REGIONAL STRATEGY

FOR HIV PREVENTION, TREATMENT AND CARE AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AMONG KEY POPULATIONS

SOUTHERN AFRICAN DEVELOPMENT COMMUNITY

TOWARDS A COMMON FUTURE

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About SADC
The Southern African Development Community (SADC) is an organization founded and maintained by countries in southern Africa that aim to further the socio-economic, political and security cooperation among its Member States and foster regional integration in order to achieve peace, stability and wealth. The Member States of SADC are Angola, Botswana, Democratic Republic of Congo, Union of Comoros, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, United Republic of Tanzania, Zambia and Zimbabwe.

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS

FOREWORD

The "Regional Strategy for HIV and AIDS Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations" is a result of a series of participatory and interactive processes that involved members of key populations, governments, civil society and development partners. It was approved, in November 2017, by SADC Ministers responsible for Health and HIV and AIDS. The Strategy is in line with the revised Regional Indicative Strategic Development Plan (RISDP) which provides the Secretariat and other SADC institutions with a clear view of SADC's approved economic and social policies and priorities.

HIV and AIDS interventions remain one of the priority areas of the revised RISDP and its overall goal is to decrease the number of HIV and AIDS infected and affected individuals and families in the SADC region, so that HIV and AIDS is no longer a threat to public health and to the socio-economic development of Member States.

In 2015, the international community transitioned from the Millennium Development Goals to the Sustainable Development Goals (SDGs), which specifically highlight the necessity of "leaving no one behind", including key populations, if the global community is to realize sustainable development. Among them is SDG 3, which aims to ensure healthy lives and promote well-being for all at all ages.

Globally and also within the SADC region, while new infections continue to decrease, the rate of decrease has declined since 2010 and in some cases, we have seen an increase in new infections, sparking fears of a rebound of the epidemic. The 2016 High Level Political Declaration has set an ambitious target for HIV prevention. Countries will be expected to reduce their new adult infections by 75 % by 2020 based on the 2010 levels. Given the decline in resources for HIV prevention since 2010, there is need to significantly increase our investment in prevention if the SADC Region is to contribute to the end of AIDS by 2030. If the SADC countries are to meet the 2020 prevention target and ending AIDS in 2030 for HIV prevention, an extra ordinary effort will be required.

It is in this context that the SADC Secretariat, in collaboration with Member States, UN Agencies, and other regional stakeholders, developed the "Regional Strategy for HIV and AIDS Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations" .

This Strategy is expected to serve as a guide to Member States in designing and implementing appropriate Sexual and Reproductive Health (SRH) and HIV prevention, treatment and care programmes for key populations focusing on the major issues that need to be addressed at policy, legal, institutional and facility levels.

SADC Executive Secretary

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
Catalytic Framework	Catalytic Framework to End AIDS, Tuberculosis and Eliminate Malaria in Africa by 2030
EAC	East African Community
HIV	Human Immunodeficiency Virus
PWID	People who inject drugs
PWUD	People who use drugs
MS	Member State
MSM	Men who have sex with men
NAC	National AIDS Council
OST	Opioid substitution treatment
SADC	Southern African Development Community
SDGs	Sustainable Development Goals
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STIs	Sexually transmitted infections
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Programme
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

GLOSSARY OF TERMS

Adolescents: Persons aged 10–19 years. Adolescents are not a homogenous group; physical and emotional maturation comes with age, but its progress varies among individuals of the same age.[1]

Gender-based violence: Violence that is directed against an individual due to their gender or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.[2]

Health care: Services provided to individuals or communities by health service providers for the purpose of promoting, maintaining, monitoring, restoring health and preventing illness. Health is defined by the World Health Organization as the state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Health has many dimensions (anatomical, physiological and mental) and is largely culturally defined.

Human rights: Rights inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status. Human rights include civil, political, social and economic rights. For instance, these include the right to life and liberty, freedom from slavery and torture, freedom of opinion and expression, the right to work and education, and many more. Everyone is entitled to these rights, without discrimination.

Key populations: Groups who, due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. They also often have legal and social issues related to their behaviours that increase their vulnerability to HIV. For the purposes of this strategy, key populations include: 1) men who have sex with men, 2) people in prisons, 3) people who use drugs, 4) sex workers and 5) transgender people. It includes young key populations who are increasingly vulnerable to HIV and have specific sexual and reproductive needs. The key populations are important to the dynamics of HIV transmission. They also are essential partners in an effective response to the epidemic.[3]

Member State: Member State is defined in the Treaty of the Southern African Development Community as a member of the Southern African Development Community.

Men who have sex with men (MSM): All men who engage in sexual and/or romantic relations with other men. The words "men" and "sex" are interpreted differently in diverse cultures and societies and by the individuals involved. Therefore, the term encompasses the large variety of settings and contexts in which male-to-male sex takes place, regardless of multiple motivations for engaging in sex, self-determined sexual and gender identities and various identifications with any particular community or social group.[4]

People who inject drugs (PWID): People who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other injectable routes. People who self-inject medicines for medical purposes – referred to as "therapeutic injection" – are not included in this definition. The definition also does not include individuals who self-inject non-psychotropic substances, such as steroids or other hormones, for body shaping or improving athletic performance. This strategy addresses all people who use drugs, but recognizes that PWID are more vulnerable to HIV due to the sharing of blood-contaminated injection equipment.[5]

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1   This definition has been adapted from the World Health Organization (WHO). Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (July 2014).
2   CEDAW, General Recommendation No. 19 (1992), para 6.
3   This definition has been adapted from the WHO. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, above n 1.
4   *Id.*
5   *Id.*

People who use drugs (PWUD): People who use illegal, psychotropic substances through any route of administration, including injection, oral, inhalation, transmucosal (sublingual, rectal, intranasal) or transdermal. This definition does not include the use of such widely used substances as alcoholic and caffeine-containing beverages and foods.[6]

Sex workers: Female, male and transgender adults (18 years of age and above) who receive money or goods in exchange for sexual services. Sex work is consensual sex between adults, can take many forms and varies between and within countries and communities. Sex work also varies in the degree to which it is more or less "formal", or organised. As defined in the Convention on the Rights of the Child, children and adolescents under the age of 18 who exchange sex for money, goods or favours are "sexually exploited" and not defined as sex workers.[7]

Sexual and reproductive health: A state of complete physical, mental and social well-being in all matters relating to the reproductive system and sexuality; it is not merely the absence of disease, dysfunction or infirmity. For sexual and reproductive health to be attained and maintained, the sexual and reproductive health rights of all persons must be respected, protected and fulfilled. Sexual and reproductive health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.[8]

Transgender: An umbrella term for people whose gender identity and expression do not conform to the norms and expectations traditionally associated with the sex assigned to them at birth. It includes people who are transsexual, transgender or otherwise gender non-conforming. Transgender people may self-identify as transgender, female, male, transwoman or transman, trans-sexual or one of many other transgender identities. They may express their genders in a variety of masculine, feminine and/or androgynous ways.[9]

Vulnerable populations: Groups of people who are particularly vulnerable to HIV infection in certain situations or contexts, such as adolescents (particularly adolescent girls in sub-Saharan Africa), orphans, street children, people with disabilities and migrant and mobile workers. These populations are not affected by HIV uniformly across all countries and epidemics. This strategy does not specifically address vulnerable populations, but it does note the specific vulnerabilities of young key populations.[10]

Young key populations: This term refers to individuals between the ages of 15 and 24 who due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. They also often have legal and social issues related to their behaviours that increase their vulnerability to HIV. For the purposes of this strategy, key populations include: 1) men who have sex with men, 2) people in prisons, 3) people who use drugs, 4) sex workers and 5) transgender people.[11]

Young people: This term refers to individuals between the ages of 15 and 24. Young people are not a homogenous group; physical and emotional maturation comes with age, but its progress varies among individuals of the same age.[12]

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6   *Id.*
7   *Id.*
8   Adapted from WHO et al. Sexual Health and its Linkages to Reproductive Health: An Operational Approach (2017).
9   *Id.*
10   *Id.*
11   *Id.*
12   *Id.*

1. INTRODUCTION

Since the turn of the century, Africa has made considerable progress in responding to the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS) pandemic. Between 2010 and 2016, new HIV infections and AIDS-related mortality among all ages in Eastern and Southern Africa dropped by 29% and 42%, respectively.[13] Southern Africa, the region most affected by HIV, is showing similar progress as the rest of the continent. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), the number of new HIV infections in Southern Africa declined by 32% from 1.4 million in 2001 to 950 000 in 2011.[14]

One of the key components for this success has been global, continental and regional bodies committing to ending HIV, and putting in place strategies enabling countries to reach that goal. The United Nations' (UN) Millennium Development Goal 6 sought to halt and reverse the spread of HIV by 2015. UNAIDS put in place a strategy entitled Getting to Zero from 2011-2015 that sought to end new infections, AIDS-related deaths and discrimination. Continentally, in 2013, the African Union reaffirmed countries' commitment to eliminating HIV and particularly recognised the need to strengthen rights-based protections for key populations and to meaningfully involve key populations in the HIV response.[15] The Southern African Development Community (SADC) issued a strategic framework from 2010-2015 aimed at decreasing the number of people living with and affected by HIV in Member States.[16]

In 2015, the international community transitioned from the Millennium Development Goals to the Sustainable Development Goals (SDGs) which specifically highlight the necessity of leaving no one behind, including key populations, if the global community is to realise sustainable development. Among them is SDG 3 which aims to ensure healthy lives and promote well-being for all at all ages. In addition, a number of other SDGs also contribute to achieving equality and equity. For instance, SDG 1 seeks to end poverty through targeting the most vulnerable and increasing access to basic resources and services, among others. UNAIDS has set ambitious targets as part of its Fast-Track strategy to end the AIDS epidemic by 2030. It seeks to have 90% of all people living with HIV knowing their HIV status by 2020 and 95% by 2030; 90% of all people diagnosed with HIV receiving sustained antiretroviral therapy by 2020 and 95% by 2030; and 90% of all people receiving antiretroviral therapy to have viral suppression by 2020 and 95% by 2030.[17] It further seeks to end discrimination by 2020. UNAIDS has issued five pillars and 10 action points to meet ensure these targets are met.[18] In addition, the UN General Assembly adopted a Political Declaration on HIV and AIDS affirming their commitment to end AIDS by 2030.[19] Some countries committed to national HIV prevention targets as part of the implementation of the Political Declaration on HIV and AIDS in an expert meeting held in 2017 at Victoria Falls, Zimbabwe. The African Union committed, among other things, to accelerating efforts to control and end AIDS in Africa by 2030 in the Catalytic Framework to End AIDS, Tuberculosis and Eliminate Malaria in Africa by 2030 (Catalytic Framework). The Declaration of the Special Summit of African Union on HIV/AIDS, Tuberculosis and Malaria in Africa by 2030, among other things, made a commitment to meaningfully engage people with HIV and members of key populations as partners in ensuring accountability and the effectiveness of the national AIDS response. SADC recently issued the HIV, tuberculosis (TB), sexual and reproductive health (SRH), Malaria Integration Programmes Strategy 2016-2020, which identifies the limited access to all services for key populations as a strategic gap and made increasing such access a priority intervention for SADC Member States.[20] The overall purpose of the SADC HIV, SRH, TB and

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13 Joint United Nations Programme on HIV/AIDS (UNAIDS). Fact Sheet (July 2017), available at http://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf (last accessed 26 September 2017).

14 UNAIDS. Getting to Zero: HIV in Eastern and Southern Africa (2013) 10.

15 African Union. Declaration of the Special Summit of African Union on HIV/AIDS, Tuberculosis and Malaria "Abuja Actions Toward the Elimination of HIV and AIDS, Tuberculosis and Malaria in Africa by 2030" (July 2013).

16 Southern African Development Community (SADC). HIV and AIDS Strategy Framework 2010-2015.

17 UNAIDS. Fast Track: Ending the AIDS Epidemic by 2030 (2014).

18 UNAIDS. Prevention Gap Report, 2016 (2016); UNAIDS. On the Fast-Track to End AIDS 2016–2021 Strategy (2015).

19 United Nations. Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030, A/70/L.52 (7 June 2016).

20 SADC. 2016-2020 HIV/TB/SRH/Malaria Integration Programmes Strategy (2017).

Malaria Programmes Integration Strategy, 2016-2020 is to create an enabling environment for SADC Secretariat to facilitate and coordinate the provision of integrated programmes and services among SADC Member States, with a view to accelerating the effective delivery of quality and comprehensive health and related social services for all people, irrespective of age, sexual orientation, marital status and gender.

2. CONTEXT

Despite the progress in and the global, continental and regional commitments to addressing HIV, the HIV response in Southern Africa still faces significant challenges that limit progress. One of the key challenges to meeting the international and regional targets is the continued high levels of HIV prevalence and vulnerability to HIV among specific populations, namely sex workers, Men who have Sex with Men (MSM), People Who Use Drugs (PWUD), transgender persons and people in prisons.[21] These groups are often referred to as key populations due to the fact that they experience an increased impact from HIV and a decreased access to services, due in part to their marginalisation and/or criminalisation.[22]

HIV prevalence among key populations in Southern Africa is consistently and considerably higher than the general population of the region. For instance, UNAIDS has estimated that almost 1 in 8 of new HIV infections in Eastern and Southern Africa region were among sex workers, MSM and PWUD.[23] Recent country data shows HIV prevalence among female sex workers in Lesotho and Swaziland was at approximately 70%; in Botswana, South Africa, Zimbabwe and Zambia nearly 60%; in Tanzania roughly 30%; in Malawi about 25%; in Mauritius at almost 15%; and in Seychelles at under 5%.[24] With respect to MSM, HIV prevalence data indicates that over 30% prevalence in Lesotho; 27% in South Africa, under 20% in Tanzania, Mauritius and Malawi; approximately 15% in Botswana, Seychelles, Swaziland and Madagascar.[25] Data on HIV prevalence among People Who Inject Drugs (PWID) in SADC countries is minimal. However, in Tanzania, Mauritius and Seychelles, HIV prevalence among PWID is at approximately 16%, 44% and 4% respectively.[26] The HIV prevalence among PWID under 25 is also high in these countries, indicating that people are getting infected with HIV at a young age. For instance, in Tanzania the HIV prevalence among PWID under 25 is 12.3%.[27]

Data on HIV prevalence among people in prisons also shows higher rates than the general population. In Lesotho, a 2011 national HIV Seroprevalence Survey among prison inmates by the Lesotho Correctional Services estimated the HIV prevalence of prisoners to be 31.4%.[28] In Swaziland, HIV prevalence among prisoners is almost 35%; approximately 28% in Zambia and Zimbabwe; almost 25% in Mozambique; almost 20% in Malawi; over 11% in Mauritius; almost 7% in Tanzania and over 4% in the Seychelles.[29] A recent study on HIV and TB prevalence rates in Southern Africa found HIV prevalence ranging from 7.2% to 34.9% and TB rates ranging from 3.6% to 7.6%.[30]

Information on HIV prevalence among transgender persons is virtually non-existent in SADC. Similarly, specific data on HIV prevalence among young key populations is scarce. However, in sub-Saharan Africa, AIDS is the leading cause of death among adolescents. Worldwide, though AIDS-related deaths decreased overall, they increased among adolescents.[31] Adolescent key populations have been found to be at higher risk for HIV than the general adolescent population.[32] Young key populations, globally, have higher rates of sexually transmitted infections (STIs), including syphilis, gonorrhea, chlamydia and herpes simplex, than adult key populations.[33]

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21 *Id.*
22 See Global Fund to Fight AIDS, Tuberculosis and Malaria. Fact Sheet. Key Populations: A Definition (July 2015).
23 UNAIDS. Prevention Gap Report, above n 18, 99.
24 *Id.* at 100. Prevalence rates for Botswana, South Africa and Malawi include male sex workers.
25 *Id.* at 101.
26 *Id.*
27 *Id.*
28 UNAIDS. Regional Synthesis: HIV Epidemic Among Sex Workers, Men who have Sex with Men, People who Inject Drugs and Transgender People: Eastern and Southern Africa Region (2016), 89.
29 Data compiled by UNAIDS based on Global AIDS Monitoring Report 2017.
30 Telisinghe, L et al. "HIV and Tuberculosis in Prisons in Sub-Saharan Africa" 388 The Lancet 1215, 1219 (17 September 2016).
31 UNICEF. For Every Child, End AIDS: Seventh Stocktaking Report, 2016 (2016) 2.
32 *Id.* at 36.
33 Delany-Moretlwe, S et al. "Providing Comprehensive Health Services for Young Key Populations: Needs, Barriers and Gaps" 18(2) Supp.1 Journal of the International AIDS Society 19833 (26 February 2015).

There is little data regarding key populations' SRH. The most information available is for female sex workers. For instance, the prevalence of gonorrhoea, chlamydia and syphilis among female sex workers in Botswana was estimated at 10.5%, 11.9% and 3.5%, respectively.[34] However, there is a high prevalence of non-HIV STIs in Africa. Though there is little data on the specific prevalence of STIs among key populations, data from 2012 shows Africa had 10% of the world's chlamydia cases; 18% of the world's gonorrhea cases; 26% of the world's trichomoniasis cases; and 42% of the world's syphilis cases.[35] In addition, cervical cancer is one of the leading causes of cancer deaths among women in Southern Africa.[36]

Given the vulnerability of key populations, this strategy seeks to operationalise current global, continental and regional commitments and address these gaps by providing Member States with a framework to develop specific programming aimed at key populations. The strategy is to be used in conjunction with existing SADC initiatives, including SADC's new strategic framework on the integration of HIV, tuberculosis, sexual and reproductive health and malaria, as well as existing international and continental initiatives, such as the SDGs and the Catalytic Framework.

The strategic framework is not a strategic plan but a guiding framework for SADC Member States. It aims to provide details on how key populations are and remain more vulnerable to HIV than the general population. It further identifies the key barriers they face in accessing HIV and SRH services, and identifies steps Member States can take to address these obstacles and thereby lower the vulnerability of key populations to HIV and increase their access HIV and SRH services.

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34 UNAIDS. Regional Synthesis, above n 28, 51.
35 Newman, L et al. "Global Estimates of the Prevalence and Incidence of Four Curable Sexually Transmitted Infections in 2012 Based on Systematic Review and Global Reporting" 10(12) PLoS ONE (2015).
36 Southern Africa Litigation Centre. Tackling Cervical Cancer: Improving Access to Cervical Cancer (2014).
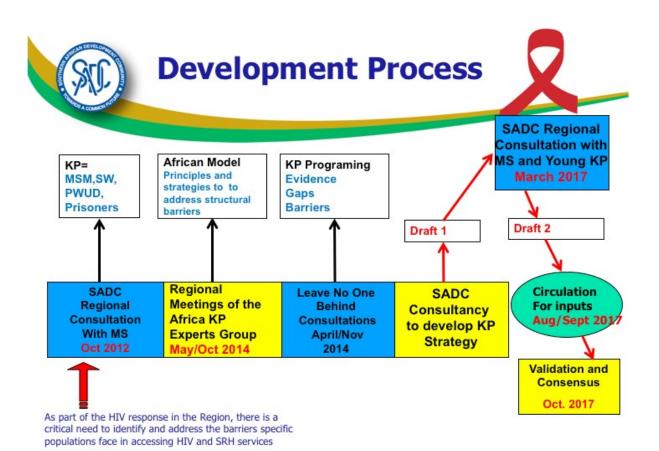
3. PROCESS OF DEVELOPING THE STRATEGY

The regional strategy is a result of a series of participatory and interactive processes that involved members of key populations, governments, civil society and development partners. The main activities that informed the development of the regional strategy are provided below.

1. A desk review was undertaken in the drafting of the strategy. Documents consulted in the desk review included global, continental and sub-regional legal and political commitments, strategies, and guidelines, national laws, academic studies, published papers, and reports from international and continental agencies.

2. There was a regional consultation with SADC Member States organised in October 2012 in Johannesburg, South Africa to discuss the crucial need to focus on access to health services for key populations. The meeting brought together the National AIDS Councils/Commissions as well as the National AIDS Control Programmes. The meeting was convened to build consensus on a regional definition of key population. To guide the process, Member States presented their definitions and discussed the needs of key populations in their countries and the strategies adopted for mitigating those needs. At the end of the meeting, participants agreed that, for this framework, key populations will include the following groups: MSM, Sex Workers, PWUD and Prisoners.[37]

3. The African Key Populations Experts Group developed a Model Regional Strategic Framework on HIV for Key Populations in Africa.[38] The African Key Populations Experts Group included sex workers, MSM, PWUD and transgender persons drawn from several African countries. The group conducted two regional meetings in May and October 2014 with financial and technical support from the United Nations Development Programme (UNDP), SADC Secretariat, East African Community (EAC) and regional civil society organisations. The model strategy, which is the first of its kind to be developed in Africa, outlines the principles and main elements necessary to address key structural barriers for achieving a comprehensive HIV prevention, treatment and care programme for key populations within the African context.

4. UNAIDS organised a working session on key populations and a regional consultation on people left behind in April and November 2014. These meetings reviewed available evidence regarding the programmatic response to HIV, identified gaps and barriers in countries and provided a platform for discussions between communities and programme/policy decision makers/managers on strengthening programming for key populations.

5. The SADC Secretariat and UNDP organised two regional consultations in March 2017 in Johannesburg, South Africa with young key populations and Member States for their inputs and comments on the draft strategy. The Member States in this meeting agreed that transgender persons should be included in the definition of key populations for the purpose of this strategy.

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37   SADC. Final Report on Regional Consultation on Key Population (October 2012).
38   UNDP. Model Regional Strategic Framework on HIV for Key Populations in Africa (December 2014).

Development Process

KP=
MSM,SW,
PWUD,
Prisoners

African Model
Principles and
strategies to to
address structural
barriers

KP Programing
Evidence
Gaps
Barriers

SADC Regional
Consultation with
MS and Young KP
March 2017

Draft 1

Draft 2

SADC
Regional
Consultation
With MS
Oct 2012

Regional
Meetings of the
Africa KP
Experts Group
May/Oct 2014

Leave No One
Behind
Consultations
April/Nov
2014

SADC
Consultancy
to develop KP
Strategy

Circulation
For inputs
Aug/Sept 2017

Validation and
Consensus
Oct. 2017

As part of the HIV response in the Region, there is a
critical need to identify and address the barriers specific
populations face in accessing HIV and SRH services

4. GUIDING PRINCIPLES

The following guiding principles underlie the development of the regional strategy and are expected to guide its implementation:

4.1 Fundamental rights

All persons, including key populations, have a right to equitable health services, which includes access to adequate HIV prevention, treatment and care, support services and SRH. They further have the following relevant rights guaranteed under international, regional and national laws: right to be free from discrimination; right to equality; right to be free from torture and cruel, inhuman and degrading treatment; right to dignity; right to security of the person; and right to information.

4.2 Political commitment

High-level political commitment is required to ensure universal access to health services. The SADC Secretariat and Member States demonstrated such commitment in the development of this regional strategy and will follow a similar principle in its implementation.

4.3 Effective partnerships

Recognising the complex and demanding nature of ensuring access to health services for key populations, the design and implementation of the regional strategy requires continuous and sustained cooperation between various stakeholders in government, key populations, civil society and the private sector. Partnerships have and will continue to include members of key populations in the design and implementation of the regional strategy.

4.4 Respect for diversity

The regional strategy acknowledges, respects and reflects the diversity of experience, sexual orientation, sexual expression, sexual identity and choice of profession among key populations. It recognises and is committed to uphold every person's right to equality, equity, dignity and freedom from stigma and violence.

4.5 Participation, inclusion and equity

Every effort has been made to ensure the substantive and meaningful engagement of key populations in the development of the regional strategy. The regional strategy further calls for the allocation of adequate resources, in terms of finance, time and expertise to ensure the effective participation and contribution of key populations during implementation.

4.6 Evidence-informed programmes of the highest standard

The regional strategy is expected to be of the highest standard, based on comprehensive, accurate and up-to-date evidence on all key population groups. To this end, key population groups are encouraged to be substantively involved in collecting reliable ground-level data, as well as analysing and corroborating the collected data. The regional strategy will also build on practical experience and on what has already been achieved in the region and elsewhere to ensure it is designed and implemented with the highest standards of effectiveness and efficiency.

4.7 Do no harm

The necessary precautions should be taken to ensure that no members of key population groups are put at risk of harm as a direct or indirect result of developing and implementing the regional strategy.

5. BARRIERS FACING KEY POPULATIONS

Properly identifying and addressing the specific barriers key populations face to accessing HIV and SRH is a critical part of the HIV response in SADC to ensure no population is left behind.[39] MSM, sex workers, transgender persons, PWUD and people in prisons have significantly higher prevalence of HIV than the general population as documented in section 1, and thus their need for services is greater. There are a number of reasons key populations are unable to access the necessary services to address their health needs. This section discusses these reasons, focusing on stigma, discrimination and violence; punitive laws; a lack of information on the needs of key populations; and a lack of programming, funds and services aimed at specific key populations.

5.1 Stigma and discrimination

All key populations identified in this strategy face high levels of stigma and discrimination which impedes their access to health services, including HIV and SRH services. Key populations face stigma and discrimination in health care settings, the workplace, families, and within communities. A study focused on southern and eastern Africa found high levels of stigma and discrimination against gay men and other MSM.[40] UNAIDS noted that HIV programmes aimed at MSM were "particularly constrained by widespread homophobia".[41] In Angola, a study found almost 3 out 4 participants experienced homophobia, and 40% of those had experienced homophobia more than once in the last 12 months.[42] This stigma and discrimination extends to health care workers which limits the use of healthcare services by MSM. In one study, about 20% of MSM surveyed were fearful of seeking health services because of their sexual orientation.[43] In the Antananarivo health district, approximately two-thirds of health-care workers expressed discriminatory attitudes towards MSM.[44]

This is also the case for sex workers and transgender persons.[45] In Maseru, 20.3% of female sex workers reported being afraid to access health services due to stigma, discrimination and violence.[46] In a 2012 integrated biobehavioural surveillance study over 12% of female sex workers in Mauritius had been refused health and public services.[47] In Angola, only 19% of female sex workers interviewed in 2008 reported being exposed to at least 1 HIV service.[48]

PWUD and people in prisons find it difficult to access services due to stigma and discrimination. For instance, in the Seychelles, 68% of PWUD reported being refused a service in the past 12 months because of their injecting drug use.[49] High levels of stigma and discrimination among implementers in prison limits the access of people in prisons to services.

5.2 Violence

All key populations experience high vulnerability to violence. MSM, female sex workers and transgender persons are likely to face gender-based violence because either they defy gender norms or are women. Transgender persons face harassment and abuse not only from police but from private individuals. Indeed, trans people have been subjected to harassment, physical violence and even murder.[50] Due

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39   UNAIDS. Prevention Gap Report, above n 18, 95.
40   AIDS and Rights Alliance for Southern Africa. HIV and Human Rights in Southern and East Africa: 2014 Report (2014) 26.
41   UNAIDS. Prevention Gap Report, above n 18, 104.
42   UNAIDS. Regional Synthesis, above n 28, 47.
43   Beyrer C et al. "Global Epidemiology of HIV Infection in Men Who Have Sex With Men" 380 The Lancet 367-77 (2012).
44   UNAIDS. Regional Synthesis, above n 28, 96.
45   Divan, V et al. "Transgender Social Inclusion and Equality: A Pivotal Path to Development" 19(2) Journal of the International AIDS Society (2016).
46   UNAIDS. Regional Synthesis, above n 28, 87.
47   *Id.* at 110.
48   *Id.* at 46.
49   *Id.* at 84.
50   *Id.*

to their vulnerability and experience of police abuse, trans persons are less likely to approach law enforcement or health services for necessary assistance.

Similarly, criminal laws leave sex workers vulnerable to abuse and violence from police and private individuals. Sex workers in southern Africa have reported a fear of and routine police abuse including sexual violence and beatings.[51] For instance, in Lesotho, almost half of female sex workers in Maseru reported having been raped at least once, and over half reported being intimidated or harassed by the police.[52] In some Member States, sex workers report that police and prosecutors cite condom possession as "evidence" of a person's engagement in sex work, to justify an arrest and/or as a basis for a conviction on prostitution-related charges.[53] In Malawi, sex workers have been arrested and then subjected to forced HIV testing by health care providers.[54] MSM also face high levels of violence. For instance, in Angola, 25% of MSM reported being forced to have sex against their will.[55]

5.3 Lack of a protective legal and policy environment

The lack of a protective legal and policy environment is a significant obstacle to key populations' ability to access services. As of 2015, approximately half of SADC Member States have specific laws criminalising consensual, same-sex relationships between adults and some aspect of sex work.[56] These punitive laws render MSM and sex workers vulnerable to violence from law enforcement and others. For instance, in the Seychelles, 44% of MSM surveyed reported being arrested in the previous twelve months.[57] Many MSM are reluctant to report human rights violations to the police due to fear that they will be arrested.

These punitive laws can also make healthcare providers more reluctant to treat sex workers and MSM as they fear being seen as condoning illegal behaviour. In Malawi, some health care providers have reported being concerned at treating MSM due to the criminal laws.[58]

Punitive and restrictive laws raise the vulnerability of people in prisons and PWUD to HIV. Legal prohibitions on the provision of sterile needles and opioid substitution treatment (OST) directly impede HIV prevention efforts. For instance, the National Drugs Enforcement Agency in the Seychelles is reportedly throwing away needles and syringes when effecting arrests, leading to sharing of needles amongst PWUD and exacerbating the risk of HIV exposure.[59] Criminal laws prohibiting same-sex sexual activity and correctional laws prohibiting sex in prisons, are often raised as a barrier to providing condoms in prisons, necessary to lower the risk of HIV transmission.[60]

In addition to punitive laws, very few countries in SADC have a protective legal and policy environment. For instance, laws prohibiting discrimination on the basis of an individual's gender identity leaving transgender persons vulnerable to discrimination with little recourse. Most countries in SADC fail to recognise the gender of trans people as they do not legally provide for gender recognition.[61] Due to their marginalisation, trans persons are vulnerable to police abuse under vague laws criminalising

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51 Southern Africa Litigation Centre and Centre for Human Rights Education Advice Assistance. No Justice for the Poor: A Preliminary Study of the Law and Practice Relating to Arrests for Nuisance-Related Offences in Blantyre, Malawi (2013).
52 UNAIDS. Regional Synthesis, above n 28.
53 Open Society Foundations. Criminalising Condoms. How Policing Practices Put Sex Workers and HIV Services at Risk in Kenya, Namibia, Russia, South Africa, the United States, and Zimbabwe (2012).
54 Meerkotter A and Southey-Swartz I. Malawi High Court Rules That Mandatory HIV Testing is Unconstitutional. SALC Blog (May 2015).
55 UNAIDS. Regional Synthesis, above n 28, 47.
56 National Geographic. Map Shows Where Being LGBT Can Be Punishable by Law (16 June 2016), available at http://news. nationalgeographic.com/2016/06/lgbt-laws-gay-rights-world-map/ (last accessed 22 September 2017). Malone, K. Sex Work in the SADC Region: The Importance of Creating a Framework to Protect Sex Workers from HIV and Human Rights Abuses. Masters Thesis (Spring 2010). Overs, C. "Sex Workers' Rights: Mapping Policy Around the World" The Guardian (15 Sept 2015). Sexuality, Poverty and Law Programme. Map of Sex Work Law available at http://spl.ids.ac.uk/sexworklaw.
57 Ministry of Health, Republic of Seychelles. Men Who Have Sex With Men in the Seychelles 2011: Integrated Biological Behavioural Surveillance Survey – Round 1 (2011).
58 Id. at 103.
59 UNDP. Seychelles Legal Environment Assessment of HIV/AIDS (2014) 116.
60 Charles Pensulo. "Malawi: World Aids Day - Malawi's Same-Sex Laws Hinder Prisoners' Access to HIV Services" AllAfrica (1 December 2015).
61 Southern Africa Litigation Centre. Laws and Policies Affecting Trasngender Persons in Southern Africa (July 2016).

vagrancy or public loitering.[62] Transwomen who are sex workers face harassment by police due to laws criminalising sex work. For young key populations, most countries in SADC fail to provide clear laws providing for age of consent to services thereby impacting the ability of young key populations to access SRH, such as obtaining contraception.[63] Lack of a protective legal and policy environment can also make it difficult for key populations to access sexual and reproductive health services, including contraception and maternal health care.[64]

5.4 Lack of data

There is a dearth of information on the needs of key population in SADC making it difficult to provide effective programming. There is almost no data regarding young key populations, transgender persons, people in prisons and PWUD in SADC.[65] In a UNAIDS study of eastern and southern African countries, no country in SADC had information on HIV prevalence for transgender populations.[66] Currently, in SADC, only 6 countries have HIV prevalence and other data on PWUD.[67]

Though most countries in SADC have some data regarding HIV prevalence among MSM and sex workers, the type of detailed information does not exist in many SADC countries. For instance, there is little information on the geographical distribution of MSM and sex workers in Member States.[68] There remains very little data on the HIV prevalence among male sex workers.

Finally, most countries in SADC do not have information on the size of the key populations in country making the development of programming difficult.

5.5 Lack of programming, funds and services aimed at key populations

In SADC, there continues to be limited funds dedicated to programming specifically for key populations and thus, minimal services effectively addressing the needs of key populations. Most countries do not dedicate funds for key populations. No country in SADC allocates specific funds for addressing the HIV needs of transgender populations as part of their HIV expenditure resulting in limited programming tailored for transgender persons.[69] A few countries do designate funds for MSM and sex worker programming, however, the funds tend to be very low with a few exceptions. For instance, Malawi in 2011/2012 spent only .4% of its total HIV expenditure on programming for female sex workers and MSM, resulting in few targeted services for MSM.[70] In Mozambique, the 2011 National AIDS Spending Assessment indicated that only 2% of the total amount allocated for HIV prevention was spent on sex workers.[71] This increased only slightly in 2015 when 3% of the total amount spent on HIV prevention was spent on sex workers.

This lack of funds results in limited specialized health services aimed at key populations.[72] For instance, given the high levels of violence female sex workers face, they may need access to a comprehensive package of gender-based violence services. One study found that sex workers in southern Africa who accessed specialised sex worker health clinics reported positive experiences compared to sex workers

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62   Divan, V. et al., above n 45.
63   WHO. Consolidated Guidelines, above n 1; Delany-Moretlwe, S et al., above n 33; UNDP. Age of Consent Research 2015 (draft); Southern Africa Trust. Age of Consent 2015 (draft).
64   See Cottingham, J. et al. Using Human Rights for Sexual and Reproductive Health: Improving Legal and Regulatory Frameworks. Bulletin of the World Health Organization (3 June 2010).
65   UNAIDS. Prevention Gap Report, above n 18, 104. SADC Parliamentary Forum et al. SRHR Amongst Key and Vulnerable Populations: A Focus on PWID, Sex Workers, LGBT and Prisoners (2016); Telisinghe, L, above n 30, 1225. UNICEF. For Every Child, End AIDS: Seventh Stocktaking Report, above n 31, 37.
66   See UNAIDS. Regional Synthesis, above n 28.
67   UNAIDS. Regional Synthesis, above n 28, 15; UNDP. Seychelles Legal Environment Assessment of HIV/AIDS (2014).
68   *Id.*
69   *Id.*
70   *Id.* at 105.
71   UNAIDS. Regional Synthesis, above n 28, 121.
72   WHO, the United Nations Population Fund and others have drafted a sex worker implementation tool which provides practical advice on implementing HIV and STI programmes for sex workers.

who accessed general services, where they reported negative experiences.[73] A recent study in some Member States found that currently available HIV services in prisons remain inadequate for addressing HIV and TB among prisoners.[74]

Similarly, there is a lack of programming addressing the needs of PWUD. PWUD need safe needle exchange programmes and access to harm reduction services. Unfortunately, in most SADC Member States, no OST programmes are available. In countries, like Madagascar, Mauritius, Seychelles and Tanzania, where OST programmes and needle exchange programmes are available, the programmes are still on a small scale and are often limited due to punitive laws related to drug use. For instance, in Madagascar, only 16.8% of people who inject drugs had accessed needle–syringe distribution programmes.[75]

Young key populations also have specific health care needs. As with young people in general, young key populations require services which respond to their particular developmental life stage.[76] For instance, studies indicate that the willingness of providers to answer questions from young people and their respect for and understanding of young people are associated with young people's intention to seek and engage in care.[77] Thus, services tailored for the life stage of young key populations is essential for reaching them. However, such services are rare in the SADC region.[78]

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73 Scorgie, F et al. "We are Despised in the Hospitals: Sex Workers' Experiences of Accessing Health Care in Four African Countries" 15(4) Cult Health Sex 450-65 (2013).
74 *Id.* at 1225.
75 UNAIDS. Regional Synthesis, above n 28, 95.
76 Delany-Moretlwe, S et al., above n 33.
77 *Id.*
78 *Id.*

6. RATIONALE FOR THE STRATEGY

Due to the heightened vulnerability of key populations, it is critical to focus on addressing the barriers they face in accessing HIV and SRH services. Addressing the barriers identified above across all key populations will not only increase their use of HIV and SRH and result in fewer members of key populations being left behind, but also it will aid countries in meeting commitments made at the national, regional, continental and global level; ensure countries' compliance with international and regional legal obligations; and provide economic benefits.[79]

Member States have made numerous commitments at national, regional, continental and international level, such as national HIV and sexual and reproductive health and rights (SRHR) strategic plans, the Catalytic Framework and the SDGs to address the health needs of key populations with a recognition that they are most at risk of being left behind. Addressing the barriers key populations face can be a significant step forward in meeting these commitments.

Removing obstacles key populations face in accessing HIV and SRH can also ensure compliance with international and regional legal obligations. The African Charter on Human and Peoples' Rights guarantees individuals the right to health and requires Member States to "take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick".[80] It further guarantees the right to be free from discrimination; right to equality; right to dignity; right to be free from torture and cruel, inhumane and degrading treatment; and right to information.[81] Similarly, at the global level, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women, among others, also guarantee individuals the same rights. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa specifically guarantees women the right to SRHR and requires Member States to "provide adequate, affordable and accessible health services, including information, education and comm unication programmes to women," among others.[82] The African Commission on Human and Peoples' Right's resolution 275 further specifically protects the rights of persons to be free from violence due to their real or imputed sexual orientation or gender identity.[83] Increasing access to services for key populations meets many of the legal obligations required under these rights.

Removing the barriers identified above also makes sound economic sense. In both concentrated and generalised epidemics, greater investment in a country's key populations is likely to improve the cost effectiveness of the response to HIV. Further the integration of HIV and SRH is likely to lower the cost of health care services. Finally, criminalisation of key populations and attempts at enforcing these laws, uses funds and resources that could be more gainfully invested elsewhere.

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79   UNICEF. For Every Child, End AIDS: Seventh Stocktaking Report, above n 31, 2.
80   Article 16 of the African Charter on Human and Peoples' Rights.
81   Other regions have also recognised the right to livelihood as part of the right to life, among others. See for example *ASK v. Government of Bangladesh*. Supreme Court of Bangladesh. Writ No. 3034 of 1999.
82   Article 14(2)(a) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.
83   African Commission on Human and Peoples' Rights. 275: Resolution on Protection against Violence and other Human Rights Violations against Persons on the Basis of their Real or Imputed Sexual Orientation or Gender Identity (2014).

7. PROGRAMMATIC INTERVENTIONS FOR KEY POPULATIONS

The international community has identified a number of programmatic interventions that have been deemed effective for increasing key populations' access to HIV and SRH services. These programmatic interventions are as follows:[84]

- Addressing legal, policy, structural and socio-cultural barriers

- Ensuring financial commitments

- Empowering both the general community and key populations

- Addressing stigma, discrimination and vulnerability to violence

- Ensuring the availability and access to comprehensive health services

7.1 Addressing legal, policy, structural and socio-cultural barriers

Legal and policy barriers influence HIV risk. Ensuring these factors contribute positively to an enabling environment to assist the delivery and impact of interventions is essential. If the legal and policy barriers are not addressed, the impact of health sector interventions will be limited. Essential activities for successful interventions to address legal and policy barriers have included, among others: training and sensitizing key populations about relevant laws, their human rights and how to access justice; advocating for reviewing and reforming laws and policies; providing access to justice and bringing cases to account for violations against key populations; and organizing legal aid programmes and legal empowerment of key populations to increase access to justice.

7.2 Ensure financial commitments

Allocating appropriate financial resources to programming for key populations is necessary to address barriers. Essential activities include, among others ensuring resource mobilization and sustainability.

7.3 General Community and key population empowerment

The empowerment of key populations has been critical in the development of successful programming. Essential activities to ensure that key populations can meaningfully participate in programmatic interventions have included, among others: developing and strengthening key population–led organizations and networks; supporting capacity building and mentoring of key populations to enable them to participate in all levels of a programme; strengthening the management and capacity of key population organizations; and supporting community mobilization and sustaining social movements.

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84   United Nations Population Fund, et al. Implementing Comprehensive HIV and STI Programmes with Men who have Sex with Men: Practical Guidance for Collaborative Interventions. (2015). UNAIDS. Guidance Note: Services for Gay Men and Other Men who have Sex with Men (2014). WHO, et al. Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions (2013). UNAIDS. Guidance Note: Services for Sex Workers (2014). UNDP, et al. Implementing Comprehensive HIV and STI Programmes with Transgender People: Practical Guidance for Collaborative Interventions (2016). United Nations Office on Drugs and Crime, et al. Implementing Comprehensive HIV and HCV Programmes with People who Inject Drugs: Practical Guidance for Collaborative Interventions (2017). WHO, et al. Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users (2009). WHO et al. Evidence for Action Technical Papers: Effectiveness of Interventions to Address HIV in Prisons (2007).

7.4 Address stigma, discrimination and vulnerability to violence

Addressing stigma, discrimination and vulnerability to violence facing key populations has resulted in reducing the barriers they face in accessing critical services. Essential activities for these successful interventions have included, among others: training among law enforcement (police), health care workers and judiciary and building institutional accountability with police to uphold the rights of key populations.

7.5 Ensure the availability of and access to comprehensive health services

A number of interventions have been found to produce the most benefit in ensuring the availability of and access to comprehensive health services. Essential activities have included, among others: providing health, psychosocial, legal and other support services to key populations who experience violence; ensuring the availability of voluntary HIV testing and counselling, pre-exposure prophylaxis, viral hepatitis, TB and SRH services, harm reduction, and male and female condom and lubricant supplies; recruiting and training community outreach workers on how to implement outreach and linking to services; and establishing safe spaces to provide community members with a comfortable place to relax, rest, get information and interact with each other and with the programme.

8. PURPOSE, OUTCOMES AND KEY RESULTS

Purpose

> **Guide the adoption and institutionalisation of a standard, comprehensive package that addresses the unique challenges in providing equitable and effective HIV and SRH rights and services to key populations in SADC.**

The regional strategy is expected to serve as a guide to Member States in designing and implementing appropriate SRH and HIV prevention, treatment and care programmes for key populations focusing on the major issues that need to be addressed at policy, legal, institutional and facility levels. Specifically, the Member States will use the strategy to:

- Design and implement effective SRH and HIV prevention, treatment and care programs for key populations which meet their needs.

- Design a package of services for key populations in line with the standard package of services as prescribed in the regional strategy.

- Ensure active and meaningful participation of key population groups in the design and implementation of the regional strategy at national and sub-national levels.

- Mobilise governmental and non-governmental organisations, civil society organisations and other stakeholders around a set of proven strategies based on their comparative advantages.

Outcomes

Once fully implemented, the regional strategy is expected to:

1. Increase or ensure availability of SRH and HIV prevention, treatment and care services to all key populations within the SADC region;

2. Design and implement holistic strategies covering the policy, legal, institutional and facility level in the SADC region;

3. Increase access to quality and comprehensive HIV and SRH services for key populations in all Member States (MS) such that 90% of members of key populations are accessing services; and

4. Ensure adequate and sustainable resource mobilisation and utilisation for HIV and SRH services for key populations.

Key results

Key Result Area 1: Stigma and discrimination against key populations, particularly at service provision points is eliminated.

Key Result Area 2: Violence against key populations is significantly reduced.

Key Result Area 3: SRH and HIV prevention, treatment, care and support programmes are scaled up for key populations and especially young key populations as per the core package of services, and are evidence informed and results-oriented.

Key Result Area 4: A reduction in legal, policy, and cultural barriers which impede key populations' access to HIV and SRH services.

9. OUTPUTS, STRATEGIES AND INDICATORS

Key Result Area 1: Stigma and discrimination against key populations, particularly at service provision points is eliminated.		
Output 1.1: Regional and national mechanisms to document and address stigma are strengthened.		
Strategies	**Indicators**	**Implementing bodies and partners**
1.1.1: Strengthening partnerships to reduce stigma against key populations: Regional and national systems put in place to establish and operationalise mechanisms for preventing, documenting and responding to situations that put key populations at risk.	1. # of Member States with institutionalised mechanisms to address stigma against key populations 2. # of Member States who have produced or updated a national key population stigma index	• SADC Secretariat • National AIDS Councils (NACs) • Key population organisations and regional networks • Civil society organisations • Development partners • UN agencies
Key Result Area 2: Violence against key populations is significantly reduced.		
Output 2.1: Access to justice for key populations who were victims of violence is improved.		
Strategies	**Indicators**	**Implementing bodies and partners**
2.1.1 Strengthening access to justice for key populations: Developing and implementing access to justice mechanisms for key populations.	3. # of Member States providing legal aid services to key population	• NACs/MOH • National Parliaments • Key population organisations and regional networks • Law and human rights experts • UN agencies • Development partners
Key Result Area 3: SRH and HIV prevention, treatment, care and support programmes are scaled up for key populations and especially young key populations as per the core package of services, and are evidence informed and results-oriented.		
Output 3.1: Access to quality and evidence-based services for key populations improved.		
Strategies	**Indicators**	**Implementing bodies and partners**
3.1.1 Develop and implement a standard regional package of services for key populations: Technical support to Member States to develop and provide a standard package of effective, evidence-based, voluntary, community-empowering SRH and HIV prevention, diagnosis, treatment and care services to all key populations.	4. # of Member States implementing minimum basic package of services for key populations 5. # of key populations or % of estimated key populations accessing combination prevention services in line with national guidelines and package of services	• NACs/Ministries of Health (MoHs) • Key population organisations and networks • UN agencies
3.1.2 Strengthening the capacity of policy makers and health care providers: Member States make SRH and HIV services available, accessible and acceptable to key populations, based on principles of medical ethics, the elimination of stigma from health care settings and the rights to health and equity, including non-discrimination and confidentiality.	6. # of Member States with functional technical working groups representing key populations in national AIDS response co-ordination mechanisms	• NACs/MoHs • Key population organisations and regional networks • UN agencies

Output 3.2: Funding for services for key populations increased.		
Strategies	**Indicators**	**Implementing bodies and partners**
3.2.1 Identifying and sustaining resources for key population interventions: Mobilise sufficient resources to provide sustainable scaled-up SRH and HIV services to all key population groups and ensure resources are utilised effectively and equitably.	7. # of Member States having specific budget allocations for key population interventions and programmes 8. # of Member States mobilizing additional financial resources from development partners for key population interventions	• NACs/MoHs • Heads of States and other government leaders • Key population organisations and regional networks • Development partners
Output Result 3.3: Epidemiological and social data on key populations strengthened.		
Strategies	**Indicators**	**Implementing bodies and partners**
3.3.1 Scaling up generation of evidence relating to key populations: Develop and implement innovative systems and protocols for knowledge production, management and dissemination on issues related to SRH, HIV and key populations with real involvement, ownership and leadership of key populations.	9. # of Member States conducting Integrated HIV Bio-Behavioural Surveillance Studies of key population groups as per UNAIDS surveillance guidelines 10. Key population issues included in the SADC regional research agenda	• NACs/MoHs • Key populations organisations and regional and global networks • Research experts from key populations and others
Output 3.4: Participation of key populations in policy and programme development, implementation, monitoring and evaluation increased.		
Strategies	**Indicators**	**Implementing bodies and partners**
3.4.1 Key population groups engaged in policy and programmes: Develop and operationalise mechanisms to ensure that key populations groups can meaningfully participate in the collection of data for the development of policy and programmes with information being sufficiently protected so that key populations groups are not put at increased risk.	11. # of Member States with mechanisms in place to ensure meaningful participation of key populations in the design and implementation of programmes	• NACs/MoHs • Key populations organisations and regional and global networks • Research experts from key populations and others

Key Result Area 4: A reduction in legal, policy, and cultural barriers which impede key populations' access to HIV and SRH services.

Output 4.1: Legal environments (including laws, policies, practices, regulations, access to justice and law enforcement) for key populations are improved.		
Strategies	**Indicators**	**Implementing bodies and partners**
4.1.1 Legal environment assessment: Advocate for a review with substantive participation of key populations of the punitive and protective laws, policies and law enforcement practices, and traditional and cultural practices applicable to key populations across the region and identify the impact of such laws, policies and practices on key populations and SRH and HIV outcomes based in part on lived experiences of key populations.	12. # of Member States with nationally validated legal environment assessments on HIV and SRH	▪ NACS/MoHs ▪ Key populations organisations and regional networks ▪ Research experts from key populations and others ▪ Legal experts ▪ UN agencies
4.1.2 Regional and national dialogue: Documentation and sharing of best practices on removing legal and policy barriers for key populations.	13. # of best practices on removing legal and policy barriers for key populations documented and shared	• NACs/MoHs • Key population organisations and regional networks • National political leaders • Regional policy makers • Regional opinion leaders • Law and human rights experts • Policy experts • UN agencies

10. IMPLEMENTATION ARRANGEMENTS

Implementation of the regional strategy will require participation of a wide range of stakeholders. Major responsibilities and roles of these stakeholders include the following:

10.1 Member States

a) Coordinate the process of adaptation and implementation of the regional strategy in their National Strategic Plans for HIV and AIDS.

b) Ensure that key population-focused SRH and HIV services are provided as per the regional minimum package.

c) Support the design and implementation of capacity development interventions for service providers, key populations and civil society organisations in line with the regional strategy.

d) Ensure that strong links and networks are created and maintained between all stakeholder including key population groups and civil society organisations.

e) Ensure that the legal and political environment is conducive to enable access to SRH and HIV services for key populations.

f) Provide a specific budget for key population programming.

10.2 Civil society/non-governmental organisations

a) Advocate for increased services by designing and implementing specific key population-friendly SRH and HIV services.

b) Advocate and promote the adaptation and implementation of the regional strategy.

c) Develop targeted messages for key population-focused SRH and HIV services.

d) Support capacity development of key population groups to meaningfully engage in the strategy.

e) Engage in resource mobilisation and income-generating projects.

Key population groups

a) Generate evidence on implementation techniques and on impact of interventions in order to refine future interventions.

b) Generate strategic information for policy and program formulation, implementation, monitoring and evaluation.

c) Establish information and knowledge sharing networks and platforms.

d) Assist in developing a minimum package of services for key populations.

SADC Secretariat

a) Ensure and encourage region-wide adaptation of the regional strategy.

b) Support resource mobilisation for capacity development of key populations and civil society organisations.

c) Provide technical support to Member States in implementation of the regional strategy.

d) Lead the development and adaptation of a minimum package of services for key populations.

e) Promote policies that facilitate access to SRH and HIV services for key populations.

f) Develop a dissemination and implementation plan for the regional strategy.

g) Coordinate implementation of the regional strategy and monitoring of progress.

h) Share best practices with other partners, including Member States.

Development partners and UN agencies

a) Support regional, national and sub-national action to implement the regional strategy.

b) Support capacity development of government, civil society organisations and key population groups.

c) Support evidence-based advocacy and national policy and program formulation for key population-focused SRH and HIV services.

d) Support civil society organisations in formulation of advocacy strategies.

e) Facilitate South-South exchange on the developing of standardised packages, changing of the legal and policy environment and training of law enforcement and healthcare workers, among others.

11. MONITORING AND EVALUATION

The monitoring and evaluation for this regional strategy will be integrated into the existing regional and international monitoring and evaluation mechanisms. The SADC Secretariat will ensure that core indicators for tracking implementation of the regional strategy are developed and reported on.

1. At the national level, NACs and MoHs will be responsible for data collection, analysis, synthesis, quality assessment and dissemination as per the monitoring and evaluation plan of the regional strategy.

2. Member States will produce annual national reports based on core indicators and submit these to the SADC Secretariat. The SADC Secretariat will produce a regional report that documents implementation progress and bottlenecks.

3. The regional annual report will be presented to the joint Ministerial meeting for Ministers of Health and Ministers responsible for HIV and AIDS for approval.

4. International agencies and academic institutions will support the monitoring process through regular and joint performance reviews.

APPENDIX A: TEMPLATE FOR NATIONAL HIV PREVALENCE DATA[85]

Country	Female sex workers	MSM	People who inject drugs	Trans	People in prisons	YSW	YMSM	YPWUD	YTrans	Young people in prisons
Angola	7.2	No data	No data	No data	No data	7.2	No data	No data	No data	No data
Botswana	61.9	13.1	No data	No data	No data	No data	No data	No data	No data	No data
Democratic Republic of the Congo	5.7	8.2	11.3	7.9	3.9	4.5	2.1	5.6	No data	No data
Lesotho	71.9	32.9	No data	No data	No data	No data	No data	No data	No data	No data
Madagascar	5.5	14.9	8.5	No data	No data	4.5	9	No data	No data	No data
Malawi	24.9*	17.3	No data	No data	19.9	No data	No data	No data	No data	No data
Mauritius	15	17.2	44.3	No data	11.8	5.5	5.5	14.3	No data	No data
Mozambique	No data	No data	No data	No data	24	No data	No data	No data	No data	No data
Namibia	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
Seychelles	4.6	13.2	3.8	No data	4.1	0	0.6	0.6	No data	0
South Africa	57.7*	26.8	No data	No data	No data	No data	No data	No data	No data	No data
Swaziland	69.7	12.6	No data	No data	34.9	64.14	No data	No data	No data	No data
United Republic of Tanzania	28	17.6	15.5	No data	6.7	No data	15.4	12.3	No data	No data
Zambia	56.4	No data	No data	No data	27.4	No data	No data	No data	No data	No data
Zimbabwe	58.9	No data	No data	No data	28	34.4	No data	No data	No data	No data

*: Data male and female sex workers

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85   UNAIDS. Regional Synthesis, above n 28; Data compiled by UNAIDS based on Global AIDS Monitoring Report 2017. UNAIDS Prevention Gap Report, above n 18.