REGIONAL SUMMARY OF FINDINGS OF AN ASSESSMENT OF HIV SERVICE PACKAGES FOR KEY POPULATIONS IN SELECTED COUNTRIES IN EASTERN AND SOUTHERN AFRICA

April 2019
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<th>Description</th>
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<tbody>
<tr>
<td>AGYW</td>
<td>Adolescent girls and young women</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral treatment</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior change communication</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-based organization</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil society organization</td>
</tr>
<tr>
<td>CCM</td>
<td>Country Coordinating Mechanism(s)</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DIC</td>
<td>Drop-in Center</td>
</tr>
<tr>
<td>ESA</td>
<td>Eastern and Southern Africa</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus group discussion(s)</td>
</tr>
<tr>
<td>FSW</td>
<td>Female sex worker(s)</td>
</tr>
<tr>
<td>GAM</td>
<td>UNAIDS Global AIDS Monitoring reports</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender-based violence</td>
</tr>
<tr>
<td>GF</td>
<td>Global Fund</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>HSRC</td>
<td>Human Sciences Research Council - South African</td>
</tr>
<tr>
<td>HTA</td>
<td>High Transmission Area</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV testing and counseling</td>
</tr>
<tr>
<td>HTS</td>
<td>HIV testing services</td>
</tr>
<tr>
<td>IBBS</td>
<td>Integrated Bio-Behavioral Surveillance</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, education and communication materials</td>
</tr>
<tr>
<td>KP</td>
<td>Key population(s)</td>
</tr>
<tr>
<td>KZN</td>
<td>KwaZulu Natal (South Africa)</td>
</tr>
<tr>
<td>LGBTI</td>
<td>Lesbian, gay, bisexual, transgender and intersex</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>MSW</td>
<td>Male sex worker(s)</td>
</tr>
<tr>
<td>NACOSA</td>
<td>Networking HIV and AIDS Community of South Africa</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------</td>
<td>------------</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>NSP</td>
<td>Needle and syringe program(s)</td>
</tr>
<tr>
<td>OI</td>
<td>Opportunistic infections</td>
</tr>
<tr>
<td>OST</td>
<td>Opioid substitution therapy</td>
</tr>
<tr>
<td>PEP</td>
<td>Post-exposure prophylaxis</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>The U.S. President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People living with HIV</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission of HIV</td>
</tr>
<tr>
<td>PR</td>
<td>Principal Recipient(s)</td>
</tr>
<tr>
<td>PrEP</td>
<td>Pre-exposure prophylaxis</td>
</tr>
<tr>
<td>PSE</td>
<td>Population size estimate(s)</td>
</tr>
<tr>
<td>PWID</td>
<td>People who inject drugs</td>
</tr>
<tr>
<td>RAR</td>
<td>Rapid assessment and response study</td>
</tr>
<tr>
<td>RTC</td>
<td>Right to Care</td>
</tr>
<tr>
<td>RTF</td>
<td>Regional task force</td>
</tr>
<tr>
<td>SOGI</td>
<td>Sexual orientation and gender identity</td>
</tr>
<tr>
<td>SOP</td>
<td>Standard operating procedure(s)</td>
</tr>
<tr>
<td>SR</td>
<td>Sub-recipient(s)</td>
</tr>
<tr>
<td>SRH(R)</td>
<td>Sexual Reproductive Health (and Rights)</td>
</tr>
<tr>
<td>SSR</td>
<td>Sub-sub-recipient(s)</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>SW</td>
<td>Sex worker(s)</td>
</tr>
<tr>
<td>SWEAT</td>
<td>Sex Workers Education and Advocacy Taskforce</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TG</td>
<td>Transgender people</td>
</tr>
<tr>
<td>TWG</td>
<td>Technical working group(s)</td>
</tr>
<tr>
<td>UCSF</td>
<td>University of California, San Francisco</td>
</tr>
<tr>
<td>UIC</td>
<td>Unique Identifier Code(s)</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Program on HIV/AIDS</td>
</tr>
<tr>
<td>VMMC</td>
<td>Voluntary medical male circumcision</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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EXECUTIVE SUMMARY

The World Health Organization (WHO) has clearly outlined the comprehensive package of services that should be available for men who have sex with men (MSM), people who inject drugs (PWID), sex workers (SW), transgender people (TG) and prisoners (WHO, 2016). Global Fund contracted APMG Health to assess the design, implementation and monitoring of national HIV service packages for key populations (KP) in 65 countries, across six regions, in which Global Fund has provided HIV grant funds.

These are the results of those assessments conducted in the region of Eastern and Southern Africa (ESA). This report is based on six country-specific desk reviews and five in-country assessment reports. Each of the latter group of assessments consisted of an initial desk review and a field assessment. The Global Fund Country Team for each country provided data sources used for completing all desk reviews. For those five countries with in-country assessments, fieldwork was conducted over the course of five days, with the exception of Kenya and South Africa, which were selected for extended visits conducted over the course of 10 days. For the five-day country visits, two KP and two sites were selected. For South Africa, three sites were selected; for Kenya, three KP were selected. All populations and sites were selected with guidance from Global Fund Country Teams and Country Coordinating Mechanisms (CCM) based on existing programs in the countries.

Table ES1. Eastern and Southern Africa Countries Assessed

<table>
<thead>
<tr>
<th>Country</th>
<th>Key Populations Selected</th>
<th>Sites Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>MSM &amp; FSW</td>
<td>Luanda &amp; Benguela</td>
</tr>
<tr>
<td>Kenya</td>
<td>MSM, FSW, PWID</td>
<td>Nairobi &amp; Mombasa</td>
</tr>
<tr>
<td>Madagascar</td>
<td>MSM &amp; FSW</td>
<td>Antananarivo &amp; Mahajanga</td>
</tr>
<tr>
<td>Malawi</td>
<td>MSM &amp; FSW</td>
<td>Salima &amp; Dowa</td>
</tr>
<tr>
<td>South Africa</td>
<td>MSM &amp; FSW</td>
<td>Johannesburg, Durban, &amp;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cape Town</td>
</tr>
</tbody>
</table>

Data were collected through the following mechanisms: document review; interviews with national stakeholders responsible for design of packages; visits to at least two sites where packages are implemented, including observation of service delivery, interviews with staff and KP focus group discussions (FGD); and interviews with and examination of monitoring forms, methods and databases. It should be noted that the primary method of assessing quality of services was through FGD with key populations. A desk review was also conducted on recent literature related to KP in the region.

There were several limitations in conducting this assessment process, including during the initial desk review portion of country assessments. For the ‘desk review only’ countries, APMG Health did not conduct an in-country assessment to collect data and information that could disprove or verify information found in the initial desk review. Data for these six countries have been included throughout this review. However, it has been noted that consultants were limited to those data provided by Global Fund in quarter four of 2017.
Due to time restrictions of country visits, only two to three sites were selected for visitation during the in-country assessments (see Table ES1). It is important to note that because of this, country assessments are not national and reports only speak to data available in the regions, districts and cities that were visited or within other reports reviewed. Also due to time restrictions, only two of the five KP were assessed during in-country data collection in most countries. This regional analysis is based on a selection of countries within a region and therefore is not representative of the entire region.

This report is one of six regional reports produced to summarize the assessment findings.

**DESIGN**

Most of the assessed countries have taken the opportunity to formally recognize some key populations in their national plans and strategies and have acknowledged the importance of servicing KP by designing tailored packages based on the WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2016). However, only Tanzania refers to all five KP in its current national strategic plan. Some countries have no evidence of the existence of TG or drug-injecting populations. This does not explain the lack of service packages for prisoners across the region and MSM populations in Botswana and Uganda.

The lack of universal inclusion of lubricants for MSM is a major concern, as is the uneven inclusion of post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP) for SW and MSM. While behavioral interventions are universally included in packages in some form, there is a notable lack of detailed standards for what these interventions include, how they are delivered and what is considered sufficient coverage.

Given the very large epidemics of TB in the region, it is remarkable that few countries have included TB testing and treatment in all KP service packages. The availability of testing and service delivery models designed specifically to target harder to reach populations (e.g. rapid testing and testing in various venues through different outreach methods) is highly variable and warrants careful planning in the design phase, according to population size and distribution.

The inclusion of specific human rights and other interventions to enhance the enabling environment is also very uneven across the region. However, both Kenya and South Africa have provided some detail of what these interventions should be for various KP, even at the ward or county level.
RECOMMENDATIONS: DESIGN OF SERVICE PACKAGES FOR KEY POPULATIONS

1. Defined packages of services should include interventions for all KP that have been identified in the country. There may be minor variations depending on local epidemiology and behavior.

2. All countries in the region require at least the basic services for each KP to be in the designed service packages. All key population packages should contain condom and lubricant distribution, with female condoms included (at least) in all SW programs and needles and syringes included (at least) in all PWID programs.

3. Needs-based services should also be included in service packages for all KP, including the offer of PEP, STI, TB and hepatitis B and C services. Pre-exposure prophylaxis should be included in MSM, TG and SW programs.

4. Critical enabler activities should be specified in all KP packages. Assessments on human rights barriers to key populations’ access to HIV services have been carried out in some of the reviewed countries (Botswana, Kenya, Mozambique, South Africa and Uganda). Similar exercises should be carried out in all countries. All countries should have a strategy to address ongoing human rights issues that impact key populations’ access to HIV and broader health services. This strategy should be explicitly linked to overall national HIV strategies and plans.

5. All countries should continue to progress toward clear definitions of coverage of all elements of service packages.

6. Other countries should consider using the methodology provided in the South African Sex Worker Plan (SANAC, 2016), which differentiates services based on the number of SW in a locality. The methods outlined in this plan of mapping the local community and circumstances of KP in each locality should be taken up elsewhere in the region.

7. Following the development of the National Guidelines for HIV/STI Programming with Key Populations in Kenya and Focus for Impact in South Africa, other countries in the region should consider mapping and providing advice to local government entities on working with KP.

8. For countries with long-standing key population responses to HIV – such as South Africa and Kenya – consideration should be given to providing flexibility for optional, enhanced services to be provided alongside core services, in order to attract clients and to address some of the underlying reasons why various KP may not want to present for HIV testing, PrEP and antiretroviral treatment (ART), or may not want to remain on ART.

9. A decision is needed at the national level about how organizations will collaborate to ensure that the needs of male and transgender SW are met.

10. Additional services may need to be defined for specific sub-populations, such as male and/or transgender SW, women who inject drugs and adolescent key populations.

11. Where mental health interventions are included in service packages, there is a need for greater understanding of the mental health needs of different KP and thus more thoughtful, realistic and well-described interventions within service packages, as well as adequate resourcing of these services.
12. The development of minimum standards for behavioral interventions that are attuned to population needs would ensure that the intent of the design of this intervention carries over into appropriate resource mobilization and implementation as well as impact.

IMPLEMENTATION

In general, service packages appear to be implemented as designed, in terms of interventions delivered. Though many interventions are not captured in regular reporting data, in-country assessments confirm that services are available at some level. There has been strong engagement by KP communities, most notably from SW and MSM, in the design and implementation in Kenya and South Africa.

Coverage for most interventions is low across the region and there appear to be particular problems in testing sufficient numbers of the right people and, when individuals test positive, linking them to care. This issue is linked to the policy of re-testing all KP every three or six months. These findings, coupled with the findings related to community violence for some MSM groups, police violence towards SW and legal issues for PWID, among others, suggest that there is a need for services beyond the core prevention services recommended in the WHO Consolidated Guidelines, i.e. condom and lubricant distribution, STI services (for SW and MSM), needle and syringe programs (NSP) and opioid substitution therapy (OST) for PWID. Rather than presenting a large set of services and informing countries that all KP need all of these services, regardless of resource constraints, it would perhaps be useful to designate several ‘enhanced’ services as options to be considered at the local level based on local population context.

In the same way that the South Africa National Sex Worker HIV Plan (SANAC, 2016) distinguishes between three tiers of SW localities, it may be worthwhile to consider service packages for key populations in a differentiated way, depending on: the level of experience of the organizations delivering services; the ability of KP to be involved in and, if possible, lead national and local responses; and, the variability of the conditions in which packages are being delivered across the country. If an approach is adopted that allows for enhanced services to be provided based on population needs, these additional services could focus on the most pressing non-health factors that are preventing KP from accessing services.

In other countries like Madagascar and Angola, programs are much smaller and, while differences exist in various towns and rural areas, it is likely to be more useful to use a standardized approach for all work with KP in the country until sufficient capacity and coverage are attained in basic services provision. Designs need to be evidence-informed and rational within the country’s circumstances and implementation would then be carried out adhering closely to the design. At this stage of its development, Malawi may benefit from the same approach.

Overall, some positive changes in the environment are reported in most countries. For example, FGD with MSM and SW in Madagascar report an overall improvement with a more favorable environment compared to five years ago. One aspect of the enabling environment, which appeared to be more common in ESA than in other regions, is the use of provincial, county and/or ward committees to
guide local KP programming. Stigma and discrimination were raised as important issues for KP in all five countries assessed with in-country fieldwork.

For all key populations, the lack of coverage data for a large number of interventions leaves significant questions about their reach, as well as quality of services.

**RECOMMENDATIONS: IMPLEMENTATION OF SERVICE PACKAGES FOR KEY POPULATIONS**

1. After determining core interventions for each key population in national, defined service packages, ensure that these services are implemented at the scale needed to address the HIV epidemic in each country. Strategies need to be put in place to ensure that core interventions are available to the majority of KP in each country, regardless of funding source or service delivery agent.

2. Introduce and maintain regular feedback sessions with clients, whose concerns should be acted on quickly through the chain of responsibility from sub sub-recipients (SSR) through sub-recipients (SR) to principal recipients (PR) and, if needed, CCM or CCM Oversight Committee. This procedure should lead to continuous quality improvement.

3. The Networking HIV and AIDS Community of South Africa’s¹ (NACOSA) approach to providing funding, guidance and standard operating procedures (SOP) for SR, within which SR are encouraged to develop specific activities based on micro planning and interactions with clients, should be considered by all other countries in the region.

4. Anova’s approach (in South Africa) to training and certifying entire health institutions to be friendly towards MSM and TG clients should be considered by all countries.

5. Given the issues described earlier as to where male and/or transgender SW are receiving services, an ongoing collaborative process should be used at the local level to determine whether SW, MSM, or TG organizations – either separately or, preferably, together - will ensure that the needs of these populations are met.

6. Differentiated service delivery should be further developed to assist in expanding reach of key interventions among KP. These include self-testing, lay provider testing, community-based testing, assisted partner notification, community-based initiation and distribution of ART for KP.

7. Outreach and support service models need to be reviewed to ensure that there are sufficient resources to ensure linkage to treatment for newly diagnosed people living with HIV (PLHIV) and case-management models in place to cover at least the first three months following diagnosis.

8. Community HIV testing and self-testing models in the region need to be assessed and guidance for expanding access and improved quality of services developed.

9. Strategies to engage countries in transition planning for the outreach (demand-creation) workforce for KP need to be strengthened.

10. Key population NGOs need to be assisted to secure resources to pursue broad health goals for their constituents, including reduction of stigma and discrimination, responses to KP-

¹ https://www.nacosa.org.za/
monitored violence and gender-based violence (GBV) and addressing other issues that increase service access obstacles for KP.

11. United Nations agencies in collaboration with regional KP organizations should work to develop a set of regional guidelines for e-outreach, covering safety and security for e-outreach workers, ethics, privacy and effective messaging.

12. Critical enabler activities have low levels of coverage and the range of activities implemented is generally much smaller than needed. As Botswana, Kenya, Mozambique, South Africa and Uganda work to reduce human rights barriers for KP, other countries in the region should study the activities implemented in these countries and their results for possible replication.

13. In countries with mature key population responses, all packages should allow for flexibility so that optional, enhanced services can be provided alongside core services in order to attract clients and to address some of the underlying reasons why various KP may not want to present for HIV testing, ART or OST (for PWID) or may not want to remain on ART or OST. Consideration should be given to providing standardized funding for enhanced services based on numbers of clients covered with a defined package of services. Standard operating procedures should be developed for implementation of these enhanced activities.

14. Safety of outreach workers, particularly among MSM, needs to be addressed through the use of written security protocols that are implemented in the training and supervision of outreach staff.

MONITORING

The process of monitoring the implementation of packages of services against their design is multifaceted. There are significant problems related to population size estimations (PSE) for some KP in some countries. In addition, the way that coverage is compiled and reported for the Global AIDS Monitoring reports (GAM) varies across countries. As part of this assessment process, there is a requirement to rate the systems used to monitor KP service packages, which is presented in Table ES2 below.

Table ES2. UIC System Scores by Country in Eastern and Southern Africa

<table>
<thead>
<tr>
<th>Country</th>
<th>Score</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>2</td>
<td>A UIC is used by PEPFAR-funded projects but not yet by GF-funded SR.</td>
</tr>
<tr>
<td>Kenya</td>
<td>2</td>
<td>At least 9 UIC currently in use. A single, national, 29-character UIC has been proposed, but faces opposition.</td>
</tr>
</tbody>
</table>
Coverage data among the countries assessed are of very questionable reliability. As shown above, none of the countries assessed has a single, national unique identifier code (UIC), though it is planned in Madagascar, Malawi and Kenya and is being discussed in South Africa. The lack of a single, universally used UIC makes de-duplication of client coverage very difficult. Due to perceived problems with UIC – such as SW stating false names and birth years, which are often used to compose a UIC – some consideration has been given to the use of biometrics in the region; however, KP organizations have not been strongly favored in some countries.

There has historically been a lack of focus on PWID in the sub-Saharan Africa region, partly driven by a belief that no or very few PWID exist there; this situation is changing, partly in response to larger numbers of PWID discovered in recent years through mapping and through police operations targeting drug trafficking. However, the biggest deficit in data on KP is among prisoners. For countries with generalized HIV epidemics (such as Botswana, South Africa and Lesotho) to have little or no data available on their prisoner populations is particularly concerning.

Gender disaggregation is carried out at PWID organizations, but little is done to disaggregate men, women and transgender SW across the region at the national level. Additionally, data are generally not disaggregated by age, making it impossible to assess the situation for different age groups, such as adolescent KP. In addition, there is a remarkably widespread use of hand-written registers of all clients, including their full names and addresses and several other pieces of data, which were meant to be kept under lock and key but were on open display on the reception counters of many NGOs. This was seen in Kenya, Madagascar and Malawi. Given the criminalization of behavior in which many KP participate, this is a dangerous practice that should be stopped immediately.

There is very little national data on HIV treatment and viral load suppression disaggregated by KP. This is partly due to the lack of accurate national coverage data and largely caused by the inability of the UIC databases to be linked anonymously with HIV-positive patient data.

An important innovation is the NACOSA Orbit database in South Africa, a cloud-based data capture space into which SW sub-recipients enter data from outreach such as HIV testing and counseling (HTC), referrals and meeting participation into the shared database used by all SR under NACOSA. Data are uploaded directly to Orbit by the SR and they may extract data for their own information and

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2 The Country Report notes that in Madagascar’s prioritized above-allocation request 2018-2020, funds are earmarked for introducing a UIC to track outreach and HIV testing activities and ensure more confidentiality for KP. The country plans on recording fingerprints via smartphones and linking these to the UIC.
planning from the database. NACOSA will soon also offer ZENESIS, an analytics platform, which is currently under development. This will enable analysis of data and sharing for strategy and decision-making.

**RECOMMENDATIONS: MONITORING OF SERVICE PACKAGES FOR KEY POPULATIONS**

1. For accurate coverage calculations, countries need to follow established guidelines to develop PSE, together with national consensus processes involving substantial representation from the KP concerned. From these processes, more accurate, agreed-upon PSE should be derived.
2. Mapping of key populations, including the involvement of community networks in mapping, should be carried out nationally where possible to aid in verifying each PSE and to aid in the planning, implementation and measurement of coverage of KP programs.
3. All countries should continue to progress toward a single UIC for all KP and a single database that is preferably accessible online for both uploading data and generating reports. The system of collecting client names and addresses (especially in paper registers, but also electronically) should cease.
4. There may need to be specific monitoring arrangements established to follow the collaborative process at the local level in order to determine whether SW, MSM or TG organizations – either separately or, preferably, together - ensure that the needs of male and/or transgender SW are met.
5. It may be necessary to establish a more effective way of capturing community empowerment and psychosocial support in routine reporting tools.
6. After determining what interventions should be considered ‘core’ in the service package design, countries should establish routine surveillance to ensure that coverage of all core interventions can be regularly measured.
7. Due to the need for accurate national data on programmatic coverage, only countries that can demonstrate appropriate use of UIC and collation of data to determine coverage of clients with a defined package of services should be considered for the ‘extended’ services mentioned in the Implementation Recommendations above.
8. Feedback loops should be extended throughout the reporting system so that problems regarding quality are quickly reported to the level at which action can be taken to remedy the situation.
9. The approach of NACOSA in South Africa to providing SR with access to a cloud-based system for data reporting should be examined for possible replication by all PR.
10. Advocacy is needed to seek greater government attention to the provision and monitoring of service packages for prisoners across the region.

**FINANCING**

It was beyond the scope of this assessment process to conduct an in-depth financial analysis of costing, allocation and expenditure related to packages of services for KP in ESA. However, a heavy reliance on Global Fund to support KP programming in all countries was observed. Cost information is a particularly critical input into the process of setting priorities and efficient allocation of resources.
and, given the urgency of scale-up to meet Fast-Track targets (UNAIDS Fast-Track: Ending the AIDS Epidemic by 2030), countries must urgently fortify their expenditure analysis and budget development processes to ensure that sufficient resources are available to implement the designed packages of services as intended.
### Table 5.3. Summary of Key Data in Participating Countries in Eastern and Southern Africa

Survey/IBBS (S); GAM (G); Programmatic Data (P); Other (O). (*) Indicates Desk Review Only. Virtually no programmatic data was found for prisoners or TG.

<table>
<thead>
<tr>
<th>Service</th>
<th>Population</th>
<th>Angola</th>
<th>Botswana*</th>
<th>Kenya</th>
<th>Lesotho*</th>
<th>Madagascar</th>
<th>Malawi</th>
<th>Mauritius*</th>
<th>Seychelles*</th>
<th>South Africa</th>
<th>Tanzania*</th>
<th>Uganda*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population Size</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimate (% of total adult population)</td>
<td>MSM</td>
<td>106,231 (0.49%)</td>
<td>781 (0.04%)</td>
<td>18,460 (0.04%)</td>
<td>11,400 (0.55%)</td>
<td>14,919 (0.07%)</td>
<td>9,616 (0.06%)</td>
<td>5,467 (0.44%)</td>
<td>1,084 (1.2%)</td>
<td>1,095,527 (2.0%)</td>
<td>50,000 (0.09%)</td>
<td>10,533 (0.23%)</td>
</tr>
<tr>
<td></td>
<td>PWID</td>
<td>N/A</td>
<td>N/A</td>
<td>18,327 (0.04%)</td>
<td>N/A</td>
<td>2,033 (&lt;0.01%)</td>
<td>N/A</td>
<td>11,677 (0.94%)</td>
<td>1,671 (1.8%)</td>
<td>75,701 (0.14%)</td>
<td>30,000 (0.06%)</td>
<td>1,597 (&lt;0.1%)</td>
</tr>
<tr>
<td></td>
<td>Prisoner</td>
<td>24,000 (0.1%)</td>
<td>4,376 (0.2%)</td>
<td>54,000 (0.12%)</td>
<td>2,073 (0.12%)</td>
<td>20,954 (0.1%)</td>
<td>14,795 (0.1%)</td>
<td>2,499 (0.18%)</td>
<td>158,111 (0.29%)</td>
<td>31,382 (0.08%)</td>
<td>54,059 (0.4%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SW</td>
<td>124,540 (0.6%)</td>
<td>4,153 (0.2%)</td>
<td>133,675 (0.3%)</td>
<td>6,300 (0.3%)</td>
<td>167,442 (0.73%)</td>
<td>31,800 (0.19%)</td>
<td>6,223 (0.5%)</td>
<td>586 (0.63%)</td>
<td>237,717 (0.45%)</td>
<td>160,000 (0.3%)</td>
<td>54,549 (0.4%)</td>
</tr>
<tr>
<td></td>
<td>TG</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1,407 (0.11%)</td>
<td>N/A</td>
<td>139,666 (0.26%)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>HIV Prevention Programming</strong></td>
<td>MSM</td>
<td>25.4% (O)</td>
<td>114.9% (P)</td>
<td>245% (P)</td>
<td>4.1% (S)</td>
<td>40.2% (S)</td>
<td>68% (O)</td>
<td>85.6% (S)</td>
<td>62% (S)</td>
<td>1.5% (O)</td>
<td>14% (O)</td>
<td>17.5% (O)</td>
</tr>
<tr>
<td></td>
<td>PWID</td>
<td>N/A</td>
<td>N/A</td>
<td>106% (P)</td>
<td>N/A</td>
<td>101.1% (P)</td>
<td>N/A</td>
<td>83.8% (S)</td>
<td>N/A</td>
<td>9.5% (O)</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SW</td>
<td>23% (O)</td>
<td>68.7% (P)</td>
<td>132% (P)</td>
<td>10% (S)</td>
<td>98.1% (P)</td>
<td>65% (O)</td>
<td>80.5% (S)</td>
<td>86.5% (S)</td>
<td>15.8% (O)</td>
<td>20% (O)</td>
<td>40% (O)</td>
</tr>
<tr>
<td><strong>Knowledge of HIV status</strong></td>
<td>MSM</td>
<td>29.6% (S)</td>
<td>79.6% (S)</td>
<td>76% (S)</td>
<td>11.6% (Maseru)</td>
<td>25.1% (P)</td>
<td>94% (O)</td>
<td>59.1% (S)</td>
<td>27.3% (S)</td>
<td>27.2% (O)</td>
<td>53.7% (G)</td>
<td>44% (G)</td>
</tr>
</tbody>
</table>

---

3 Where programmatic data are used, coverage values have been calculated using available programmatic coverage data as numerators, and nationally accepted PSE as denominators.
4 All data sources are provided in footnotes to tables for each KP in Implementation.
5 Coverage with prevention package as defined in national design documents.
6 Percentage of KP that have received an HIV test in the past 12 months and know their results.
<table>
<thead>
<tr>
<th>Service</th>
<th>Population</th>
<th>Angola</th>
<th>Botswana*</th>
<th>Kenya</th>
<th>Lesotho*</th>
<th>Madagascar</th>
<th>Malawi</th>
<th>Mauritius*</th>
<th>Seychelles*</th>
<th>South Africa</th>
<th>Tanzania*</th>
<th>Uganda*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiretroviral therapy</td>
<td>MSM</td>
<td>50.8% (G)</td>
<td>N/A</td>
<td>63% (S)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>29.0% (O)</td>
<td>N/A</td>
<td>N/A</td>
<td>34.2% (S)</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>PWID</td>
<td>N/A</td>
<td>N/A</td>
<td>58% (S)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>51.7% (S)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>SW</td>
<td>50.8% (G)</td>
<td>N/A</td>
<td>73% (S)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>90% (O)</td>
<td>N/A</td>
<td>N/A</td>
<td>22.7% (O)</td>
<td>N/A</td>
</tr>
</tbody>
</table>
BACKGROUND

In 2017, approximately 40% of new HIV infections were among key populations and their sexual partners (UNAIDS, 2018). A range of policy and legal barriers and harmful social factors increase the HIV vulnerability of KP and undermine their access to HIV and other services. The criminalization of sex between men, sex work, drug use and HIV transmission, as well as high rates of incarceration, homophobia, transphobia, violence and social marginalization all serve to influence risk practices and undermine access to services. Women in key populations face specific challenges and barriers, including GBV and poorly tailored services. These factors further intensify their vulnerability to HIV. Male KP also face high levels of violence.

While the WHO has clearly outlined the comprehensive package of services that should be available for MSM, PWID, SW, TG and prisoners (WHO, 2016), these populations rarely have access to the full range of recommended services (UNAIDS, 2015).

Global Fund contracted APMG Health to review the design, implementation and monitoring of national HIV service packages for KP in 65 countries across six regions in which GF has provided HIV grant funds. Out of the 65 countries included, 55 countries were selected based on the Global Fund KPI2g (2014-2016) results, where key population size estimations were classified as ‘nationally adequate’ by 2016. An additional 10 countries were selected based on discussions with Global Fund regional teams and consultation with global partners.

The specific objectives of this assessment were:

1. To determine whether HIV service packages as designed in the national guidelines or supported by Global Fund programs are in line with international standards and guidelines (e.g. WHO Consolidated Guidelines for Key Populations, Key Populations Implementation Tools, among others) and are appropriate to epidemiological context;
2. To examine the implementation of HIV service packages in reaching intended target groups, taking into account specific needs and vulnerabilities within sub-groups of KP (e.g. age, sex), along with the coverage and reported quality of these programs;
3. To assess whether the monitoring framework, tools and other mechanisms set up by implementation partners are appropriate to local contexts and are used effectively to regularly report on programmatic coverage;
4. To examine the enabling environment and other factors facilitating and inhibiting the availability, accessibility and utility of intervention services; and,
5. Where possible, to determine the degree to which financial resources are made available and used accountably for funding the implementation of service packages for KP.
These objectives were completed through a combination of desk review and in-country visits, as further described below. This report is one of six regional reports produced to summarize the assessment findings.⁷

⁷ Regional reports are available on Eastern and Southern Africa, Wes and Central Africa, Middle East and North Africa, Asia and the Pacific, Latin American and the Caribbean, and Eastern Europe and Central Asia. A global report is also available.
METHODOLOGY

COUNTRY ASSESSMENTS

Each of the country assessments consisted of an initial desk review and a field assessment. The Global Fund Country Team for each country provided data sources used for completing a desk review prior to the country visit. In the case of ESA, the major sources of information are:

- Global Fund Performance Framework
- Integrated Bio-Behavioral Surveillance Survey Reports (IBBS Reports)
- National strategic plans
- Monitoring and Evaluation (M&E) Plans
- Global Fund Funding Request Reports & Concept Notes
- GAM
- Global Fund Program Update data
- Programmatic Spot Checks
- Cross-checking of findings at a debrief with PR and other stakeholders

Out of the 11 countries assessed for the ESA region for this project, data collection ended with the completion of a desk review for six countries. In five of the countries, a follow-up field assessment was carried out to verify and expand data collected during the initial desk review process.

Each field assessment was conducted over the course of five days, with the exception of Kenya and South Africa, which were each conducted over the course of 10 days. For each country, two KP and two sites were selected with guidance from The Global Fund Country Teams and CCM, with the exception of South Africa, where three sites were selected, and Kenya, where three key populations were selected.

Table 1. Eastern and Southern Africa Key Population and Site Selection

<table>
<thead>
<tr>
<th>Country</th>
<th>Key Populations Selected</th>
<th>Sites Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>MSM &amp; FSW</td>
<td>Luanda &amp; Benguela</td>
</tr>
<tr>
<td>Kenya</td>
<td>MSM, FSW &amp; PWID</td>
<td>Nairobi &amp; Mombasa</td>
</tr>
<tr>
<td>Madagascar</td>
<td>MSM &amp; FSW</td>
<td>Antananarivo &amp; Mahajanga</td>
</tr>
<tr>
<td>Malawi</td>
<td>MSM &amp; FSW</td>
<td>Salima &amp; Dowa</td>
</tr>
<tr>
<td>South Africa</td>
<td>MSM &amp; FSW</td>
<td>Johannesburg, Durban, &amp; Cape Town</td>
</tr>
</tbody>
</table>

One international consultant and one local consultant carried out in-country assessments, with the exception of South Africa, where two international consultants and one local consultant carried out the assessment. The majority of the data collected during each country assessment were collected through:
Assessment of HIV Service Packages for Key Populations
Eastern and Southern Africa

• An initial meeting with representatives of CCM, PR and SR working with key populations
• Visits to at least two sites for observation of package delivery
• Visits to SR/SSR to examine M&E forms and systems
• Key informant interviews
• Focus group discussions (There were a total of 247 key populations representatives across all five countries)
• Debrief for PR

REPORTING PROCESSES

Country reports for both desk-review only and in-country assessment countries have been produced and used to prepare each regional report. Countries were grouped by UNAIDS regions. Each regional report provides analysis of trends and recommendations for consideration for decision-makers and influencers working across the region. This report provides summary and analysis of the 11 countries assessed in the ESA region, as displayed in Table 2. A literature review was also conducted on recent literature related to KP in the region.

Table 2. Eastern and Southern Africa Countries Assessed

<table>
<thead>
<tr>
<th>Eastern and Southern Africa</th>
<th>Desk Review &amp; In-Country Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td></td>
</tr>
<tr>
<td>Madagascar</td>
<td></td>
</tr>
<tr>
<td>Malawi</td>
<td></td>
</tr>
<tr>
<td>South Africa</td>
<td></td>
</tr>
<tr>
<td>Desk Review Only</td>
<td></td>
</tr>
<tr>
<td>Lesotho</td>
<td></td>
</tr>
<tr>
<td>Mauritius</td>
<td></td>
</tr>
<tr>
<td>Seychelles</td>
<td></td>
</tr>
<tr>
<td>Tanzania</td>
<td></td>
</tr>
<tr>
<td>Uganda</td>
<td></td>
</tr>
<tr>
<td>Botswana</td>
<td></td>
</tr>
</tbody>
</table>

It should be noted that the countries selected for this region were not selected on the basis of being a regionally representative sample. While this report will present trends observed across these 10 countries, extrapolation of the findings to other countries in the region should be done with caution. The findings of this assessment may be instructive for development of policy or practice across the region, but any country-level decisions should always be grounded in the reality of the specific country context.
The scale of the ESA region’s HIV epidemic remains massive. An estimated 800,000 people in the region acquired HIV in 2017 and an estimated 380,000 people died of AIDS-related illness. Mozambique, South Africa and the United Republic of Tanzania accounted for more than half of new HIV infections and deaths from AIDS-related illness in the region in 2017 (UNAIDS, 2018).

As shown in Figure 1, among the 19.6 million PLHIV in ESA at the end of 2017, 81% were aware of their HIV status, an increase from 77% in 2016. The gap to achieving the first 90 of the 90–90–90 targets in 2017 was 1.7 million PLHIV. About 12.9 million people in the region were accessing ART in 2017, or 66% of all PLHIV. The gap to achieving the second 90 of the 90–90–90 targets in 2017 was three million PLHIV. The estimated percentage of PLHIV who achieved viral suppression increased from 48% in 2016 to 52% in 2017. The gap to achieving the third 90 in 2017 was the viral suppression of an additional four million PLHIV. Botswana and Eswatini (formerly Swaziland) have nearly achieved the 90–90–90 testing and treatment targets (UNAIDS, 2018).
Insufficient attention is given to KP in the region despite extremely high HIV prevalence among them. Population size estimates suggest there are nearly one million sex workers in need of services (UNAIDS, 2018). Only in sub-Saharan Africa do studies show HIV prevalence amongst female sex workers (FSW) higher than 50%; and MSM in Africa are estimated to be 3.8 times more likely to be living with HIV than the general population (HEARD, 2015).

**Population Size Estimates and HIV Prevalence in Eastern and Southern Africa**

Despite being the region with the largest population of PLHIV, there is controversy about some of the key statistics related to KP. In South Africa, there is general agreement on the PSE of all key populations except SW, with agreement on prevalence rates for most key populations. However, there are some differences of opinion about prevalence among MSM. The HSRC survey (South African National HIV Prevalence, Incidence and Behavior Survey) and an IBBS study by the University of California, San Francisco (UCSF) are currently underway, with results due in early 2019. These studies should answer some of the outstanding questions about core data.

In Malawi, by contrast, there are most likely significant underestimates of population sizes as well as disagreements about HIV prevalence rates for both MSM and SW. As with other data on HIV in Angola, KP PSE and HIV prevalence in the country are inconsistent and most recent surveys concentrate in either Luanda only, or Luanda and Benguela. In Madagascar, the national estimate of 14,919 MSM in a population of 24 million appears remarkably low.
Problems with PSE in particular have led to program coverage estimates that are unlikely or, in some cases, impossible: coverage rates of over 100% have been found for MSM in Madagascar and for SW in Kenya.

Table 3. Population Size Estimation and HIV Prevalence by Key Population for In-Country Assessment Countries

<table>
<thead>
<tr>
<th>Key Population</th>
<th>Angola</th>
<th>Kenya</th>
<th>Madagascar</th>
<th>Malawi</th>
<th>South Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM PSE</td>
<td>106,231</td>
<td>18,460</td>
<td>14,919</td>
<td>9,616</td>
<td>1,095,527</td>
</tr>
<tr>
<td>MSM HIV Prevalence</td>
<td>2.0%</td>
<td>18.2%</td>
<td>14.8%</td>
<td>17.3%</td>
<td>28.0%</td>
</tr>
<tr>
<td>PWID PSE</td>
<td>-</td>
<td>18,327</td>
<td>2,033</td>
<td>-</td>
<td>75,701</td>
</tr>
<tr>
<td>PWID HIV Prevalence</td>
<td>-</td>
<td>18.7%</td>
<td>8.5%</td>
<td>-</td>
<td>14.0%</td>
</tr>
<tr>
<td>FSW PSE</td>
<td>124,540</td>
<td>133,675</td>
<td>167,442</td>
<td>31,800</td>
<td>237,717</td>
</tr>
<tr>
<td>FSW HIV Prevalence</td>
<td>2.2%</td>
<td>29.3%</td>
<td>5.6%</td>
<td>24.9%</td>
<td>59.6%</td>
</tr>
<tr>
<td>Prisoner PSE</td>
<td>24,000</td>
<td>54,000</td>
<td>20,954</td>
<td>14,795</td>
<td>158,111</td>
</tr>
<tr>
<td>Prisoner HIV Prevalence</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>23.0%</td>
</tr>
<tr>
<td>TG PSE</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>139,666</td>
</tr>
<tr>
<td>TG HIV Prevalence</td>
<td>9.9%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>General population</td>
<td>1.24%</td>
<td>3.2%</td>
<td>0.1%</td>
<td>5.8%</td>
<td>13%</td>
</tr>
</tbody>
</table>

---

8 All data from 2016 PEPFAR COP, except TG prevalence: PLACE Study 2016, data from Luanda only; and general population prevalence, UNAIDS 2018a, and prisoner PSE, World Prisons Brief 2016
9 All data from NASCOP 2018 PowerPoint presentation delivered during key informant interview; except general population prevalence, UNAIDS, 2018a, and prisoner PSE, World Prisons Brief 2016
10 All data from Mapping and KP PSE 2014: except general population prevalence, UNAIDS 2018a, and prisoner PSE, World Prisons Brief 2016
11 All PSE data from 2017, PLACE II (draft); all prevalence data from 2013 BBS; except general population prevalence, UNAIDS 2018a, and prisoner PSE, World Prisons Brief 2016
12 Setswe et al. 2015
13 SANAC 2017
14 Setswe et al. 2015
15 SANAC 2017
16 Setswe et al. 2015
17 SWEAT 2013
18 World Prisons Brief 2016
19 SANAC 2017
20 Setswe et al. 2015
21 UNAIDS 2018a
## Table 4. Population Size Estimation and HIV Prevalence by Key Population for Desk Review Only Countries

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>781</td>
<td>13.1%</td>
<td>-</td>
<td>-</td>
<td>4,153</td>
<td>61.9%</td>
<td>4376</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lesotho</td>
<td>11,400</td>
<td>32.9%</td>
<td>11,677</td>
<td>44.3%</td>
<td>6,300</td>
<td>71.9%</td>
<td>2,564</td>
<td>31.4%</td>
<td>1,407</td>
<td>-</td>
</tr>
<tr>
<td>Mauritius</td>
<td>5,467</td>
<td>20.0%</td>
<td>1,671</td>
<td>3.8%</td>
<td>6,223</td>
<td>22.3%</td>
<td>2,225</td>
<td>11.8%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Seychelles</td>
<td>1,084</td>
<td>13.2%</td>
<td>386</td>
<td>4.6%</td>
<td>586</td>
<td>4.6%</td>
<td>423</td>
<td>6.7%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Tanzania</td>
<td>50,000</td>
<td>17.6%</td>
<td>30,000</td>
<td>15.5%</td>
<td>160,000</td>
<td>28.0%</td>
<td>31,382</td>
<td>16.7%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Uganda</td>
<td>10,533</td>
<td>13.2%</td>
<td>1,597</td>
<td>-</td>
<td>54,549</td>
<td>34.2%</td>
<td>54,049</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

---

22 All data from 2012 BBS: except prisoner PSE from World Prisons Brief 2016 and general population prevalence UNAIDS 2018a
25 All data from GARPR 2014 except PWID PSE from NACP (2014); MSM and FSW PSE from UNAIDS 2017; prisoner PSE, World Prisons Brief, 2016; prisoner prevalence from NACP 2017; and general population prevalence, UNAIDS 2018a
26 All data from UAC 2014 except MSM and FSW prevalence and prisoner PSE, World Prisons Brief 2016; and general population prevalence, UNAIDS 2018a
27 GARPR 2014
28 UNAIDS 2017
29 UNAIDS 2017
30 GARPR 2014
31 UNAIDS 2017
32 NSP 2011/12-2017/18
33 NSP 2011/12-2017/18
Several countries in ESA have developed Cascades of Care disaggregated by KP and these are revealing interesting differences both between key populations and in the overall epidemic response.

For example, Malawi’s overall progress towards the 90-90-90 HIV treatment targets was 73-89-91 in 2016. However, HIV treatment cascades for key populations reveal significantly greater gaps (Figure 2). While a recent PLACE II study (UNC, 2018) in specific localities shows that HIV testing coverage is higher among KP than the general population, treatment coverage and treatment adherence is far lower. From the PLACE II study results, linkage to ART appears to be the main ‘leak’ in the cascade for MSM, while treatment adherence appears to be the main ‘leak’ for FSW.

Figure 2. Self-reported FSW and MSM HIV Cascades in PLACE II (UNC, 2018)

![Figure 2: Self-reported FSW and MSM HIV Cascades in PLACE II (UNC, 2018)](image)

Figure 3 shows an MSM Cascade developed by Mombasa SR, the HIV & AIDS People’s Alliance (HAPA). While viral load suppression is not currently tracked as part of routine reporting, HAPA report that a new HIV testing services (HTS) register will include viral load monitoring.
Overall, ESA is home to countries with highly sophisticated data and the ability to analyze this data to a fine level of granularity as well as countries that require substantial capacity building in ensuring that basic data such as PSE and HIV prevalence estimates among KP are acceptable.

**Sex Workers**

The HIV situation among SW was assessed in all five countries visited as well as the six countries that only had desk reviews. Sex workers in many countries examined have the highest HIV prevalence among KP (ranging from 4.6% in the Seychelles to 71.9% in Lesotho). A HIV prevalence of above 30% was also recorded in South Africa, Botswana and Uganda. Coverage data (according to Table 1) show that, for most countries reviewed, SW have the highest coverage, especially for HIV prevention services, when compared to other key populations.

However, significant issues continue to affect the ability of countries to reach and to provide services to high proportions of SW. First, most countries use the term ‘sex worker’ to refer to FSW, with few or no programs available for male or transgender SW. Second, legal issues continue to cause problems both for SW and for organizations trying to reach them with services. Sex work and the selling and buying of sexual services remain illegal in South Africa, Kenya and Madagascar. While it is not illegal in Malawi, aspects of sex work are criminalized. Sex work is only legal in Angola.

Community empowerment among SW is easy to observe in South Africa and Kenya; however, it seems to be at a low level in Madagascar and non-existent in Angola. Even in countries with a substantial history of SW empowerment activities, stigma and discrimination remain major obstacles to accessing HIV and other health services. Focus group discussion participants in Johannesburg and Nairobi refer to stigma from healthcare workers as a reason not to attend health clinics. In Malawi, FSW rarely disclose sex work activities to health service providers due to real and perceived stigma, limiting high-impact interventions that target SW. Female sex workers in Angola experience high levels of stigma, discrimination and all types of violence. In Madagascar, the *National Strategic Plan for a multi-sectoral...*
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*Response to STI, HIV and AIDS 2018-2022* states that 73.5% of FSW experience discrimination at the family level. Violence against SW is identified as a major issue in FGD in South Africa and Angola, while FGD participants in Durban (South Africa) and Madagascar report that levels of police violence have fallen in recent years.

One of the problems in establishing the size of male and transgender SW populations may lie in definitions and the ways that individuals from these communities view their behavior. For example, in Madagascar, only 6.4% of MSM interviewed during the 2014 IBBS stated that they were sex workers, but 78.8% reported having received money in exchange for sexual relationships. Also, some organizations working with MSM and TG also work with male and transgender SW, meaning that any coverage or other relevant data may be contained in MSM or TG datasets rather than in SW data. For example, one MSM services implementer in Mombasa notes that of their 108 members, around 30 are MSM and the rest are male sex workers (MSW).

**Men who have Sex with Men**

The HIV situation among MSM was assessed in all five countries visited as well as the six countries that only had desk reviews. Coverage of HIV programs – most of which began years or even decades after work started with sex workers – is generally lower than among SW across the region.

Same-sex sexual acts are criminalized in Malawi and Kenya. Same-sex sexual acts and same-sex marriage is legal in South Africa and there are no laws against homosexuality in Madagascar. The situation in Angola is unclear but it seems that at this time no one is prosecuted for homosexual acts. Stigma and discrimination remain major barriers to accessing HIV and other health services. One study in Malawi found that 34.3% of MSM respondents reported experiencing human rights abuses, 17.6% of participants reported that they were afraid to seek health care because of their sexual orientation and fewer than 10% had disclosed their sexual orientation in interactions with health workers (Baral et al., 2009). MSM in Madagascar face high levels of stigma with associated violence and rejection from society: 36.1% of MSM surveyed in the 2014 IBBS reported feeling discriminated at the community level, but only 6.2% reported this in medical settings.

Intergenerational, transactional sex among MSM due to socioeconomic inequality and poverty is common in Angola. Heavy use of alcohol and marijuana in sexual relations is usual. Key informants and FGD participants during in-country assessments agree that condom use is infrequent in that context as well as with regular partners.
People Who Inject Drugs

The HIV situation among PWID was only assessed in Kenya, but some data are available from other countries. Drug use is illegal in all countries in the region. Among PWID in Kenya, HIV prevalence is more than three times higher than the general population, at 18.7% (NASCOP, 2018). There are approximately 18,327 [12,617–23,978] PWID in Kenya. During the country visit, new sex-disaggregated data were acquired for PWID during key informant interviews. While these data show a dramatically elevated HIV epidemic among women who inject drugs (36% self-reported HIV prevalence compared to 17% among men), women also reported higher levels of enrollment in care and higher enrollment in ART.

Figure 4. PWID who self-reported HIV status, enrolment in care, treatment and retention in treatment (NASCOP, 2017)

The mapping and Key Populations PSE 2014 in Madagascar estimated the PWID population at 2,033. The towns with PWID populations are Antananarivo, Nosy Be, Toamasina, Mangily and Toliara, with 87.6% of PWID found in Antananarivo. However, a PSE from 2012, which covered only three towns, provided a much higher estimate: 11,818 in Antananarivo, 1,431 in Toamasina and 1,196 in Antsiranana.

According to Madagascar’s, the HIV prevalence rate among PWID in Madagascar is 8.5%, compared to 7.1% in 2012. Prevalence rates are significantly higher in Antananarivo when compared to the other towns. Heroin and cocaine are the two most frequently used drugs among PWID in Madagascar. Fewer than 30% of sexually active male PWID are MSM, but more than 85% of sexually active female PWID are FSW.

A 2015 study in South Africa found an HIV prevalence of 14.0% among PWID, which is the consensus prevalence used in the country’s 2017-2022 National Strategic Plan (SANAC, 2017). Substantial PWID populations are estimated for South Africa (75,701), Mauritius (11,677) and Tanzania (30,000), and
HIV prevalence among PWID in Mauritius (44.3%) is the highest in the region. No PWID estimates are available for Angola, Malawi, Botswana or Lesotho.

**Transgender People**

The HIV situation among TG was not assessed in any of the five countries visited. However, some data are available from the countries. Transgender people are not criminalized in South Africa and cross-dressing is also not criminalized. Transgender people are protected by the following legal protections: i) constitutional prohibition of discrimination based on gender diversity; ii) prohibitions of discrimination in employment based on gender diversity; iii) legal recognition of a third gender; and, iv) other non-discriminatory provisions specifying gender diversity (South Africa GAM Report, 2017). Setswe et al. (2013) estimate the TG population in South Africa at almost 140,000. However, there are very scarce data pertaining to HIV rates and risks among transgender people in South Africa.

Of the other 10 countries assessed, only Mauritius had a separate figure for TG (1,407) and none of the countries assessed have an estimate of HIV prevalence for this KP (with the exception of Angola, which states an HIV prevalence of 9.9%). It is generally noted in the PSE for most countries assessed that TG and MSM estimates are combined. The process of undertaking separate PSE and prevalence studies among TG people in the region will likely take several years.

**Prisoners**

The HIV situation among prisoners was not assessed in any of the five countries visited. Prisoner data was not available for six countries and, among those with available data, HIV prevalence ranged from 6.7% in Tanzania to 23% in South Africa.

In South Africa, prisoners are occasionally listed as a KP for surveillance and prevention efforts, but very little information is provided on this population and specific HIV prevention efforts necessary to address their vulnerability. The 2017-2022 National Strategic Plan, which cites 2009/2010 data from the Department of Correctional Services, found an HIV prevalence of 23.0% among prisoners (DSC, 2010, as cited in SANAC, 2017).

In Madagascar, it is not clear from the information gathered during this assessment whether HIV prevention interventions are implemented in prisons. There are no indicators and results for HIV prevention services in prisons. Nursing staff within prison settings had not, by 2015, been trained in HIV counseling and screening. When prisoners have HIV, complicated administrative processes delay their access to medical care. During the in-country visit, referral doctors confirmed that external healthcare personnel conducted HIV testing in prisons and that they sent ART treatment to prisoners without ever meeting them for any follow-up or tests.
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ANALYSIS: DO WE KNOW WHAT WE NEED TO KNOW ABOUT KEY POPULATIONS IN EASTERN AND SOUTHERN AFRICA?

As expected for the region with the largest number of PLHIV, data in ESA are substantially more complete than for the other regions; however, gaps remain. As noted above, the lack of PSE, HIV prevalence data and information about risk behaviors for the region’s TG is understandable, given such information in most countries has been aggregated with those for MSM. However, substantial work is now required to understand the similarities and differences between these populations to ensure that service packages are appropriate for the two KP and that accurate service coverage can be reported.

Similarly, the confusion about whether SW, MSM/TG, MSM or TG agencies should collect data about male and transgender SW is understandable. However, the data observed in other regions suggests that behavior, risks and HIV prevalence among male, female and transgender SW can be very different, so a decision needs to be made about which agency will work with each population and SW PSE, prevalence and coverage statistics need to be derived for each male, female and transgender SW.

It should be noted that there are specific problems with PSE for MSM in the region, as the MSM PSE for Angola and Madagascar are much lower than has been reported in other countries with similar-sized populations.

There has historically been a lack of focus on PWID in the sub-Saharan Africa region, partly driven by a belief that no, or very few, PWID exist there. However, each time a country carries out a study of drug use (including drug injecting) in the region, a number of PWID is usually found. Given that the number of PWID in all countries of the region are likely to be much smaller than MSM and SW (except in Mauritius), it is sensible to start by ensuring that data for MSM and SW are accurate. To gain accurate data on MSM programming, appropriate studies are needed of the TG community, so this KP should also be emphasized for core data collection. After this has been achieved or where funding is available, PWID RAR (Rapid Assessment and Response Studies) should follow. An easy way to determine whether drug injecting is present in a country is to ask MSM and SW if they or their friends ever inject drugs. This can provide preparatory data for PWID studies.

The biggest deficit in data on KP in ESA is among prisoners. For countries with generalized HIV epidemics (such as Botswana and Lesotho) to have no data available on prisoners is particularly concerning. Globally, little is known about HIV in prisons or the coverage of HIV programs in prisons, but the difference in ESA between the data for other key populations is particularly dramatic. More research is needed to learn about the situation for prisoners in the region.
For all countries assessed, consultants were able to review the current national strategic plans, action plans, outlines of state-provided HIV services and national programs. Package design is assessed below based on key national reference documents, as detailed in Table 5. It should be noted that this is a sign of success in itself: several countries in the region had no defined packages of services for KP five or seven years ago. All assessment findings for each country are based on the package of services described in its latest HIV program review.

**Table 5. Key Populations Identified in Countries Assessed**

*Desk-review only country*

<table>
<thead>
<tr>
<th>Country</th>
<th>Key Populations Identified in Nationally Endorsed HIV Strategies/Plans</th>
<th>Document(s) Defining Service Packages for Key Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>None[^34]</td>
<td>National Strategic Plan 2015-2018</td>
</tr>
<tr>
<td>Madagascar</td>
<td>MSM, PWID, FSW</td>
<td>National Strategic Plan for a Multi-Sectoral Response to STI, HIV and AIDS 2018-2022</td>
</tr>
</tbody>
</table>

[^34]: MSM and FSW not identified in the National Strategic Plan; only in the Global Fund Concept Note 2015
[^35]: Does not identify key populations, but identified most at-risk populations (MARPs) which include: sex workers, truck drivers, seasonal farm workers and construction workers; the 2014 Concept Note identifies SW, MSM, and adolescents
[^36]: Other vulnerable populations identified: young girls and women, people in prisons and other closed settings, fishing communities, truck drivers, street children, people with disabilities, migrant populations, mobile workers and PLHIV
[^37]: Also includes mobile and migrant populations
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<table>
<thead>
<tr>
<th>Country</th>
<th>Key Populations</th>
<th>National Strategic Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mauritius*</td>
<td>MSM, FSW, PWID</td>
<td>National Strategic Framework 2013-2016</td>
</tr>
<tr>
<td>Seychelles*</td>
<td>MSM, FSW, PWID</td>
<td>National Strategic Framework 2012-2016</td>
</tr>
<tr>
<td>South Africa</td>
<td>Prisoners, MSM, people who use drugs (including PWID), SW, TG</td>
<td>National Strategic Plan for HIV, TB and STIs 2017-2022</td>
</tr>
</tbody>
</table>

It is important to note that South Africa and Kenya have taken great steps beyond outlining KP service packages in their national strategic plans. In South Africa, separate strategic plans were developed to address HIV among SW (SANAC, 2017), MSM and TG and others (SANAC, 2017a). The Sex Worker Plan provides specific and detailed differentiated approaches depending on the numbers of SW in each locality.

Focus for Impact is a central approach in the South Africa National Strategic Plan. It maps the country down to ward level for estimated data on KP. It is housed in an online database, onto which SR and other registered implementers upload adjustments, improvements, or data revisions based on their mapping and research at the local level. Information, data and insights identifying populations most at risk in areas most severely affected by HIV and TB are provided through online and phone-based graphic applications and key data sets. In addition to countrywide comprehensive prevention, care and treatment, additional efforts are concentrated in identified HIV and TB high-burden areas. The purpose of the Focus for Impact Strategy is to ensure saturation of high-impact prevention and treatment services and strengthened context-specific efforts to address the social and structural factors that increase vulnerability to infection. The approach supports coordination, monitoring and decision-making in the HIV, TB and STI response. However, while useful for focusing and anticipating demand in the general population and for adolescent girls and young women (AGYW), the database does not yet include data on KP down to the ward level.

Kenya developed its National Guidelines for HIV/STI Programming with Key Populations (NASCOP, 2015) as well as its HIV Prevention Revolution Road Map to assist all government entities and NGOs down to county level to plan and implement programming for KP. However, this multiplicity of guidelines caused reviewers some problems when assessing the design of packages. The issues are illustrated in Table 6, where the packages described in the National Strategic Framework, the National Guidelines for Key Populations and the Prevention Revolution Roadmap are compared.

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38 Other vulnerable populations identified: young women, couples, PLHIV
39 FSW are mentioned in the plan; however, no package of services is outlined for FSW or other KP in this document
Table 6: Comparison between the WHO-defined comprehensive package of interventions for key populations and the interventions included in the Package of Services for MSM, SW and PWID as defined in three national policy documents in Kenya

<table>
<thead>
<tr>
<th>WHO comprehensive package of interventions for key populations</th>
<th>Inclusion of the element in national policies and guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential health sector interventions</td>
<td></td>
</tr>
<tr>
<td>Comprehensive condom and lubricant programming</td>
<td>Yes</td>
</tr>
<tr>
<td>Harm reduction interventions for substance use (in particular, NSP and OST)</td>
<td>Yes</td>
</tr>
<tr>
<td>Behavioral interventions</td>
<td>Yes</td>
</tr>
<tr>
<td>HIV testing and counseling</td>
<td>No</td>
</tr>
<tr>
<td>HIV treatment and care</td>
<td>No</td>
</tr>
<tr>
<td>Prevention and management of co-infections and other co-morbidities, including viral hepatitis, TB and mental health conditions</td>
<td>Yes (HPV among FSW/MSM and Hepatitis B and C for PWID)</td>
</tr>
<tr>
<td>Sexual and reproductive health interventions</td>
<td>No</td>
</tr>
<tr>
<td>Essential strategies for an enabling environment</td>
<td></td>
</tr>
<tr>
<td>Supportive legislation, policy and financial commitment, including decriminalization of behaviors of key populations</td>
<td>Yes</td>
</tr>
<tr>
<td>Addressing stigma and discrimination</td>
<td>No (part of generic prevention package but not specified as for key and vulnerable populations)</td>
</tr>
<tr>
<td>Community empowerment</td>
<td>Yes</td>
</tr>
<tr>
<td>Addressing violence against people from key populations</td>
<td>Yes</td>
</tr>
</tbody>
</table>

40 Kenya’s October 2014 Key Populations Programming Guidelines define sixteen essential elements that should be provided to key populations with a further seven desirable package elements.
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Due to the variations between packages, only the Prevention Roadmap – the most detailed of the package descriptions – are used for the regional analysis below.

Methods used to develop the national KP service packages vary across the region. In South Africa, SWEAT began developing national service packages prior to the work done by international agencies. For these and for packages for the lesbian, gay, bisexual, transgender and intersex (LGBTI) communities, very strong community involvement led to many key informants stating that these processes were community-led. Similarly, in Kenya and Mauritius, strong NGOs representing SW and MSM were involved in developing service packages. Also in Kenya and Mauritius, harm reduction agencies – sometimes comprising current and ex-drug users – were involved in developing PWID services. There was less evidence of involvement of key population members in developing service packages for KP in Malawi, Angola and Madagascar.

A report by Esom et al (2016) on a study by AMSHeR (African Men for Sexual Health and Rights) calls into question the level of KP representative involvement in designing service packages. This study included a survey of 99 respondents from 25 African states, as well as a FGD and both in-person and telephone interviews with KP representatives in Kenya, Malawi, Uganda and Tanzania. According to the survey, 42% of respondents engaged with the development of national HIV strategic plans, 33% were consulted about Global Fund concept notes and only 19% were consulted on the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) country operational plans. Far smaller numbers reviewed and had input into final draft documents in each process, fewer still saw the budgets and unsurprisingly, most were dissatisfied with how well they felt the resulting plans and funding would meet KP needs.

Critical enablers are absent in several countries’ package design and, where present, often refer to all KP. Below are set out specific critical enabler activities for each key population. The following apply to all KP in Tanzania, South Africa, Mauritius, Malawi and Kenya, related to laws and policies:

- **Tanzania**: provide legal advice and support; ensure laws protecting the rights of PLHIV; improve the legal and policy environment to allow access to health services for KP and “enforce supportive policies.”
- **South Africa**: “eliminate […] punitive laws that burden key and vulnerable populations; justice for persons facing stigma, discrimination, legal injustices; expand and strengthen access to legal support, including legal literacy and access to legal aid; improve legal literacy about human rights and laws relevant to HIV and TB; sensitize law-makers and law enforcement agents.”
- **Mauritius**: increase access to legal aid; reduce legal barriers to access HIV prevention, treatment and care; identify problematic laws and review/repeal them for harmonization with international commitments; review existing laws and policies to ensure that they do not encourage stigma and discrimination or constitute a barrier to HIV prevention, treatment, care & support; conduct ‘Know your rights’ literacy programs.
Malawi: social and legal protections for persons living with HIV and AIDS and key and vulnerable populations, including advocating for legal reform; advocacy for the adoption of the Rights-based HIV Bill; review of penal code; building capacity around legal literacy and access to justice.

Kenya: improve national and county legal and policy environment for protection of KP and PLHIV; improve access to legal and social justice and protection from stigma and discrimination in the public and private sector; increase protection of human rights and improved access to justice for PLHIV, KP and other priority groups including women, girls and boys; sensitize law and policy makers on the need to enact human rights sensitive laws and policies and the implications of a non-responsive legal and policy environment for key and priority populations for their HIV response; implement commitments of the Global Fund Principles on human rights, the sustainable development goals and national laws, and Identify remaining gaps and track improvement /changes; lobby for county legislation and policy on HIV-related stigma and discrimination and GBV; facilitate decentralization & sensitization of communities about the HIV Tribunal in order to facilitate access to justice and redress in cases of HIV-related discrimination or other legal matters.

The following apply to all KP in Tanzania, South Africa, Mauritius, Malawi and Kenya related to stigma and discrimination:

- Tanzania: “reducing stigma and discrimination and addressing barriers to HIV and health services” and “interventions to reduce stigma and discrimination.”

- South Africa: “eliminate stigma and discrimination that burden key and vulnerable populations”; “reduce stigma through community education”; “develop community-centered social mobilization strategy with a specific focus on stigma.”

- Mauritius: challenge discrimination against groups of people who are marginalized, including people with disabilities, orphans, refugees, asylum seekers, foreign migrants, SW, MSM and LGBTI, PWID and older persons; "support socioeconomic empowerment of key populations in the fight against stigma and discrimination to ‘reintegrate key populations into the social fabric of society.'"

- Malawi: reduce discrimination in access to services and increase capacity training to prevent unfair discrimination.

- Kenya: implement stigma reduction campaigns; sensitize and engage communities and leaders such as religious leaders and elders on KP and HIV to reduce stigma and to increase service uptake; use human rights approach to assist programs in pursuing zero tolerance to stigma and discrimination; deploy behavior change communication (BCC) interventions at the community level to address stigma and cultural barriers; reduce self-reported stigma and discrimination related to HIV and AIDS by 50%; facilitate county and community engagement forums to reduce stigma and discrimination; support routine national survey to determine the levels of stigma and discrimination at national and county level; and, sensitize health care workers to reduce stigmatizing attitudes in healthcare settings.

The following apply to all KP in South Africa, Tanzania and Kenya related to community empowerment:
Kenya: empower communities and workplaces to ensure improved capacity and capability to take charge of their health and to strengthen community-based intervention such as psychosocial support groups and peer support.

Tanzania: “empowering the community, including ownership and leadership.”

South Africa: community empowerment and social mobilization; use of formal/informal peer networks to create demand; support key and vulnerable populations’ social capital by encouraging community networks that include advocacy agendas for equal health and human rights.

The following apply to all KP in South Africa, Tanzania, Mauritius, Malawi and Kenya related to violence:

- Tanzania: provide GBV prevention and support; address gender inequality and violence.
- South Africa: carry out violence screenings as essential care; increase access to provision of services for all survivors of sexual and gender-based violence” including 24-hour GBV command center; provide support for survivors of sexual assault.
- Malawi: patient intake at appropriate healthcare services to include screening questions to identify GBV survivors and training and sensitization for healthcare providers to include content on appropriate management of GBV survivors.
- Kenya: reduce level of sexual and gender-based violence for PLHIV, KP, women, boys and men by 50%; implement GBV prevention and response programs; address the issue of violence against KP through appropriate crisis response mechanisms; community engagement to addresses social-cultural issues that perpetuate GBV.

**Sex Workers**

All countries assessed have identified SW as a key population in their national plans and designate a package of services for this population. While some countries specify FSW and others do not, it does not appear that any country is explicitly including MSW when designing packages. The assessment below considers primarily FSW.

While all 11 countries assessed specify the provision of condoms as part of a SW service package; only four specify the provision of lubricant and four specify the provision of female condoms. Six countries include various levels of community outreach to SW, with four of these (Angola, Botswana, Madagascar and South Africa) specifying peer-to-peer outreach as a key strategy and three countries (Madagascar, Seychelles and South Africa) specifying the use of peers in HTC.

All countries have ART available for SW; however, only Madagascar provides psychosocial and legal support; South Africa has a peer-educator model for monitoring adherence; and Tanzania offers palliative care and nutrition information. Botswana and Mauritius include specific psychosocial support services.
Only six countries specify screening and treatment of TB in service packages; only South Africa specifies screening for, vaccination for and treatment of viral hepatitis; and six countries specify STI screening and treatment services, with Angola specifying specific drop-in centers for screenings. Mauritius and South Africa offer cervical cancer screening; and South Africa includes preventative and emergency contraception and pregnancy termination.

**Table 7. Comparison of national packages of HIV services for SW with elements in the WHO Consolidated Guidelines for Key Populations**

Angola, Botswana, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Seychelles and South Africa include SW (not just FSW) as a key population; Tanzania defined FSW as a key population; and Uganda defined FSW as a key population, but there is no information in their reports about service packages specifically for FSW.

<table>
<thead>
<tr>
<th>WHO Guidance</th>
<th>Summary of Findings for Eleven Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comprehensive condom and lubricant programming</td>
<td>Of the 11 countries, 10 include some sort of condom and/or lubricant distribution in service packages for SW (Seychelles does not); however, Uganda does not specify that these services are targeted to SW in any way and rather simply defines them as part of their national strategy. Four of the countries include lubricant in distribution (Angola, Botswana, Lesotho and South Africa). Only four countries include female condoms (Kenya, Madagascar, South Africa and Uganda).</td>
</tr>
<tr>
<td>2. Behavioral interventions</td>
<td>All countries include behavioral interventions in service packages for SW; Uganda does not specify that these services are targeted to SW. Six countries include various levels of community outreach through BCC/IEC (Angola, Botswana, Lesotho, Madagascar, Mauritius and South Africa). Four countries include peer-to-peer methodologies (Angola, Botswana, Madagascar and South Africa). Three countries include harm/reduction (Angola, Botswana and South Africa). PrEP and PEP are specified for SW in Kenya.</td>
</tr>
<tr>
<td>3. HTC</td>
<td>All 11 countries include HTC in service packages for SW; Uganda does not specify that these services are targeted to SW in any way and rather simply defines them as part of their national strategy. Madagascar, Seychelles and South Africa utilize a peer-to-peer methodology.</td>
</tr>
<tr>
<td>4. HIV treatment and care</td>
<td>Ten of the 11 countries include HIV treatment and care in service packages for SW; Seychelles does not. Nine countries have clear guidelines for ART within service packages (Angola, Botswana, Kenya, Lesotho, Madagascar, Mauritius, South Africa, Tanzania and Uganda); however, Uganda does not specify that these services are targeted to SW. Additionally, Madagascar provides psychosocial and legal support, South Africa, a peer-educator model for monitoring adherence and Tanzania offers palliative care and nutrition information.</td>
</tr>
</tbody>
</table>
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5. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions

Nine of the 11 countries include prevention and management of co-infections and other co-morbidities in service packages for SW (Botswana and Seychelles do not); Uganda does not specify that these services are targeted to SW. Six countries (Lesotho, Madagascar, Mauritius, Tanzania, South Africa and Uganda) specify screening and treatment of TB in service packages. Botswana and Mauritius include specific psychosocial support services. Only one country, South Africa, specifies screening for, vaccination for, and treatment of viral hepatitis.

6. Sexual and reproductive health interventions

Of the 11 countries, 10 include SRH intervention in service packages for SW (Seychelles does not); however, Uganda does not specify that these services are targeted to SW. Six countries (Angola, Botswana, Lesotho, Madagascar, South Africa and Tanzania) specify screening and treatment services and Angola designed specific drop-in centers for screenings. Two countries offer cervical cancer screening (Mauritius and South Africa). Additionally, South Africa includes preventative and emergency contraception and pregnancy termination.

7. Supportive laws and policies

Not mentioned in designs in Angola, Botswana, Lesotho, Madagascar, Seychelles or Uganda. No specific SW activities mentioned in Tanzania, South Africa, Mauritius, Malawi or Kenya.

8. Addressing stigma and discrimination

Not mentioned in designs in Angola, Botswana, Lesotho, Madagascar, Seychelles, or Uganda. No specific SW activities mentioned in Tanzania, South Africa, Mauritius, Malawi, or Kenya.

9. Community empowerment

Not mentioned in designs in Angola, Lesotho, Madagascar, Malawi, Mauritius, Seychelles or Uganda. No specific SW activities mentioned in South Africa, Tanzania, or Kenya.

10. Addressing violence

Not mentioned in designs in Angola, Lesotho, Madagascar, Seychelles or Uganda. No specific SW activities mentioned in Malawi, Mauritius, South Africa, Tanzania or Kenya.

Overall, there is more variation in service package design than might be expected in this region. The packages are highly variable in level of detail and types of interventions specified.

Men who have Sex with Men

All countries include MSM as a KP in their country and all (except Uganda) have developed a specific package of services for MSM. All packages (except in Seychelles) include condoms as a primary prevention intervention and lubricants are included in MSM packages in only seven countries. Only Mauritius distributed female condoms to MSM. Peer education is specified in the packages for Angola, Madagascar and Tanzania. Angola, Kenya and South Africa also specify harm reduction counseling (for drug use) as part of their MSM package, while Mauritius also does sex venue-based outreach for MSM in order to reach male SW.

All countries but Botswana have specific guidelines for providing HTC to MSM; Mauritius provides couples testing; Madagascar and South Africa provide community-based testing; and South Africa offers self-testing. ART is available to MSM in all countries, with seven countries specifying clear...
guidelines for ART within MSM service packages. Only five countries specify screening and treatment of TB in service packages. Angola, Kenya, Lesotho, Madagascar, South Africa and Tanzania specify STI screening and treatment services; Angola has specific drop-in centers for STI screening; and, South Africa is the only country to offer rectal care and treatment.

Table 8. Comparison of national packages of HIV services for MSM with elements in the WHO Consolidated Guidelines for Key Populations

All 11 countries in ESA identified MSM as KP.

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<tr>
<td>1. Comprehensive condom and lubricant programming</td>
<td>Ten of the 11 countries distribute condoms; Seychelles does not. Uganda does not specify that these services are targeted to MSM in any way and rather simply defines them as part of their national strategy. Only seven of the 11 countries distribute lubricant: Angola, Kenya, Madagascar, Malawi, Mauritius, South Africa and Tanzania. Lesotho distributes lubricant, though through CSOs and not as part of a national intervention. Mauritius is the only country that distributed female condoms.</td>
</tr>
<tr>
<td>2. Behavioral interventions</td>
<td>All 11 countries include some sort of behavior change component in their national strategy; however, one country (Uganda) does not specify that these services are targeted to MSM. Peer education is specified in the packages for Angola, Madagascar and Tanzania. Three countries also specify harm reduction counseling (for drug use) as part of their MSM package (Angola, Kenya and South Africa); while Mauritius also does sex venue-based outreach for MSM, allowing them to reach MSM who are also SW or clients of SW. Kenya specifies PrEP and PEP for MSM.</td>
</tr>
<tr>
<td>3. HTC</td>
<td>All but one country provide HTC for MSM (Botswana does not, only for SW). Angola and Uganda provide testing for KP in general, though not necessarily MSM. Lesotho and Madagascar provide referrals for HTC services (Madagascar through peer-to-peer educators). Seychelles also provides peer-to-peer education. Only Mauritius provides couples testing. Madagascar and South Africa provide community-based testing; and only South Africa offers self-testing.</td>
</tr>
<tr>
<td>4. HIV treatment and care</td>
<td>Ten of the 11 countries include HIV treatment and care in service packages for MSM (Seychelles does not). Seven countries have clear guidelines for ART within service packages (Angola, Lesotho, Madagascar, Mauritius, South Africa, Tanzania and Uganda); however, Uganda does not specify that these services are targeted to MSM.</td>
</tr>
<tr>
<td>5. Prevention and management of co-infections and other co-morbidities, including viral</td>
<td>Nine of the 11 countries include prevention and management of co-infections and other co-morbidities in service packages for MSM (Botswana and Seychelles do not), Uganda does not specify that these services are targeted to MSM. Only Lesotho, Madagascar, Mauritius, South Africa and Uganda specify screening and treatment of TB in service packages. Mauritius is the only country to include specific psychosocial</td>
</tr>
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</table>
hepatitis, tuberculosis and mental health conditions | support services. South Africa and Tanzania are the only two countries to include specific services for cancer screening and screening and immunizations for hepatitis B and C.

6. Sexual and reproductive health interventions | Of the 11 countries, eight include SRH intervention in service packages for MSM (Botswana, Mauritius and Seychelles do not); however, Uganda does not specify that these services are targeted to MSM in any way and rather simply defines them as part of their national strategy. Angola, Kenya, Lesotho, Madagascar, South Africa and Tanzania specify screening and treatment services and Angola designed specific drop-in centers for screenings. South Africa is the only country to offer rectal care and treatment and Tanzania is the only country to offer VMMC.

7. Supportive laws and policies | Not mentioned in designs in Angola, Botswana, Lesotho, Madagascar, Seychelles, or Uganda. No specific MSM activities mentioned in Tanzania, South Africa, Mauritius, Malawi or Kenya.

8. Addressing stigma and discrimination | Not mentioned in designs in Angola, Botswana, Lesotho, Madagascar, Seychelles, or Uganda. No specific MSM activities mentioned in Tanzania, South Africa, Mauritius, Malawi or Kenya.

9. Community empowerment | Not mentioned in designs in Angola, Lesotho, Madagascar, Malawi, Mauritius, Seychelles, or Uganda. No specific MSM activities mentioned in South Africa, Tanzania or Kenya.

10. Addressing violence | Not mentioned in designs in Angola, Lesotho, Madagascar, Seychelles, Uganda. No specific MSM activities mentioned in Malawi, Mauritius, South Africa, Tanzania or Kenya.

Overall, the design of MSM service packages adhere fairly closely to WHO guidelines, but the lack of inclusion of condom distribution in one country and of lubricant distribution in four countries is very problematic.

People Who Inject Drugs

Six countries define PWID as a KP: Kenya, Madagascar, Mauritius, Seychelles, Tanzania and Uganda⁴¹. South Africa defined PWID as a KP; however, there is no information in the report about services packages specifically for PWID.

Harm reduction services arrived later in ESA than in some other regions and this is perhaps part of the reason that only four countries include both NSP and OST programs and only Tanzania includes overdose management. Mostly, the programs are similar across the six countries, but Kenya and Tanzania have a substantial number of services not included in the packages of other countries.

⁴¹ Due to the lack of a defined comprehensive service package for KP in Uganda, it is difficult to compare services provided to KP with the WHO Key Population Global Guidance. However, a comparison is made against the services outlined in the Strategic Objectives under the Thematic Goals within the National HIV and AIDS Strategic Plan (2015/2016-2019/2020). These are included for comparison on the assumption that these services either address KP specifically or might be accessed by KP in mainstream services, UAC 2015
Table 9. Comparison of national packages of HIV services for PWID with the WHO Consolidated Guidelines for Key Populations

<table>
<thead>
<tr>
<th>WHO Guidance</th>
<th>Summary of Findings for Six Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comprehensive condom and lubricant programming</td>
<td>Five of the six countries distribute male condoms to PWID (Seychelles does not) and two distribute female condoms (Mauritius and Uganda). Only Mauritius specifically states lubricant distribution in their service package.</td>
</tr>
<tr>
<td>2. Harm reduction interventions for substance use (in particular, NSP and OST)</td>
<td>Of the six countries, four include OST and NSP in their service packages (Kenya, Madagascar, Mauritius and Tanzania, though Tanzania only offers NSP at a demonstration site). Seychelles only indicates harm reduction measures, but there are no specifics about activities. Tanzania offers overdose management, drug detoxification and relapse prevention.</td>
</tr>
<tr>
<td>3. Behavioral interventions</td>
<td>All six countries include behavior interventions in their service packages. However, Uganda does not specify that these services are targeted to PWID. Kenya, Madagascar and Tanzania include peer education and support. Kenya, Mauritius and Seychelles include targeted outreach programs. Tanzania also offers psychosocial support, socio-economic and related reintegration services, personal development and family reintegration. Kenya specifies PrEP and PEP for PWID.</td>
</tr>
<tr>
<td>4. HTC</td>
<td>All six countries include HTC in their service packages; however, Uganda does not specify that these services are targeted to PWID. Mauritius, Tanzania and Uganda have specific activities related to linkage to care. Kenya, Madagascar and Seychelles adopt a peer-to-peer approach. Mauritius is the only country to include couples testing.</td>
</tr>
<tr>
<td>5. HIV treatment and care</td>
<td>Five of the six countries include HIV treatment and care in service packages (Seychelles does not). Only Madagascar includes psychosocial support. Kenya, Madagascar and Tanzania include ART care. Tanzania includes palliative care.</td>
</tr>
<tr>
<td>6. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions</td>
<td>Five of the six countries include prevention and management of co-infections and co-morbidities in service packages (Seychelles does not). All five countries screen for TB and Mauritius offers prophylaxis. All five countries screen for other, non-specific OI; only Kenya and Tanzania list Hepatitis B and C screening specifically.</td>
</tr>
</tbody>
</table>

42 It should be noted that while the Kenyan National Framework includes condom distribution, the “Prevent Revolution Roadmap” does not include condom distribution for PWID.
7. Sexual and reproductive health interventions

Five of the six countries include SRH interventions in service packages (Seychelles does not). Madagascar, Tanzania and Uganda include specific STI interventions and treatment. Mauritius includes a specific focus on cervical cancer screening.

8. Supportive laws and policies

Not mentioned in designs in Angola, Botswana, Lesotho, Madagascar, Seychelles or Uganda. No specific PWID activities mentioned in Tanzania, South Africa, Mauritius, Malawi or Kenya.

9. Addressing stigma and discrimination

Not mentioned in designs in Angola, Botswana, Lesotho, Madagascar, Seychelles or Uganda. No specific PWID activities mentioned in Tanzania, South Africa, Mauritius, Malawi or Kenya.

10. Community empowerment

Not mentioned in designs in Angola, Lesotho, Madagascar, Malawi, Mauritius, Seychelles or Uganda. No specific PWID activities mentioned in Kenya. South Africa (additional to general KP activities) calls for community awareness and advocacy programs for PWID. Tanzania’s design (additional to general KP activities) calls for the establishment of peer support groups.

11. Addressing violence

Not mentioned in designs in Angola, Lesotho, Madagascar, Seychelles or Uganda. No specific PWID activities mentioned in Malawi, Mauritius, South Africa, Tanzania, or Kenya.

In terms of community empowerment and enabling environment activities, the former does not feature as a component of the PWID package in any of the countries assessed, though a reference is made to empowerment of PWID in Mauritius. Enabling environment activities are mentioned only in broad terms (affecting all key populations), except in Kenya, where, in addition to the overall interventions mentioned below, the following are specified:

- Basic hygiene kits and child care support for females who use/inject drugs
- Economic enhancement via vocational training and income generating activities

National networks of PWID exist in Kenya and Tanzania.

Overall, as expected given the small numbers of PWID in most countries in the region, there are fewer countries with PWID service packages, but the packages that exist generally adhere to the WHO Consolidated Guidelines with the exception of OST.

**Prisoners**

It is of great concern that only three countries specified service packages for prisoners. Of the programs available for assessment, all provide some form of behavioral interventions; two provide condoms; Lesotho and Tanzania offer voluntary medical male circumcision (VMMC); Lesotho offers access to prevention of mother-to-child transmission of HIV (PMTCT) services for pregnant and nursing mothers; and none provide harm reduction services. All countries provide ART, STI and TB screening and treatment, but only Madagascar and Tanzania extend services to screening and treatment of opportunistic infections (OI); and only Tanzania offers screening and treatment for viral hepatitis and injection site care.
### Prisons

<table>
<thead>
<tr>
<th>WHO Guidance</th>
<th>Summary of Findings for Three Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comprehensive condom and lubricant programming</td>
<td>Lesotho and Tanzania have condom distribution programs and Lesotho specifically includes lubricants. There is no information available for Madagascar.</td>
</tr>
<tr>
<td>2. Harm reduction interventions for substance use (in particular, NSP and OST)</td>
<td>Lesotho includes harm reduction in its strategies, however, no programmatic detail is given in the report. Madagascar and Tanzania do not include harm reduction in strategies for prisoners.</td>
</tr>
<tr>
<td>3. Behavioral interventions</td>
<td>All three countries have behavioral intervention activities with prisoners. Lesotho and Tanzania offer peer education programs and they both offer psychosocial support either through groups or individually and life-skills training. Madagascar’s interventions focus on education around human rights, GBV and disease prevention.</td>
</tr>
<tr>
<td>4. HTC</td>
<td>All three countries provide on-site HTC; Lesotho offers access to PEP.</td>
</tr>
<tr>
<td>5. HIV treatment and care</td>
<td>All three countries provide treatment and care. Lesotho provides on-site care in some facilities; all three provide referrals. Madagascar includes social and legal support; and Tanzania includes palliative care and nutrition.</td>
</tr>
<tr>
<td>6. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions</td>
<td>All three countries provide screening and treatment for TB. Madagascar and Tanzania extend services to screening and treatment of OI. Only Tanzania offers screening and treatment for viral hepatitis and injection site care.</td>
</tr>
<tr>
<td>7. Sexual and reproductive health interventions</td>
<td>All three countries offer access to STI testing and treatment. Lesotho and Tanzania offer VMMC. Lesotho also offers access to PMTCT services for pregnant and nursing mothers.</td>
</tr>
<tr>
<td>8. Supportive laws and policies</td>
<td>Not mentioned in designs in Angola, Botswana, Lesotho, Madagascar, Seychelles or Uganda. No specific prisoner activities mentioned in Tanzania, South Africa, Mauritius, Malawi or Kenya.</td>
</tr>
</tbody>
</table>
9. Addressing stigma and discrimination

Not mentioned in designs in Angola, Botswana, Lesotho, Madagascar, Seychelles or Uganda. No specific prisoner activities mentioned in Tanzania, South Africa, Mauritius, Malawi, or Kenya.

10. Community empowerment

Not mentioned in designs in Angola, Lesotho, Madagascar, Malawi, Mauritius, Seychelles or Uganda. No specific prisoner activities mentioned in South Africa, Tanzania or Kenya.

11. Addressing violence

Not mentioned in designs in Angola, Lesotho, Madagascar, Seychelles or Uganda. No specific prisoner activities mentioned in Malawi, Mauritius, South Africa, Tanzania or Kenya.

In terms of community empowerment and enabling environment activities, the former does not feature as a component of the prisoners’ package in any of the countries assessed. Enabling environment activities are mentioned only in broad terms (affecting all KP).

Overall, prisons programming falls well below what is recommended in the WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2014) for most of the region.

**Transgender People**

Only Angola, South Africa and Tanzania define TG as a key population. While Angola defines TG as a KP, there is no information in the report about services packages specifically for TG. For South Africa, the service package for TG is currently included in the service package for MSM with the addition of sexual and reproductive health (SRH) interventions. For Tanzania, the service package is also included with MSM.

In terms of community empowerment and enabling environment activities, the former does not feature as a component of the TG package in any of the countries assessed, though South Africa is working on a package for this population at present and this is likely to include community empowerment. Enabling environment activities are mentioned only in broad terms (affecting all KP).

Overall, service packages for TG can be categorized as weak, but it must be remembered that in most countries, at least some TG have access to MSM service packages.

**Other**

It should be noted that in Kenya, an additional service package has been added for all KP, called “Key interventions for removing human rights-related barriers to access.” This package includes:

- Training of health care providers and other leaders on human rights to establish an enabling environment and to promote “friendly” services that meet the needs of the key and
vulnerable groups; and advocacy among law enforcers and county government on the punitive legislations and municipal by-laws that inhibit KP from accessing health services.

Enabling environment activities affecting all KP are specified in broad terms in the Madagascar, Tanzania and Botswana national strategic plans. In the Prevention Revolution Roadmap in Kenya, several key interventions are included in the packages for MSM, SW and PWID:

- Human rights protection and promotion
- Social support
- Psychosocial support mechanisms
- GBV prevention programs
- Health care providers and police sensitivity trainings
Assessment of HIV Service Packages for Key Populations
Eastern and Southern Africa

ANALYSIS: ARE PACKAGE DESIGNS MEETING INTERNATIONAL STANDARDS?

Most of the assessed countries have taken the opportunity to formally recognize some KP in their national plans and strategies and have acknowledged the importance of servicing KP by designing tailored packages based on WHO Consolidated Guidelines for HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2014).

However, there are some notable deviations from the above-mentioned guidelines. Only Tanzania refers to all five KP in its national strategic plan. Some other countries have no evidence of TG or PWID populations; however, this does not explain the lack of service packages for prisoners and, for Botswana and Uganda, for MSM.

The lack of universal inclusion of lubricants for MSM is a major concern, as is the uneven inclusion of PEP and PrEP for SW and MSM. As will be noted further below, the lack of specificity in most packages to account for important subpopulations – male and/or transgender SW, women who inject drugs, adolescent key populations – can lead to confusion and difficulties in implementation and monitoring.

While behavioral interventions are universally included in packages in some form, there is a notable lack of detailed standards for what these interventions include, how they are delivered and what is considered sufficient coverage.

Other complementary services, addressing co-morbidities and related health needs need more careful consideration in most countries. In particular, given the very large epidemics of TB in the region, it is remarkable that few countries have included TB testing and treatment in all KP service packages. While services for TB, HCV, STI and other reproductive health issues may be available in the country in general, some KP may be able to access these services in the same manner as the general population; but in environments of stigma, discrimination and violence, it is often necessary to tailor these services to be more accessible to key populations and to state explicitly that KP have the right to access them.

The availability of testing models designed specifically to reach harder to reach populations (such as rapid testing in various venues and through different outreach methods) is highly variable and warrants careful planning in the design phase, according to population size and distribution.

The inclusion of specific human rights and other interventions to enhance the enabling environment is also very uneven across the region but both Kenya and South Africa provide some detail of what these interventions should be for various KP down to the ward or county level.

RECOMMENDATIONS: DESIGN OF SERVICE PACKAGES FOR KEY POPULATIONS

1. Defined packages of services should include services for all KP that have been identified in the country. There may be minor variations depending on local epidemiology and behavior.
2. All countries in the region require at least the basic services for each KP to be in the designed service packages. All KP packages should contain condom and lubricant distribution; with female condoms at least included in all SW programs; and needles and syringes included in at least all PWID programs.

3. Needs-based services should also be included in service packages for all KP, including the offer of PEP, STI, TB and hepatitis B and C services. PrEP should be included to be offered to at least MSM, TG and SW.

4. Critical enabler activities should be specified in all KP packages. Assessments on human rights barriers to key populations’ access to HIV services have been carried out in some of the reviewed countries (Botswana, Kenya, Mozambique, South Africa and Uganda). Similar exercises should be carried out in all countries. All countries should have a strategy to address ongoing human rights issues that impact key populations’ access to HIV and broader health services. This strategy should be explicitly linked to overall national HIV strategies and plans.

5. All countries should continue to progress towards clear definitions of coverage for all elements of service packages.

6. Other countries should consider using the methodology used in the South African Sex Worker Plan (SANAC, 2016), which differentiates services based on the number of SW in a locality. The methods outlined in this plan of mapping the local community and circumstances of KP in each locality should be taken up elsewhere.

7. Following the development of the National Guidelines for HIV/STI Programming with Key Populations in Kenya and Focus for Impact in South Africa, other countries in the region should consider mapping and providing advice to local government entities on working with KP.

8. For countries with long-standing key population responses to HIV – such as South Africa and Kenya – consideration should be given to providing flexibility for optional, enhanced services to be provided alongside core services, in order to attract clients and to address some of the underlying reasons why various KP may not want to present for HIV testing, PrEP, or ART, or may not want to remain on ART.

9. A decision is needed at the national level about how organizations will collaborate to ensure that the needs of male and transgender SW are met.

10. Additional services may need to be defined for specific sub-populations such as male and/or transgender SW, women who inject drugs and adolescent KP.

11. Where mental health interventions are to continue to be included in service packages, there is a need for greater understanding of the mental health needs of different KP and therefore more thoughtful, realistic and well-described interventions included in service packages and adequate resourcing of these services.

12. The development of minimum standards for behavioral interventions, which are attuned to population needs, would ensure that the intent of the design of this intervention carries over into appropriate resource mobilization and implementation as well as impact.
More than in any other region assessed, the contents of the HIV service packages in ESA appear to be driven by the needs of the client more than by the minimum standards in the national guidelines; this is particularly true in the cases of Kenya and South Africa. This client-driven approach appears to work well in the context of strong KP-led implementers who are closely in touch with the communities they serve. It also appears to work well in the context of very good PR-SR relationships with strong feedback loops and communication mechanisms (observed across the KP NGOs in Kenya and for SW NGOs in South Africa). In many cases in these countries, implementers have augmented and extended the national package to include innovative aspects that were reported to support client retention in care (i.e. nutritional support, dignity packs, child care, gender-responsive approaches, family engagement/support, etc.).

For Madagascar and Angola, there is less evidence that implementers are responding to the needs of local KP, with more emphasis on trying to provide the basic package of services described in the national design.

In Malawi, the comprehensive packages as defined in the HIV Prevention Strategy and as drafted for the anticipated national KP guidelines are far more extensive than what is currently being delivered on the ground. Global Fund implementers report the current package to mostly consist of three things (1) health information on prevention, (2) provision of condoms and lubricants, and (3) HTC. As such, several elements are not currently being implemented as designed. For instance:

- PrEP for MSM is not implemented. A PrEP research study for SW at 3 drop-in centers in Blantyre is under DHA review, though PrEP for FSW is not part of any of the KP packages in Malawi, as currently designed.
- HPV vaccinations are not being implemented for MSM or FSW. HBV vaccinations (as designed for MSM) are also not being implemented.
- STI screening and treatment, GBV interventions and cervical cancer screening are reported to be considered ‘extras’ to the minimum package.

Funding limitations, absence of national KP guidelines and reliance on referrals to the public health system are cited as the main reasons for these discrepancies.

Across the region, service packages are delivered along a continuum by civil society, private and governmental providers. Prevention services are provided primarily by NGOs and community-based
organizations (CBOs), often utilizing peer educators or peer navigators to conduct outreach or drop-in in ‘hot spots’ where FSW, MSM and PWID are found in the greatest density. Services may be provided through mobile outreach (e.g. through mobile units) or at static locations (e.g. drop-in centers).

The point of intersection between government and non-government service providers tends to be either HIV testing or linkage to care. In many cases, NGOs or CBOs are able to deliver community-based rapid testing on site (either mobile or static) and conduct referrals or accompaniment to care only for those who test positive. In other environments, clients are referred to or accompanied to care facilities to initiate testing for HIV. NGO and CBO support beyond the point of HIV diagnosis may or may not continue, depending on models employed and resource availability. HIV treatment and care are then generally provided by government service providers in government facilities, though ART provision is increasingly being outsourced to a variety of delivery mechanisms, from chronic disease clubs in South Africa, to key population-led CBOs in Kenya and South Africa.

Coverage of KP with service packages varies widely across the region, as do the definitions of coverage. As noted in Table 1, the key indicator should be coverage of a KP with the defined package of services (as shown in the Design section of this report). However, this is impossible in most countries because the service package often includes ART, for which coverage figures are usually not disaggregated by key population (this is discussed further in the Monitoring section.) In addition, some countries use different definitions of coverage in GAM and other reports. As shown in the tables below, some coverage estimates come from research reports and others from IBBS surveys, rather than from programmatic data. Recommendations on this issue are contained in the Monitoring Section of this report’s recommendations.

Of the five countries assessed through in-country visits, most key medical services for PLHIV are free of charge. In all countries, this includes ART and CD4 and viral load tests (where available). But in Madagascar, OI diagnosis and treatment require payment by the patient, as do STI medications in both Madagascar and Angola.

Implementation of critical enabler activities has been patchy across the 11 countries surveyed. As noted in the Design section, several countries have few or no critical enabler activities in their service packages. But evidence is found of implementation in some countries and some positive changes in the environment are reported in most countries. For example, MSM and SW FGD participants in Madagascar report an overall improvement, with a more favorable environment compared to five years ago.

One aspect of the enabling environment, which appears to be more common in ESA than in other regions, is the use of provincial, county and/or ward committees to guide local KP programming. Each region of Madagascar has a Regional Task Force (RTF) that is responsible for improving coordination at a local level. In Kenya, regular engagement between implementers and county governments and between local chiefs and community leaders has facilitated service provision, reducing community backlash and interference during outreach. There are 17 county-level KP technical working groups (TWG) with multi-stakeholder dialogue and engagement. During the country visit, the effects of these
local efforts were seen, as the majority of KP implementers report that they are largely left alone by law enforcement and the community in providing services and carrying on with their work. Implementers report cultivating relationships with landlords for the drop-in centers to ensure they are well aware of how they intend to use the space.

Stigma and discrimination are raised as important issues by KP in FGD in all five countries with in-country assessments. Stigma and discrimination for MSM and FSW is high in Angola, but less so in certain public health centers. There have been efforts to train healthcare professionals to reduce stigma and discrimination affecting key populations, but the program effectiveness has been low to date. There are ongoing efforts to address stigma and discrimination against KP and PLHIV more generally. Both LINKAGES and PSI are carrying out activities in Angola to ensure health facilities are more welcoming to KP and undertaking advocacy to reduce stigma and discrimination. According to the Global Fund Concept Note, there are plans to employ community agents to work on sensitizing communities about stigma surrounding HIV and KP.

As MSM are criminalized in Malawi and FSW are marginalized under current regulations, both groups experience stigma and discrimination from the general public as well as from health care and social service providers (Malawi NAC, 2014). Across multiple behavioral studies, MSM report being afraid to seek health services. Human rights abuses, GBV and “self-stigma” are also found to be key inhibitors in accessing HIV services for both FSW and MSM (Ruberintwari et al., 2016). The National Strategic Plan for HIV and AIDS (2015-2020) and the National HIV Prevention Strategy (2015-2020) both identify a number of structural interventions to address these inhibitors.

In light of these challenges, UNAIDS in Malawi has identified the creation of an enabling legal environment and the reduction of stigma and discrimination in society as a key issue for the Fast-Track approach. Transformative dialogue sessions are being led by UNAIDS, bringing together police, KP and religious leaders, among others (UNAIDS, 2016). These are being modeled after successful experiences in South Africa, where there is a think tank on HIV, rights and justice.

The Madagascar National Strategic Plan for a multi-sectoral response to STI, HIV and AIDS 2018-2022 states that the level of stigma and discrimination towards PLHIV is high. It also indicates that 73.5% of FSW experience discrimination. The MSM network Solidarité des MSM is financially supported to conduct an advocacy program for the rights of the LGBTI community. Médecins du Monde is currently implementing a community treatment observatory in five regions that includes building the capacity of KP NGOs to monitor and collect data for advocacy. This is the only project identified that aims at documenting potential barriers to service access and subsequent use of the data generated to inform interventions.

The Kenya National HIV and AIDS Stigma and Discrimination Index (2015) shows that key populations (MSM, SW and PWID) experience double the stigma associated with their sexual behaviors, practices and HIV status. Children living with HIV are also significantly affected as a result of stigma, which could limit their access to services. Results of the general population survey show that 55.0% of those
surveyed believe that SW are contributing to the spread of HIV, while 44.8% believe that MSM and drug users deserve to get HIV.

In Uganda, despite a lack of activities to address GBV in the KP service packages, it is reported that the proportion of PLHIV that report cases of GBV have fallen in recent years. In 2013, PEPFAR supported programs in the country reached 543,833 individuals with interventions that explicitly addressed GBV; 609,020 individuals with interventions and services that addressed legal rights and the protection of women and girls impacted by HIV; and 943,964 individuals with interventions that explicitly addressed norms about masculinity related to HIV (APMG Health Uganda Desk Review, 2018).

Service packages - as currently designed and delivered in the five countries - may not be effective in reaching adolescent and young KP.

Detailed assessments of package implementation are presented below by population.

**FSW Package Implementation**

While all the countries visited had methods for coordinating SW programs, South Africa has a remarkable group of national organizations working on these issues. The Networking HIV and AIDS Community of South Africa manages the Global Fund SW program, overseeing 14 SR that deliver the core intervention package. Within this, different SR have slightly different specialties or approaches. Service packages, SOP, tools and systems are provided by NACOSA for a wide range of functions, including M&E, outreach and referral.

One of the central roles of the PR is to provide a framework of procedures, templates, data flow processes, oversight and operational guidance in order to ensure that standards are met and the program is correctly delivered. Sub-recipient managers, staff and peers require orientation to the program and systems and training in a range of key competencies. A basic two-week orientation/training course is offered by NACOSA for key SR staff. Additional training is provided depending on the standards and approaches of individual SR, with Lifeline Durban, for example, providing a ten-day counseling training course for lay counselors.

The Sex Workers Education and Advocacy Taskforce (SWEAT) has provided a key document that guides the values and processes for working with SW, providing a nationally-accepted SOP for process and outreach that guides good practice (SWEAT, 2015). More detail is embedded in contracts and job descriptions.

Country visits verified that where prevention services are delivered according to package design, this is done primarily through outreach by peer educators. Most outreach is done at hotspots, though some is provided in static locations (e.g. drop-in centers). Internet-based outreach is not widely used in the assessed countries. Participants of FGD and key informant interviews note violence as a major barrier to providing and receiving outreach services.
Outreach workers are expected to reach high numbers of clients: one implementer in Kenya reports a ratio of one peer educator to 114 clients, acknowledging that the recommended ratio is 1:90. Motivating peer educators is reported to be a challenge in Global Fund-supported FSW programs in Malawi. One SR that implements both Global Fund and LINAKGES FSW programs reports challenges such as the fact that LINKAGES peer educators get stipends and Global Fund peer educators do not; because of this, the SR report losing many peer educators from the Global Fund program and noted that peer educator retention is far higher in the LINKAGES program.

In Angola, interventions for behavior change are carried out through peer educators in Luanda and Benguela, but nowhere else in the country. There is no defined mechanism to evaluate the impact of these interventions. Paying peer educators according to target populations reached seems to incentivize indiscriminate testing and HIV positive rates in program interventions range from 1-2%, much lower than HIV prevalence reported in surveys for KP. The peer-educator model is well known by the SR and SSR, but no bottom-up mechanism exists through which to provide feedback and discuss potential alternatives to services provided.

In South Africa, outreach is augmented with two strategies known as workshops and support groups. One-off workshops focusing on training on particular skills or knowledge are provided by SR a few times a year for groups of around 30 SW. Workshops might cover HIV, PreP, STI, condom use, clinic referral processes, and human and legal rights. Support groups are described as more difficult to get right, but provide valuable on-going small group support. They provide a series of more frequent, smaller meetings, offering training over several sessions, alongside facilitated peer psychosocial supports. Groups may follow a curriculum over six or 10 sessions. Support groups generally target sub-populations, such as PLHIV, potential PrEP clients, or SW who are using drugs. This enables training and discussion to concentrate on their particular needs and interests, and within their own contexts, groups might discuss ART adherence, treatment literacy, sexual and reproductive health and rights (SRHR), or topics the members identify in successive meetings. While similar approaches are used in other countries in the region, only in South Africa are these observed to be a standard part of the service package, complete with SOP.

Also in South Africa, programs are adapted as they expand to different contexts. For example, in the move from urban areas to peri-urban and rural areas, changes are needed to approaches, protocols, forms and skills requirements. Different phases in engagement also require differentiation, with mapping and establishment of peer groups, leading to site familiarity and awareness raising, then shifting into routine program delivery over time. Although not formally referred to as micro-planning, SR follow a process of community mapping through networking and hotspot analysis in all new sites to establish local level denominators (target population estimates) and to discuss local context, needs and priorities (See case study below).

*Case Study: Lifeline cohort approach*

There is a split occurring between the types of outreach programs for KP, with many outreach workers being asked to concentrate on finding new HIV cases at the expense of ongoing work with current clients. This has been the outcome of much of the “test and treat” rhetoric of recent years. However, there may be significant
benefits in continuing to undertake a “cohort” approach in which an outreach team strives to visit all or almost all members of a KP in a given geographic area on a regular basis with the objective of preventing HIV among those who are HIV-negative and preventing onward transmission and facilitating linkage to care among those who are HIV-positive.

One example of this approach is Lifeline’s work with sex workers in peri-urban areas outside Durban in South Africa. Lifeline Durban provides services in two of the six districts (Ugu and Ilembe) in the province of KwaZulu Natal (KZN). At the time of visiting, the program operated in three sub-districts of the Ugu district, with a total of 58 SW sites. The program in Ilembe district had been curtailed due to violence in the area.

Most of Lifeline’s work is carried out using SOP, tools and systems provided by NACOSA (a SW PR for South Africa). Sub-recipient management, staff and peers require orientation to the program and systems and training in a range of key competencies. A basic two-week orientation training course is offered by NACOSA for key SR staff. Lifeline Durban also provides a 10-day counseling training course for lay counselors. Professional nurses employed by Lifeline complete Department of Health (DoH) training to become accredited for ART initiation and management, enabling them to provide direct services to HIV-positive SW.

Peer-led outreach is the cornerstone of the SW program. Peers are recruited and trained and then allocated to teams. Following a standardized set of outreach processes, peers engage with SW in the way most appropriate to the nature of sex work in the area, such as through day or night outreach and in consideration of whether or not this is the first encounter. Working in the relatively contained and stable rural communities of southern KZN, Lifeline Durban has designed peer outreach using a cohort approach to good effect. When introduced to new SW, peers attempt to link them into an existing group or cohort, planning and tracking a series of contacts and progressive education with the same peer educator over time.

For the 58 SW sites, site profiles are regularly updated using a Site Mapping Tool to include estimates of SW numbers, age ranges and workspaces, as well as HTS yield totals per site. While useful for continuously triangulated PSE and useful in budgeting, additional details on current issues, needs, rights, or access would enable more thorough micro-planning.

Lifeline cooperates closely with DoH mobile clinics, which offer HIV test and treat, TB testing, STI diagnosis and treatment and pap smears. Once nurse accreditation is complete, they will also offer ART and PrEP. The mobile clinic visits 25 SW sites each month over around eight days per month. The SR provides social mobilization, referrals and follow-up, and markets the mobile’s schedule and services into target communities. A representative of the mobile clinic told consultants: “It would be difficult if Lifeline wasn’t here. We can’t get the girls organized. We see the peer educators as our partners.” Following contact with the mobile clinic, SW may be referred to their local permanent clinic, while remaining in a cohort supported by a peer. This model has been found to be both effective and suitably connected into the public health system.

Key factors in Lifeline’s successful approach include the organization’s long history of work with SW and other vulnerable populations in the Durban region, the use of its core strength in counseling training as a key service provided to clients and the close linkage that the NGO has formed with DoH facilities such as mobile clinics. While the cohort approach may not be the most appropriate form of service delivery in all circumstances, it can
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be very effective in maintaining low levels of HIV transmission, even in circumstances of a high community and KP prevalence of HIV.

Condom distribution is confirmed as a core intervention across the five countries, though the inclusion of lubricant is inconsistent, and condom stock-outs have been reported in Madagascar. Measuring ‘reach’ in the Global Fund-supported FSW program in Malawi is defined as receiving health information on prevention, provision of condoms and lubricants and HTC. Screening and treatment for STI, GBV interventions and cervical cancer screening are considered ‘extras’ to the minimum package. In Madagascar, there is a heavy reliance on peer educators to obtain condoms and although SW know of healthcare centers where they can get condoms, they rely predominantly on peer educators for this service.

In Kenya, among the three KP examined, the clinical service package for sex workers is observed to be the most comprehensive. Apart from a wide range of HIV and reproductive health services, SW implementers in Kenya were observed to have stock of isoniazid preventive therapy (IPT), which was reported to be available to all HIV positive clients, as well as cotrimoxazole for all co-infected clients.

All interactions with SW in South Africa, including outreach, workshops, support groups and clinics, offer and promote HTC services. Rapid testing is offered during outreach and private testing venues are available at all group meetings by HTC-trained peers and/or professional nurses in the employ of the SR. In a particularly sustainable model, one SR in Durban works in close collaboration with DoH mobile clinics, directly linking SW with public sector services during outreach.

While quarterly testing targets seem to be being achieved in South Africa, there is a risk of retesting the same group each quarter, including sometimes retesting PLHIV who know their status. Targets may be met with people who are most easily accessed while not necessarily reaching those reluctant to test. In Angola, HIV tests are formally available in HTC points, but stock outs are frequent, particularly outside the capital. Lack of HIV tests at the point of service is one of the contributors to loss-to-follow-up. Similar issues are reported in Madagascar.

Linkage to care is a standing challenge in South Africa and requires intensive peer resources and a relatively low client-to-peer ratio in order to be effective. Individual peer follow-up, either personal or telephonic, has been found to be the most effective support to linkage to care. Strategies include personalized contact, established trust, offers of accompaniment, tear-off referral slips, and customized services offered in non-medical sites, such as pap smear campaigns in hotels and sex work venues. If referral follow-through stalls, peers might go as far as queuing on behalf of a SW, in the hope that they are available and willing to arrive at the clinic later in the day.

43 Referral slips come in two parts: one is provided to the client and the other is kept by the outreach worker or peer educator. Some programs then marry the slips (which should be marked with the client’s UIC) by asking the referred service provider to provide the presented slips each month. This can keep track of which clients actually took up referrals.
In Madagascar, linkage to care is ensured by a PLHIV navigator from the Reseau MAD’AIDS\(^{44}\) network or the healthcare personnel that performs the HIV test. There is no formal process for people who test HIV-positive to be linked to treatment and care. However, the navigators are PLHIV who are on call at health care centers to offer counseling to PLHIV and to accompany them to obtain their treatment, acting as a mediator between the healthcare personnel and the patients. Ensuring a strong link to care is an issue when outreach testing is done, since navigators are not systematically present.

Access by SW to ART across the region was uneven. One implementer in Kenya notes that they so far have an over 98% initiation rate onto ART, which is aided by having on-site, same-day ART initiation. This implementer reports having 798 active clients living with HIV, of whom 93% are at viral load suppression. However, data acquired during the country visit reveal significant gaps in enrollment in care and in ART coverage among young FSW compared to older FSW (Figure 5).

**Figure 5. FSW who self-reported HIV status, enrollment in care, treatment and retention in treatment in Kenya (NASCOP, 2017)**

The need for and usefulness of ‘safe spaces’ for SW is a regular theme of FGD in the country assessments. A Global Fund-supported site in Kenya reports opening its clinic doors as a space for other projects that the SW themselves are organizing, including economic empowerment and advocacy activities. This practice has been a success factor for making it a community space, as it encourages community members to come regularly for services and to remain in care. Another source of support and advice is a 24-hour SW support helpline that offers telephonic counseling and access to a list of potential service providers in each area to whom callers can be referred, if available. There

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\(^{44}\) [http://www.madaids.onusida.net/?lang=fr](http://www.madaids.onusida.net/?lang=fr)
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are substantial data in these helpline call records on where incidents have occurred and on the most commonly reported problems.

While police violence has reportedly diminished in Madagascar, there are still reports of harassment for free sex, extortion and forcing the FSW to collaborate in investigations to find other criminals in Antananarivo. In Mahajanga, efforts to sensitize the police force seem to have worked, as there are no issues reported there.

South African SW programs often emphasize human rights issues that affect access by SW to HIV and other health services. The NACOSA detailed SOP and toolkit for human rights includes instructions for full documentation of violations (often rape), applicable laws and by-laws, human rights screening tools to identify problems and types of violence and perpetrators. South African SR with strong programming in advocacy, human rights and psychosocial support disagree with a primary focus on biomedical interventions and health issues and ‘chasing numbers’ for testing. They undertake to deliver a package that is strongly integrated with life skills, personal development and psychosocial support (as outlined in the Lifeline Cohort Approach case study above).

NACOSA also funds Sisonke (the national sex worker organization) in six provinces through the Global Fund grant. Sisonke Provincial Coordinators hold feedback sessions with peers, review quality of services and help to hold SR accountable. Sisonke offers support, advice and legal intervention in cases of human rights violations.

Adolescent SW are very hard to reach. Female sex worker FGD participants in Kenya express enormous challenges reaching AGYW who sell sex. These participants say there is a need for a tailored service package for this group. Similarly, in Malawi, one of the major challenges was reaching AGYW who sell sex. Despite the HIV Prevention Strategy defining the FSW package to include “Under-age girls: referral to OVC, child protection and other support services”, most FGD participants report that there are no services available for these girls and young women.

Data are not available in any country for the following interventions (and are therefore deleted in the tables):

- PrEP: There were 5,614 SW initiated on PrEP in the 12 months to January 2018 (Mugo, 2018). SW are being offered PrEP in South Africa, but no details are available on coverage. PrEP is not available for SW in Madagascar, Angola or Malawi.
- PEP
- ART drug interactions
- PMTCT
- Hepatitis prevention and management of co-infections
- Nutrition
- Safe abortion and post-abortion care

Without any data on coverage for these services, it is not possible to assess the extent to which they are available in the countries assessed.
Table 11. Summary of Service Coverage for SW
Survey/IBBS (S); GAM (G); Programmatic Data (P)*; Other (O); (*) Indicates Desk Review Only

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Angola</th>
<th>Botswana*</th>
<th>Kenya</th>
<th>Lesotho*</th>
<th>Madagascar</th>
<th>Malawi</th>
<th>Mauritius*</th>
<th>Seychelles*</th>
<th>South Africa</th>
<th>Tanzania*</th>
<th>Uganda*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive condom and lubricant programming*</td>
<td>82.5%47 (S)</td>
<td>90.1%48 (P)</td>
<td>58%49 (S)</td>
<td>83%50 (P)</td>
<td>62.8%51 (S)</td>
<td>60%52 (O)</td>
<td>86%53 (S)</td>
<td>86.5%54 (S)</td>
<td>86.1%55 (G)</td>
<td>70.2%56 (G)</td>
<td>66%57 (G)</td>
</tr>
</tbody>
</table>

45 Where programmatic data is used, coverage values have been calculated using available programmatic coverage data as numerators and nationally accepted PSE as denominators.
46 Percentage of SW reporting the use of a condom with their most recent client
47 IBBS 2016
48 GF PUDR 2017
49 NASCOP 2017 Polling Booth Survey
50 GF TB and HIV Concept Note 2014
51 IBBS 2012
52 UNC 2018 (Draft PLACE II Study); Sites: Blantyre, Chiradzulu, Dedza, Dowa, Karonga, Kasungu, Khotakota, Lilongwe, Machinga, Mangochi, Mchinji, Mulanje, Mwanza, Mzuzu, Nkhata bay, Nsanje, Ntcheu, Salima, Thyolo, Zalewa and Zomba
53 IBBS 2012
54 IBBS 2015
55 GARPR 2015
56 GAM 2017
57 GAM 2016
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<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
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<th>Seychelles*</th>
<th>South Africa</th>
<th>Tanzania*</th>
<th>Uganda*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage of HIV prevention programs among sex workers&lt;sup&gt;58&lt;/sup&gt;</td>
<td>23%&lt;sup&gt;59&lt;/sup&gt; (O)</td>
<td>68.7%&lt;sup&gt;60&lt;/sup&gt; (P)</td>
<td>132%&lt;sup&gt;61&lt;/sup&gt; (P)</td>
<td>10%&lt;sup&gt;62&lt;/sup&gt; (S)</td>
<td>98.1%&lt;sup&gt;63&lt;/sup&gt; (P)</td>
<td>65%&lt;sup&gt;64&lt;/sup&gt; (O)</td>
<td>80.5%&lt;sup&gt;65&lt;/sup&gt; (S)</td>
<td>86.5%&lt;sup&gt;66&lt;/sup&gt; (S)</td>
<td>15.8%&lt;sup&gt;67&lt;/sup&gt; (O)</td>
<td>20%&lt;sup&gt;68&lt;/sup&gt; (O)</td>
<td>40% (G)&lt;sup&gt;69&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

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<sup>58</sup> Coverage with prevention package as defined in national design documents

<sup>59</sup> Cited in NSP 2015-18

<sup>60</sup> GF PUDR 2017

<sup>61</sup> NASCOP 2018, Leaving No One Behind: Key Population Programme in Kenya; PowerPoint presentation delivered during key informant interview

<sup>62</sup> IBBS 2014

<sup>63</sup> PSI programmatic progress status 2017

<sup>64</sup> UNC 2018 (Draft PLACE II Study); Sites: Blantyre, Chiradzulu, Dedza, Dowa, Karonga, Kasungu, Khotakota, Lilongwe, Machinga, Mangochi, Mchinji, Mulanje, Mwanza, Mzuzu, Nkhata bay, Nsanje, Ntcheu, Salima, Thyolo, Zalewa and Zomba

<sup>65</sup> IBBS 2012

<sup>66</sup> IBBS 2015

<sup>67</sup> SANAC 2016, *The South African National Sex Worker Plan 2016-2018* Pretoria: 37,500 SW covered (range 35,000-40,000) of PSE of 237,717

<sup>68</sup> GF Concept Note 2014

<sup>69</sup> GAM 2016
<table>
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<tr>
<th>Health Sector Interventions</th>
<th>Angola</th>
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<th>Mauritius*</th>
<th>Seychelles*</th>
<th>South Africa</th>
<th>Tanzania*</th>
<th>Uganda*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of HIV status&lt;sup&gt;70&lt;/sup&gt;</td>
<td>73.2%&lt;sup&gt;71&lt;/sup&gt; (S)</td>
<td>57%&lt;sup&gt;72&lt;/sup&gt; (P)</td>
<td>85%&lt;sup&gt;73&lt;/sup&gt; (S)</td>
<td>N/A</td>
<td>40.2%&lt;sup&gt;74&lt;/sup&gt; (S)</td>
<td>92%&lt;sup&gt;75&lt;/sup&gt; (O)</td>
<td>42.7%&lt;sup&gt;76&lt;/sup&gt; (S)</td>
<td>53.8%&lt;sup&gt;77&lt;/sup&gt; (S)</td>
<td>22.7%&lt;sup&gt;78&lt;/sup&gt; (S)</td>
<td>45.3% (Dar es Salaam) - 58.8% (Unguja)&lt;sup&gt;79&lt;/sup&gt; (S)</td>
<td>N/A</td>
</tr>
<tr>
<td>ART coverage&lt;sup&gt;80&lt;/sup&gt;</td>
<td>50.8%&lt;sup&gt;81&lt;/sup&gt; (G)</td>
<td>N/A&lt;sup&gt;82&lt;/sup&gt;</td>
<td>73%&lt;sup&gt;83&lt;/sup&gt; (S)</td>
<td>N/A</td>
<td>N/A</td>
<td>90.%&lt;sup&gt;84&lt;/sup&gt; (O)</td>
<td>N/A</td>
<td>N/A</td>
<td>23.4% (Johannesburg) - 45.3% (Cape Town)&lt;sup&gt;85&lt;/sup&gt; (O)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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<sup>70</sup> Percentage of FSW that have received an HIV test in the past 12 months and know their results
<sup>71</sup> IBBS 2016
<sup>72</sup> GAM 2017
<sup>73</sup> NASCOP 2017 Polling Booth Survey
<sup>74</sup> IBBS 2016
<sup>75</sup> UNC 2018 (Draft PLACE II Study); Sites: Blantyre, Chiradzulu, Dedza, Dowa, Karonga, Kasungu, Khotakota, Lilongwe, Machinga, Mangochi, Mchinji, Mulanje, Mwanza, Mzuzu, Nkhata bay, Nsanje, Ntcheu, Salima, Thyolo, Zalewa and Zomba
<sup>76</sup> IBBS 2012
<sup>77</sup> IBBS 2015
<sup>78</sup> IBBS 2013/14
<sup>79</sup> IBBS 2010
<sup>80</sup> ART coverage among SW living with HIV
<sup>81</sup> GARPR 2016
<sup>82</sup> No KP specific data for ART was found, but overall, Botswana estimates that 84% of PLHIV have started ART, UNAIDS 2018a
<sup>83</sup> NASCOP 2017 Polling Booth Survey
<sup>84</sup> UNC 2018 (Draft PLACE II Study); Sites: Blantyre, Chiradzulu, Dedza, Dowa, Karonga, Kasungu, Khotakota, Lilongwe, Machinga, Mangochi, Mchinji, Mulanje, Mwanza, Mzuzu, Nkhata bay, Nsanje, Ntcheu, Salima, Thyolo, Zalewa and Zomba
<sup>85</sup> USCF/ ANOVA/ WRHI 2014, South Africa Health Monitoring Study (SAHMS), The Integrated Biological and Behavioural Survey among Female Sex Workers. San Francisco
MSM Package Implementation

All countries visited during the assessment process were implementing prevention programs for MSM as designed. MSM programs assessed in the region tend to be much younger than SW programs. Unfortunately, coverage of service packages is hard to assess, as the only programmatic figures available (rather than those from IBBS) are 105.2% in Madagascar, though independent studies provide estimates of 1.5% in South Africa and 68% in Malawi. When considering financing, maturity of programs, enabling environment and data systems in these countries, it is likely that South Africa is an under-estimate, while Malawi and (obviously) Madagascar are over-estimates.

In South Africa, service packages, SOP, tools and systems are provided by the PR Right to Care (RTC) for organizational functions including M&E, outreach and referral. However, comparisons of the outreach tool used by two SR show some substantial differences in approach. Capacity building for staff and peers also varies, with Anova (see below) offering thorough training for staff and peers and setting a useful benchmark for other SR.

**Anova Training for MSM site peer coordinators**

- Site coordinators should have Matriculation level education
- Training by NACOSA on the GF program (2 weeks)
- Basic HIV, STI, and TB training (HAST) (10 days)
- Adherence counseling (2 days)
- MSM sensitization provided by nurse mentors both to SR and clinic staff (2 days)
- TG sensitization to SR and clinics (2 days)
- Proficiency testing with the National Health Laboratory Services (occasionally)

In addition to active outreach into likely MSM gathering spaces, pop-up gazebos in South Africa offer IEC and rapid testing in clearly branded and labeled public spaces. These testing sites are considered preferable by many MSM to DoH clinics.

“It is not easy for a young black man to go to the clinic for an HIV test, because the neighbors might be there, gossiping.” (MSM FGD in South Africa)

Three gazebos are set up for each site, so that additional time taken for post-test counseling when testing produces positive results do not prevent a steady flow of clients and do not draw undue attention to positive clients. While clear branding helps to identify services, it is more suitable to use relatively subtle branding, not explicitly referring to ‘gay’ or LGBTI services, in order to maintain confidentiality and to allow people to approach the services without fearing being identified as gay to passersby. The emphasis on ‘out and proud,’ while appropriate for the advocacy work of the SR, may be a barrier to access for some MSM seeking HIV testing. Providing referral information and results letters that have gay and LGBTI logos on them may also act as a linkage barrier for MSM newly-diagnosed with HIV, who may be reluctant to present them at the clinic. Similar to the SW program,
MSM program implementers in South Africa use workshops and support groups for education and support.

Data on cascades show HIV-positive yields to be lower than expected in South Africa. The RTC cascade reflects problems with identifying and including PLHIV from KP. In the RTC cascade data, only 3% of those tested are HIV positive, well below the prevalence in the general population (19%) and only 0.4% of people reached disclose their known HIV+ status.

Figure 6. South Africa RTC Cascade Example (October-December 2017)

In Kenya, most implementers report following the national guidelines for peer educator ratios (1:50/55). However, one implementing organization reports having a 1:75 ratio, but acknowledges that this is not optimal and explains that it was only due to a funding restriction. Peer educators in Madagascar are, in some areas, insufficient to cover the number of MSM locally and some peer educators complained that their supervisors are not always MSM and therefore cannot accompany the peer educator to the field. A secondary-level academic qualification is required to be a supervisor, which automatically excludes a large part of the community. There is a challenge for MSM in remote rural areas to access HIV services.

In both Malawi and Angola, key informants express doubts about whether all people being reached are actually MSM. In Malawi, the suspicion was founded on the very high reach of the program in only its first year and compounded by the very low testing yield: only 3% of tests were found to be HIV positive. In Angola, key informants suggest the payment process for peer educators (based on the number of HIV tests carried out) may be leading to indiscriminate testing and HIV positive rates in program interventions range from 1-2%, which is much lower than HIV prevalence reported in surveys for KP.
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Condom and lubricant provision is regarded as important in all countries visited; however, concerns are expressed about the quantity of condoms and lubricant provided (and regular stock outs) in Madagascar, where there is a heavy reliance on peer educators to obtain condoms. Although the KP know of healthcare centers where they can get condoms, they rely predominantly on peer educators for this service. Stock outs of condoms were reported during field visits.

HIV testing is acceptable in most countries with no problems being reported in Kenya, Madagascar, or South Africa. The MSM community in Madagascar expresses appreciation for ‘Top Réseau,’ a network of gay-friendly medical centers where they can obtain HTS discreetly. These are private medical centers that were sensitized by PSI-Madagascar to be welcoming towards MSM. MSM can receive HIV testing at these centers with a referral coupon distributed by peer educators. In Angola, HIV tests are formally available in HTC points, but stock outs are frequent, particularly outside of the capital.

PrEP is increasingly available to MSM in Kenya and South Africa, but not yet in the other countries (though the Malawi package design calls for its introduction). In Kenyan MSM FGD, many participants report that PrEP is the best part of the service package; and about 80% of one focus group reports being on PrEP.

Linkage to care is a common problem at the national level in all five countries visited, though there are some examples of success at the local level. For example, one implementer in Kenya reports a total reach of about 3,000 MSM, but said they have only linked 21 to ART. Given an HIV prevalence of more than 18%, the program should expect to identify and link a higher number of individuals.

RTC (October-December 2018) provides a linkage to care cascade (Figure 7) that shows that 22% of HIV-positive referrals are lost to follow-up or decline referral for care. Reasons for “other” referral outcomes include: Clients on Wellness; Pre–ART; Treatment Readiness Counseling; and, Opportunistic Infections.

Figure 7. Kenya: RTC Referral Outcomes Example (October-December 2018)
Human rights issues were raised repeatedly at FGD in Kenya. Several MSM said they frequently have to spend their own money to bail each other out when arrested for being MSM. Also, when there are homophobic attacks in the community and the person has called for help, there is often no program support. Especially if the person has to change residences and move from one location to another for their security, they use their own money for this. Law enforcement may demand money in order to intervene when needed. It is not uncommon for the police to have a vehicle but not have any fuel, for which they then demand payment.

The MSM community in Madagascar requests more capacity building of MSM-led NGOs and networks for a more effective advocacy on respect of their rights. The main concerns expressed in the Malawi MSM FGD are about personal security, confidentiality and being abandoned by their families or church. In the first year of Malawi’s GF MSM program, 114 District Health Office staff had been trained on rights and management of KP focusing on MSM and TG and over 200 health service providers across 5 districts had been trained to deliver community-based outreach and moonlight HTC and STI screening.

In South Africa, Anova has invested intensively in developing and supporting LGBTI-friendly clinics. They have developed formal curricula, standards and capacity building materials. This takes place at three levels, the Anova Centres of Excellence, DoH Regional Leadership Sites and DoH Competent Clinics (see box below). Services for KP have greatly improved at these sites and access to KP-friendly clinics is increasing in the priority districts.

ANOVA CLINIC SUPPORT LEVELS

- **Two Centres of Excellence** in Johannesburg and Cape Town funded by USAID. Anova directly manages these clinics, employing a doctor, PHC nurse, counselors, and a data capturer.
- **Twelve DoH Regional Leadership Sites** around the country, where 100% of the staff, from unskilled to management, are trained as appropriate to their role, on the rights, needs, and medical concerns of MSM. Ongoing technical assistance is provided, coordinated by nurses known as ‘champions.’ GF may also fund KP-specific or essential equipment.
- **336 DoH Competent Clinics** around the country (133 GF funded and 203 USAID funded), where 75% of all staff, from unskilled to management, are sensitised on MSM concerns, SOGI awareness, and/or trained in clinical concerns and appropriate services and management for MSM.

Economic empowerment is mentioned as a major issue at MSM FGD in Angola and Kenya. One implementer in Kenya says this is an important part of the package, since the majority of their clients are male SW. This implementer has started growing local vegetables and chickens and from this they are able to generate income as well as provide nutritional support to help with ART adherence.

Also in Kenya, economic empowerment is reported to extend to the peer educators. If they want to go back to school, they are supported. Opportunities are provided within the organizations to advance. The fact that implementers provide employment opportunities to community members is
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cited as a significant positive aspect of package delivery by many peer educators, outreach workers, receptionists, clinicians and other SR employees. This also appears to contribute to attracting and retaining MSM in care. There is strongly expressed appreciation for MSM-led service delivery during FGD.

Psychosocial support is rated very highly as a service provided by MSM implementers in Kenya. While community empowerment and psychosocial support elements of the package are designed and delivered in some countries, they do not appear to be well monitored or reported.

Both MSM implementers visited in Kenya report that they have adolescent and young MSM in their communities – many of school going age – but there are mixed responses about whether they would be provided with services if they come to the drop-in center or if peer educators find them during outreach. One implementer reports that there are about 20 adolescent MSM around the area where they operate; however, the implementer cannot register individuals, since they worry they will be perceived as ‘recruiting’ MSM. Instead, they link them with Family Health Options Kenya, which is a youth organization in the area. It is illegal for implementers to provide services to KP clients under the age of 18 (as reported by every implementer). According to FGD participants, adolescent MSM can come for accessing services, but they are not recorded as clients. Also, they do not benefit from the community empowerment or psychosocial support elements, which others say are so critical for retention in care.

In Malawi, there is concern among SR and SSR that adolescent MSM cannot be reached with current services.

Data are not available in any country for the following interventions:

- PEP
- Community-based testing and counseling
- Nutrition
- Anal cancer treatment

Without any data on coverage for these services, it is not possible to assess the extent to which they are available in the countries assessed.
Table 12. Summary of Service Coverage for MSM
Survey/IBBS (S); GAM (G); Programmatic Data (P); Other (O); (*) Indicates Desk Review Only

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Angola</th>
<th>Botswana*</th>
<th>Kenya</th>
<th>Lesotho*</th>
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<th>Malawi</th>
<th>Mauritius*</th>
<th>Seychelles*</th>
<th>South Africa</th>
<th>Tanzania*</th>
<th>Uganda*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive condom and lubricant programming</td>
<td>33%88 (S)</td>
<td>84.2%89 (G)</td>
<td>79%90 (S)</td>
<td>61% (Maseru) - 64% (Leribe)91 (S)</td>
<td>57.2%92 (S)</td>
<td>81.2%93 (O)</td>
<td>50.9%94 (S)</td>
<td>N/A</td>
<td>80.7%95 (G)</td>
<td>62.8%96 (G)</td>
<td>38.2%97 (Kampala) (O)</td>
</tr>
</tbody>
</table>

86 Where programmatic data is used, coverage values have been calculated using available programmatic coverage data as numerators and nationally accepted PSE as denominators.
87 Percentage of men reporting using a condom the last time they had anal sex with a male partner.
88 NSP 2014
89 GAM 2016
90 NASCOP 2017 Polling Booth Survey
91 GF Concept Note 2014
92 IBBS 2014
93 UNC 2018 (Draft PLACE II Study); Sites: Blantyre, Chikwawa, Dedza, Karonga, Kasungu, Lilongwe, Machinga, Mangochi, Mulanje, Mwanza, Mzuzu, Nkhata bay Salima, Thyolo, Zalewa and Zomba
94 IBBS 2012
95 GAM 2016
96 GARPR 2014
97 HIV Infection among Men Who Have Sex with Men in Kampala, Uganda - A Respondent Driven Sampling Survey
### Health Sector Interventions

**Coverage of HIV prevention programs among MSM**

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Angola</th>
<th>Botswana*</th>
<th>Kenya</th>
<th>Lesotho*</th>
<th>Madagascar</th>
<th>Malawi</th>
<th>Mauritius*</th>
<th>Seychelles*</th>
<th>South Africa</th>
<th>Tanzania*</th>
<th>Uganda*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage of HIV prevention programs among MSM&lt;sup&gt;98&lt;/sup&gt;</td>
<td>25.4%&lt;sup&gt;99&lt;/sup&gt; (O)</td>
<td>114.9%&lt;sup&gt;100&lt;/sup&gt; (P)</td>
<td>245%&lt;sup&gt;101&lt;/sup&gt; (O)</td>
<td>4.1%&lt;sup&gt;102&lt;/sup&gt; (S)</td>
<td>40.2%&lt;sup&gt;103&lt;/sup&gt; (S)</td>
<td>68%&lt;sup&gt;104&lt;/sup&gt; (O)</td>
<td>85.6%&lt;sup&gt;105&lt;/sup&gt; (S)</td>
<td>62%&lt;sup&gt;106&lt;/sup&gt; (S)</td>
<td>1.5%&lt;sup&gt;107&lt;/sup&gt; (O)</td>
<td>14%&lt;sup&gt;108&lt;/sup&gt; (O)</td>
<td>17.5%&lt;sup&gt;109&lt;/sup&gt; (O)</td>
</tr>
</tbody>
</table>

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<sup>98</sup> Coverage with prevention package as defined in national design documents
<sup>99</sup> Cited in NSP 2015-18
<sup>100</sup> GF PUDR 2017
<sup>101</sup> NASCOP 2018; GF PR reports reaching 90% of their 8500 coverage target in 2014-16
<sup>102</sup> IBBS 2014
<sup>103</sup> IBBS 2014
<sup>104</sup> UNC 2018 (Draft PLACE II Study); Sites: Blantyre, Chikwawa, Dedza, Karonga, Kasungu, Lilongwe, Machinga, Mangochi, Mulanje, Mwanza, Mzuzu, Nkhata bay Salima, Thyolo, Zalewa and Zomba
<sup>105</sup> IBBS 2012
<sup>106</sup> IBBS 2011
<sup>108</sup> GF Concept Note 2014
<sup>109</sup> Country Progress Report 2015-2016
### Assessment of HIV Service Packages for Key Populations
#### Eastern and Southern Africa

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
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<th>South Africa</th>
<th>Tanzania*</th>
<th>Uganda*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of HIV status</td>
<td>29.6%(^{110}) (S)</td>
<td>79.6%(^{111}) (S)</td>
<td>76%(^{113}) (S)</td>
<td>11.6% (Maseru) - 16.6% (Leribe)(^{114}) (S)</td>
<td>25.1%(^{115}) (P)</td>
<td>94%(^{116}) (O)</td>
<td>59.1%(^{117}) (S)</td>
<td>27.3%(^{118}) (S)</td>
<td>27.2%(^{119}) (O)</td>
<td>53.7%(^{120}) (G)</td>
<td>44%(^{121}) (G)</td>
</tr>
</tbody>
</table>

\(^{110}\) Percentage of MSM that have received an HIV test in the past 12 months and know their results

\(^{111}\) NSP 2014

\(^{112}\) IBBS 2012

\(^{113}\) NASCOP 2017 Polling Booth Survey

\(^{114}\) GF Concept Note 2014

\(^{115}\) ES-NAC program results 2017

\(^{116}\) UNC 2018 (Draft PLACE II Study); Sites: Blantyre, Chikwawa, Dedza, Karonga, Kasungu, Lilongwe, Machinga, Mangochi, Mulanje, Mwanza, Mzuzu, Nkhata bay Salima, Thyolo, Zalewa and Zomba

\(^{117}\) IBBS 2012

\(^{118}\) IBBS 2011


\(^{120}\) GARPR 2014

\(^{121}\) GARPR 2015/16
<table>
<thead>
<tr>
<th>Health Sector</th>
<th>Angola</th>
<th>Botswana*</th>
<th>Kenya</th>
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<th>South Africa</th>
<th>Tanzania*</th>
<th>Uganda*</th>
</tr>
</thead>
<tbody>
<tr>
<td>ART coverage</td>
<td>50.8%¹²² (G)</td>
<td>N/A¹²⁴</td>
<td>63%¹²⁵ (S)</td>
<td>N/A</td>
<td>N/A</td>
<td>29%¹²⁶ (O)</td>
<td>N/A</td>
<td>N/A</td>
<td>34.2%¹²⁷ (S)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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¹²² Percentage of the PLHIV in a KP receiving ART in the past 12 months

¹²³ AIDSINFO 2016; UNAIDS 2016 (AIDSINFO refers to a “Special Study, 2016” but does not identify the study)

¹²⁴ No KP specific data for ART was found but overall, Botswana estimates that 84% of PLHIV have started ART, UNAIDS 2018a

¹²⁵ UNC 2018 (Draft PLACE II Study); Sites: Blantyre, Chikwawa, Dedza, Karonga, Kasungu, Lilongwe, Machinga, Mangochi, Mulanje, Mwanza, Mzuzu, Nkhata bay Salima, Thyolo, Zalewa and Zomba

¹²⁶ UNC 2018 (Draft PLACE II Study); Sites: Blantyre, Chikwawa, Dedza, Karonga, Kasungu, Lilongwe, Machinga, Mangochi, Mulanje, Mwanza, Mzuzu, Nkhata bay Salima, Thyolo, Zalewa and Zomba

¹²⁷ IBBS 2015/16: average of JNB-43.04%; MAF-29.35%; BLO-36.36%; CPT-40.00%; POL-22.35
Assessment of HIV Service Packages for Key Populations
Eastern and Southern Africa

PWID PACKAGE IMPLEMENTATION

Service packages for PWID were only reviewed in Kenya as part of the in-country assessments, but some other data are available.

In Kenya, the PWID package is implemented with fidelity to the WHO guidelines and the national guidelines, except for elements that have been added at some sites, including nutrition support and overdose management. While specific guidelines are still in development, programming to reach women who inject drugs is observed, such as: female peer educators; women’s only hours/days; monthly doctors’ hours for gynecological services; dignity packs, including sanitary wear; child care at drop-in centers; and, provision of services to their children. During a site visit, one implementer in Mombasa reported that 12% of their clientele are women.

Considering that the country reports zero domestic funding for KP, it is important to note that the county governments are providing OST in Nairobi and Mombasa. Encouraging the government to take on program elements for PWID can be very difficult, so this should be seen as a significant success in Kenya’s response from a standpoint of political will and domestic investment. However, this aspect of the package is largely reported to be unsatisfactory to clients. Reasons cited are long distances to travel, erratic opening hours and unfriendly staff. Still, most OST centers are at capacity and there is a demand for more enrollment of clients, but nowhere to refer them.

Despite these positive aspects, at two PWID sites, it is observed and reported that identification of PLHIV is a challenge, with low levels of testing yield. One implementer reports testing 2,236 PWID for HIV from July to September 2017, but only finding four positive clients among this group (0.1% yield). Another implementer displays testing yield data of 1,250 tested and 51 HIV positive (4% yield). Recalling that HIV prevalence among PWID in Kenya is reported to be 18.7%, the program should expect to be finding higher numbers. There may be a need for more targeted HIV testing strategies, including indexing, in order to get better value for money and to identify and link PWID living with HIV.

Case Study: Work by Reach Out Trust with women who inject drugs

Globally, most programs working with PWID encounter difficulties in reaching women who inject drugs. One organization with an impressive record is Reach Out Trust in Mombasa (Kenya), where around 12% of clients are women injectors. The Trust provides some services such as needle-syringe provision and education through outreach and uses a Drop-In Center (DIC) in a convenient location near drug-using areas to provide a wider range of services, including HIV testing, primary health care, ART and a range of basic medical and support services.

The managers of the Trust told consultants that most PWID in Mombasa live in semi-demolished buildings in very unsafe surroundings. Many women injectors who live in these circumstances have children and are concerned about their children’s fate more than about their own health. This was confirmed in a FGD held at the Trust, in which six women injectors took part.
Both the Trust management and the women injectors in the FGD agree that several factors led to such a large group of women accessing services at the DIC. First, around 50% of the staff are female, including some outreach staff, all medical and most administrative staff. This means that women do not feel like they are entering a ‘male only’ environment. Most importantly, according to the clients, the center provides ‘dignity packs’ including sanitary wear and other essential items. There are also women-only days and hours at the center. On such days, childcare is provided and the women share a nutritious lunch while discussing relevant issues related to HIV, injecting drug use, child rearing and women’s health.

All PWID programs should consider the example of Reach Out Trust and determine whether there are simple and possibly low-cost ways to increase the involvement of women who inject drugs in harm reduction programs.

In Madagascar, peer education programs cover PWID for sensitization and referral to HIV testing. People who inject drugs also have access to testing, treatment and care services. However, there are only eight peer educators planned, which seems limited considering the official PSE of 2,033 PWID. The legal framework prevents OST at the moment; there is a law that considers giving safe injection material to PWID as ‘facilitating drug use’, which is a punishable offense. Global Fund supported NSP until September 2016. The sole NGO providing NSP, AINGA AIDES, has continued a very limited NSP under other project-based short-term funding. Currently, the NGO covers Antananarivo only and reports not having enough material to distribute a sufficient number of needles and syringes to clients.

The Madagascar National Strategic Plan for a Multi-sectoral Response to STI, HIV and AIDS 2018-2022 reports that an HIV and Human Rights commission is operational, jointly coordinated by the Ministry of Public Health and the Ministry of Justice to ensure that the rights of KP are respected and that they access health care. Priority actions include: reducing police repression of PWID to enable NSP to operate and ensuring gender equality by integrating HIV in the fight against GBV.

Data are not available in any country for the following interventions:

- PrEP
- PEP
- Other harm reduction, including other drug dependency treatment
- ART-related prevention
- Community-based testing and counseling
- ART drug interactions
- Mental health services and management of co-morbidities
- Nutrition

Without any data on coverage for these services, it was not possible to assess the extent to which they are available in the countries assessed.
### Table 13. Summary of Service Coverage for PWID

Survey/IBBS (S); GAM (G); Programmatic Data (P); Other (O); (*) Indicates Desk Review Only

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Kenya</th>
<th>Madagascar</th>
<th>Mauritius*</th>
<th>Seychelles*</th>
<th>Tanzania*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive condom and lubricant programming</td>
<td>70.3%(^{129}) (S)</td>
<td>41.8%(^{131}) (S)</td>
<td>38.2%(^{132}) (S)</td>
<td>27.3%(^{133}) (S)</td>
<td>29.4%(^{134}) (G)</td>
</tr>
<tr>
<td>Coverage of HIV prevention programs among PWID</td>
<td>106%(^{136}) (P)</td>
<td>101.1%(^{137}) (P)</td>
<td>83.8%(^{138}) (S)</td>
<td>N/A</td>
<td>9.5%(^{139}) (G)</td>
</tr>
<tr>
<td>Harm reduction - NSP(^{140})</td>
<td>72(^{141}) (O)</td>
<td>N/A</td>
<td>123(^{142}) (P)</td>
<td>N/A</td>
<td>155(^{143}) (G)</td>
</tr>
<tr>
<td>Harm reduction - Safe injection practices(^{144})</td>
<td>88%(^{145}) (S)</td>
<td>68.4%(^{146}) (S)</td>
<td>83.8%(^{147}) (S)</td>
<td>N/A</td>
<td>29.1%(^{148}) (G)</td>
</tr>
<tr>
<td>Harm reduction - OST(^{149})</td>
<td>8.8%(^{150}) (P)</td>
<td>N/A</td>
<td>37.1%(^{151}) (P)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

\(^{128}\) Where programmatic data is used, coverage values have been calculated using available programmatic coverage data as numerators and nationally accepted PSE as denominators

\(^{129}\) Percentage of PWID that reports the use of a condom at last sexual intercourse

\(^{130}\) Polling Booth Survey 2015

\(^{131}\) IBBS 2016

\(^{132}\) IBBS 2011

\(^{133}\) IBBS 2011

\(^{134}\) GARPR 2014

\(^{135}\) Coverage with prevention package as defined in national design documents

\(^{136}\) NASCOP 2018, Leaving No One Behind: Key Population Programme in Kenya; PowerPoint presentation delivered during key informant interview

\(^{137}\) PSI programmatic progress status 2017

\(^{138}\) IBBS 2011

\(^{139}\) GARPR 2014

\(^{140}\) Number of needles and syringes distributed per year per PWID

\(^{141}\) Kenya AIDS Response Progress Report 2016

\(^{142}\) GF Programmatic results 2017

\(^{143}\) GARPR 2014

\(^{144}\) Percentage of PWID who reported using sterile injecting equipment the last time they injected

\(^{145}\) NASCOP 2017 Polling booth survey

\(^{146}\) IBBS 2016

\(^{147}\) IBBS 2011

\(^{148}\) GARPR 2014

\(^{149}\) Coverage of OST

\(^{150}\) National Programme data 2016, cited in GAM 2016

\(^{151}\) GF Programmatic results 2017
### Assessment of HIV Service Packages for Key Populations

#### Eastern and Southern Africa

**Health Sector Interventions**

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
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<th>Mauritius*</th>
<th>Seychelles*</th>
<th>Tanzania*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of HIV status 152</td>
<td>74%153 (S)</td>
<td>33.2%154 (P)</td>
<td>25.2%155 (S)</td>
<td>22.8%156 (S)</td>
<td>20.2% (Unguja) - 38% (Zanzibar)157 (S)</td>
</tr>
<tr>
<td>ART coverage158</td>
<td>58%159 (S)</td>
<td>N/A</td>
<td>51.7%160 (S)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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152 Percentage of PWID that have received an HIV test in the past 12 months and know their results
153 NASCOP 2017 polling booth survey
154 ES-NAC program results 2017
155 IBBS 2011
156 IBBS 2011
157 GARPR 2014
158 Proportion of PWID who report currently being on ART
159 NASCOP 2017 polling booth survey
160 IBBS 2011
PRISONER AND TG PACKAGE IMPLEMENTATION

The only data available on prisoners from the five countries is from Madagascar, where 13.9% of prisoners reportedly have been tested for HIV. From the information gathered during the assessment, it is not clear whether HIV prevention interventions are implemented in prisons. During the in-country visit in Madagascar, referral doctors confirmed that external healthcare personnel conduct HIV testing and that they sent ART to prisoners without ever meeting them for any follow-up or tests.

The only data on TG programs has been included above in MSM programming, where it was available.

Analysis: Are packages being implemented as designed?

In general, packages appear to be implemented as designed, in terms of interventions delivered. Though many interventions are not captured in regular reporting data, in-country assessments confirmed that services are available at some level. Again, this should be seen as a success. It is evident that some interventions in some countries began prior to the introduction of defined packages of services, but the guidance from international organizations, coupled with national design processes, appears to have broadened the types of services available to KP. Also, there has been strong engagement by the KP communities in at least the SW and MSM designs and in implementation in Kenya and South Africa.

Coverage for most interventions is low across the region – with the exception of the remarkable rates above 100% noted above – and there appear to be particular problems in testing sufficient numbers of the right people and, where they test positive, linking them to care. This finding, coupled with the findings related to community violence for some MSM groups, police violence towards SW, legal issues for PWID and so on, suggests that there is a need for services beyond the core prevention services recommended in the WHO Consolidated Guidelines, i.e. condom and lubricant distribution, STI services (for SW and MSM) and, NSP and OST (for PWID). Rather than presenting a large set of services (the full lists contained in the WHO, UNODC and UNFPA guidelines) and informing countries that all KP need all these services, regardless of resource constraints, it would perhaps be useful to designate some enhanced services as options to be considered at the local level, based on local population context.

A distinction needs to be drawn between a program that appears not to be implemented as designed – for example, SW programs in Malawi – or that appears to be implemented in quite different ways by different SR, without any rationale for the different approaches – such as MSM programs in South Africa – and those programs that deliver modified service packages, based on the expressed needs of clients. All KP programs visited in Kenya and SW programs in South Africa are examples of these programs that are not afraid to vary package elements based on clients’ needs. The approach of NACOSA to providing funding, guidance and SOPs for SR, within which the SR are encouraged to develop specific activities based on micro planning and interactions with clients, should be considered by all other countries in the region.
In the same way that the South African Sex Work Plan distinguishes between three tiers of SW localities, it may be worthwhile to consider service packages for KP in a differentiated way, depending on: the maturity of the organizations delivering services; the ability of KP to be involved in and, if possible, lead national and local responses; and the variability of the conditions in which packages are being delivered across the country.

Using such a differentiated approach, it is easy to see why some KP service packages in South Africa and Kenya are deviating from standard service packages. Both countries have:

- A long history of advocacy by and for KP, leading to strong involvement in the design of service packages.
- For at least some KP, a substantial history of managing local responses to HIV among their key populations.
- A legal and policy environment designed to enable excellent programming in South Africa and strong policy support in Kenya.
- Large geographical areas with large populations and highly variable living circumstances for KP in urban, peri-urban and rural areas.

If an approach is adopted that allows for enhanced services to be provided based on population needs, these additional services could focus on the most pressing non-health factors that are preventing KP from accessing services. In the case of SW at Roodepoort (South Africa), the biggest issue may be the way that SW are kept virtually enslaved by brothel owners, leaving the SW without time or resources to seek health services. In the case of MSM in Nairobi, it might be the constant fear of arrest and the need for funds to bail out colleagues and friends. In the case of female PWID in Mombasa, it might be assistance for their children that would attract many more clients to the DIC.

In other countries like Madagascar and Angola, programs are much smaller and, while differences exist in various towns and rural areas, it is likely to be more useful to use a standardized approach for all work with KP in the country until sufficient capacity and coverage are attained in basic services provision; designs need to be evidence-informed and rational within the country’s circumstances and implementation would then be carried out adhering closely to the design. At this stage of its development, Malawi may benefit from the same approach.

**Critical enablers**

It should be noted that several of these issues are extensively covered in the SADC (2018) Regional Strategy for HIV and AIDS Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations. The Strategy has four key result areas:

- Stigma and discrimination against KP, particularly at service provision points is eliminated.
- Violence against KP is significantly reduced.
- Sexual and reproductive health and HIV prevention, treatment, care and support programs are scaled up for KP and especially young KP as per the core package of services and are evidence-informed and results-oriented.
A reduction in legal, policy and cultural barriers that impede key populations’ access to HIV and SRH services.

For all populations, the lack of coverage data for a large number of interventions leaves significant questions about their reach as well as quality of services.

RECOMMENDATIONS: IMPLEMENTATION OF SERVICE PACKAGES FOR KEY POPULATIONS

1. After determining core interventions for each key population in national, defined service packages, ensure that these services are implemented at the scale needed to address the HIV epidemic in each country. Strategies need to be put in place to ensure that core interventions are available to the majority of KP in each country, regardless of funding source or service delivery agent.

2. Introduce and maintain regular feedback sessions with clients, whose concerns should be acted on quickly through the chain of responsibility from sub-sub-recipients (SSR) through sub-recipients (SR) to principal recipients (PR) and, if needed, CCM or CCM Oversight Committee. This procedure should lead to continuous quality improvement.

3. The Networking HIV and AIDS Community of South Africa’s\textsuperscript{161} (NACOSA) approach to providing funding, guidance and standard operating procedures (SOP) for SR, within which SR are encouraged to develop specific activities based on micro planning and interactions with clients, should be considered by all other countries in the region.

4. Anova’s approach (in South Africa) to training and certifying entire health institutions to be friendly towards MSM and TG clients should be considered by all countries.

5. Given the issues described earlier as to where male and/or transgender SW are receiving services, an ongoing collaborative process should be used at the local level to determine whether SW, MSM or TG organizations – either separately or, preferably, together - will ensure that the needs of these populations are met.

6. Differentiated service delivery should be further developed to assist in expanding reach of key interventions among KP. These include self-testing, lay provider testing, community-based testing, assisted partner notification, community-based initiation and distribution of ART for KP.

7. Outreach and support service models need to be reviewed to ensure that there are sufficient resources to ensure linkage to treatment for newly diagnosed people living with HIV (PLHIV) and case-management models in place to cover at least the first three months following diagnosis.

8. Community HIV testing and self-testing models in the region need to be assessed and guidance for expanding access and improved quality of services developed.

9. Strategies to engage countries in transition planning for the outreach (demand-creation) workforce for KP need to be strengthened.

10. Key population NGOs) need to be assisted to secure resources to pursue broad health goals for their constituents, including reduction of stigma and discrimination, responses to KP-

\textsuperscript{161} https://www.nacosa.org.za/
related violence and gender-based violence (GBV) and addressing other issues that increase service access obstacles for KP.

11. United Nations agencies in collaboration with regional KP organizations should work to develop a set of regional guidelines for e-outreach, covering safety and security for e-outreach workers, ethics, privacy and effective messaging.

12. Critical enabler activities have low levels of coverage and the range of activities implemented is generally much smaller than needed. As Botswana, Kenya, Mozambique, South Africa and Uganda work to reduce human rights barriers for KP, other countries in the region should study the activities implemented in these countries and their results for possible replication.

13. In countries with mature key population responses, all packages should allow for flexibility so that optional, enhanced services can be provided alongside core services in order to attract clients and to address some of the underlying reasons why various KP may not want to present for HIV testing, ART or OST (for PWID) or may not want to remain on ART or OST. Consideration should be given to providing standardized funding for enhanced services based on numbers of clients covered with a defined package of services. Standard operating procedures should be developed for implementation of these enhanced activities.

14. Safety of outreach workers, particularly among MSM, needs to be addressed through the use of written security protocols that are implemented in the training and supervision of outreach staff.
IV: Monitoring Systems

KEY POINTS

- All countries with an in-country assessment, with the exception of Madagascar, are partially utilizing a UIC that allows for de-duplication.
- None of the countries assessed are using a single UIC on a national level; therefore, coverage data that is available is likely inaccurate.
- Many programs in the countries assessed are using hand-written reporting mechanisms, which are often times not kept secure.
- Data collection on TG is oftentimes being collected with SW or MSM populations.
- Very limited data regarding prisoners are being collected throughout the countries assessed.

The process of monitoring the implementation of packages of services against their design is multi-faceted. Revisiting what was discussed at the beginning of this report, there are significant problems related to PSE for some KP in some countries. In addition, the way that coverage is compiled and analyzed for the GAM varies across countries. In some countries' GAM reports, a mixture of programmatic and IBBS data are used, as if the figures are interchangeable; but there can be significant problems with the design and/or implementation of IBBS studies. The differences between IBBS results and programmatic data findings can be very large (see Tables 11-13 above). Given what has been reported below on monitoring systems, some of these problems may be attributable to issues in program reporting, but it seems likely that many IBBS studies continue to have sampling problems that over-represent the behavior of people who are regular clients of HIV prevention agencies.

As part of this assessment process, there is a requirement to rate the systems used to monitor KP service packages. The results of this process (Table 14) show that most countries have UIC systems, though none has the same coding system used for all KP across the country.

Table 14. UIC System Scores by Country in Eastern and Southern Africa

0: No data/evidence of UIC found;
1: Monitoring contacts, which disallows de-duplicated reporting;
2: Partially using UIC, which disallows de-duplicated reporting. This includes scenarios where UIC are used in some regions of the country or different UIC are used in the country but not harmonized;
3: Nationally using UIC, which allows de-duplicated reporting. This includes the scenario where different UIC are used but harmonized.

<table>
<thead>
<tr>
<th>Country</th>
<th>Score</th>
<th>Notes</th>
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Page 78
<table>
<thead>
<tr>
<th>Country</th>
<th>UIC Count</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td>Angola</td>
<td>2</td>
<td>A UIC is used by PEPFAR-funded projects but not yet by GF-funded SR.</td>
</tr>
<tr>
<td>Kenya</td>
<td>2</td>
<td>At least 9 UIC currently in use. A single, national 29-character UIC has been proposed but faces opposition. One CDC-supported PWID services implementer is using delinked fingerprints as a UIC.</td>
</tr>
<tr>
<td>Madagascar</td>
<td>1</td>
<td>Client code used for outreach but not easy to de-duplicate.³⁶²</td>
</tr>
<tr>
<td>Malawi</td>
<td>2</td>
<td>Only 1 of 4 SR visited was using a UIC, but the PR is planning to use the LINKAGES-developed UIC with all SR.</td>
</tr>
<tr>
<td>South Africa</td>
<td>2</td>
<td>Several UIC are used by different implementers.</td>
</tr>
</tbody>
</table>

Coverage data among the countries assessed are of very questionable reliability. As shown above, none of the countries assessed has a single, national UIC (though it is planned in Madagascar, Malawi and Kenya and is being discussed in South Africa). The lack of a single, universally used UIC makes de-duplication of client coverage very difficult. For example, when two PWID agencies were visited in Mombasa and it was learned that they use different codes, agencies were asked how they could be sure it was not double-counting a client from the other agency. The response was simply, “we know them all” – which for agencies seeing over 1,000 clients seems an inefficient and ineffective method to ensure accurate records. This problem was also mentioned in Malawi where participants in FGD report high mobility among their peers and a tendency to rove between different service providers (both between Global Fund implementers and LINKAGES, as well as between different Global Fund implementers).

In South Africa, there seems to be a possible inconsistency in the reporting of first encounters in outreach and cumulative numbers of people reached. Quarterly totals of MSM reached appear to include duplicates of people reached. Without electronic tracking using consistent UIC, accurate reporting of unique individuals reached is impossible and the totals for reach are likely to include multiple contacts with the same individual between quarters.

Due to perceived problems with UIC – such as SW stating false names and birth years, which are often used to make up parts of UIC – some consideration has been given to the use of biometrics in the region. However, KP organizations have not been strongly in favor of this new development in some countries. In January 2017, the Kenya Key Population Consortium wrote to partners and donors on a proposal by the Kenyan Government to use delinked fingerprinting for the collection of KP size estimates during an upcoming IBBS. The letter highlighted fears of safety that the populations faced with the use of biometrics due to criminalization of the three target groups for the study. In South Africa, similar fears are mentioned in FGD.

³⁶² The Country Report notes that in Madagascar’s prioritized above-allocation request 2018-2020, funds are earmarked for introducing a UIC to track outreach and HIV testing activities and to ensure more confidentiality for KP. The country plans on recording fingerprints via smartphones and linking these to the UIC.
Gender disaggregation is carried out at PWID services, but little is done to disaggregate men, women and transgender SW across the region, at least at the national level. Data on adolescent KP are generally not recorded. Strangely, the monthly reporting form used by all SR funded through Kenyan Red Cross has columns for 0-14 and 15-19 year olds; however, as noted in the previous section, KP agencies are generally unwilling to record services provided to adolescents, as this is illegal.

In addition, there is a remarkably widespread use of hand-written registers of all clients – including their full names and addresses and several other pieces of data – which are meant to be kept under lock and key, but which were on open display on the reception counters of many NGOs. This was seen in Kenya, Madagascar and Malawi. Given the criminalization of the behavior in which many KP participate, this is a dangerous practice that should be stopped immediately.

South Africa has a particularly problematic recording system, as all HIV tests require written consent. Anova clients need to complete two overlapping, but slightly different forms for HTC, required by RTC and Gauteng Provincial DoH respectively. These forms require full names and addresses. Anova at least ensures that data remain in sealed envelopes and are signed for by a staff member who then places them in a locked system managed by the organization’s M&E department.

Beyond overall coverage figures, both South Africa and Kenya show a remarkable level of facility with data analytics and using data for decision-making, as demonstrated by the NASCOP diagram on sex work (Figure 5 above) and the RTC MSM cascades (Figures 6 and 7 above). The NASCOP example led to new strategies to increase linkage to and retention in care for younger SW. One implementer in Kenya reports color-coding their hot spots (red, yellow and green) to prioritize reach and coverage and intensity of services. This appeared to be a good strategy for maximizing efficiency and value for money with a more targeted approach to peer outreach.

Hand-drawn data visualizations were observed on the walls of organizations offering KP services in Kenya, Malawi and South Africa.

There are very limited national data on HIV treatment and viral load suppression that is disaggregated by key population. Partly, this is due to the lack of accurate national coverage data, but largely it is caused by the inability of the UIC databases to be linked anonymously with HIV-positive patient data. An important innovation is the NACOSA Orbit database in South Africa (see Case Study below), a cloud-based data capture space into which SW SR enter data from outreach forms, HTC, referrals and meeting participation into the shared database used by all SR under NACOSA.

Case Study: NACOSA data system for PR and SR use

While most countries have a system whereby data is collated at the national level – often as part of the reporting process to GF by PR – few countries have worked on the issues of data use for programming by PR and SR.

The organization NACOSA (the GF PR in South Africa that works with sex work SR) supports the active use of data in planning. By hosting quarterly SR meetings, which include a half-day on data review (showing graphs and data drawn from Orbit), SR are encouraged to examine both their own coverage and other data and that of their
colleagues to determine what changes in programming might achieve better results. Mini-excel training and data-related capacity building are also provided to SR. NACOSA managers told the consultants: “There has been a shift in SR. They are now more interested in data and results.”

Effective, consistent centralized management of data is being supported by NACOSA hosting centralized M&E data. The Orbit database is a cloud-based data capture space into which SW SR enter data from outreach forms, HTS, referrals and meeting participation into the shared database used by all SR under NACOSA. Data are uploaded directly by SR to Orbit, and the SR may extract basic data for their own information and planning from the database. “Orbit enables SR to understand their data, gets them to work with data and use it to improve programming methods,” said the NACOSA managers. NACOSA will soon also offer ZENESIS, an analytics platform, which will enable analysis of data and sharing for strategy and decision-making.

NACOSA sought and received funding from GF and other sources for the development of both Orbit and ZENESIS, but the key factor in developing and operating the data system appears to be a strong belief on the part of NACOSA management that SR are in the best position to use data for decision-making – if given the skills, relevant data and time to do so. This approach should be encouraged both regionally and globally.

Another innovation in Malawi, led by the University of North Carolina, is a forum for bringing KP implementation information together. This research group has come up with an online platform – which they are piloting – for implementers to discuss service provision, networking, etc. Implementers can post problems and discuss solutions, among other topics. The creation of this platform is in response to frustrations that were experienced with surveys. According to key informants, people said they are tired of surveys, as they are not capturing the real issues. Real time discussion in online forums, as well as in the Key Populations Technical Working Group, is aimed at creating a more realistic picture of KP implementation in the country.

Only a small proportion of facilities (Burundi 30%, Kenya 78%, Rwanda 51.2%, Tanzania 27.3% and Uganda 36.6%) collect data on KP; however, it is encouraging that most facilities utilize the Health Management Information System (HMIS) for data management, with the main challenge being that the majority still rely on the paper-based system for collecting client data (Burundi 86.7%, Kenya 100%, Rwanda 46.5%, Tanzania 81.8% and Uganda 68.8%). Therefore, facilities should be supported in disaggregating data for service delivery, especially information on KP and, where possible, using electronic databases, as these are easy to share and can be quickly processed to support targeted service delivery for these populations.
Analysis: Do we have enough information to determine how well packages are implemented?

As expected for the region with the largest number of PLHIV, data in ESA are substantially more complete than for the other regions, but gaps remain. As noted above, the lack of PSE, HIV prevalence and incidence data and information about risk behaviors for the region’s TG is understandable, given that such information in most countries has been aggregated with those for MSM. However, substantial work is now required to understand the similarities and differences between these two populations, in order to ensure that service packages are appropriate for each KP and that accurate service coverage can be reported. It should be noted that there are specific problems with PSE for MSM in the region, with the estimates for Angola and Madagascar being much lower than has been reported in other countries with similar-sized populations.

Similarly, the confusion about whether SW, MSM/TG, MSM or TG agencies should be collecting data about male and/or transgender SW is understandable. However, the data observed in other regions suggest that behavior, risks and HIV prevalence among men, women and TG who sell sex can be very different, so a decision needs to be made about which agency will work with each population, and SW PSE, prevalence and coverage statistics need to be derived for each of male, female and TG SW.

There has historically been a lack of focus on PWID in the sub-Saharan region, partly driven by a belief that no or very few PWID exist there. But each time a country carries out a study of drug use (including drug injecting) in the region, a number of PWID is usually found. Given that the number of PWID in all countries of the region is likely to be much smaller than MSM and (except in Mauritius where the PSE for PWID is so large) sex workers, it is sensible to start by ensuring that data for MSM and SW are accurate. After this has been achieved or where funding is available, PWID studies should follow. An easy way to determine whether drug injecting is present in a country is to ask MSM and SW if they or their friends ever inject drugs. This can provide preparatory data for PWID studies.

The biggest deficit in data on KP is among prisoners. For countries with generalized HIV epidemics (such as Botswana, South Africa and Lesotho) to have little or no data available on prisoners is particularly worrying. Globally, little is known about HIV in prisons or the coverage of HIV programs in prisons, but the difference in ESA between the data for other KP is particularly dramatic. More work needs to be done to learn about the situation for prisoners in the region.

The use of hand-written registers of clients is very worrying. While arrangements can be made with police and paramilitary services so that they will respect the confidentiality of NGO client lists, a simple change of government or change in a directive by a Minister could expose many people to police harassment, criminal prosecution, or imprisonment. The anonymous UIC system was developed in the 1990s exactly to prevent the collection of names and addresses of KP. While solving this issue in the countries of the region will take time and significant effort, a standardized approach in each country to anonymous, de-duplicated coverage data is crucial to the success of these programs.
An IAVI (2017) report noted that grants, African civil society organizations (CSOs) face challenges in identification of clear measurement milestones, impact and reliable measure of attribution. Advocacy and policy processes are often conducted in conjunction with multiple players and include different processes and stages (both short and long-term) of decision-making. Establishing causality and attribution of success to a certain organization or specific strategy remains challenging.

**Recommendations: Monitoring of Service Packages for Key Populations**

1. For accurate coverage calculations, countries need to follow established guidelines to develop PSE together with national consensus processes involving substantial representation from the KP concerned. From these processes, more accurate, agreed upon PSE should be derived.

2. Mapping of KP, including the involvement of community networks in mapping, should be carried out nationally where possible to aid in verifying each PSE and to aid in planning, implementing and measuring coverage of KP programs.

3. All countries should continue to progress towards a single UIC for all key populations and a single database, preferably accessible online, for both uploading data and generating reports. The system of collecting client names and addresses (especially in paper registers, but also electronically) should cease.

4. There may need to be specific monitoring arrangements established to follow the collaborative process at the local level in order to determine whether SW, MSM, or TG organizations – either separately or, preferably, together – ensure that the needs of male and/or transgender SW are met.

5. It may be necessary to establish a better way of capturing community empowerment and psychosocial support in routine reporting tools.

6. After determining what interventions should be ‘core’ in the service package design, establish routine surveillance to ensure that all coverage of all core interventions can be regularly measured.

7. Due to the need for accurate national data on programmatic coverage, only countries that can demonstrate appropriate use of UIC and collation of data to determine coverage of clients with a defined package of services should be considered for the extended services mentioned in the Implementation Recommendations above.

8. Feedback loops should be extended throughout the reporting system so that problems regarding quality are quickly reported to the level at which action can be taken to remedy the situation. Advocacy is needed to seek greater governmental attention to the provision and monitoring of service packages for prisoners across the region.

9. The approach of NACOSA in South Africa to providing SR with access to a cloud-based system for data reporting should be examined for possible replication by all PR.
As in the other sections of this report, the issue of financing KP packages varies widely among the five countries assessed in the ESA region. The one common theme among the countries is that all work with KP (apart from medical services) is paid for by external donors, with the exception of South Africa.

Madagascar has budgeted US$130M for its 2018-22 HIV Strategic Plan. Remarkably, the country devoted almost US$40M of this amount to HIV prevention among SW, with much smaller sums (all under US$0.5M) for HIV prevention among MSM, PWID and prisoners. The country is heavily dependent on Global Fund for funding KP programming. Any gaps between Global Fund grants results in the cessation of all peer education programs, including HIV prevention, condom distribution and referral for HIV testing.

France’s “5% Initiative” has provided €273,220 in technical support to the HIV sector, including civil society capacity building, and €145,607 is currently being spent on other forms of technical support for the national HIV response. USAID is a large bilateral donor, but does not specifically fund KP programming. Project-based foreign aid from Switzerland and Germany has supported projects such as advocacy for the rights of the LGBTI community.

The Kenyan National Strategic Framework (2015-2019) disaggregates total resource needs by nine program areas but does not include KP resource needs. The National Guidelines for HIV-STI Programming with Key Populations also does not provide resource needs estimates. However, the country’s 2014 Global Fund Concept Note provides a breakdown of funding needs by key population for the two years, 2015-2017:

- FSW programming: US$27.7M
- MSM programming: US$8.8M
- PWID programming: US$9.7M

Funding for the overall HIV response in Kenya is 25% domestic and 75% external, but key informants during the country visit confirmed that all KP programs are externally funded: 68% by PEPFAR, 19% by Global Fund and 13% by other external partners.
Malawi’s Global Fund allocation for the 2017-2019 funding cycle is US$370,804,766, plus US$10,000,000 in catalytic funding for reducing HIV among AGYW and strengthening data systems. PEPFAR’s total planned spending for HIV in Malawi in 2017 was US$126,660,944 (PEPFAR, 2017). During the country visit, it was reported that all KP programs are externally funded. In Angola, most of the external funding for KP service packages comes from PEPFAR (US$12.5M in 2017), with the remainder coming from Global Fund (US$2,035,481 for 2016-2018).

The South African HIV Response is 80% government funded, including 100% of treatment and 20% funded by development partners, with 3% from GF. The government is only able to fund a minimum package of services for KP, with additional services dependent on donor funding. The South African Government has committed R86.5M (approximately US$7M) in 2018/2019 for the High Transmission Areas (HTA) program: this includes services for KP, but the amounts are not disaggregated. The PEPFAR South Africa 2018 budget is not disaggregated by KP, but provides for:
- US$31,397,797 on “other sexual prevention” which includes work with MSM, SW and TG; and
- US$344,438 on injecting and non-injecting drug use.

**Analysis: Are countries prepared to adequately finance packages of services for key populations?**

It was beyond the scope of this assessment process to conduct an in-depth financial analysis of costing, allocation and expenditure related to packages of services for KP in ESA. However, what was found is a heavy reliance on Global Fund to support KP programming in all countries. Cost information is a particularly critical input into the process of setting priorities and efficient allocation of resources and given the urgency of scale-up to meet Fast-Track targets, countries must urgently fortify their expenditure analysis and budget development processes to be sure that sufficient resources are available to implement the designed packages of services as intended.
PART VI: LIMITATIONS

There were several limitations in conducting this assessment process, including during the initial desk review portion of the country assessments. It is important to note that six of the 11 countries within the ESA region were limited to ‘desk review only,’ meaning that APMG Health did not conduct an in-country assessment to collect data and information that could disprove or verify the information found in the initial desk review. Desk review data from these six countries has been included throughout this review.

The desk review process was limited by contractual time allowed (an average of two consultant days was allotted to each review) and by the scope of the review: sources reviewed were limited to those provided by Global Fund Country Teams in the last quarter of 2017.

The list of documents used for conducting these assessments has been considerably expanded for those countries selected for an in-country assessment. To the highest degree possible, data were expanded upon and verified by the in-country visits, however this process was also subject to time restrictions. Only two sites and two populations were selected for focus in each country. It is important to note that because of this, country assessments may not have been representative of the national situation, and reports only speak to the data available in the regions, districts and cities that were visited or within other reports reviewed. This has therefore limited the amount of data and information about the other KP that were not selected for in-country data collection. Within the regional report for ESA, this presents a particular limitation for the prisoner and TG key populations, which were not selected as a KP of focus in any of the five country visits.

Data were collected in-country by only one international and one local consultant, which limited the amount of site visits, key informant interviews and FGD consultants were able to conduct while in-country.

During the in-country data collection, program staff identified FGD participants. Therefore, respondents selected may not have been representative of KP more broadly. Focus group participants could have experienced peer pressure or pressure from program staff to give biased answers to the moderator’s questions. Focus group discussions also seemed to be made up of program participants who sought services fairly regularly or were even peer educators themselves. Therefore, the viewpoints of those members of KP who do not receive services, or face more barriers in receiving services, may not be represented. Focus group discussions were often conducted in local languages and therefore at times, were translated for the international consultant. One limitation of this is that only some of the information that participants gave were actually recorded and presented in the country report.
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### Health Sector Interventions

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<tbody>
<tr>
<td>1</td>
<td>HIV prevention (condoms, lubricant, PrEP, PEP, VMMC)</td>
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</tr>
<tr>
<td>2</td>
<td>Harm reduction interventions for substance use, in particular NSP, OST and naloxone for overdose management</td>
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</tr>
<tr>
<td>3</td>
<td>HIV testing and counselling</td>
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<tr>
<td>4</td>
<td>HIV treatment and care</td>
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<tr>
<td>5</td>
<td>Prevention and management of co-infections and other co-morbidities, including viral hepatitis, TB and mental health conditions</td>
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</tr>
<tr>
<td>6</td>
<td>Sexual and reproductive health interventions</td>
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### Critical enablers

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<td>1</td>
<td>Supportive legislation, policy and financial commitment, including decriminalization of behaviors of key populations</td>
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<tr>
<td>2</td>
<td>Addressing stigma and discrimination</td>
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<tr>
<td>3</td>
<td>Accessible, available and acceptable health services</td>
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<tr>
<td>4</td>
<td>Community empowerment</td>
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<td>5</td>
<td>Addressing violence against people from key populations</td>
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