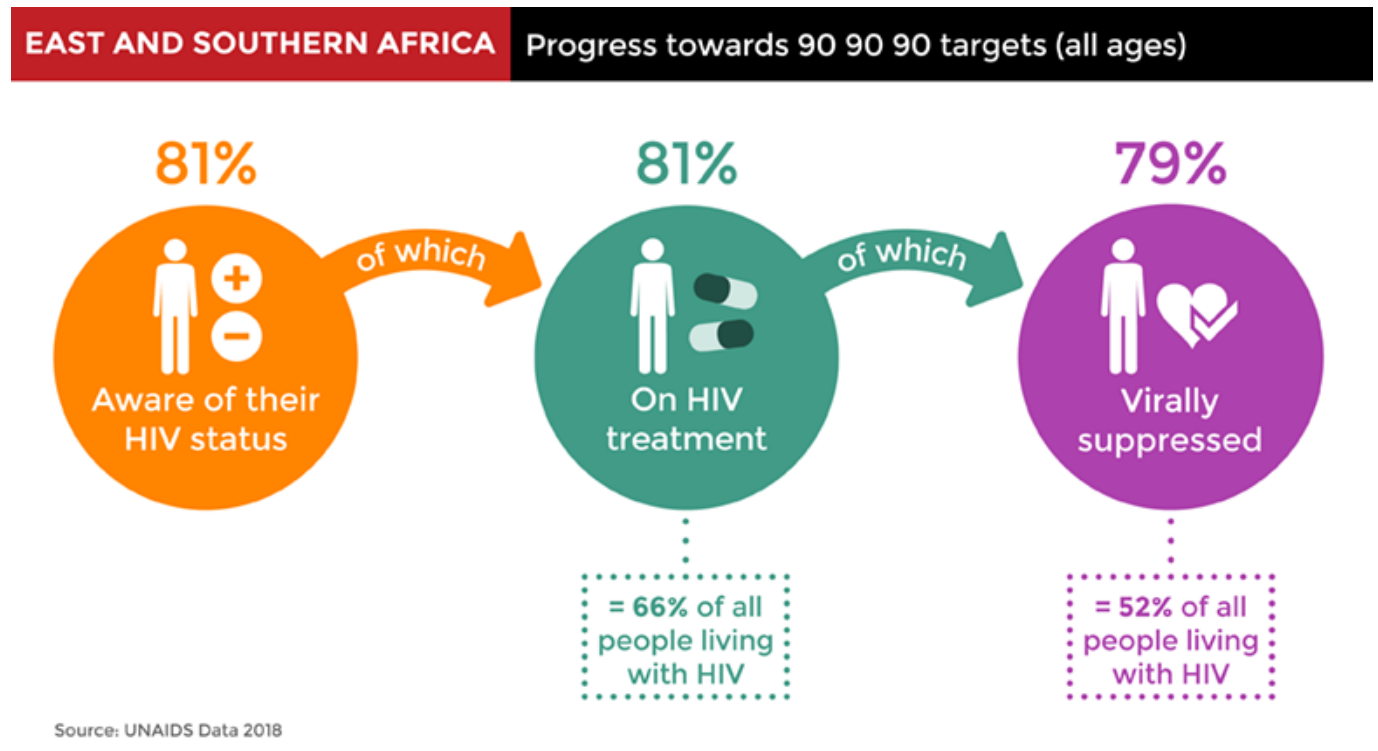
Explore this page to find out more about [populations most affected by HIV](#), [testing and counselling programmes](#), [prevention programmes](#), [antiretroviral treatment](#), [civil society's role](#), [HIV and TB](#), [barriers to HIV prevention](#), [funding](#), and the [future of HIV and AIDS in East and Southern Africa](#).

East and Southern Africa is the region hardest hit by HIV. It is home to 6.2% of the world's population but over half of the total number of people living with HIV in the world (19.4 million people). In 2016, there were 790,000 new HIV infections, 43% of the global total. [1](#)

South Africa accounted for one third (270,000) of the region's new infections in 2016. Another 50% occurred in eight countries: Mozambique, Kenya, Zambia, Tanzania, Uganda, Zimbabwe, Malawi, and Ethiopia. [2](#)

Just under half a million people (420,000) died of AIDS-related illnesses in the region in 2016, although the number of deaths has fallen significantly from 760,000 in 2010.³

Despite the continuing severity of the epidemic, huge strides have been made towards meeting the [UNAIDS 90-90-90 targets](#). In 2016, 76% of people living with HIV were aware of their status, 79% of them were on treatment (equivalent to 60% of all people living with HIV in the region), and 83% of those on treatment had achieved viral suppression (equivalent to half of all people living with HIV in the region).⁴



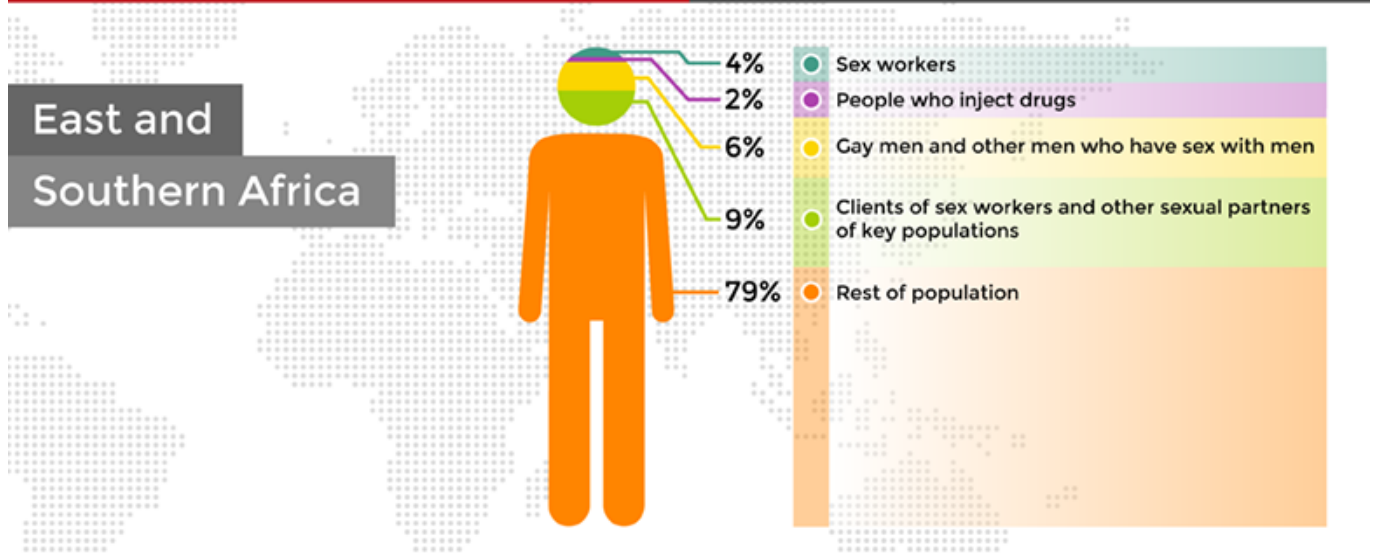
Avert www.avert.org

Between 2010 and 2016, new HIV infections declined by 56% among children (0-14 years) to 77,000. New infections among adults declined by 29% over the same period, although there is significant variation between countries. Declines were greatest in Mozambique, Uganda and Zimbabwe. While in Ethiopia and Madagascar, the annual number of new infections increased.⁵

Women account for 56% of adults living with HIV in the region.⁶ Young women (aged 15-24 years) accounted for 26% of new HIV infections in 2016, despite making up just 10% of the population.⁷

Although East and Southern Africa's HIV epidemic is driven by sexual transmission and is generalised, meaning it affects the population as a whole, certain groups such as sex workers and men who have sex with men have significantly higher HIV prevalence rates. For example, in 2016 Lesotho reported HIV prevalence among the general population at 25%, the second highest in the world, yet prevalence was even higher among sex workers at 72% and men who have sex with men at 33%.⁸

Groups most affected by HIV in East and Southern Africa



Young women and HIV in East and Southern Africa

In 2016, HIV prevalence among young women (15-24 years) in the region was double that of young men (3.4% compared to 1.6%), and in some countries the disparity between genders is even greater.⁹

The reasons behind this are numerous and complex. For example, the existence of high levels of transactional sex and age-disparate sexual relationships in many countries increase young women's HIV vulnerability.¹⁰ Studies from Zimbabwe and Uganda, which have marriage patterns comparable with many other parts of the region, found young married women with partners who were 16 or more years older than them were at three times greater risk of HIV infection than those with partners 0-15 years older than themselves.¹¹

A 2014 UNAIDS assessment of demographic and health surveys carried out in the region suggests young women face higher levels of spousal physical or sexual violence than women from other age groups.¹² Again, this heightens HIV risk - for example, a South African study found young women who experienced intimate partner violence were 50% more likely to have HIV than young women who had not experienced violence.¹³

Although knowledge among young people is improving, only 37% of young women and 41% of young men have comprehensive and correct knowledge of HIV prevention.¹⁴ In addition, only 29% of adolescent women (aged 15-19) at high risk of HIV infection used a condom the last time they had sex, compared to 44% of their male counterparts.¹⁵ Such low levels of condom use may be partly reflective of the fact that around half of the region's countries impose age-restrictions on buying condoms.¹⁶

Children and HIV in East and Southern Africa

The main route for HIV transmission among children is through birth (see later section on preventing mother-to-child transmission). However, East and Southern Africa also has high levels of underage, child and forced marriage.

In 2015, child marriage was estimated to affect 37% of girls in Eastern and Southern Africa.¹⁷ This equates to 7 million child brides.¹⁸ As ever, there are regional differences. For example, in Ethiopia, 14% of women are married before they are 15 and 40% are married before they are 18.

Whereas in eSwatini, 1% are married before they are 15 and 5% before they are 18.¹⁹

Girls who marry as children are more likely to be beaten or threatened by their husbands than girls who marry later. They are also more likely to describe their first sexual experience as forced. As minors, child brides are rarely able to assert their wishes, such as whether to practice safer sex.²⁰ These factors all increase HIV risk.

Increased political will to curb child marriage is growing in the region. In 2015, Malawi increased the legal marriage age to 18 and in 2016 Zimbabwe outlawed child marriages.²¹ In 2015, Ethiopia developed a national strategy to address child marriage and female genital mutilation.²²

Sex workers and HIV in East and Southern Africa

Although sex workers are disproportionately affected by HIV in every country in the region, HIV prevalence among this population varies greatly between countries, ranging from 1.3% in Madagascar to more than 70% in Lesotho and Namibia. In Botswana, Malawi, Rwanda and Zimbabwe more than half of female sex workers are living with HIV.²³

Although the number of new HIV infections among sex workers in 2014 was lower than among men who have sex with men in the region, the substantial (but undocumented) number of clients of sex workers who are exposed to HIV means HIV among this key population group has the greatest impact on the region's epidemic overall.²⁴

It is estimated that at least 90% of sex workers in the region are female, although selling sex is also common among men who have sex with men and transgender people.²⁵ The majority of the region's countries identify sex workers in their national HIV strategies.²⁶ Despite this, how many sex workers are being reached with prevention and treatment is difficult to determine due to a lack of reported data.²⁷

Condom usage by sex workers and their clients varies greatly. In some cases, sex workers have no access to condoms or are unaware of their importance. In other cases, police actively confiscate or destroy sex workers' condoms. A 2012 study in Kenya, South Africa and Zimbabwe found evidence of physical and sexual abuse and harassment of sex workers who carry condoms. Police were also using the threat of arrest on the grounds of condom possession to extort and exploit sex workers.²⁸

Modelling estimates in Kenya show that a reduction of approximately 25% of HIV infections among sex workers may be achieved when physical or sexual violence is reduced.²⁹

Men who have sex with men (MSM) and HIV in East and Southern Africa

While data on men who have sex with men (sometimes referred to as MSM) in East and Southern Africa is limited, HIV prevalence ranges from 3.8% in Angola to 36% in South Africa. Overall, one in three men who have sex with men is living with HIV in the region.³⁰

HIV transmission between men who have sex with men accounted for 6% of new infections in the region in 2014.³¹ However, evidence suggests the majority of the region's men who have sex with men also engage in heterosexual sex, often with wives or other long-term female partners.³² The HIV epidemic among men who have sex with men is therefore interlaced with the epidemic in the wider population.³³

Although limited, data reported between 2011 and 2015 suggest condom use exceeded 70% in South Africa, Kenya and Rwanda, and was above 50% in Comoros, Lesotho, Madagascar and Mauritius. eSwatini, Uganda and Tanzania reported levels below 50% at 46%, 39% and 14% respectively.³⁴

The vast majority of national AIDS plans or strategies in the region identify men who have sex with men as a key population. However, specific programmes for this group are extremely limited and constrained by widespread homophobia and, in some countries, the criminalisation of same-sex practices.³⁵

People who inject drugs (PWID) and HIV in East and Southern Africa

Kenya, Madagascar, Mauritius, Mozambique, South Africa and Tanzania are all home to significant populations of people who inject drugs (sometimes referred to as PWID). Although regional data is limited, country surveys among people who inject drugs suggest high HIV prevalence.³⁶ It is estimated that people who inject drugs accounted for 2% of new HIV infections in the region in 2014.³⁷

In Kenya, HIV prevalence among people who inject drugs was 18% in 2011, compared to 5.6% among the general population.³⁸, with HIV prevalence among women who inject drugs thought to be twice that of men who inject drugs.³⁹

In 2015, an estimated 19.4% of people who inject drugs in South Africa were living with HIV.⁴⁰ A 2015 study in five South African cities found 32% of men and 26% of women who inject drugs regularly shared syringes and other injecting equipment and nearly half reused needles.⁴¹

Evidence from Kenya, Mauritius, Seychelles and Tanzania suggests many people who inject drugs acquire HIV before the age of 25.⁴²

Prisoners and HIV in East and Southern Africa

Although data is limited, East and Southern Africa is thought to have one of the highest rates of HIV prevalence among prisoners in the world. This is reflective of high HIV prevalence in the general population and the continued criminalisation of key population groups. It is also due to the fact that prisons are high risk environments for HIV transmission, fuelled by over-crowding, limited access to health care, drug use, unsafe injecting practices, sexual violence, unprotected sex and tattooing.⁴³

Transgender people and HIV in East and Southern Africa

No country in the region has national data on HIV among transgender people. However, it is thought that prevalence among this group is extremely high.⁴⁴ Improving data - and disaggregating data on transgender people from data relating to men who have sex with men - is critical to improve health outcomes for this group.

HIV testing and counselling (HTC) in East and Southern Africa

In recent years, a number of countries in the region such as Botswana, Kenya, Uganda, Malawi and Rwanda have implemented national campaigns to encourage uptake of HIV testing and counselling (HTC). In 2016, 76% of people living with HIV had knowledge about their status - an improvement from 72% in 2015.⁴⁵

Access to HTC has been a major barrier to testing up-take and a number of strategies have been used to address this. Provider-initiated testing remains the region's main approach, but community-based testing is growing as it has been shown to be effective in reaching large numbers of first-time testers, diagnosing people living with HIV at earlier stages of infection, and linking those who test positive to care. Workplace and door-to-door testing, using rapid diagnostic tests, is also

increasing.⁴⁶

HIV-related stigma remains a huge barrier to testing, something that self-testing kits may help to side-step. In 2015, Kenya announced plans to introduce self-test kits.⁴⁷ In the same year, self-testing began in Malawi, Zambia and Zimbabwe through the four-year STAR (Self-Testing Africa Research) Project. By 2017, the STAR Project had distributed nearly 750,000 self-test kits across the three countries.⁴⁸

Evidence from STAR suggests that, when provided as part of a community-based approach, self-testing is increasing HIV testing among men and adolescents in the region, groups that have been previously hard to reach. It has also been shown to improve the proportion of key populations testing positive who then access treatment.⁴⁹

I decided to get tested so that I could be aware of my HIV status. I have big dreams that I would like to achieve in life like everybody else and I want to stay healthy and prevent myself from HIV infection. I also encourage my friends and fellow young people to go for HIV testing regularly and take control of their lives.

- Keisha Eldred Mushi, HTC participant, Dar es Salaam, Tanzania⁵⁰

HIV prevention programmes in East and Southern Africa

In 2016, around 790,000 people in East and Southern Africa were newly infected with HIV.⁵¹

A number of countries in the region have conducted large-scale prevention programmes in an effort to contain and reduce their HIV epidemics. In 2015, Ethiopia, Malawi, eSwatini and Zimbabwe looked at how to revitalise their national prevention programmes. In the same year, government representatives of Kenya, Zimbabwe and South Africa met to plan the development of a regional roadmap to accelerate scale-up of combination HIV prevention services at local levels and increase investments for combination HIV prevention.⁵²

Programmes for young women

In 2013 ministers of health and education from countries across the region committed to bringing in a raft of programmes to address the barriers that prevent girls and young women from accessing services. Focuses include keeping girls in school, comprehensive sexuality education, girl-friendly sexual and reproductive health services, eliminating gender-based violence and female genital mutilation, and economic and political empowerment.⁵³

Case study: DREAMS

DREAMS aims to reduce HIV infections among adolescent girls and young women by 40% in Kenya, Lesotho, Malawi, Mozambique, South Africa, eSwatini, Tanzania, Uganda, Zambia, and Zimbabwe by 2017. It focuses on social isolation, economic disadvantage, discriminatory

cultural norms, orphanhood, gender-based violence and education.[54](#)

As of early 2018, reporting on its 2017 targets has yet to be released but results released in 2016 show DREAMS had reached more than 1 million adolescent girls and young women with comprehensive HIV prevention services[55](#)

Condom availability and use

Condom availability varies widely by country, with only five countries meeting the United Nations Population Fund (UNFPA) regional benchmark of 30 male condoms distributed per man per year between 2011 and 2014.[56](#)

Condom use at last sex among adults with more than one sexual partner in the past 12 months is low, estimated at 23% among men and 33% among women. There is substantial variation among countries, ranging from 7% among men in Madagascar to 83% among men in eSwatini. Condom use among men who pay for sex is higher, at about 60%.[57](#)

HIV education and approach to sex education in East and Southern Africa

In 2013, 20 countries in the region committed to improving sexual and reproductive education for young people. By 2015, 14 were providing comprehensive sexuality education (CSE) and life skills in at least 40% of primary schools; 15 were providing CSE/life skills in at least 40% of secondary schools; and 18 were including sexual and reproductive health (SRH) and CSE training for people training to be teachers.[58](#)

A number of HIV prevention awareness campaigns targeting adults have also proven successful including the multi-country One Love campaign and South Africa's Love-Life.[59](#)

Prevention of mother-to-child transmission (PMTCT) in East and Southern Africa

Significant progress has been made in the prevention of mother-to-child transmission (PMTCT) of HIV in East and Southern Africa.

Between 2010 and 2015, new HIV infections declined by 66% among children (0-14 years) to an estimated 56,000.[60](#) However, in 2016 this rose to 77,000.[61](#)

The general decline in infections is due to the rapid increase in PMTCT services, from 61% coverage in 2010 to 89% in 2016. This equates to 854,000 pregnant women who are living with HIV on antiretroviral treatment (ART) in the region.[62](#)

In 2016, Botswana, Namibia, South Africa, eSwatini and Uganda had PMTCT coverage above 95%, Zimbabwe had 93% coverage, and Kenya, Mozambique, Rwanda, Malawi, Tanzania and Zambia had coverage of 80% or above. At the other end of the scale, Madagascar had just 3% coverage, South Sudan had 29% coverage, and Angola and Eritrea had coverage of around 40%.[63](#)

Voluntary medical male circumcision (VMMC) in East and Southern Africa

In 2007, the World Health Organization (WHO) and UNAIDS recommended voluntary medical male circumcision (VMMC) as a key component of HIV prevention in countries with a generalised epidemic, following the discovery that male circumcision could reduce the risk of sexual

transmission of HIV from females to males by 60%.

In response, VMMC accelerated rapidly in the region between 2008 and 2014, reaching 3.2 million circumcisions per year. In 2015 and 2016 this fell to around 2.6 million circumcisions, although trends vary among countries. By 2015, VMMC among adult men was still below 30% in Botswana, Malawi, Namibia, Rwanda, eSwatini, Uganda, Zambia and Zimbabwe.⁶⁴

Harm reduction in East and Southern Africa

Harm reduction interventions that help prevent HIV transmission, such as needle and syringe programmes (NSPs), education on safe injecting practices and opioid substitution therapy (OST), exist on a relatively small scale in the region but they are growing.

Kenya, Mauritius, South Africa, the Seychelles and Tanzania all offer NSP and OST services⁶⁵ and in 2017 Uganda began piloting NSPs.⁶⁶

Kenya and South Africa are leading the way on scaling up harm reduction programmes.⁶⁷ For example, Kenya introduced NSPs and OST in 2012. By 2015, nearly 90% of people who inject drugs reported using a clean syringe last time they injected compared to 51.6% in 2012.⁶⁸

Pre-exposure prophylaxis (PrEP) in East and Southern Africa

In 2015, South Africa became the first country in the region to fully approve pre-exposure prophylaxis (PrEP), the use of antiretroviral drugs to protect HIV-negative people from HIV before potential exposure to the virus. A month later, Kenya followed suit, specifically with young women and girls in high-incidence areas. Zimbabwe has since began implementing PrEP,⁶⁹ .

As evidence grows showing the effectiveness and acceptability of PrEP, particularly for key populations and those unable to negotiate condom use, roll-out is accelerating.

Antiretroviral treatment (ART) in East and Southern Africa

Antiretroviral treatment (ART) programmes have been scaled-up dramatically in East and Southern Africa over the past decade.

In 2016, there were an estimated 11.7 million people on ART in region. This is a three-fold increase from 2010 numbers and represents 60% of people living with HIV in East and Southern Africa.⁷⁰

More women than men are on treatment as men are less likely to test for HIV and are more likely to interrupt or drop out of treatment. In South Africa, for example, 51% of women living with HIV are on ART compared with 37% of men living with HIV. Consequently, men in the region are more likely than women to die of AIDS-related causes despite being less likely than women to acquire HIV.⁷¹

This disparity is partly due to harmful gender norms that prevent men from seeking help, accepting care or admitting to having a highly-stigmatised condition such as HIV.⁷²

In 2016, the proportion of children living with HIV on treatment increased to 51% from 19% in 2010. Over 60% of children living with HIV were on ART in Botswana, Kenya, Namibia and eSwatini in 2016.⁷³

All countries in the region are at least implementing 2013 WHO treatment guidelines, which expanded eligibility for ART for people with a CD4 count of 500 or less. Kenya, Malawi, Namibia,

Uganda, Lesotho, Botswana and South Africa have adopted the 2015 WHO guidelines to immediately offer treatment to people diagnosed with HIV, known as 'test and treat' or 'treat all'.⁷⁴

Although South Africa has the largest number of people (3.9 million) with HIV on ART, its treatment coverage reaches just over half of those who need it and falls below the regional average.⁷⁵ In 2016, treatment coverage was highest in Botswana (83%) and Rwanda (80%).⁷⁶

Weak health and community systems continue to undermine the effective scale-up of 'test and treat' approaches. Further gaps in the provision of treatment are caused by humanitarian emergencies and food insecurity in some places. As a result, only half of all people living with HIV in East and Southern Africa in 2016 had achieved the viral suppression necessary to prevent onward HIV transmission.⁷⁷ However, Botswana has achieved the 2020 target of 73% viral suppression (set by UNAIDS), and eSwatini is close at 68%.⁷⁸

Data reported to UNAIDS from 12 countries in the region showed that about 44% of people accessing ART in East and Southern Africa accessed routine viral load testing in 2016 – key to monitoring ART effectiveness.⁷⁹

Civil society's role in East and Southern Africa

Many civil society organisations (CSOs) were set up in response to the HIV epidemic and continue to play a critical role in the region's response today.

A significant proportion of CSOs are led by the communities they serve and as a result are better able to reach people living with HIV and key populations. Many are engaged in SRH service delivery and advocacy.⁸⁰

Funding for civil society, particularly community-led groups, has tended to come from international donors, and has been dwindling since the 2008 global economic recession.⁸¹ The United States of America's reintroduction in 2017 of the Mexico City policy, also known as the 'global gag rule', which blocks US funds to any overseas organisation involved in abortion advice and care, is likely to result in further funding cuts for many CSOs working on HIV and sexual and reproductive health in the region.⁸² Repressive laws against drug use, sex work and same sex relations also constrain the actions of many CSOs concerned with the rights and health of key populations.

Encouragingly, national and regional support for civil society has been growing in recent years, with UNAIDS reporting increasing interest from several governments in understanding the unique contributions community groups have in addressing HIV.⁸³

HIV and tuberculosis (TB) in East and Southern Africa

In 2016, ten countries in the region (Angola, Ethiopia, Kenya, Lesotho, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe) were classified by WHO as being among the 30 countries with the highest tuberculosis (TB) burden.⁸⁴

TB is a leading cause of death for people living with HIV. Overall, 240,000 people with HIV died of TB-related deaths in 2016.⁸⁵

However, the number of HIV/TB-related deaths in East and Southern Africa is decreasing, falling by 32% since 2004. This is due to the expansion of ART and the integration of HIV/TB services, which has resulted in 77% of people diagnosed with TB and HIV co-infection in the region starting or continuing ART as of 2014.⁸⁶

South Africa has made gains in providing people living with HIV with isoniazid preventative therapy

(IPT), which stops people from developing active TB, but IPT is not sufficiently accessible in the rest of the region.⁸⁷

Barriers to the HIV response in East and Southern Africa

Stigma and discrimination

HIV-related stigma and discrimination remains a major barrier to tackling HIV in East and Southern Africa. Cultural beliefs about HIV and AIDS around contamination, sexuality and religion have played a crucial role in the development of HIV-related discrimination.⁸⁸ Moreover, studies have shown how healthcare workers' negative and discriminatory views towards HIV-positive people are influenced by, and often similar, to those in the general population.⁸⁹

The region remains a largely hostile environment for men who have sex with men, sex workers, transgender people, and people who use drugs. People from key affected populations often experience heightened levels of stigma and discrimination as a result.⁹⁰ This often prevents people from accessing HIV services.⁹¹ For example, many sex workers do not wish to disclose their occupation to healthcare providers and consider stigma and discrimination a major barrier to HIV testing.⁹²

The status of women

Women and girls in the region often face discrimination in terms of access to education, employment and healthcare. Men often dominate heterosexual relationships, and gender-based violence levels are high, especially for young women.⁹³

Legal barriers

Overly broad criminalisation of HIV exposure, non-disclosure and transmission in the region continues to stigmatise people living with HIV, which undermines public health initiatives, and is ultimately damaging to HIV prevention.⁹⁴

The criminalisation of sex work, drug use, and same sex practices, as well as the lack of legal recognition of gender identity, compounds key affected populations' inability to access HIV services.⁹⁵ Among countries in the region, 17 criminalise some aspect of sex work and 15 criminalise same-sex relationships.⁹⁶ Some progress has been made however, with both the Seychelles and Mozambique repealing provisions that criminalise sex between men in 2016.⁹⁷

Structural and resource barriers

A number of areas with high HIV prevalence, particularly rural areas, have a lack of health care workers. This is due to a lack of funding for healthcare, coupled with a continual 'brain drain' of healthcare staff from the region to high-income countries, and an internal 'brain drain' from rural to urban areas, and from the public to private sector. To overcome the lack of qualified workforce, many countries have implemented task-shifting programmes and given community health care workers increasing responsibilities.⁹⁸

Data issues

Despite key populations being disproportionately affected by HIV in the region, data on these groups is lacking. This makes targeting interventions that address key population needs, or charting the success of such programmes, extremely difficult.

Data collection and monitoring of people living with HIV is important for improving the consistency of care people receive, which ultimately helps people adhere to treatment. However, many countries in the region do not have such systems in place due to a lack of technical capacity, human resource availability and coordination. This makes tracking people across prevention and treatment services difficult and leads to inaccuracies in reported data.⁹⁹

However, a number of countries are starting to address this including Botswana, eSwatini, Tanzania and Namibia.¹⁰⁰

Funding for HIV in East and Southern Africa

Between 2006 and 2016 resources available for HIV services in the region have more than doubled, reaching an estimated US\$ 9.6 billion at the end of 2016.¹⁰¹

However, many countries continue to rely on external funding, with eight dependent on donors for more than 80% of their HIV response.¹⁰² For example, 97.5% of Tanzania's HIV response is funded internationally.¹⁰³ This figure stands at around 70% in Zimbabwe and Kenya.¹⁰⁴¹⁰⁵ South Africa is the exception where approximately 80% of the national response is financed through domestic resources.¹⁰⁶

In 2015, the East African Community and the South African Development Community endorsed action frameworks on sustainable financing that commit countries to increase domestic spending, address inefficiencies in health services, and explore innovative financing mechanisms in the next five years.¹⁰⁷

The future of HIV and AIDS in East and Southern Africa

Tackling the HIV epidemic in East and Southern Africa is a long-term task that requires sustained effort and planning from both domestic governments and the international community.

In order to meet UNAIDS' 2020 targets, between 2017 and 2020 the region must diagnose 2.7 million people living with HIV who did not previously know their HIV status, start an additional 4.1 million people on ART, and ensure an additional 4.5 million people living with HIV achieve viral suppression.¹⁰⁸

Girls and young women must be placed at the centre of the response if the region is to drastically reduce HIV. This means meaningfully addressing gender inequality and inequity, tackling harmful traditional practices such as child marriage, and increasing educational opportunities.¹⁰⁹

Insufficient financial resources, combined with the lack of strategic information, has led to many high-impact HIV prevention programmes not being implemented to the necessary standard or scale in the region. These systems must be strengthened to enable the region's HIV response to be evidence-based, and ultimately more effective.

Countries in East and Southern Africa will need to assess how to allocate what are currently limited resources. For example, increased linkages between sexual and reproductive health (SRH) and HIV services have been shown to increase access and uptake for both SRH and HIV services. Using the skills of civil society organisations and the ability of communities most affected by HIV to implement services will be crucial to achieving effective results with limited resources.

Fundamental barriers to treatment, particularly HIV-related stigma and discrimination and HIV-specific criminal legislation, must also be overcome. Removing such barriers would encourage

more people to get tested and seek out treatment, reducing the burden of HIV across the region.

Serious challenges remain in terms of key affected populations, including the criminalisation of same-sex sexual relations, drug use and sex work, insufficient implementation of harm-reduction programmes, and insufficient protection of people from discrimination, harassment, violence and abuse arising from sexual orientation or gender identity. In many countries the prioritisation of key populations within national AIDS plans and strategies has not resulted in sufficient financial allocation and programme implementation to address their needs.¹¹⁰ However, in some countries, key affected community networks are emerging and regional networks now exist for female sex workers and men who have sex with men. These networks are essential to strengthen the response for key affected populations.¹¹¹

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- 8. UNAIDS (2017) '[UNAIDS DATA 2017](#)' [pdf]

In 2016, 25% of new HIV infections in sub-Saharan Africa (no data available specifically for East and Southern Africa) were among key affected populations and their sexual partners, despite these groups making up a fraction of the total population. Yet programming for key populations remains insufficient and many people from these groups face stigma, discrimination and legal barriers that prevent them from accessing HIV services. UNAIDS (2017) '[Ending AIDS: Progress towards the 90-90-90 targets](#)' [pdf]

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