Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations 2024-2030

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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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Foreword

The Revised Regional Strategy for HIV and AIDS Prevention, Treatment, and Care, and Sexual and Reproductive Health and Rights (SRHR) among Key Populations (2024-2030) was developed through an inclusive, consultative process involving Governments, Key Populations, Civil Society, and Development Partners. This revision builds on the foundations laid in the original strategy, which was developed in 2012. The revised strategy underscores the region's commitment to health equity, human rights, and addresses the needs of vulnerable groups, in particular key populations at risk of HIV.

This revised strategy aligns with the SADC Regional Indicative Strategic Development Plan (RISDP) 2020-2030, which outlines priorities for an inclusive environment, where all citizens enjoy sustainable economic well-being. HIV remains a central focus, with the aim of increasing access to quality services, improve quality of life of People Living with HIV and moving towards an AIDS-free generation. This aligns with both the SADC Protocol on Health and the broader goal of achieving Universal Health Coverage (UHC). The strategy seeks to overcome barriers to HIV prevention, treatment, and care, ensuring that all populations, especially the most vulnerable, receive comprehensive, accessible, and person-centered services.

The transition in 2015 from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs) emphasized the principle of "leaving no one behind." This principle is especially important for key populations, who face heightened vulnerabilities to HIV. Tailored interventions are necessary to ensure equitable access to health services, addressing disparities and enhancing overall health outcomes.

Since the adoption of the previous strategy in 2017, the region has achieved notable progress, such as the introduction of pre-exposure prophylaxis (PrEP), long-acting injectable ART, and the integration of HIV services with sexual and reproductive health, among others. However, challenges persist, including stagnation or rising infection rates in certain areas and the impacts of the COVID-19 pandemic, economic instability and dwindling support from key donors. This strategy is being ushered into an era of drastic funding reductions for HIV and AIDS and broader health support. In tandem, this is the period of the 8th Replenishment of the Global Fund on AIDS, Tuberculosis and Malaria, hence signifying a critical juncture in the continued response to HIV and AIDS.

The 2024 review of the strategy identified the need for adaptation in response to emerging challenges, while continuing to pursue the UNAIDS 95-95-95 targets. These targets aim for 95% of people living with HIV (PLHIV) to know their status, 95% to be on treatment, and 95% of those on treatment to achieve viral suppression. The strategy also sets out new objectives for combination HIV prevention, to ensure that 95% of individuals at risk of HIV have access to effective, person-centered prevention options.

Under the sexual and reproductive health and rights, the strategy aims to meet the needs of women as key populations, ensuring 95% of women of reproductive age have their HIV and SRH needs addressed, and that 95% of pregnant and breastfeeding women living with HIV achieve viral suppression to prevent mother-to-child transmission.

A key aspect of the strategy is its commitment to the UNAIDS 10-10-10 targets, which aims to reduce the impact of punitive legal environments, stigma, discrimination, and gender-based violence. Specifically, the strategy seeks to ensure that fewer than 10% of countries have legal barriers to accessing HIV services, fewer than 10% of PLHIV and key populations face stigma and discrimination, and fewer than 10% of women and girls experience gender-based violence.

The revised strategy guides SADC Member States in designing and implementing inclusive, rights-based HIV and SRH programmes for key populations, addressing policy, legal, institutional, and service delivery barriers. By aligning with SADC Vision 2050, the Africa Health Strategy, and Agenda 2063, the strategy contributes to building equitable, resilient, and sustainable health systems in Southern Africa, bringing the region closer to a world where health equity is realized, and HIV is ended as a public health threat.

H.E Elias M. Magosi
SADC Executive Secretary

Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
COVID-19	Coronavirus disease 2019
CSO	Civil society organisation
DRC	Democratic Republic of Congo
ESA	Eastern and Southern Africa
GAM	Global AIDS Monitoring
HIV	Human Immunodeficiency Virus
KP	Key population
KRA	Key Result Area
MoH	Ministry of Health
MSM	Men who have sex with men
NAC	National AIDS Council
NGO	Non-governmental organisation
OST	Opioid substitution therapy
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
PWUD	People who use drugs
RISDP	Regional Indicative Strategic Development Plan
SADC	Southern African Development Community
SDG	Sustainable Development Goal
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
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: Any intentional act or failure to act – whether threatened or actual – against a person on the basis of their gender that results, or is likely to result, in physical, sexual or psychological harm. Gender-based violence is committed against women, girls, men, boys, people from sexual minorities and people with gender nonconforming identities. It may be perpetrated by intimate partners, family members, friends, colleagues, social contacts, strangers and people in positions of authority.[2]

Health: 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.[3]

Health care: Preventive, curative and palliative services and interventions provided to people or populations for the purpose of promoting, maintaining, monitoring or restoring physical, mental or emotional well-being.

Human rights: Human rights are rights people have simply because they are born as human beings. Human rights are not granted by any state. These universal rights are inherent to all people, regardless of nationality, sex, gender, national or ethnic origin, colour, religion, language or any other status.[4] 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 (KPs): 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 of all genders; 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 transmission of HIV, viral hepatitis and sexually transmitted infections. They are also essential partners in an effective response to the epidemic. People can be members of more than one key population group and have more than one risk behaviour, and some people may engage in risk behaviours without identifying as members of a particular group.[5]

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 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.[6]

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1 This definition has been adapted from World Health Organization (WHO). 2022. *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2022)*. Geneva: WHO.

2 Joint United Nations Programme on HIV/AIDS (UNAIDS). 2024. *UNAIDS terminology guidelines*. Geneva: UNAIDS. Licence: CC BY-NC-SA 3.0 IGO.

3 WHO. 2022. *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2022)*. Geneva: WHO.

4 Office of the High Commissioner for Human Rights (OHCHR). What are human rights? Geneva: OHCHR (https://www.ohchr.org/en/what-are-human-rights).

5 This definition has been adapted from WHO. 2022. *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2022)*. Geneva: WHO.

6 WHO. 2022. *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2022)*. Geneva: WHO.

People who inject drugs (PWID): People who inject psychoactive substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives, including new psychoactive substances. 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. This strategy addresses all people who use drugs but recognises that PWID are more vulnerable to HIV due to the sharing of blood-contaminated injection equipment.[7]

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.[8]

Sex workers: Female, male, trans and gender diverse adults (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally. 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.[9]

Sexual and reproductive health (SRH): A state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, and not merely the absence of disease, dysfunction or infirmity. For SRH to be attained and maintained, the SRH rights of all persons must be respected, protected and fulfilled.[10] All individuals have the right to make decisions governing their own bodies and to access the information, goods, facilities and services that support this right. These decisions include those related to sexuality, reproduction and the use of SRH services.[11] SRH 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.[12]

Transgender and gender-diverse people: An umbrella term for people whose gender identity and expression differ from that typically associated with sex assigned at birth. The identities of transgender people include men, women, a combination of genders and no gender. Transgender people may or may not access gender-affirming care, including medical care such as hormonal replacement therapy or surgery, and non-medical care. Transgender people may self-identify as transgender, female, male, nonbinary, transgender woman or transgender man, or one of many other transgender identities. They may express their genders in a variety of masculine, feminine and/or androgynous ways.[13]

Vulnerable populations: Groups of people who are particularly vulnerable to HIV infection and developing AIDS due to unequal opportunities, social exclusion, unemployment or precarious employment, and other social, cultural, political, legal and economic factors.[14] These include 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.

Young key populations: This term refers to young women, men and gender diverse people aged 15–24 who are members of key populations such as young gay men and other men who have sex with men, young transgender people, young people who inject drugs, and young people aged 18 years and

7 *Ibid*.
8 *Ibid*.
9 *Ibid*.
10 Adapted from WHO. 2006. Defining sexual health. Geneva: WHO (https://www.who.int/teams/sexual-and-reproductive-health-and-research/key-areas-of-work/sexual-health/defining-sexual-health).
11 UNAIDS. 2024. *UNAIDS terminology guidelines*. Geneva: UNAIDS. Licence: CC BY-NC-SA 3.0 IGO.
12 Adapted from WHO et al. 2017. *Sexual Health and its Linkages to Reproductive Health: An Operational Approach (2017)*. Geneva: WHO.
13 UNAIDS. 2024. *UNAIDS terminology guidelines*. Geneva: UNAIDS. Licence: CC BY-NC-SA 3.0 IGO.
14 *Ibid*.

over who are sex workers and juvenile offenders. Young key populations often have needs that are unique. Their meaningful participation is critical to a successful HIV response.[15]

Young people: Individuals between the ages of 15 and 24 years.[16] Young people are not a homogenous group; physical and emotional maturation comes with age, but its progress varies among individuals of the same age.[17] In 2022, young people (aged 15–24 years) represented about 16% of the global population, but accounted for an estimated 27% of new HIV infections and 3.2 million young people living with HIV.[18]

15 *Ibid*.

16 UNAIDS. 2021. *Global AIDS Strategy 2021–2026: End Inequalities. End AIDS*. Geneva: UNAIDS (https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy).

17 WHO. 2022. *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2022)*. Geneva: WHO.

18 UNAIDS epidemiological estimates, 2023, as mentioned in UNAIDS. 2024. *Youth Next Level: guidance to strengthen sustainable youth-led HIV responses*. Geneva: UNAIDS. Licence: CC BY-NC-SA 3.0 IGO (https://www.unaids.org/sites/default/files/media_asset/youth-next-level_en.pdf).

1. Introduction

Since the turn of the century, Africa, particularly East and Southern Africa (ESA), the region most affected by HIV, has made considerable progress in responding to the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) pandemic. Between 2010 and 2023, the number of new HIV infections and AIDS-related mortality among all ages in ESA dropped by 59% and 57%, respectively.[19] According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), the number of new HIV infections in ESA declined from 1.4 million in 2001 to 600,000 in 2010 and 260,000 in 2023.[20] In addition, there has been substantial improvement in the uptake of antiretroviral therapy (ART), with 83% of people living with HIV (PLHIV) receiving ART in 2022 – a significant rise from just 25% coverage in 2010.[21]

Furthermore, at least six Southern African countries – Botswana, Eswatini, Malawi, United Republic of Tanzania, Zambia and Zimbabwe – have reached the 2025 UNAIDS targets, with 95% of PLHIV knowing their status, 95% of those aware of their status receiving treatment, and 95% of those treated achieving a suppressed viral load.[22] Lesotho and Namibia are among the 10 countries close to achieving the 95-95-95 target, having reached over 86% viral suppression among PLHIV on treatment.

Comparative data on the HIV cascade for key populations is scarce. However, the few examples available show that ART coverage among key populations is generally lower than national averages. While overall ART coverage in Zimbabwe and Zambia was 98% in 2023, ART coverage in Zambia was 64.5% for men who have sex with men (MSM), 74.6% for people who inject drugs (PWID), 68.4% for sex workers and 17.1% for transgender people. In Zimbabwe, the ART coverage rate for sex workers was 83.4%.[23] These figures suggest that, despite efforts to reach key populations, there remains an opportunity to further increase ART coverage to match national levels and sustain the progress made in the HIV response.

One of the key components for progress in the region 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.[24] UNAIDS put in place a strategy entitled Getting to Zero from 2011 to 2015 that sought to end new infections, AIDS-related deaths and discrimination.[25] 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.[26] The Southern African Development Community (SADC) issued a strategic framework from 2010 to 2015 aimed at decreasing the impact of HIV in Member States.[27]

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. SDG

19 UNAIDS. 2024. *The Urgency of Now: Global AIDS Update 2024*. Geneva: UNAIDS (https://www.unaids.org/sites/default/files/media_asset/2024-unaids-global-aids-update_en.pdf).
20 UNAIDS. 2013. *Getting to Zero: HIV in Eastern and Southern Africa*. Geneva: UNAIDS; UNAIDS. 2024. *The Urgency of Now: Global AIDS Update 2024*. Geneva: UNAIDS (https://www.unaids.org/sites/default/files/media_asset/2024-unaids-global-aids-update_en.pdf) .
21 UNAIDS. 2023. *The path that ends AIDS*. Geneva: UNAIDS. Licence: CC BY-NC-SA 3.0 IGO (https://www.aidsdatahub.org/sites/default/files/resource/2023-unaids-global-aids-update-path-ends-aids-report.pdf#page=140.00).
22 UNAIDS. 2024. *The Urgency of Now: Global AIDS Update 2024*. Geneva: UNAIDS (https://www.unaids.org/sites/default/files/media_asset/2024-unaids-global-aids-update_en.pdf).
23 UNAIDS. 2024. *Global AIDS Monitoring Report 2024*. Geneva: UNAIDS.
24 United Nations. 2000. Millenium Development Goals – AIDS. New York: United Nations (https://www.un.org/millenniumgoals/aids.shtml).
25 UNAIDS. 2011. *Getting to Zero*. Geneva: UNAIDS (https://www.unaids.org/sites/default/files/sub_landing/files/JC2034_UNAIDS_Strategy_en.pdf).
26 African Union. 2013. *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 2023"*. Abidjan: African Union.
27 SADC. *SADC HIV and AIDS Strategy Framework 2010-2015*. Windhoek: SADC.

3 aims to ensure healthy lives and promote well-being for all at all ages.[28] Furthermore, other SDGs contribute to achieving equality and equity – for example, SDG 1 seeks to end poverty by targeting the most vulnerable and increasing access to basic resources and services, among others.

When the 2017 Regional Strategy for HIV and AIDS Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations was formulated, the global and continental focus aimed to ensure that 90% of people living with HIV were aware of their status, 90% of those diagnosed were receiving treatment, and 90% of those on treatment had a suppressed viral load by 2020, with aspirations to reach 95% across these metrics by 2025. However, new interim targets for 2025 were introduced in June 2021[29] to align with the 2030 SDGs, including the aim to end AIDS.

The 2025 targets, outlined in the Global AIDS Strategy 2021–2026,[30] prioritise PLHIV and other vulnerable groups such as key populations. The HIV prevention target in the Global AIDS Strategy is that 95% of people living at risk of HIV infection are using appropriate, prioritised, person-centred and effective combination prevention options. The Global HIV Prevention Strategy's road map to achieve this goal comprises five priority pillars.[31] The first pillar aims to ensure that all key populations have access to evidence- and human rights-based combined prevention and harm reduction programmes that are free from stigma and discrimination. There is a heightened focus on eliminating societal and legal barriers to service delivery and integrating HIV services with other essential services needed by these populations. Beyond striving to meet the 95-95-95 targets, the 2025 targets aim for 95% of women to access HIV and SRH services. The priority pillars also advocate for 90% of PLHIV and those at risk, including key populations, to be linked to people-centred and context-specific integrated services. Additionally, the 10-10-10 targets for removing social and legal impediments towards an enabling environment for access to or the utilisation of HIV services require that:

- fewer than 10% of countries have punitive legal and policy environments that deny or limit access to services;
- fewer than 10% of PLHIV and key populations experience stigma and discrimination; and
- fewer than 10% of women, girls, PLHIV and key populations experience gender inequality and violence.

In 2017, the UN General Assembly adopted a Political Declaration on HIV and AIDS, reaffirming their commitment to end AIDS by 2030.[32] Some countries committed to national HIV prevention targets as part of the implementation of the Political Declaration on HIV and AIDS at 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.[33] Additionally, the African Union Plan of Action on Drug Control and Crime Prevention (2019–2023) guides countries in designing national drug policies and programmes. The Plan of Action provides guidance for the integration of measures to reduce harm associated with drug use, including the implementation of a comprehensive package of health services for PWID and the prevention and management of HIV, sexually transmitted infection (STIs), Hepatitis C and tuberculosis (TB) among people who use drugs (PWUD).[34] The Declaration of the Special Summit of the African Union

28 United Nations. 2015. Sustainable Development Goals – Goal 3. New York: United Nations (https://sdgs.un.org/goals/goal3).

29 United Nations General Assembly. 2021. *Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030*. New York: United Nations (https://www.unaids.org/sites/default/files/media_asset/2021_political-declaration-on-hiv-and-aids_en.pdf).

30 UNAIDS. 2021. *Global AIDS Strategy 2021–2026: End Inequalities. End AIDS*. Geneva: UNAIDS (https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy).

31 UNAIDS. 2022. *HIV Prevention 2025 – Road Map: Getting on track to end AIDS as a public health threat by 2030*. Geneva: UNAIDS. Licence: CC BY-NC-SA 3.0 IGO (https://hivpreventioncoalition.unaids.org/en/prevention-road-map).

32 United Nations General Assembly. 2021. *Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030*. New York: United Nations (https://www.unaids.org/sites/default/files/media_asset/2021_political-declaration-on-hiv-and-aids_en.pdf).

33 African Union. 2016. *Catalytic Framework to End AIDS, Tuberculosis and Eliminate Malaria in Africa by 2030*. Abidjan: African Union (https://au.int/sites/default/files/pages/32904-file-catalytic_framework_8pp_en_hires.pdf).

34 African Union. 2019. *African Union Plan of Action on Drug Control and Crime Prevention (2019–2023)*. Abidjan: African

on HIV/AIDS, Tuberculosis and Malaria in Africa by 2030, among other things, made a commitment to meaningfully engage PLHIV and members of key populations as partners in ensuring accountability and the effectiveness of the national AIDS response.

In 2018, the SADC Parliamentary Forum, in collaboration with partners, developed the Minimum Standards for the Protection of the Sexual and Reproductive Health of Key Populations to address stigma, discrimination and violence faced by these groups.[35] This initiative, aligned with the 2017 Regional Strategy for HIV and AIDS Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations, aimed to engage Member States in reforming punitive laws, policies and practices. These standards provide a framework for parliamentarians to make interventions at both parliamentary and constituency levels to safeguard the SRH of key populations and to promote the right to health for all individuals. The standards serve as a central parliamentary and policy tool for guiding critical reforms, fostering a growing consensus among SADC national parliaments to protect key populations.

In addition, the Strategy for Sexual and Reproductive Health and Rights (SRHR) in the SADC Region 2019–2030 was endorsed in 2018 to improve SRHR for all people in the region.[36] This strategy guides Member States in developing and refining their national strategies, enhancing data collection and monitoring for SRHR and HIV-related outcomes, particularly among key populations. In parallel, the Regional Strategy and Framework of Action for Addressing Gender-Based Violence 2018–2030 was also endorsed, providing a regional approach to combating gender-based violence.[37] The SADC HIV and AIDS Strategic Framework aims to reach the 2025 and 2030 HIV and AIDS targets to close HIV prevention and treatment coverage gaps, with an emphasis on most-affected populations. These strategies, along with the SADC Regional Indicative Strategic Development Plan (RISDP) 2020–2030, which includes provisions for HIV and key populations,[38] help Member States improve data collection and monitoring of the regional HIV response, ensuring more effective protection for key populations.

Union.

35 SADC Parliamentary Forum. 2018. *SADC Parliamentary Forum minimum standards for the protection of the Sexual and Reproductive Health of Key Populations in the SADC Region*. Windhoek: SADC.

36 SADC. 2019. *Strategy for Sexual and Reproductive Health and Rights in the SADC Region 2019–2030*. Windhoek: SADC (https://www.sadc.int/sites/default/files/2024-06/Final_SADC_SRHR Strategy.pdf).

37 SADC. 2018. *SADC Regional Strategy and Framework of Action for Addressing Gender Based Violence, 2018–2030*. Windhoek: SADC (https://www.sadc.int/sites/default/files/2022-06/SADC_Regional_Strategy_and_Framework_of_Action_for_Addressing_Gender-Based_Violence_2018-2030.pdf).

38 SADC. 2020. *SADC Regional Indicative Strategic Development Plan (RISDP) 2020–2030*. Windhoek: SADC.

2. Context

Despite the progress made 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, MSM, PWUD, transgender persons, and people in prisons.[39] These groups are often referred to as key populations because they experience an increased impact from HIV and decreased access to services, due in part to their marginalisation and/or criminalisation.[40]

The progress assessment of the SADC regional strategy conducted in 2024 documented that between 2018 and 2024, the achievement rate of the strategy's indicators improved from 62% to 75%, indicating significant progress in the region. However, key populations still face significant barriers to HIV services due to stigma, legal challenges and inadequate health care provision, particularly in meeting the prevention, treatment, care and support needs of young key populations. Several strategic initiatives, including the SADC Minimum Standards for Key Populations, aim to address these disparities. Despite improvements in scaling up HIV services, especially with the adoption of pre-exposure prophylaxis (PrEP) and differentiated service delivery models, challenges remain in fully reaching key populations. Progress has been made in reducing stigma and violence against key populations, with promising practices such as Botswana's anti-gender-based violence initiatives.[41] However, violence remains a pervasive issue, exacerbated by anti-gender movements and post-pandemic criminalisation trends. Funding for key population interventions is highly donor-dependent and increasingly under pressure, with a growing need for domestic resource mobilisation.

The latest data shows that HIV incidence decreased among all key populations from 2010 to 2022 in the region, but at slower rates among gay men and other MSM and PWID.[42] Additionally, recent estimates for sub-Saharan African countries show that in places with 80% ART coverage in the general population, coverage was about 11–13% lower among female sex workers and MSM, and 30% lower among transgender women.[43]

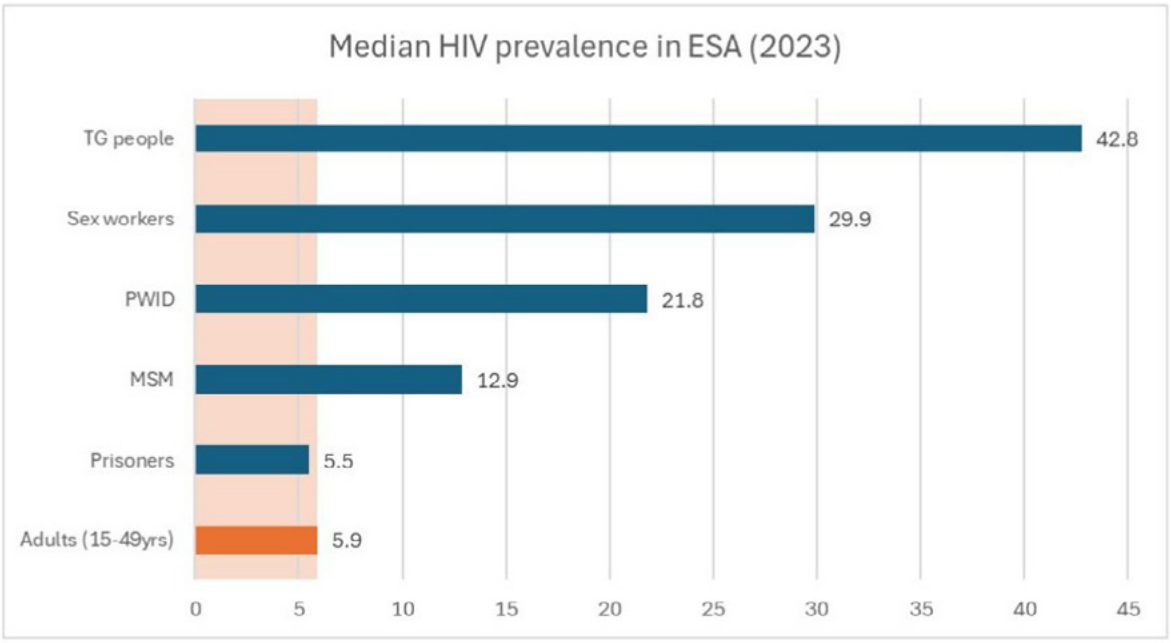
The median HIV prevalence among key populations in ESA is consistently higher than the HIV prevalence among adults (aged 15–49 years) at 5.9% (CI: 4.9–6.9%), as illustrated in Figure 1.[44]

According to the UNAIDS Key Population Atlas (2024),[45] HIV prevalence among MSM was 27.2% in Eswatini, 29.7% in South Africa, 22.8% in Zambia, 12.9% in Malawi and 7.8% in Namibia.[46] Botswana reported a prevalence of 14.8%, while the Comoros, the Democratic Republic of Congo (DRC) and Zimbabwe reported lower prevalence rates at 1.8%, 7.1% and 8.1%, respectively.[47] The current HIV prevalence among MSM and transgender women in sub-Saharan Africa is alarming and consistently high across all regions and countries.[48] Information on HIV prevalence among transgender people in

39 SADC. 2017. *2016-2020 HIV/TB/SRH/Malaria Integration Programmes Strategy*. Windhoek: SADC
40 Global Fund to Fight AIDS, Tubercolosis and Malaria. 2015. *Fact Sheet. Key Populations: A Definition* Geneva: GFATM UNAIDS.
41 SADC. 2024. *Progress Review of the SADC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights Among Key Populations*. Windhoek: SADC.
42 UNAIDS. 2024. *The Urgency of Now: Global AIDS Update 2024*. Geneva: UNAIDS (https://www.unaids.org/sites/default/files/media_asset/2024-unaids-global-aids-update_en.pdf).
43 *Ibid*.
44 UNAIDS. 2023. *The path that ends AIDS: UNAIDS Global AIDS Update 2023*. Geneva: UNAIDS. Licence: CC BY-NC-SA 3.0 IGO (https://www.aidsdatahub.org/sites/default/files/resource/2023-unaids-global-aids-update-path-ends-aids-report.pdf#page=140.00).
45 UNAIDS. 2024. UNAIDS Key Population Atlas. Geneva: UNAIDS (https://kpatlas.unaids.org/dashboard). Accessed between August and September 2024.
46 Global AIDS Monitoring data accessed through the UNAIDS Key Population Atlas between August and September 2024.
47 UNAIDS. 2024. UNAIDS Key Population Atlas. Geneva: UNAIDS (https://kpatlas.unaids.org/dashboard). Accessed between August and September 2024.
48 Kloek, M., Bulstra, C.A., van Noord, L., Al-Hassany, L., Cowan, F.M. and Hontelez, J.A.C. 2022. HIV prevalence among men who have sex with men, transgender women and cisgender male sex workers in sub-Saharan Africa: a systematic

SADC is scant and shows HIV prevalence rates of 28% in Mauritius,[49] 58% in South Africa, 8.9% in Zambia and 17.6% in Zimbabwe.[50]

Figure 1. Median HIV prevalence in the general population and key populations in ESA countries, 2023



Source: UNAIDS. 2023. *The path that ends AIDS: UNAIDS Global AIDS Update 2023*. Geneva: UNAIDS. Licence: CC BY-NC-SA 3.0 IGO (https://www.aidsdatahub.org/sites/default/files/resource/2023-unaids-global-aids-update-path-ends-aids-report.pdf#page=140.00)

Prevalence among sex workers was 62.3% in South Africa, 60.8% in Eswatini and 50% in Malawi.[51] In Botswana and Zimbabwe, the prevalence was between 40% and 42%, and in Mauritius and Namibia, it was 18.2% and 29.9%, respectively, with the United Republic of Tanzania at 15.4%.[52] The prevalence is much lower in Comoros (0.5%)[53] and DRC (7.7%).[54]

Data on PWID indicates high HIV prevalence in specific countries. Mauritius and South Africa reported a prevalence of 21.2% and 21.8%, respectively; Zambia 10.9%, Seychelles 8.1%[55] and DRC 3.9%.[56] HIV prevalence among prisoners is reported to be 7% in South Africa, 12.3% in Zambia, 16.7% in Zimbabwe, 1.4% in DRC, 0.9% in Malawi and 0.4% in Seychelles.[57]

In terms of coverage of key populations with comprehensive HIV prevention services, the latest Global Prevention Coalition prevention scorecard data indicates that most results are in the “very low” range

review and meta-analysis. J Int AIDS Soc. 2022 Nov;25(11):e26022. doi: 10.1002/jia2.26022. PMID: 36419343; PMCID: PMC9684687.

49 *Ibid*.

50 UNAIDS. 2024. UNAIDS Key Population Atlas. Geneva: UNAIDS (https://kpatlas.unaids.org/dashboard). Accessed between August and September 2024.

51 *Ibid*.

52 *Ibid*.

53 *Ibid*.

54 As reported directly by the country.

55 *Ibid.*

56 UNAIDS. 2024. UNAIDS Key Population Atlas. Geneva: UNAIDS (https://kpatlas.unaids.org/dashboard). Accessed between August and September 2024.

57 *Ibid*.

for condom use and coverage of prevention interventions, with insufficient data for the transgender and PWID communities (Figure 2).[58]

Figure 2. HIV prevention coverage among key populations

Indicators (2023 results)	Angola	Botswana	Comoros*	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius*	Mozambique	Namibia	Seychelles*	South Africa	Tanzania	Zambia	Zimbabwe	Source
Condom use reported by sex workers with most recent client (%)		76		48	50	62		65			42			72		95	GAM/IBBS
% of all sex workers who received at least two HIV prevention interventions in the past three months	51	90		38	9	31	93	68		57			34	90		79	GAM/IBBS/programme data
Condom use at last anal sex among MSM (%)		78		57	80	46		79			55		72		58	69	GAM/IBBS
% of all MSM who received at least two HIV prevention interventions in the past three months	3	32		39	29	26	28	65		31	33		10	4	5	26	GAM/IBBS/programme data
Safe injecting practices among PWID (%)				23													GAM/IBBS
% of all PWID who received at least two HIV prevention interventions in the past three months				23	37		100	0		40			17	11	3		GAM/IBBS/programme data
Condom use among transgender people (%)				52				50					77			82	GAM/IBBS
% of all transgender people who received at least two HIV prevention interventions in the past three months				12									2		6	28	GAM/IBBS/programme data
Prevention strategy includes core elements of prisoners prevention package	<50%	<50%		<50%	>50%		<50%	<50%			none		>50%	>50%	>50%	>50%	NCPI

very good
good
medium
low
very low
insufficient data

Source: Global AIDS Monitoring data accessed through the UNAIDS Key Population Atlas between August and September 2024.

Note: * Countries are not part of the DPC prevention scorecard database; GAM – Global AIDS Monitoring; IBBS – integrated bio-behavioural surveys; NCPI – National Commitments and Policy Instrument.

In 2024, all SADC countries except for Angola have PrEP in their national protocols.[59] While the global total number of PrEP users is well below UNAIDS targets, PrEP use is increasing in sub-Saharan Africa. In some countries in ESA, the number of people who received oral PrEP at least once in the past 12 months more than doubled between 2021 and 2023.[60] However, studies have shown that PrEP discontinuation among key populations is a challenge, and a study in Zambia concluded that the barriers to using PrEP included effects of PrEP being mistaken for antiretroviral drugs used to treat HIV, anticipated stigma and concerns about side effects based on both misinformation and experience.[61] Stigmatised identities, particularly that of MSM, served as a barrier to PrEP use.[62] The fear of being mislabelled as having HIV was of greatest concern for female sex workers.[63]

Injectable PrEP has seen significant uptake in the SADC region. In 2024, Malawi, South Africa, Zambia and Zimbabwe introduced injectable PrEP, with a total of 3,850 initiations reported during the first half of 2024 across these four countries.[64] Additionally, the dapivirine vaginal ring (DVR), a long-acting HIV PrEP option for women, is available in eight SADC countries: Botswana, Eswatini, Lesotho, Malawi, Namibia, South Africa, Zambia and Zimbabwe.[65]

There is little data regarding key populations' SRH, although literature is available for female sex workers and MSM. Syphilis prevalence among MSM varies across the SADC region, with Eswatini at 42%,

58 The full scorecard is available at https://hivpreventioncoalition.unaids.org/sites/default/files/attachments/key_populations_scorecard_scorecard_0.pdf.
59 WHO. 2024. *Updates on HIV policies uptake*, July 2024. Geneva: WHO (https://cdn.who.int/media/docs/default-source/hq-hiv-hepatitis-and-stis-library/policy-uptake-ppt-2024-v5_mb.pdf).
60 UNAIDS. 2024. *The Urgency of Now: Global AIDS Update 2024*. Geneva: UNAIDS (https://www.unaids.org/sites/default/files/media_asset/2024-unaids-global-aids-update_en.pdf).
61 *Ibid*.
62 *Ibid*.
63 Stoebenau, K., Muchanga, G., Ahmad, S. et al. 2024. Barriers and facilitators to uptake and persistence on prep among key populations in Southern Province, Zambia: a thematic analysis. *BMC Public Health* 24, 1617 (https://doi.org/10.1186/s12889-024-19152-y).
64 AVAC. PrEPWatch Data Dashboard (https://data.prepwatch.org/).
65 UNAIDS. 2024. *The Urgency of Now: Global AIDS Update 2024*. Geneva: UNAIDS (https://www.unaids.org/sites/default/files/media_asset/2024-unaids-global-aids-update_en.pdf).

Botswana at 3.2%, Comoros at 1.8%, Zambia at 4.3% and Zimbabwe at 4.8%.[66] Syphilis prevalence among sex workers was about 30% in Eswatini, Malawi and Zimbabwe. Botswana and Zambia each recorded a prevalence of about 10%, and Comoros of 1.5%.[67] The only recorded data on syphilis prevalence among transgender people is from Malawi (12%) and Mauritius (29%).[68]

In 2021, Africa had 25.6% of the world's total cases of the four curable STIs among adults.[69] In addition, cervical cancer is the leading cause of cancer-related deaths among women in sub-Saharan Africa.[70]

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 the Minimum Standards for the Protection of the Sexual and Reproductive Health of Key Populations, the SADC HIV and AIDS Strategic Framework 2025–2030, the Strategy for Sexual and Reproductive Health and Rights in the SADC Region 2019–2030, the Regional Strategy and Framework of Action for Addressing Gender-Based Violence 2018–2030 and existing international and continental initiatives, such as the SDGs, the African Union Plan of Action on Drug Control and Crime Prevention (2019–2023) and the Catalytic Framework.

The strategic framework is not a strategic plan but a guide 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 faced by key populations when accessing HIV and SRH services. The strategic framework also identifies steps Member States can take to address these obstacles, thereby reducing the vulnerability of key populations to HIV and increase their access to HIV and SRH services.

66 Global AIDS Monitoring data accessed through the UNAIDS Key Population Atlas between August and September 2024.
67 UNAIDS. 2024. *The Urgency of Now: Global AIDS Update 2024*. Geneva: UNAIDS (https://www.unaids.org/sites/default/files/media_asset/2024-unaids-global-aids-update_en.pdf).
68 *Ibid*.
69 WHO. 2021. *Global progress report on HIV, viral hepatitis and sexually transmitted infections, 2021. Accountability for the global health sector strategies 2016–2021: actions for impact*. Geneva: WHO. Licence: CC BY-NC-SA 3.0 IGO.
70 WHO. 2024. *Status of the Cervical Cancer Elimination Initiative in WHO African Region*. Brazzaville: WHO.

3. Process of developing the strategy

The regional strategy is a result of a series of participatory processes that involved members of key populations, governments, civil society and development partners. The main activities that informed the development of the 2017 regional strategy and its update in 2024 are provided below.

1. A regional consultation in 2012 with SADC Member States discussed the crucial need to focus on access to health services for key populations and built consensus on a regional definition of key populations. A desk review was also undertaken to inform the process. The African Key Populations Experts Group, which included sex workers, MSM, PWUD and transgender persons drawn from several African countries, developed a Model Regional Strategic Framework on HIV for Key Populations in Africa in 2014.[71] The model strategy, which was the first of its kind to be developed in Africa, outlined the principles and main elements necessary to address key structural barriers to achieving a comprehensive HIV prevention, treatment and care programme for key populations within the African context. UNAIDS also organised working sessions and regional consultations to identify gaps and barriers in countries and discuss strengthening programming for key populations. Once a draft strategy was ready in 2017, the SADC Secretariat and UNDP organised regional consultations with young key populations and Member States for their inputs and comments, and it was validated in October 2017.

2. The SADC regional strategy was implemented from 2018, and progress reports were produced annually between 2018 and 2021. However, the reports were not standardised and did not provide comprehensive information, and it was decided that a comprehensive progress review was needed in 2024 to inform the next iteration of the strategy. The 2024 assessment was based on the following processes:

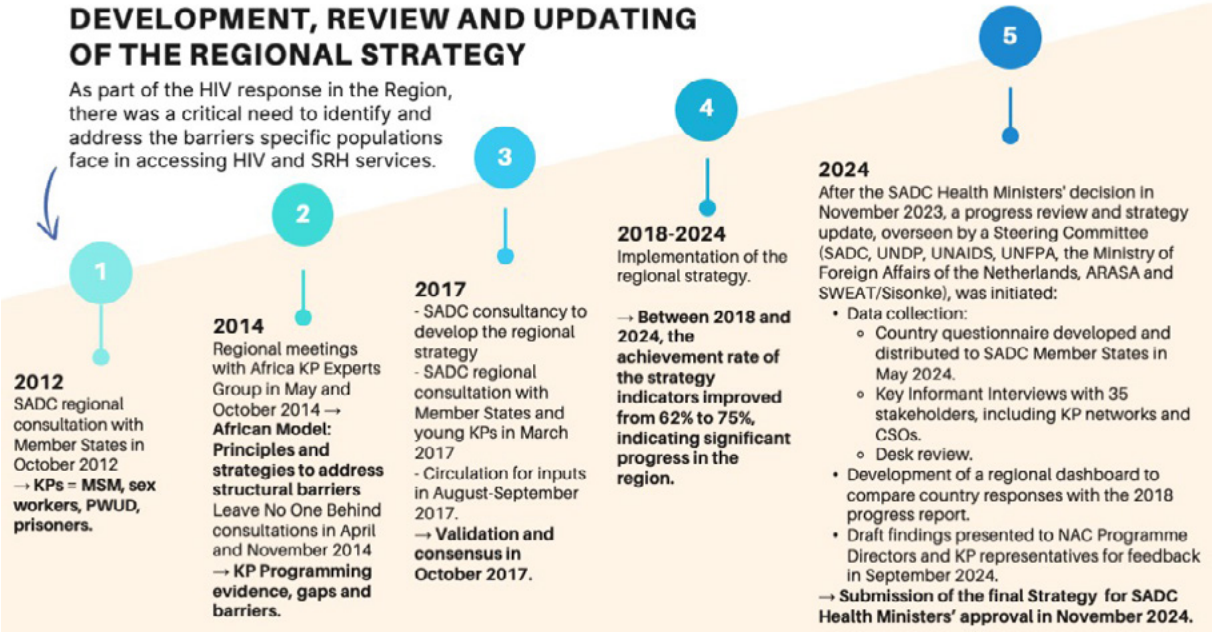
    - Following the decision of the SADC Health Ministers in November 2023, a Steering Committee, including representatives from SADC, UNDP, UNAIDS, UNFPA, the AIDS and Rights Alliance for Southern Africa (ARASA) and SWEAT/Sisonke, was established to oversee the review.
    - A country questionnaire, based on the strategy's performance framework, was developed, translated and distributed in May 2024 to collect data on key populations and feedback. Orientation sessions were held, with continuous follow-ups to ensure participation.
    - Key informant interviews in the form of semi-structured interviews were conducted with 35 stakeholders, including key population networks, civil society organisations (CSOs), donors and regional partners.
    - A comprehensive desk review was performed, using grey and peer-reviewed literature, reports, and data from international bodies and CSOs.
    - Country responses were compiled into a regional dashboard and compared to the 2018 progress report. A scoring system was applied, colour-coded for implementation status.
    - Data from the desk review, questionnaires and interviews was used to draft the progress review, which was presented to NAC Programme Directors and key population representatives during online consultations and in-person meetings at the SADC annual NAC Directors' meeting for feedback.

3. Based on the progress review, the 2017 regional strategy was updated in October 2024. After revisions based on multiple consultations, the final progress review and updated strategy were submitted to the SADC Health Ministers for approval in November 2024.

71 United Nations Development Programme (UNDP). 2014. *Model Regional Strategic Framework on HIV for Key Populations in Africa*. New York: UNDP.

Figure 3 illustrates the process of developing and updating the 2017 SADC regional strategy.

Figure 3. Process of developing and updating the 2017 SADC regional strategy



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 services. People 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, inhumane 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 require continuous and sustained cooperation between various stakeholders in government, key populations, civil society and the private sector, and regional and international organisations. Effective partnerships will be characterised by transparency, mutual respect and the active involvement of all stakeholders, particularly those of key populations, to ensure that the strategy is inclusive and impactful.

4.4 Respect for diversity

The regional strategy acknowledges, respects and reflects the diversity of experience, sexual orientation, gender expression, gender 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. It further emphasises the importance of intersectionality, recognising that individuals within key populations often navigate overlapping identities and experiences which can intensify their vulnerability to stigma, discrimination and health inequities. Programmes should be attentive to these, so that all their needs can be addressed.[72] The strategy also recognises the complexities in classifying individuals who belong to multiple key population groups, as these intersecting identities pose unique challenges in addressing health disparities and ensuring tailored interventions. To address this, countries are encouraged to focus on measuring what is most important for their specific epidemic.

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, including young key populations, during design, implementation and monitoring and evaluation.

72 The Global Fund. 2022. *HIV programming at scale for and with key populations: Allocation period 2023–2025.* Geneva: The Global Fund (original work published 2019, updated 20 December 2022).

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. Moreover, the strategy encourages continuous exploration and adoption of innovative solutions, including leveraging new technologies, digital health tools and novel programme delivery methods. By integrating cutting-edge advances with evidence-based practices, the strategy remains dynamic and responsive to emerging health challenges, ultimately leading to better health outcomes for all populations, particularly those most at risk.

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.

4.8 Gender-transformative approach

The regional strategy adopts a gender-transformative approach that addresses the root causes of gender-based inequalities and empowers all individuals, regardless of gender. This involves challenging harmful gender norms, roles and stereotypes, preventing gender-based violence, removing gender barriers to services and advocating for gender equality.[73]

4.9 Youth-led approaches

The regional strategy commits to prioritising youth-led, youth-friendly and youth-inclusive approaches to ensure that young key populations play a central role in shaping and implementing health initiatives. This involves empowering them to take leadership positions in the design, implementation and evaluation of HIV responses, recognising their unique perspectives and lived experiences. The strategy encourages collaboration with youth-led organisations to promote youth-friendly services that are accessible, non-discriminatory and tailored to the needs of diverse youth key populations.[74]

73 UNAIDS. 2024. *UNAIDS terminology guidelines*. Geneva: UNAIDS. Licence: CC BY-NC-SA 3.0 IGO; Partnership to Inspire, Transform and Connect the HIV Response (PITCH). 2020. *What does it take to achieve a gender transformative HIV response?* Brighton, UK: PITCH (https://frontlineaids.org/wp-content/uploads/2020/10/Pitch-Gender-Guide-FINAL.pdf).

74 UNAIDS. 2024. *Youth Next Level: guidance to strengthen sustainable youth-led HIV responses*. Geneva: UNAIDS. Licence: CC BY-NC-SA 3.0 IGO (https://www.unaids.org/sites/default/files/media_asset/youth-next-level_en.pdf).

5. Barriers facing key populations

Properly identifying and addressing the specific barriers key populations face in accessing HIV and SRH is a critical part of the HIV response in SADC to ensure no population is left behind.[75] MSM, sex workers, transgender persons, PWUD and people in prisons have significantly higher prevalence of HIV than the general population, as documented in sections 1 and 2, 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, including stigma, discrimination and violence; punitive laws; lack of information on the needs of key populations; and 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 impede their access to health services, including HIV and SRH services. Key populations face stigma and discrimination in health care settings, the workplace, families and communities.

Data related to stigma and discrimination experienced by key populations is limited, but in the countries that reported on this indicator, levels remain far from the targeted less than 10% among MSM (31.9% in DRC, 33.9% in Eswatini and 25.7% in Zambia), among PWID (53.8% in Comoros, 29.9% in DRC, 56.1% in Zambia), among sex workers (29.6% in Comoros, 33% in DRC and Eswatini, 61.5% in Zambia and 56.4% in Zimbabwe) and among transgender people (32.1% in DRC).[76]

Many individuals from key populations reported avoiding going to health care facilities in the past 12 months due to stigma and discrimination. Half (49%) of sex workers in Malawi, 34% in Eswatini, 43.3% in Zimbabwe, 29.6% in Comoros and 24.2% in Zambia have avoided seeking health care for this reason.[77] Among transgender people, 10.8% in Zimbabwe and 36% in DRC reported avoiding health care due to stigma and discrimination.[78] For MSM, 11.9% in Comoros, 12.9% in Malawi, 8.3% in Zimbabwe, 17.8% in DRC, 24% in Eswatini and 29.3% in Zambia avoided health care.[79] Additionally, 14% of PWID in DRC, 54.7% in Comoros and 44.6% in Zambia avoided health care services due to stigma and discrimination.[80]

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, physical violence and abuse from police and private individuals.[81] Due to their vulnerability and experience of police abuse, transgender persons are less likely to approach law enforcement authorities or health care facilities for necessary assistance.

The only available data on violence among transgender people in the SADC region is from DRC, where 23.5% of transgender people reported experiencing sexual and/or physical violence in the past 12

75 UNAIDS. 2021. *Global AIDS Strategy 2021–2026: End Inequalities. End AIDS*. Geneva: UNAIDS (https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy); WHO. 2022. *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2022)*. Geneva: WHO.

76 Global AIDS Monitoring data accessed through the UNAIDS Key Population Atlas between August and September 2024.

77 UNAIDS. 2021. *Global AIDS Strategy 2021–2026: End Inequalities. End AIDS*. Geneva: UNAIDS (https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy); WHO. 2022. *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2022)*. Geneva: WHO.

78 *Ibid*.

79 *Ibid*.

80 *Ibid*.

81 Office of the United Nations High Commissioner for Human Rights (OHCHR). 2024. The struggle of trans and gender-diverse persons. Geneva: OHCHR (https://www.ohchr.org/en/special-procedures/ie-sexual-orientation-and-gender-identity/struggle-trans-and-gender-diverse-persons).

months.[82] Among MSM, 3% in Malawi, 9% in Eswatini, 26.1% in DRC and 25.7% in Zambia have faced similar violence.[83] For sex workers, the rates range from 12% to 19% in Eswatini, Malawi and Mauritius, rising to 27.8% in DRC, 49% in Zimbabwe and 81% in Zambia.[84] Additionally, 13% of PWID in Zambia and 27.7% in DRC reported experiencing sexual and/or physical violence during the same period.[85]

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. Latest data (2022) from the National Commitments and Policy Instrument 2017–2024 indicates that all SADC countries maintain punitive legal frameworks regarding criminalisation related to at least one key population, 14 SADC Member States criminalise some aspect of sex work, all SADC countries criminalise possession of small amounts of drugs – except for Mauritius, which has recently amended the law to conditional criminalisation – and six countries have specific laws criminalising consensual, same-sex relationships between adults (Figure 4).[86]

Figure 4. SADC countries with discriminatory and punitive HIV-related laws (NPCI 2017–2024)

Countries with discriminatory and punitive HIV-related laws	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Criminalisation or prosecution based on general criminal laws of HIV non-disclosure, exposure or transmission	Yes	Yes	No	Yes	No	Yes	Yes	x	No	Yes	Yes	No	x	Yes	x	No
Criminalisation of transgender people	Yes	No	No	No	No	No	No	Yes	No	No	No	No	No	No	Yes	No
Criminalisation of sex work	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Criminalisation of same–sex sexual acts in private	No	No	Yes	No	Yes	No	No	Yes	No	No	*	No	No	Yes	Yes	Yes
Criminalisation of possession of small amounts of drugs	Yes	Yes	Yes	Data not available	Yes	Yes	Yes	Yes	**	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Yes No Data not available

Source: National Commitments and Policy Instrument, 2017–2024, supplemented by additional sources, 2024 (see references in regional factsheets and http://lawsandpolicies.unaids.org/).

Note: x Prosecutions exist based on general criminal laws; * Source: UNAIDS. 2024. *The Urgency of Now: Global AIDS Update 2024*. Geneva: UNAIDS (https://www.unaids.org/sites/default/files/media_asset/2024-unaids-global-aids-update_en.pdf); ** Conditional criminalisation. Source: Mauritius Dangerous Drugs Act 2000, as amended in 2022.

82 UNAIDS. 2021. *Global AIDS Strategy 2021–2026: End Inequalities. End AIDS*. Geneva: UNAIDS (https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy); WHO. 2022. *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2022)*. Geneva: WHO.
83 *Ibid*.
84 *Ibid*.
85 Global AIDS Monitoring, 2023.
86 *Ibid.*

South Africa has initiated the process of decriminalising sex work. Furthermore, among all SADC countries, only South Africa allows legal gender change.[87] A progressive step that goes beyond criminalisation would be the enactment of laws and policies that de-pathologise gender diversity and allow for legal change of gender without surgery. This is a necessary pathway towards reproductive justice and basic gender-affirming reproductive health and rights services for transgender people.[88]

Mauritius has amended its Dangerous Drugs Act to include provisions for an alternative approach for PWUD, reflecting a shift towards a rehabilitation-focused legal framework. A person arrested with small amounts of drugs can now be referred to rehabilitation rather than facing prosecution, if approved by both the Commissioner of Police and the Director of Public Prosecutions. The individual is then assessed by the Drug Users Administrative Panel, which began its operations in April 2024, to determine if they are willing to undergo treatment and direct them to a rehabilitation facility if appropriate.

These punitive laws render key populations vulnerable to violence from law enforcement personnel and others. As decriminalisation can be a lengthy process, UNAIDS recommends relaxing the enforcement of punitive laws and policies.[89] Promising practices such as the South African Police Service's Dignity, Diversity and Policing project can be replicated to protect key populations despite criminalising contexts.[90]

Many MSM and sex workers are reluctant to report human rights violations to the police due to fear that they will be arrested. These punitive laws can also make health care providers more reluctant to treat key populations, as they fear being seen as condoning illegal behaviour.

Punitive and restrictive laws raise the vulnerability of people in prisons and PWID to HIV. Legal prohibitions on the provision of sterile needles and opioid substitution treatment (OST) directly impede HIV prevention efforts. 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.[91]

In addition to punitive laws, very few SADC countries have a protective legal and policy environment. For instance, the lack of laws prohibiting discrimination on the basis of an individual's gender identity leaves transgender persons vulnerable to discrimination with little recourse. Most SADC countries fail to recognise the gender of transgender people, as they do not legally provide for gender recognition.[92] Due to their marginalisation, transgender people are vulnerable to police abuse under vague laws criminalising vagrancy or public loitering.[93] Transgender women who are sex workers face harassment by police due to laws criminalising sex work. The lack of a protective legal and policy environment can also make it difficult for key populations to access SRH services, including contraception and maternal health care.[94]

The interconnected impact of stigma, discrimination and institutional barriers on HIV outcomes shows how stigma and discrimination against key populations by health care providers and the community in general on cultural and moral grounds render them susceptible to violence by private individuals and/or law enforcement agents.

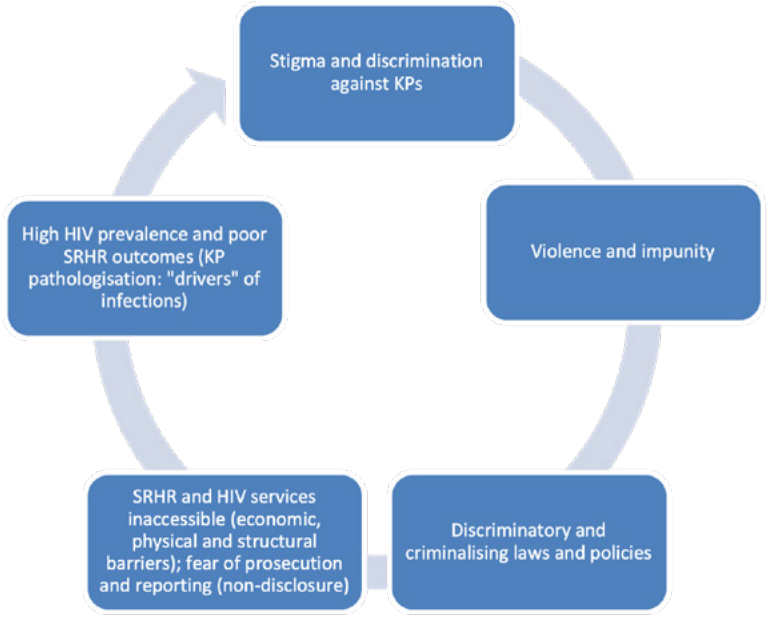
87 UNAIDS. 2022. *National Commitments and Policy Instrument 2021*. Geneva: UNAIDS (https://lawsandpolicies.unaids.org/topicresult?i=923&lan=en).
88 UNAIDS. 2024. *HIV and Transgender People. Global AIDS Update. Thematic briefing*. Geneva: UNAIDS.
89 UNAIDS. 2024. *The Urgency of Now: Global AIDS Update 2024*. Geneva: UNAIDS (https://www.unaids.org/sites/default/files/media_asset/2024-unaids-global-aids-update_en.pdf).
90 For more information, see Global Law Enforcement & Public Health Association Inc. 2024. The South African Police Service's Dignity, Diversity And Policing Project: The Promotion And Protection Of Human Rights, Dignity And Safety For All (https://glepha.com/the-south-african-police-services-dignity-diversity-and-policing-project-the-promotion-and-protection-of-human-rights-dignity-and-safety-for-all/).
91 Struthers, J. 2023. Locked and forgotten: African prisoners have been left behind in the fight against HIV. AIDSmap (https://www.aidsmap.com/news/dec-2023/locked-and-forgotten-african-prisoners-have-been-left-behind-fight-against-hiv).
92 Southern Africa Litigation Centre (SALC). 2016. Laws and Policies Affecting Transgender Persons in Southern Africa. Johannesburg: SALC.
93 Divan, V. et al. 2016. Transgender Social Inclusion and Equality: A Pivotal Path to Development. *Journal of the International AIDS Society* 19 (2).
94 WHO. 2022. *Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations*. Geneva: WHO. Licence: CC BY-NC-SA 3.0 IGO.

Due to prevailing hostility towards key populations in Southern Africa, acts of violence against key populations are not taken seriously; given a lack of legal mechanisms that are gender-transformative, effective or responsive to key populations' needs, such acts are neither documented nor prosecuted, leaving them covered with impunity. Such impunity is implicitly and institutionally condoned by the criminalisation of acts commonly performed by key populations and other punitive/discriminatory laws, which drive them away from services for fear of being outed, judged or reported by service providers.

In addition, prevailing societal norms related to moral judgements surrounding key populations can significantly hinder provision of essential health services, such as harm reduction programmes for PWID. These norms often reflect resistance to the acceptance of a viable and proven approach.

At the end of this cycle, the result is a rise in HIV infections, poor SRHR outcomes and key populations remaining the gatekeepers or pockets of HIV transmission, AIDS-related deaths and ineffective prevention, leading to a biased association of key populations' identity with high risk of HIV and STIs (pathologisation), causing further stigma.

Figure 5. The interconnected impact of stigma, discrimination and institutional barriers on HIV outcomes



This underscores the importance of fostering collaboration among health care providers, law enforcement officers, community leaders and religious figures to shift perceptions, build trust and promote the health and rights of key populations. Sustainable progress requires coordinated efforts to align public health strategies with social acceptance, ensuring harm reduction services are accessible, supported and effectively implemented.

5.4 Lack of data

There is a dearth of information on the needs of key populations in SADC, making it difficult to provide effective programming. There is very limited data regarding young key populations, transgender persons, people in prisons and PWUD. Currently, only five SADC countries report HIV prevalence among PWID, while four countries have prevalence data on transgender populations. Three countries lack any prevalence data for key populations altogether.[95]

95 UNAIDS. 2024. *Global AIDS Monitoring 2024*. Geneva: UNAIDS.

Though most SADC countries have some data regarding HIV prevalence among MSM and sex workers, detailed information such as the geographical distribution of MSM and sex workers and HIV prevalence among male sex workers in Member States is practically non-existant.[96]

Additionally, as documented in the strategy's progress assessment (2024), there are gaps in national population size estimates for key populations in the SADC region. Thirteen countries have estimates for MSM, 12 for sex workers, 8 for PWID and transgender people, and 5 for prisoners. There are concerns among countries about developing more nationally representative studies. These gaps hinder the ability to implement targeted HIV interventions.

Data on access to SRH services such as family planning and maternal health services, including prevention of mother-to-child transmission (PMTCT) services for key populations, which would be crucial in determining a PMTCT cascade per key population (where relevant), is lacking.

Community-led monitoring initiatives, if inclusive of key populations, provide an opportunity to generate data on bottlenecks that key populations experience when they are seeking services, and strategies to address them.

Data needs not only to be generated on various issues across different key populations to guide policy development, but also to be deliberately disaggregated to identify the bottlenecks in current delivery models and gaps in HIV and SRHR service coverage.

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

In SADC countries, limited funds are dedicated to programming specifically for key populations; thus, there are insufficient services effectively addressing their needs.

During the review of the progress made under the 2017 regional strategy, only three countries could estimate the proportion of HIV funding for key population interventions, and five countries could estimate the percentage of the budget needed for national-scale key population interventions that is currently funded, which was between 3% and 17%.

Most SADC countries rely heavily on international funding for HIV interventions for key populations, with only a few of them reporting any significant domestic funding for these populations.[97] Botswana reported in 2019 that 100% of interventions for transgender individuals were funded domestically, and South Africa reported that 25% of interventions targeting prisoners and 34% targeting sex workers were funded domestically.[98] Mauritius reported that 90% of funding for its OST programme is sourced domestically, and Seychelles reported that over 90% of its HIV programme is funded domestically.[99]

Botswana reported 5% domestic funding for MSM interventions in 2019, and other countries such as Angola, Malawi, Mozambique and South Africa report relying entirely on international funding for these interventions; similarly, interventions for sex workers, PWID, transgender persons and prisoners in other countries also exhibit high dependency on international funding.

In comparison, overall donor dependency for HIV programmes across ESA was 61% in 2023.[100] The examples of funding of interventions targeting key populations in the SADC region tend to show an even higher dependency on international funding than the overall rate in the ESA region. Many of these key population interventions are entirely dependent on international support, which raises sustainability concerns. Changes in donor priorities or reductions in international aid could significantly impact the continuity and effectiveness of HIV prevention and care programmes for key populations.

96 Divan, V. et al. 2016. Transgender Social Inclusion and Equality: A Pivotal Path to Development. *Journal of the International AIDS Society* 19 (2).
97 Global AIDS Monitoring country reports, last updated in July 2024: https://hivfinancial.unaids.org/hivfinancialdashboards.html#.
98 *Ibid.*
99 Reported directly by the country.
100 UNAIDS reference data, 2023.

Currently, advancements in key population interventions are largely driven by donor priorities, which presents an opportunity for the SADC Secretariat to step in and ensure that regional strategies are more closely aligned with these efforts, that key population programmes remain high on donor agendas and that more aligned collaboration and co-funding initiatives are implemented. An increase in domestic investment would also improve the sustainability of interventions targeting key populations.

Beyond the funding concerns, there are critical gaps in the programming and service delivery for key populations in SADC countries. While there are significant efforts in HIV prevention and treatment, with initiatives such as service delivery models tailored to key populations, some services remain underdeveloped or completely absent in many settings. For example, access to mental health services is limited across much of the SADC region, especially for PWID, transgender people and prisoners.

Similarly, there is a lack of programming addressing the needs of PWID, who need safe needle exchange programmes and access to harm reduction services. Unfortunately, in most SADC Member States, no OST programmes are available. In countries such as DRC, South Africa and the United Republic of Tanzania, where OST programmes and needle exchange programmes are available, the programmes are often on a small scale and limited due to punitive laws related to drug use. Mauritius and Seychelles are the only two countries reporting dedicated institutions for harm reduction programmes which are widely available at national level and domestically funded.

5.6 Gaps in addressing young key populations' needs

Young key populations have specific health care needs which are largely underserved across the SADC region, with many countries failing to provide targeted interventions and programmes. As with young people in general, they require services which respond to their particular developmental life stage.[101] The health, well-being and life prospects of adolescents are shaped by their ability to access good-quality SRH services.[102]

However, they face various challenges across the region, including legal, social and policy-related obstacles. Health systems tend to cater to adults, services can be expensive, and legal requirements for parental or caregiver consent for HIV testing are major hindrances in many countries. Stigma and restrictive social norms push services even further from the reach of young key populations.[103]

HIV testing coverage among adolescents aged 15–19 is, on average, 9 percentage points lower in countries that require parental consent for those under 18, compared to countries where the age requirement for testing is 16 or younger.[104] The WHO recommends removing or relaxing these age-of-access laws[105] to improve adolescents' health-seeking behaviours and increase HIV testing rates.[106]

In some countries, promising practices exist, such as the development of a strategy to ensure evidence-informed interventions for young key populations in South Africa and the development of a Medical Management Protocol for Intersex Persons in Zambia.

101 Rosen, J.G., Stone, E.M. and Mbizvo, M.T. 2023. Age-of-consent requirements and adolescent HIV testing in low-and middle-income countries: multinational insights from 51 population-based surveys. *Int J STD AIDS* 34(3):168–174.
102 Starrs, A.M., Ezeh, A.C., Barker, G., Basu, A., Bertrand, J.T., Blum, R. et al. 2018. Accelerate progress: sexual and reproductive health and rights for all – report of the Guttmacher–Lancet Commission. *Lancet* 391(10140):2642–2692.
103 Ninsiima, L.R., Chiumia, I.K. and Ndejjo, R. 2021. Factors influencing access to and utilisation of youth-friendly sexual and reproductive health services in sub-Saharan Africa: a systematic review. *Reprod Health* 18(1):135.
104 Rosen, J.G., Stone, E.M. and Mbizvo, M.T. 2023. Age-of-consent requirements and adolescent HIV testing in low-and middle-income countries: multinational insights from 51 population-based surveys. *Int J STD AIDS* 34(3):168–174.
105 WHO. 2021. *Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach*. Geneva: WHO (https://www.who.int/publications/i/item/9789240031593).
106 McKinnon, B. and Vandermorris, A. 2019. National age-of-consent laws and adolescent HIV testing in sub-Saharan Africa: a propensity-score matched study. *Bull World Health Organ*. 97(1):42–50.

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 increase their use of HIV and SRH services, resulting in fewer members of key populations being left behind. It will also 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.[107]

Member States have made numerous commitments at national, regional, continental and international levels, such as national HIV and 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".[108] 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.[109]

Similarly, at the global level, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights and 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 communication programmes to women", among others.[110] The African Commission on Human and Peoples' Right's Resolution 275 specifically protects the rights of persons to be free from violence due to their real or imputed sexual orientation or gender identity.[111] Increasing access to services for key populations meets many of the legal obligations required under these rights.

As many SADC countries make significant progress towards achieving the 95-95-95 targets, key populations, who have historically faced higher risks of HIV infection, continue to bear a disproportionate burden of the disease. In this context, the concept of a dynamic epidemic emerges, emphasising the need for sustained attention and targeted interventions where the epidemic is most active and challenging. Removing the barriers identified above and addressing the dynamic epidemic 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. Furthermore, 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 use funds and resources that could be more gainfully invested elsewhere.

107 United Nations Children's Fund (UNICEF). 2016. *For Every Child, End AIDS: Seventh Stocktaking Report*. New York: UNICEF (https://data.unicef.org/resources/every-child-end-aids-seventh-stocktaking-report-2016/).
108 Article 16 of the African Charter on Human and Peoples' Rights.
109 Other regions have also recognised the right to livelihood as part of the right to life, among others. See, for example, ASK vs. Government of Bangladesh. Supreme Court of Bangladesh. Writ No. 3034 of 1999.
110 Article 14(2)(a) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.
111 African Commission on Human and Peoples' Rights. 2014. *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*. Banjul: African Commission on Human and Peoples' Rights.

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:[112]

- 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; and
- ensuring the availability and access to comprehensive health services.

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

Legal, policy, structural and socio-cultural barriers influence HIV risk. Ensuring these factors contribute positively to an enabling environment to assist the delivery and impact of interventions is essential. If these barriers are not addressed, the impact of health sector interventions will be limited. Essential activities for successful interventions to address legal, policy, structural and socio-cultural barriers include, among others:

- training and sensitising key populations, including young key populations, about relevant laws, their human rights and how to access justice;
- advocating for reviewing and reforming punitive laws and policies;
- addressing age-of-access laws and policies that restrict young people's independent access to HIV services;
- providing access to justice and bringing cases to account for violations against key populations;
- organising legal aid programmes and legal empowerment of key populations to increase access to justice;
- enforcing protective laws;
- training police and law enforcement officials to reduce harassment, violence and arbitrary arrests of key populations;
- fostering cooperation between police and public health sectors to improve access to services for those most at risk;
- engaging faith-based organisations, religious leaders and faith communities in public health efforts and fostering inclusive messaging;
- addressing gender-based violence through legal reforms, community programmes and survivor support services; and
- promoting gender equality, empowering women and engaging men in transforming harmful gender norms.

112 WHO. 2022. *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*. Geneva: WHO; UNAIDS. 2021. *Global AIDS Strategy 2021–2026*. Geneva: UNAIDS; The Global Fund. 2022. *HIV programming at scale for and with key populations: Allocation period 2023–2025*. Geneva: The Global Fund (original work published 2019, updated 20 December 2022).

7.2 Ensuring financial commitments

Allocating appropriate financial resources to programming for key populations is necessary to address barriers. Organisations and networks of key populations should be supported and funded to plan, implement and monitor services. Critical activities include, among others, ensuring resource mobilisation and sustainability and increasing domestic funding where possible to ensure that all programme essentials are budgeted for.

7.3 Empowering the general community and key populations

Key population participation and leadership are essential for effective HIV programmes. In line with the 30-80-60 UNAIDS target,[113] SADC countries will strive to ensure that at least 30% of testing and treatment services, 80% of HIV prevention programmes for key populations, and 60% of programmes supporting societal enablers are delivered by community-led organisations. Essential activities to ensure that key populations meaningfully participate in programmatic interventions include, among others: developing and strengthening organisations and networks of key populations; 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 organisations of key populations; and supporting and sustaining wider community mobilisation and social movements.

7.4 Addressing 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 include, among others, training of law enforcement officers (especially the police), health care workers and the judiciary, and building institutional accountability with the police to uphold the rights of key populations. Programmes must also be to scale for widespread impact and ensure the safety and security of those seeking and delivering services.

7.5 Ensuring 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. As per WHO guidelines, the recommended package of essential services for key populations is shown in Table 1.

In countries where key population communities are receiving the comprehensive package of services, specific data can be drawn from this, such as the PMTCT cascades for sex workers under pregnancy care, to further inform the need for more tailored interventions.

Essential activities also include, among others: providing health, psychosocial, legal and other support services to key populations who experience violence; delivering high-impact, evidence-based, people-centred combination HIV prevention, treatment and care; recruiting community outreach workers and training them to implement outreach and linking to services; establishing safe spaces to provide community members with a comfortable place to relax, rest, obtain information and interact with each other and with the programme; linkages to other health services needed by key populations; and virtual outreach and online interventions to complement in-person programming and expand reach. Differentiated service delivery models ensure that these services are more accessible and acceptable to key populations.

All interventions should be age-sensitive, addressing the unique needs of different age groups within key populations to provide appropriate and effective care across the lifespan.

113 UNAIDS. 2021. *Global AIDS Strategy 2021–2026: End Inequalities, End AIDS*. Geneva: UNAIDS, p. 141 (https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy).

Table 1. Recommended package of essential services for key populations, as per WHO guidelines, 2022

Interventions			Sex workers	MSM	Transgender persons	PWID	Prisoners
Essential for impact	Health interventions	**Prevention of HIV, viral hepatitis and STIs** Condoms and lubricant Pre-exposure prophylaxis for HIV Post-exposure prophylaxis for HIV and STIs Prevention of vertical transmission of HIV, syphilis and Hepatitis B Hepatitis B vaccination Addressing chemsex	✓	✓	✓	✓	✓
		Diagnosis HIV testing STI testing Hepatitis B and C testing	✓	✓	✓	✓	✓
		Treatment HIV treatment Screening, diagnosis, treatment and prevention of HIV-associated TB STI treatment Treatment for Hepatitis B and C	✓	✓	✓	✓	✓
	Enabling interventions	Removing punitive laws, policies and practices Reducing stigma and discrimination Community empowerment Addressing violence	✓	✓	✓	✓	✓
Essential for broader health	Health interventions	Mental health	✓	✓	✓	✓	✓
		Screening and treatment for hazardous and harmful alcohol and other substance use	✓	✓	✓	✓	✓
		Anal health	✓	✓	✓		✓
		Conception and pregnancy care	✓		✓	✓	✓
		Contraception	✓		✓	✓	✓
		Gender-affirming care			✓		
		Prevention, assessment and treatment of cervical cancer	✓		✓	✓	✓
		Safe abortion	✓		✓	✓	✓
		TB prevention, screening, diagnosis and treatment				✓	✓
			✓	Interventions common to all key populations			

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 countries

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, with a focus 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 programmes which meet the needs of key populations;
- 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 subnational levels; and
- mobilise governmental and non-governmental organisations, CSOs and other stakeholders around a set of proven strategies based on their comparative advantages.

Outcomes

Once fully implemented, the regional strategy is expected to:

- increase or ensure availability of SRH and HIV prevention, treatment and care services to all key populations within the SADC region;
- design and implement holistic strategies at the policy, legal, institutional and facility level in the SADC region;
- increase access to quality and comprehensive HIV and SRH services for key populations in all Member States such that 95% of members of key populations are accessing services; and
- ensure adequate and sustainable resource mobilisation and utilisation for HIV and SRH services for key populations.

Key results

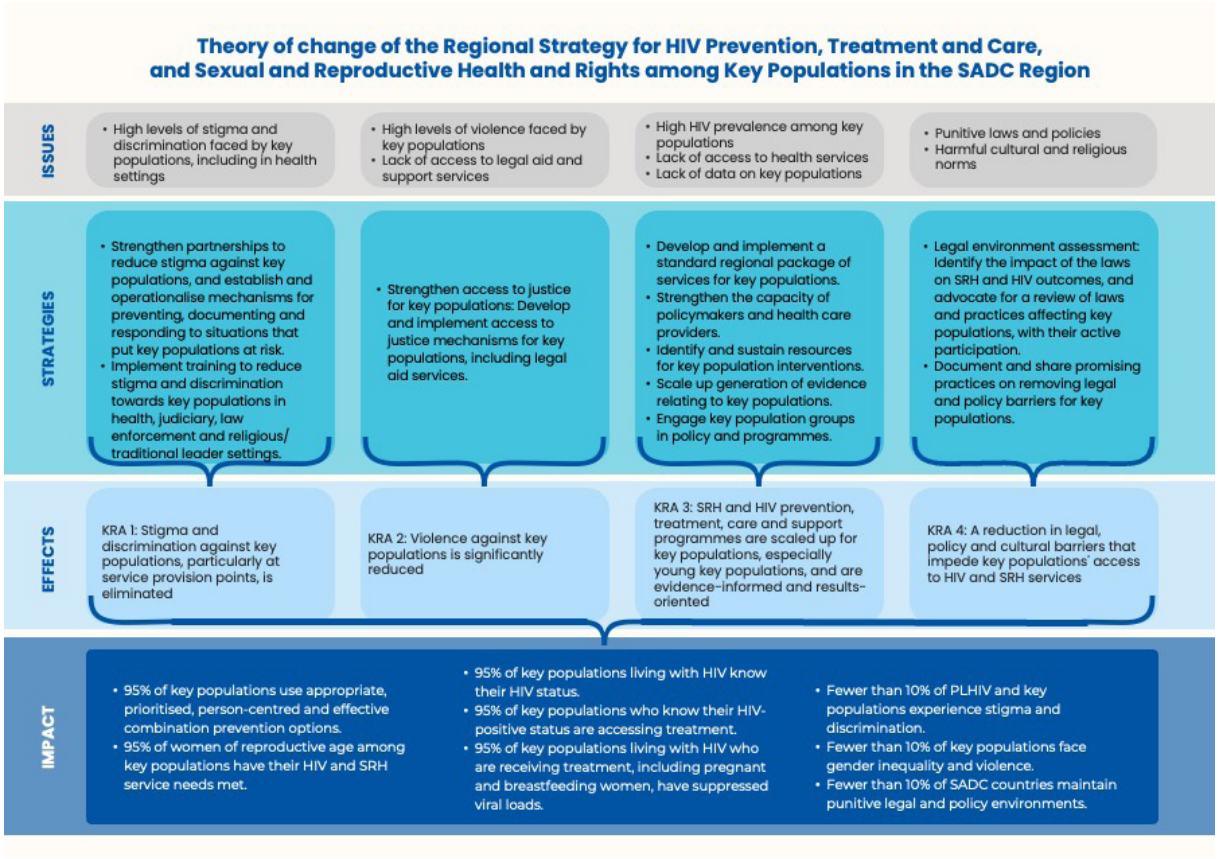
Key Result Area 1: Stigma and discrimination against key populations, particularly at service provision points, is eliminated.

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.

Figure 6. Theory of change of the Regional Strategy for HIV Prevention, Treatment and Care, and Sexual and Reproductive Health and Rights among Key Populations



9. Outputs, strategies and indicators

Key Result Area (KRA) 1: Stigma and discrimination against key populations, particularly at service provision points, is eliminated		
KRA Indicators: A. Percentage of key populations who report experiencing stigma and discrimination B. Percentage of key populations who avoid seeking health care services due to fear of stigma and discrimination		
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: Put in place regional and national systems 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 accessible to key populations to respond to stigma against them 2. # of Member States where training to reduce stigma and discrimination towards key populations is implemented in: (i) health; (ii) judiciary; (iii) law enforcement; and (iv) religious/traditional leader settings	• SADC Secretariat • National AIDS Councils (NACs) • Ministries of Health (MoHs) • Ministries of Justice/Attorney General's Office • Key population organisations and regional networks • CSOs • Professional associations for the judiciary, health care, law enforcement and religious/traditional leadership • International funders and development partners • UN agencies
Key Result Area 2: Violence against key populations is significantly reduced		
KRA Indicator: C. Percentage of key populations who experienced violence in the past 12 months		
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: Develop and implement access to justice mechanisms for key populations	3. # of Member States providing legal aid services accessible to key populations	• NACs/MoHs • Ministries of Justice/Attorney General's Offices • Judicial associations and legal professional bodies • Law enforcement agencies (police and others) • Key population organisations and regional networks • CSOs • Law and human rights experts • National human rights commissions • UN agencies • International funders and 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		
KRA Indicators: D. HIV prevalence among key populations E. Syphilis prevalence among key populations F. HIV testing and status awareness among key populations G. Coverage of combined HIV prevention programmes among key populations H. Antiretroviral therapy coverage among people living with HIV in key populations I. HIV expenditure by origin of resources J. Number of countries that generate integrated bio-behavioural surveys and population size estimates for at least two key population groups of interest K. Number of countries that use key population surveillance data for programmatic purposes L. Level of engagement of key populations in the national responses		
Output 3.1: Access to quality and evidence-based services for key populations is improved		
Strategies	**Indicators**	**Implementing bodies and partners**
3.1.1: Developing and implementing a standard regional package of services for key populations: Give 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 that are providing the comprehensive package of services outlined in the WHO guidelines such that the services are accessible to all key populations	• NACs/MoHs • Key population organisations and networks • CSOs • UN agencies • International funders and development partners

3.1.2: Strengthening the capacity of policymakers and health care providers: Ensure 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	5. # of Member States that have validated national protocols including specific ethical principles for key populations for: (i) integrated services; (ii) combined prevention; (iii) differentiated service delivery; (iv) legal and social services; and (v) community outreach services	• NACs/MoHs • Key population organisations and regional networks • CSOs • Health professional associations • UN agencies • International funders and development partners
Output 3.2: Funding for services for key populations is 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	6. # of Member States having specific budget allocations for key population interventions and programmes in their National Strategic Plans or annual budgets 7. # of Member States mobilising additional financial resources for key population interventions	• SADC Secretariat • NACs/MoHs • Heads of States and other government leaders • Ministries of Finance • Parliamentary committees on health/budget • Private sector • Key population organisations and regional networks • CSOs • International funders and development partners
Output Result 3.3: Epidemiological and social data on key populations is 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	8. # of Member States conducting integrated HIV bio-behavioural surveillance studies and population size estimates of at least two key population groups of interest disaggregated by age, sex and sub-group in the last 3 years 9. # of Member States that use key population surveillance data for programmatic purposes	• NACs/MoHs • Key population organisations and regional and global networks • Research experts from key populations and others • CSOs • UN agencies • International funders and development partners
Output 3.4: Participation of key populations in policy and programme development, implementation, monitoring and evaluation is 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 population groups can meaningfully participate in the collection of data for the development of policy and programmes, with information being sufficiently protected so that key population groups are not put at increased risk	10. # of Member States where programme design and implementation, monitoring and evaluation are led by key populations or they are key participants	• NACs/MoHs • Key population organisations and regional and global networks • CSOs • International funders and development partners

Key Result Area 4: A reduction in legal, policy and cultural barriers which impede key populations' access to HIV and SRH services		
KRA Indicator: M. Criminalisation of key populations		
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	11. # of Member States having developed a nationally validated action plan based on a legal environment assessment on HIV and SRH	• NACs/MoHs • Ministries of Justice or equivalent • Key population organisations and regional networks • CSOs • Legal aid organisations • National human rights commissions • Parliamentary committees on justice/health • National Parliaments • Traditional and religious leaders • Research experts from key populations and others • Legal experts • UN agencies
4.1.2: Regional and national dialogue: Support documentation and sharing of promising practices on removing legal and policy barriers for key populations	12. # of promising practices on removing legal and policy barriers for key populations documented and shared	• SADC Secretariat • NACs/MoHs • Key population organisations and regional networks • CSOs • National political leaders • Regional policymakers • Regional opinion leaders • Other subregional organisations (e.g. Indian Ocean Organisation) • Law and human rights experts • Academic and research institutions • Policy experts • UN agencies • International funders and development partners

10. Implementation arrangements

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

Member States

- Coordinate the process of adaptation and implementation of the regional strategy in their National Strategic Plans for HIV and AIDS, including the possibility to identify and address the needs of their own vulnerable populations or other key populations specific to their context.
- Ensure that key population-focused SRH and HIV services are provided as per the regional minimum package.
- Support the design and implementation of capacity development interventions for service providers, key populations and CSOs in line with the regional strategy.
- Ensure that strong links and networks are created and maintained among all stakeholders, including key population groups and CSOs.
- Ensure that the legal and political environment is conducive to enable access to SRH and HIV services for key populations.
- Provide a specific budget for key population programming.

Civil society/non-governmental organisations

- Advocate for increased services by designing and implementing specific key population-friendly SRH and HIV services.
- Advocate and promote the adaptation and implementation of the regional strategy.
- Develop targeted messages for key population-focused SRH and HIV services.
- Support capacity development of key population groups to meaningfully engage in the strategy.
- Engage in resource mobilisation and income-generating projects.
- Participate in the monitoring of the regional strategy.
- Contribute to demand creation for HIV and SRH services.

Key population groups

- Generate evidence on implementation techniques and on the impact of interventions in order to refine future interventions.
- Generate strategic information for policy and programme formulation, implementation, monitoring and evaluation.
- Establish networks and platforms to share information and knowledge.
- Assist in regularly reviewing and updating the minimum package of services for key populations.
- Participate in programme design, implementation and monitoring to ensure that services are tailored to address the specific needs of key populations

SADC Secretariat

- Ensure and encourage region-wide adaptation of the regional strategy.
- Support resource mobilisation for capacity development of key populations and CSOs.
- Identify and mobilise technical support and resources to support Member States in the implementation of the regional strategy.
- Lead the continuous adaptation of a minimum package of services for key populations.
- Promote policies that facilitate access to SRH and HIV services for key populations.
- Develop a robust and comprehensive dissemination and implementation plan for the regional strategy in collaboration with CSOs and other relevant stakeholders.
- Coordinate implementation of the regional strategy and monitoring of progress.
- Share promising practices with other partners, including Member States, to enhance country-level efforts, including hosting South–South learning retreats and knowledge exchange platforms.

Development partners and UN agencies

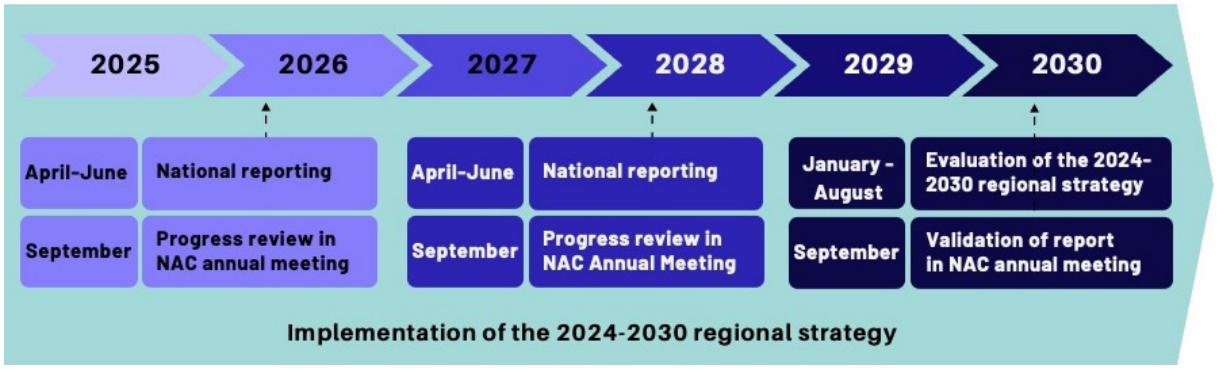
- Support regional, national and subnational action to implement and monitor the regional strategy.
- Support capacity development of governments, CSOs and key population groups.
- Support evidence-based advocacy and national policy and programme formulation for key population-focused SRH and HIV services.
- Support CSOs in the formulation of advocacy strategies.
- Facilitate South–South exchange on the developing of standardised packages, changing of the legal and policy environment and training of law enforcement and health care 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, based on the Performance Monitoring Plan (Appendix C). The SADC Secretariat will ensure that core indicators for tracking implementation of the regional strategy are developed and reported on.

1. The SADC Secretariat will ensure the monitoring of the strategy by:
    - developing monitoring and evaluation tools for the strategy;
    - requesting National AIDS Control Programmes/National AIDS Commissions (NACs) to complete a country questionnaire to inform progress at national levels;
    - collecting data from public sources (such as Global AIDS Monitoring (GAM) reports, the Key Population Atlas website and the HIV Prevention Scorecard) to inform progress at output and Key Result Area levels;
    - compiling the data into a regional report;
    - conducting field visits where necessary and appropriate;
    - producing a regional report that documents implementation progress and bottlenecks in Member States' national reports and discuss the findings at the annual NAC Directors' meeting; and
    - presenting the regional report to the joint ministerial meeting for Ministers of Health and Ministers responsible for HIV and AIDS for approval.
2. At the national level, Member States will be responsible for:
    - NACs and MoHs to ensure data collection, analysis, synthesis, quality assessment and dissemination as per the regional strategy's Performance Monitoring Plan. Monitoring systems should be adapted to local specificities with appropriate disaggregation, while ensuring data privacy, building local capacity, and enabling real-time data monitoring to improve responsiveness. Member States will ensure the meaningful participation of CSOs and key populations groups in this process.
    - Every two years, Member States will produce national reports based on core indicators and submit these to the SADC Secretariat.
3. International agencies and academic institutions will support the monitoring process through regular and joint performance reviews, including UN partners for support and technical assistance needs.

Figure 7. Monitoring and evaluation timeline for the regional strategy 2024–2030



Appendix A: National HIV prevalence data

Table 2. Prevalence rates among key populations – most recent data from 2018 onwards (%)[114]

Country	Female sex workers	MSM	PWID	Transgender people	People in prisons	Young sex workers	Young MSM	Young PWID	Young transgender people	Young people in prisons
Angola	–	–	–	–	–	–	–	–	–	–
Botswana	42.2	14.8	–	–	–	–	–	–	–	–
Comoros	0.5	1.8	–	–	–	–	2	0	–	–
Democratic Republic of Congo	7.7*	7.1	3.9	–*	1.4	4.8	–	0.6	–	2.6
Eswatini	60.8	27.2	–	–	–	31.7	7.3	–	–	–
Lesotho	–	–	–	–	–	–	–	–	–	–
Madagascar	–	–	–	–	0.3	–	–	–	–	–
Malawi	49.9	12.9	–	–	0.9	–	4.6	–	–	–
Mauritius	18.2	–	21.2	28*	–	–	–	–	–	–
Mozambique	–	–	–	–	–	–	–	–	–	–
Namibia	29.9	7.8	–	–	–	14	3.6	–	–	–
Seychelles	–	–	8.1*	–	0.4	–	–	–	–	0
South Africa	62.3	29.7	21.8	58	7	–	0	12.2	–	–
United Republic of Tanzania	15.4	8.4	–	–	–	–	–	–	–	–
Zambia	–	22.8	10.9	8.9	12.3	–	–	–	–	–
Zimbabwe	40.2	8.1	–	17.6	16.7	14.3	1.7	–	18.1	–

Source: UNAIDS, Global AIDS Monitoring 2024.

Note: * As reported directly by the country; – No data.

114 UNAIDS. Global AIDS Monitoring 2024. The most recent prevalence rate has been selected for inclusion. Prevalence rates reported prior to 2018 were excluded from this table to ensure the data reflects the most current information.

Appendix B: Regional dashboard 2018–2024

The regional dashboard is a snapshot of the progress achieved in terms of the level of implementation of the strategy's indicators between 2018 and 2024. The country ratings are based on 2018 and 2024 progress reports. Data for 2024 ratings was sourced from responses submitted by NACs to a standard country questionnaire, and ratings were calculated considering all five key populations and more in-depth issues such as accessibility of services to also inform progress linked to the strategy's Key Result Areas.

INDICATORS	YEAR	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia
# of Member States with institutionalised mechanisms to address stigma against key populations	2018															
	2024															
# of Member States that have produced or updated a national key population stigma index	2018															
	2024															
# of Member States providing legal aid services to key populations	2018															
	2024															
# of Member States implementing a minimum basic package of services for key populations	2018															
	2024															
# of key populations or % of estimated key populations accessing combination prevention services in line with national guidelines and a package of services	2018															
	2024															
# of Member States with functional technical working groups representing key populations in national AIDS response coordination mechanisms	2018															
	2024															
# of Member States having specific budget allocations for key population interventions and programmes	2018															
	2024															
# of Member States mobilising additional financial resources from development partners for key population interventions	2018															
	2024															
# of Member States conducting integrated HIV bio-behavioural surveillance studies of key population groups as per UNAIDS surveillance guidelines	2018															
	2024															
Key population issues included in the SADC regional research agenda	2018	Priority research themes have been included in the HIV Strategic Framework 2008 research ag														
	2024	Data not available														
# of Member States with mechanisms in place to ensure meaningful participation of key populations in the design and implementation of programmes	2018															
	2024															
# of Member States with nationally validated legal environment assessments on HIV and SRH	2018															
	2024															
# of best practices on removing legal and policy barriers for key populations documented and shared	2018															
	2024															

	Data not available
	Activity not implemented
	Activity partially implemented
	Activity fully implemented

Appendix C: Performance Monitoring Plan

It is important to acknowledge that community-generated data and initiatives do not absolve the State and its institutions of their primary responsibility to uphold, promote and ensure access to HIV and SRHR services. In addition to delivering culturally adapted HIV and SRHR services, protecting service users from violations and abuses by third parties, the State's obligation includes conducting studies, raising awareness and delivering education programmes. In cases where these efforts are lacking or ineffective, CSOs and communities step in to fill the gap, but they require institutional support and resources to do so effectively. The community-sourced data column includes questions that serve as guidance for the data collector or principal investigator to fill the gaps left by government-owned data sources.

Table 3. Performance Monitoring Plan

KRA 1: Stigma and discrimination against key populations, particularly at service provision points, is eliminated		
INDICATORS[115]		**DATA SOURCE**
A. Percentage of key populations who report experiencing stigma and discrimination		GAM indicator 6.5
B. Percentage of key populations who avoid seeking health care services due to fear of stigma and discrimination		GAM indicator 6.6
OUTPUT 1.1: Regional and national mechanisms to document and address stigma are strengthened		
STRATEGY 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		
INDICATORS	**DATA SOURCE**	**COMMUNITY-SOURCED DATA**
1. # of Member States with institutionalised mechanisms accessible to key populations to respond to stigma against them	NAC in consultation with CSO and KP representatives Documentation: Reports of National Human Rights Institutions	Are the mechanisms community-led or State-led? Are key population-related issues and cases of stigma and discrimination reported and addressed? How accessible is the mechanism (geographical, entry point for people, time to process the case, including referral)? Does the national mechanism feed into a regional mechanism?
2. # of Member States where training to reduce stigma and discrimination towards key populations is implemented in: (i) health; (ii) judiciary; (iii) law enforcement; and (iv) religious/traditional leader settings	NAC in consultation with CSO and KP representatives Documentation: Curriculum/modules of professional or practical training	Are the training programmes institutionalised or project-based? Are the training programmes delivered by non-governmental organisations (NGOs) or do they participate? Do key population representatives lead or meaningfully participate in these training programmes?
KRA 2: Violence against key populations is significantly reduced		
INDICATORS		**DATA SOURCE**
C. Percentage of key populations who experienced violence in the past 12 months		UNAIDS Key Population Atlas
OUTPUT 2.1: Access to justice for key populations who were victims of violence is improved		

115 All indicators should be disaggregated by type of key population: sex workers, MSM, transgender people, PWID, and prisoners and people in closed settings.

STRATEGY 2.1.1: Strengthening access to justice for key populations: Developing and implementing access to justice mechanisms for key populations		
INDICATORS	**DATA SOURCE**	**COMMUNITY-SOURCED DATA**
3. # of Member States providing legal aid services accessible to key populations	NAC in consultation with CSO and KP representatives Documentation: Programmatic reports from legal aid services	Do legal literacy programmes exist, and are they implemented for all key populations? If yes, are these programmes tailored to the needs of each key population, and are they aware of them? Do they use them? Do NGOs and organisations of key populations have opportunities to conduct human rights advocacy for increased access to justice?
KRA 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		
INDICATORS		**DATA SOURCE**
D. HIV prevalence among key populations		GAM indicator 1.3
E. Syphilis prevalence among key populations		GAM indicator 7.4 (A, B, D)
F. HIV testing and status awareness among key populations		GAM indicator 1.4
G. Coverage of combined HIV prevention programmes among key populations		GAM indicator 1.6 (A–D) GAM indicator 1.7
H. Antiretroviral therapy coverage among people living with HIV in key populations		GAM indicator 2.6
I. HIV expenditure by origin of resources		GAM indicator 8.3
J. Number of countries that generate integrated bio-behavioural surveys and population size estimates for at least two key population groups of interest		Based on average scores from the consolidated results of the corresponding indicators 8 from the strategy indicators (see below).
K: Number of countries that use key population surveillance data for programmatic purposes		Based on average scores from the consolidated results of the corresponding indicators 9 from the strategy indicators (see below)
L. Level of community engagement of key populations in the national responses		Based on average scores from the consolidated results of the corresponding indicator 10 from the strategy indicators (see below)
OUTPUT 3.1: Access to quality and evidence-based services for key populations is improved		
STRATEGY 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		
INDICATORS	**DATA SOURCE**	**COMMUNITY-SOURCED DATA**
4. # of Member States that are providing the comprehensive package of services outlined in the WHO guidelines such that the services are accessible to all key populations	NAC in consultation with CSO and KP representatives Documentation: National protocols, national strategic plans	Are the services accessible (urban vs. rural, travel distances/wait time, age of consent, economic vs. physical and language accessibility)? Are these services acceptable to key populations (quality of care, services free of stigma and discrimination, rights of recipients of care are protected)? What are the gaps in terms of service provision?

STRATEGY 3.1.2: Strengthening the capacity of policymakers 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		
INDICATORS	**DATA SOURCE**	**COMMUNITY-SOURCED DATA**
5. # of Member States that have validated national protocols including specific ethical principles for key populations for: (i) integrated services; (ii) combined prevention; (iii) differentiated service delivery; (iv) legal and social services; and (v) community outreach services	NAC in consultation with CSO and KP representatives Documentation: National protocols	Have representatives of key populations participated in the development and validation of the protocols? Do communities record and report instances of unethical service delivery/provision?
OUTPUT 3.2: Funding for services for key populations is increased		
STRATEGY 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		
INDICATORS	**DATA SOURCE**	**COMMUNITY-SOURCED DATA**
6. # of Member States having specific budget allocations for key population interventions and programmes in their National Strategic Plans or annual budgets	NAC Documentation: National Strategic Plan, National AIDS Spending Assessment (NASA) and/or NAC budgets	Are communities of key populations aware of ongoing or planned interventions targeting them? Have communities been informed of such interventions and their corresponding budget?
7. # of Member States mobilising additional financial resources for key population interventions	NAC in consultation with CSO and KP representatives Documentation: NASA and/or country/CSO budgets, reports to funders	CSOs/NGOs and organisations of key populations: Has funding from development partners (national and international funders) increased, decreased or remained stable for key population programmes/services in the NGO sector?
OUTPUT 3.3: Epidemiological and social data on key populations is strengthened		
STRATEGY 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		
INDICATORS	**DATA SOURCE**	**COMMUNITY-SOURCED DATA**
8. # of Member States conducting integrated HIV bio-behavioural surveillance studies and population size estimates of at least two key population groups of interest disaggregated by age, sex and sub-group in the last 3 years	NAC in consultation with CSO and KP representatives Documentation: Integrated bio-behavioural surveys and population size estimates	Were key population representatives involved in the design, implementation and validation of the studies? Have key population groups or activists who participated in the studies been acknowledged and given credit? What are the priority gaps in terms of key population data?
9. # of Member States that use key population surveillance data for programmatic purposes	NAC in consultation with CSO and KP representatives Documentation: National HIV surveillance system	Are key population representatives involved in fora where the surveillance data is discussed for developing strategies or adjusting existing strategies and interventions?

OUTPUT 3.4: Participation of key populations in policy and programme development, implementation, monitoring and evaluation is increased		
STRATEGY 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		
INDICATORS	**DATA SOURCE**	**COMMUNITY-SOURCED DATA**
10. # of Member States where programme design and implementation, monitoring and evaluation are led by key populations or they are key participants	NAC in consultation with CSO and KP representatives Documentation: CSO programme data and reports on community engagement; minutes of national technical working groups	Do formal or informal organisations of key populations exist? Can organisations of key populations be officially recognised (legal registration)? Do organisations of key populations have access to funding to implement projects? Or do they participate in programme implementation via other NGOs? Are the mechanisms for community participation adapted to key populations? Is the participation meaningful at all levels and at all times it is required/recommended?
KRA 4: A reduction in legal, policy and cultural barriers which impede key populations' access to HIV and SRH services		
INDICATORS		**DATA SOURCE**
M. Criminalisation of key populations		UNAIDS Key Population Atlas
OUTPUT 4.1: Legal environments (including laws, policies, practices, regulations, access to justice and law enforcement) for key populations are improved		
STRATEGY 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		
INDICATORS	**DATA SOURCE**	**COMMUNITY-SOURCED DATA**
11. # of Member States having developed a nationally validated action plan based on a legal environment assessment on HIV and SRH	NAC in consultation with CSO and KP representatives Documentation: Legal environment assessment or equivalent; action plan	What are the main challenges that have been encountered in conducting legal environment assessments or implementing action plans in this area? Are there action plans to implement recommendations from the legal environment assessment? What accountability and monitoring options does the community have and implement?
STRATEGY 4.1.2: Regional and national dialogue: Documentation and sharing of promising practices on removing legal and policy barriers for key populations		
INDICATORS	**DATA SOURCE**	**COMMUNITY-SOURCED DATA**
12. # of promising practices on removing legal and policy barriers for key populations documented and shared	NAC in consultation with CSO and KP representatives Documentation: Best practices report; documentation of the changes (judgement/ new policy)	Best practices from community and CSO levels

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