



Treatment Coverage among Key Populations in Five Fast-Track Cities

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Background

- Fast-Track Cities around the world are committed to attaining 95-95-95 targets by 2025, including the target that 95% of PLHIV diagnosed with HIV are on Antiretroviral therapy.
- UNAIDS reported that in 2021, key populations accounted for less than 5% of the global population, but they and their sexual partners comprised 70% of new HIV infections (UNAIDS 2022)
- While many cities have made progress against these targets in the last few years, closing the gaps to reach these targets requires understating sub-population epidemics, particularly among key and vulnerable populations that may have fallen through the cracks

Methods

5 Fast-Track cities were included in this assessment

- Amsterdam
- eThekweni
- Johannesburg
- London
- Nairobi

Data Sources

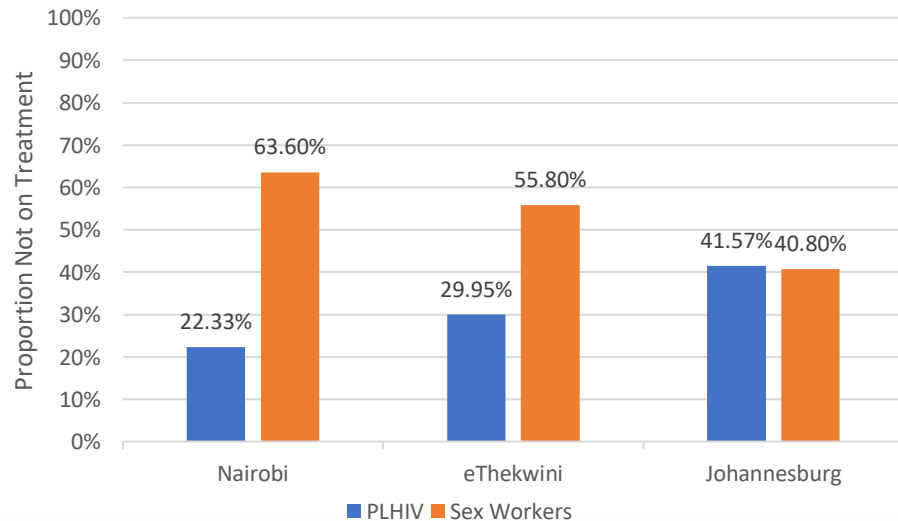
- City estimates reported by Fast-Track Cities between 2019-2021
- Key Population estimates
 - Reported by Fast-Track Cities between 2019-2021
 - UNAIDS AIDSInfo 2017-2020

Methods Continued:

- Aggregate City
 - Proportion on of PLHIV on ART
 - Proportion of PLHIV not on ART*
- Key Populations (Sex Worker, MSM, PWID)
 - Proportion of PLHIV attributed to each KP category
 - Proportion of PLHIV in KP category on ART
 - Proportion PLHIV in KP category not on ART
 - Not on ART Treatment Burden (proportion of key population category not on treatment, out of all PLHIV not on treatment)

Results: Sex Workers

City	Aggregate City					Sex Worker							SOURCE
	Number PLHIV	Treatment Coverage	Not On treatment (%)	On treatment	Not on Treatment	Prop of PLHIV	Number Sex Workers LHIV	Treatment Coverage	Not On treatment (%)	On treatment	Not on Treatment	Not on Treatment burden	
Nairobi	190993	77.67%	22.33%	148335	42658	15.44%	29494	36.40%	63.60%	10736	18758	43.97%	FTC 2017
eThekwini	652959	70.05%	29.95%	457,368	195,591	1.07%	7015	44.20%	55.80%	3101	3914	2.00%	GAM 2019
Johannesburg	677538	58.43%	41.57%	395889	281649	72.33%	490033	59.20%	40.80%	290100	199934	70.99%	GAM 2019



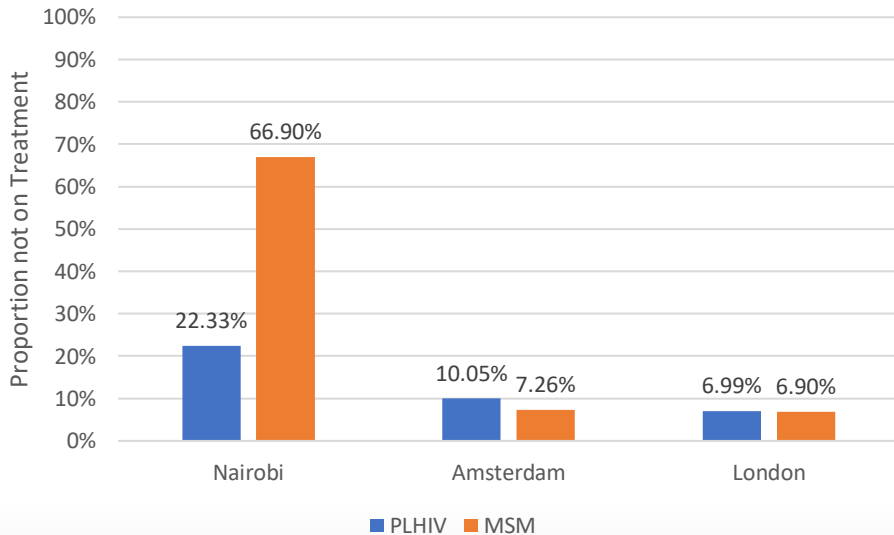
Nairobi: 15% of PLHIV are sex workers and sex workers living with HIV contribute to 43.97% of all PLHIV not on treatment

eThekwini: 1.07% on PLHIV are sex workers and sex workers living with HIV contribute to 2% of all PLHIV not on treatment.

Johannesburg: 77.3% if PLHIV are sex workers living with HIV contribute to 70.99% of all PLHIV not on treatment.

Results: MSM

City	Aggregate City					MSM							SOURCE
	Number PLHIV	Treatment Coverage (%)	Not On treatment (%)	On treatment	Not on Treatment	Prop of PLHIV	Number MSM LHIV	Treatment Coverage (%)	Not on treatment (%)	On treatment	Not on Treatment	Not on Treatment burden	
Nairobi	190993	77.67%	22.33%	148335	42658	5.24%	10000	33.10%	66.90%	3310	6690	15.68%	FTC 2017
Amsterdam	6420	89.95%	10.05%	5775	645	72.90%	4680	92.74%	7.26%	4340	340	52.71%	FTC 2020
London	38600	93.01%	6.99%	35900	2700	52.59%	20300	93.10%	6.90%	18900	1400	51.85%	FTC 2017



Nairobi: 5.24% of PLHIV are MSM and MSM living with HIV contribute to 15.68% of all PLHIV not on treatment

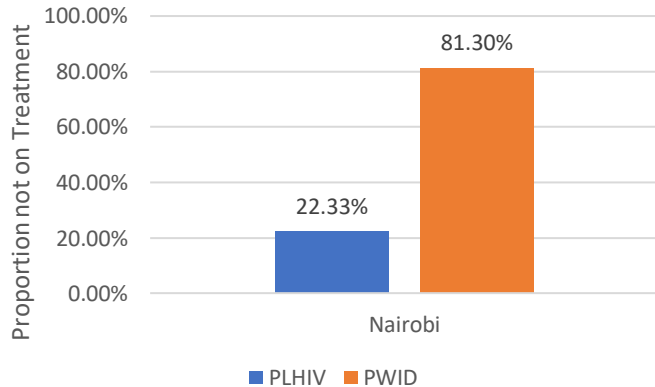
Amsterdam: 72.9% of PLHIV are MSM and MSM living with HIV contribute 52.71% of all PLHIV not on treatment.

London: 52.59% of PLHIV are MSM and MSM living with HIV contribute 51.85% of all PLHIV not on treatment.



Results: PWID

City	Aggregate City					PWID							SOURCE
	Number PLHIV	Treatment Coverage	Not On treatment (%)	On treatment	Not on Treatment	Prop of PLHIV	Number PWID LHIV	Treatment Coverage	Not on treatment (%)	On treatment	Not on Treatment	Not on Treatment burden	
Nairobi	190993	77.67%	22.33%	148335	42658	3.25%	6216	18.70%	81.30%	1162	5054	11.85%	FTC 2017



Nairobi: 3.25% of PLHIV are PWID and PWID living with HIV contribute to 11.85% of all PLHIV not on treatment

Conclusions

- Key populations attribute for large portions of people living with HIV in many cities.
- However, in some cities, Key Populations are significantly falling between the cracks, with large proportions not on treatment.
- Achieving 95-95-95 targets and ultimately zero new HIV infections and HIV related deaths necessitates disaggregated data that can strategically inform HIV programming to close the gaps.