Model Regional Strategic Framework on HIV for Key Populations in Africa

Developed by the African Key Populations Experts Group

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
AU	African Union
EAC	East African Community
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
MDG/s	Millennium Development Goal/s
MOT	Modes of Transmission
MSM	Men who have sex with men
NAC/s	National AIDS Councils
NSP/s	National Strategic Plan/s on HIV and AIDS
NSWP	The Global Network of Sex Work Projects
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
people with HIV	People living with HIV
PWID	People who inject drugs
PWUD	People who use drugs
REC	Regional Economic Community
SADC	Southern African Development Community
UNAIDS	Joint United Nations Programme for HIV/AIDS
UNDP	United Nations Development Programme
USAID	The U.S. Agency for International Development
WHO	World Health Organisation

1. Background, Purpose and Guiding Principles

1.1 Background

Over the last decade Africa has made considerable progress in responding to the HIV and AIDS pandemic with new infections on the decline. There was a 33% drop in new HIV infections among all ages in sub-Saharan Africa between 2005 and 2013 and a 19% reduction since 2010. Despite this impressive achievement, the HIV response in Africa still faces significant challenges and limitations that undermine results and limit progress towards universal access. Major amongst these challenges is the disproportionately high level of infection and vulnerability to HIV among specific key population groups. For example, 17 of the top 18 countries where HIV prevalence among sex workers exceeds 20% are situated in sub-Saharan Africa. Median HIV prevalence among sex workers in sub-Saharan Africa is 20% compared with the global median of 3.9%. While this challenge is being increasingly recognized by different stakeholders at global, regional and national levels, progress in ensuring equitable and effective HIV prevention, treatment and care services for these key population groups is compromised by complex social, economic and political factors. Significant political and community leadership is required to end stigma and violence and to review punitive laws, all measures which will enable and encourage key population groups to access HIV services.

Various efforts are being made by different stakeholders to address this problem. one such effort is work of ***the African Key Populations Experts Group***, (herein after referred to as the Experts Group) which brings together a pool of experts composed of sex workers, men who have sex with men, transgender people and people who inject drugs drawn from different parts of Africa. The Experts Group primarily aims to facilitate the design and implementation of equitable and effective HIV prevention, treatment, and care services for key populations. Accordingly it is in the process of developing a Model Regional Strategic Framework (herein after referred to as the Framework) that could be adopted by regional organizations in Africa. In developing the Framework, the Experts Group takes into consideration the realities of the social and political environments within which key populations live and identifies strategic issues which can be addressed at a regional level.

The Experts Group is a dynamic group that will expand as necessary to include other key population experts to ensure that experiences from across Africa are continuously used to inform the design and implementation of HIV programs for key populations.

In May 2014 the Experts Group conducted a three day regional meeting to identify the key components of a Model Strategic HIV Framework that speak to the specific needs and entitlements of key populations. The meeting was attended by more than twenty professionals and practitioners representing the different key population groups. Technical and financial assistance to the regional meeting as well as subsequent activities was provided by the UNDP RSCA. SADC and EAC also provided technical inputs to the process.

1.2 Purpose

The *Framework on HIV for Key Populations in Africa* developed by the Experts Group is primarily intended to be used by the various Regional Economic Communities (RECs) in Africa. The RECs are expected to adapt the Framework to their specific context and use it to initiate dialogue and promote the adoption of a standard package of strategies and programmes for implementation within their

Member States. In addition, it is also intended for use by civil society and key population groups across Africa as an advocacy tool to ensure provision of specific and focused HIV prevention, treatment, and care services for key population groups. The Model Regional Strategic Framework is expected to be a living document that will be refined and updated based on different contexts and experiences in different parts of Africa.

The Framework is not a definitive guide to service provision for key populations, but is intended for use with other guidance such as the report of the Global Commission on HIV and the Law – *Risks, Rights and Health (2012);* the WHO (2014) *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*[1]*;* the UNDP Discussion Paper *Transgender Health and Human Rights (2013);* and the UNAIDS *Guidance Papers on Sex Work and on Injecting Drug Use*.

1.3 Guiding Principles

The following guiding principles underlie both the formulation and the implementation of the *Framework*:

Respect for diversity

The Framework acknowledges, respects, and reflects the diversity of experiences, sexual orientations, sexual expressions, gender identities, occupational choices, choices around drug use among key populations. It recognises and is committed to uphold every person's right to equality, equity, dignity, and freedom from stigma and violence.

Participation and inclusion

All key population groups should participate substantively and meaningfully in all stages of developing, implementing, monitoring and evaluating HIV strategies and interventions outlined in the Framework. Implementation of the Framework should be based on true partnership among different key population groups and between key populations and other national and regional stakeholders, including Member States. .

Equity

Adequate resources—in terms of money, time, and expertise —should be invested to strengthen capacities of all key population groups in order to ensure their effective participation and contribution to the processes of development and implementation of HIV strategies emerging out of the Framework.

Evidence informed programmes of the highest standard

Strategies and programme emerging out of the Framework should be of the highest standard and based on accurate, up-to-date, and comprehensive evidence on all key population groups. Key population groups should be substantively involved in collecting reliable ground-level data, as well as analysing and corroborating the data.

[1] WHO (2011) *Global health sector strategy on HIV/AIDS 2011–2015*, Geneva, World Health Organization (http://whqlibdoc.who.int/publications/2011/9789241501651_eng.pdf, accessed 21 July 2014).

Do no harm

Strategies and programmes emerging out of the Framework should ensure that no members of key population groups are put at risk as a direct or indirect result of implementing those strategies or programmes. That is, they abide by the principle of 'do no harm'.

Build on experience

New strategies and programmes emerging out of the Framework are built on practical experience and on what has already been achieved in the region.

2. Key Populations

2.1 Who are Key Populations?

The World health Organisation (WHO) defines key populations as 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. The 2014 WHO *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*[2] focuses on five key populations: Men who have sex with men; People who inject drugs; People in prisons and other closed settings; Sex workers; and Transgender people. People in prisons and other closed settings are included in the WHO guideline because of the often high levels of incarceration of men who have sex with men, people who inject drugs, sex workers and transgender people and because of the increased risk behaviours and lack of HIV services in prison settings. According to WHO, key populations are important to the dynamics of HIV transmission in all countries and in all settings and are essential partners in an effective response to the epidemic.

UNAIDS additionally includes people living with HIV and clients of sex workers among key populations in all countries and finds a strong link between various kinds of mobility and heightened risk of HIV exposure, depending on the reason for mobility and the extent to which people are outside their social context and norms.

Both WHO and UNAIDS emphasise the importance of working with younger members of key populations who are especially vulnerable to HIV and make a distinction between 'Key Populations' and 'Vulnerable Populations'. 'Key Populations' being sex workers, men who have sex with men, transgender people and people who inject drugs in all countries and contexts and 'Vulnerable Populations' being any additional populations highly vulnerable to, or affected by HIV, according to evidence of the national and sub-national epidemiological and social context.[3]

Irrespective of formal definition, what fundamentally defines key populations in the context of HIV is: ***1) increased risk and vulnerability to HIV compared to any other population group; and 2) social exclusion and their experience of stigma and violence.*** Punitive laws and legal practices that penalise all or some aspects of their practices, occupations, and identities make it extremely difficult for key

[2] WHO (2011) *Global health sector strategy on HIV/AIDS 2011–2015*, Geneva, World Health Organization (http://whqlibdoc.who.int/publications/2011/9789241501651_eng.pdf, accessed 21 July 2014).

[3] UNAIDS (2011) *Guidance for Partnerships with Civil Society, Including People Living with HIV and Key Populations*; UNAIDS (2011) *Terminology Guidelines.*

populations to access essential HIV and other services or claim security from violation of their citizenship and human rights.

In line with the above, the Framework defines key populations as: 1) **Male, Female, Transgender Sex workers; 2) Men who have sex with men; 3) Transgender people and; 4) People who inject drugs.** The *Framework* further notes that these four key populations not only are part of the general population, as spouses, partners and parents, with many being married or in committed relationships, but can also overlap. For example, a male transgender sex worker can also inject drugs. Detailed descriptions of each key population group are given below.

2.1.1 Sex workers

Sex worker organisations as well as several international organizations including the UN recognize sex work as work based on contractual arrangements where sexual services are negotiated and sold or exchanged between consenting adults, with the terms of engagement having been agreed upon between the seller and the buyer of sexual services. By definition, a sex worker may be a female, male, or transgender people (above 18 years of age) who consensually sells sexual services to consenting adult clients.[4] Under the International Labour Office's new international labour standard[5], sex workers have the same entitlements as all other informal workers. Sex workers operate either part or full time under diverse working arrangements, typologies, and working environments

2.1.2 Men who have sex with men (MSM)

MSM is an inclusive public health term coined to define the sexual behaviours of adult males who have consensual sex with other males, regardless of how they define their sexual identity or sexual orientation or whether they identify with any particular community or social group. The words 'man' and 'sex' are interpreted in many different ways in diverse cultures and contexts, as well as by the individuals involved. As a result, the term MSM covers a large variety of settings and contexts in which male-to-male sex takes place. Some MSM define their sexual identity as non-heterosexual—gay, homosexual, bisexual or other culture-specific concepts that describe same-sex sexual or romantic attraction. But many men who have sex with men see themselves as heterosexuals, and can have sex with men out of sexual desire, for expediency, because of segregation from women, for money or for many other reasons and compulsions.[6] It is interesting to note that over the years from being a public health or epidemiological concept, the term 'MSM' has been appropriated by many non-gay identified men to describe their more ambiguous gender and sexual identities and their sexual and romantic engagement with other men.

2.1.3 Transgender people

A recent US study estimated that 0.3 percent of the US adult population may be transgender. A study in the Netherlands found that 0.6 percent of those born male and 0.2 percent of those born female wished to alter their body through hormones or surgery to match their gender identity. Transgender or 'trans' is an umbrella term to define anyone whose gender identity—that is, their sense of being

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[4] UNAIDS (updated 2012) *UNAIDS Guidance Note on HIV and Sex Work, Annexes*.

[5] International Labour Organisation (2010) Recommendation concerning HIV and AIDS and the world of work, 2010 (no. 200). Geneva: International Labour Office, 2010.

[6] Caceres, Aggleton, Galea, (2008) "Sexual diversity, social inclusion and HIV/AIDS", AIDS, 2008, 22 (Suppl 2):S45–S55; WHO (2011) *Prevention and Treatment of HIV and other sexually transmitted infections among Men who have Sex with Men and Transgender people: Recommendations for a public health approach*.

female, male, in-between, or something else altogether, and/or their gender expression—that is, how they express their femininity or masculinity, is different from the socially accepted norms of their biological gender or sex assigned at birth. This includes, for example, biological males who think of themselves as women, or act or dress like women know by such terms in Africa as *meme* (for trans women in Namibia) and *kuchu* (for trans, lesbian, gay and bisexual people in Uganda). In Kenya, transgender people are asking the courts to protect their right to change names or sex details on documents.[7]

However, not everyone who behaves differently from their socially ascribed gender norms is a transgender person, unless they identify themselves as one. Transgender people may self-identify as transgender, female, male, transwoman or transman, trans-sexual, or one of many other culture specific transgender identities. Some transgender people do not identify themselves as either male or female, that is they do not conform to any particular gender. Transgender people can live full or part of time as members of a gender which is not their biological one. Until recently, in the context of HIV prevention, transgender people were included among MSM. However, there has been a clear demand from transgender people for an independent constituency status in the global HIV response - especially given the higher vulnerability of transgender women and the specific health needs of all transgender people.[8]

2.1.4 People who inject drugs

People who inject drugs refers to people who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other injectable routes. People who self-inject medicines for medical purposes—referred to as "therapeutic injection"—or those who self-inject non-psychotropic substances, such as steroids or other hormones, for body shaping or improving athletic performance are not included in this definition. In the context of HIV, people who inject drugs are at specific risk of HIV transmission due to the sharing of blood-contaminated injection equipment.[9]

2.2 HIV among Key Populations

2.2.1 HIV in sub-Saharan Africa

In the past decade or so, striking gains have been made in addressing the AIDS epidemic globally and in Africa. In 2013 global new HIV infections fell by 33% as compared with 2001—from 3.4 million to 2.1 million, representing the lowest levels this century. New HIV infections among adults and

[7] UNDP Discussion Paper Transgender Health and Human Rights, December 2013

[8] Open Society Foundation (2013) *Transforming Health: International Rights-based Advocacy for Trans Health*, accessed 21 July 2014 at: www.opensocietyfoundations.org/reports/transforming-health; UNDP (2013) *Discussion Paper: Transgender Health and Human Rights*; Baral et al, (2007) " Elevated risk for HIV infection among men who have sex with men in low- and middle income countries 2000–2006: a systematic review", PLoS Medicine, 2007, 4:e339.

[9] WHO (2014) *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*.

adolescents also decreased by 50% or more in 26 countries over the same period. At the end of 2013 there were 12.9 million people on ART.[10] [11]

There are currently an estimated 24.7 million people living with HIV in sub-Saharan Africa, nearly 71% of the global total. Ten countries—Ethiopia, Kenya, Malawi, Mozambique, Nigeria, South Africa, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe—account for 81% of all people living with HIV in the region and half of those are in only two countries—Nigeria and South Africa.[12] The number of AIDS-related deaths in sub-Saharan Africa fell by 39% between 2005 and 2013. A significant decline (48%) was seen in South Africa. Other countries that recorded major declines in AIDS-related deaths include Rwanda (76%), Eritrea (67%), Botswana (58%), Burkina Faso (58%), Ethiopia (63%), Kenya (60%), Zimbabwe (57%), Malawi (51%) and the United Republic of Tanzania (44%).

This success is primarily due to the rapid increase in the number of people on antiretroviral therapy. The region has witnessed an expansion in the coverage of HIV treatment to record numbers of people for the past three years. In 2013 alone, 1.7 million additional people living with HIV received antiretroviral therapy.

New infections are also on the decline. There was a 33% drop in new HIV infections among all ages in the region between 2005 and 2013. Since 2010, the number of new HIV infections in Ghana decreased by 43% and by 41% in Malawi.

2.2.2 HIV among key populations globally and in sub-Saharan Africa

Among key populations globally, the burden of HIV has remained disproportionately high while their access to equitable HIV prevention, care, and treatment services is very limited. The evidence suggests that this limited access to service of key populations is a major driver of new HIV infection.[13] Research shows that globally, HIV prevalence among female sex workers is 13.5 times higher than among all women aged 15–49 years. Even in countries with a generalised epidemic, the HIV prevalence among sex workers is much higher than among the general population. Similarly MSM are 19 times more likely to be living with HIV than the general population[14] and the incidence of HIV among MSM is rising in several parts of the world. Among people who inject drugs HIV prevalence is estimated to be 28 times higher than in the rest of the adult population.[15] Transgender women are 49 times more likely to acquire HIV than all adults of reproductive age[16].

[10] Global Plan refers to the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive, that was launched in July 2011 at the United Nations General Assembly High Level Meeting on AIDS. Of the 22 priority countries in the Global Plan, 21 were in sub-Saharan Africa.

[11] UNAIDS (2014) *The Gap Report*; UNAIDS (2013) *Report on the global AIDS Epidemic*; WHO (2013) *Global Tuberculosis Report*; AU, NEPAD and UNAIDS (2013) *Delivering Results towards Ending AIDS, Tuberculosis and Malaria in Africa*; African Union (2013) *African Union Accountability Report on Africa-G8 Partnership Commitments 2013*.

[12] ibid

[13] Baral S, Beyrer C, Muessig K, et al. Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis. *The Lancet infectious diseases.* Jul 2012;12(7):538-549; Wolfe D, Carrieri MP, Shepard D. Treatment and care for injecting drug users with HIV infection: a review of barriers and ways forward. *Lancet.* Jul 31 2010;376(9738):355-366; Sullivan PS, Carballo-Dieguez A, Coates T, et al. Successes and challenges of HIV prevention in men who have sex with men. *Lancet.* Jul 28 2012;380(9839):388-399.

[14] *Ibid*.

[15] UNAIDS (2014) *The Gap Report.*

[16] UNAIDS (2014) *The Gap Report.*

A growing body of epidemiological evidence shows that this worldwide trend is reflected in Africa too. In African countries where data is available, new HIV infections are found to be much higher among key populations than the general population. According to the modes of transmission (MOT) studies conducted in different countries, much of the new infections (30% in Burkina Faso, 34% in Kenya, 37% in Nigeria, 43% in Ghana and 45% in Benin) occur among key populations. [17]

Seventeen of the top 18 countries where HIV prevalence among sex workers exceeds 20% are found in sub-Saharan Africa. Median HIV prevalence among sex workers in sub-Saharan Africa is 20% compared with the global median of 3.9%. A recent analysis in sub-Saharan Africa found a pooled HIV prevalence of 36.9% among female sex workers[18]. Only 3 African countries, the Democratic Republic of Congo, Madagascar and the Comoros, report an HIV prevalence of less than 6% among sex workers – and 92% of all HIV/AIDS deaths attributed to sex work occur among African women.[19]. Female sex workers have a slightly higher prevalence than their male counterparts, but with a median HIV prevalence of 13%, male sex workers also have significantly higher risk of infection than the general population. HIV prevalence among gay men and other men who have sex with men is also very high in the region. A 2007 study found MSM were 3.8 times as likely to have HIV infection as other men in Africa.[20] In 2012, the highest median HIV prevalence rates amongst MSM around the world were reported in Western and Central Africa (19%) and East and Southern Africa (15%).[21] While precise measures for this population are not easily available, the high levels of HIV prevalence among gay men and other men who have sex with men must not be ignored and HIV services must be made available. In addition, significant political and community leadership is required to end stigma, violence and decriminalize homosexuality and, thus, enable and encourage men who have sex with gay men and other men to access HIV services.

2.3 Factors Increasing Vulnerability of Key Populations to HIV

The Experts Group identified a range of priority issues that contribute to the high level of vulnerability of key populations in Africa to HIV. These issues can be loosely categorised under three headings: 1) Stigma, violence and punitive law; 2) Lack of equitable and effective access to HIV prevention, treatment and care services; and 3) lack of data on key populations and HIV in Africa.

2.3.1 Stigma, violence and punitive laws

In the majority of countries across the world[22], some or all of key population practices are criminalised, or are controlled by punitive regulations, policies, or law enforcement practices. Evidence shows that this severely restricts access to HIV services as well as to justice and other entitlements for key populations.

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[17] WHO (2011) *Global health sector strategy on HIV/AIDS 2011–2015*, Geneva, World Health Organization (http://whqlibdoc.who.int/publications/2011/9789241501651_eng.pdf, accessed 21 July 2014).

[18] UNAIDS (2013) *Report on the Global AIDS Epidemic*.

[19] Prüss-Ustün , Wolf, Driscoll, Degenhardt, Neira, Calleja, (2013) "HIV due to female sex work: regional and global estimates", quoted in Das A, Horton R. "Bringing sex workers to the centre of the HIV response", L*ancet* 2014, published online 22 July 2014, http://dx.doi.org/10.1016/S0140-6736(14)60933-8.

[20] Baral, Sifakis, Cleghorn, et al. (2007) "Elevated risk for HIV infection among men who have sex with men in low- and middle-income countries 2000–2006: a systematic review", PLoS Med. 2007;4(12).

[21] UNAIDS (2013) *Report on the Global AIDS Epidemic*.

[22] UNAIDS (2013) *Report on the Global AIDS Epidemic*.

For example, sex work, or aspects of it, is criminalised in 35 African countries[23], while 30 African countries criminalise same-sex relationships in some way, often with penalties of up to 14 years imprisonment. Some countries allow for life imprisonment and even the death penalty for those convicted[24].

Transgender people are not legally or even socially recognised in most African countries. The social or policy environment that would make it safe for transgender people to express their gender identity or seek services for their specific health and HIV related needs, does not exist in most settings. Sexual abuse and rape of trans men is common in some countries, including parts of Africa. So-called 'corrective rape' punishes trans men for daring to step outside gender roles prescribed to those assigned female at birth. These rapes "increase the risk of sexually transmitted infections, result in unwanted pregnancies, mental health issues and suicide, and have resulted in documented police-mediated negligence and abuse." In 2011, in response to community concerns, South Africa established a national task force on homophobic and transphobic hate crime, with a specific focus on 'corrective rape'.[25]

With regard to people who inject drugs, approaches to drug use in most AU member states focus overwhelmingly on criminalisation and the imposition of harsh penalties rather than on public health measures. Many countries have policies of compulsory detention in prisons or in drug rehabilitation centres, as 'treatment' for people who use or inject drugs[26]. People who inject drugs are routinely detained, and are denied any health services while in prison, including HIV prevention or treatment, drug overdose or withdrawal management services. It has been estimated that between 56% and 90% of people who inject drugs will be incarcerated at some stage.

The Global Commission on HIV and the Law found that over 60 countries across the world make it a crime to expose another person to HIV or to transmit it, noting that "such laws do not increase safer sex practices. Instead, they discourage people from getting tested or treated, in fear or being prosecuted for passing HIV to lovers or children."[27] Although, a number of African countries have shown a commitment towards reviewing their restrictive legislation, several others are introducing new laws criminalising HIV transmission and/or same sex relationships.

Such criminalisation of sex work, same-sex practices, and drug use, and often of people who practice these, reflect deep-seated stigma against key populations and their practices. It also exacerbates the extreme social marginalisation of key populations. Legal sanctions and social exclusion of key populations expose them to violence from state and non-state actors, and pose extensive barriers to their access to justice, health and other essential services, including HIV prevention, treatment, and care services. Often driven underground by fear, these key populations face the direct risk of violence and abuse every day and this in turn reinforces an environment which contributes to their high risk of acquiring HIV. When risks of extreme and often fatal violence, incarceration, eviction, banishment

[23] UNAIDS (2010) *Making the Law Work for the HIV Response: A snapshot of selected laws that block or support access to HIV prevention, treatment, care and support*.
[24]ILGA (2013) *Africa from a Gay and Lesbian Human Rights Perspective;* [24] See www.criminalisation.gnpplus.net (Accessed 10th April 2014).
[25] UNDP Discussion Paper Transgender Health and Human Rights, December 2013
[26] UNAIDS (2013) *Report on the Global AIDS Epidemic*.
[27] GCHL (2012) Risks, Rights & Health at p8

from family and immediate community, or loss of livelihood are persistent and imminent, avoiding HIV risk or seeking HIV services can become difficult or impossible.

Even when key populations access services, service providers often lack the necessary knowledge or skills to provide appropriate and quality HIV services to different groups of key populations. Genuine fear of disclosure of their identities and the concomitant and real possibility of abuse and/or arrest means that many members of key populations are reluctant to access services

In many countries because of such extreme stigma and increasingly harsh legal environments key population groups often find themselves in situations of collective crisis. They rarely have any social support or solidarity at times of such crisis from other members of the community. In times of crisis allies, who are otherwise sympathetic to key population issues, withdraw their public support fearing state reprisals or community sanction. Most HIV prevention or treatment programmes, have no provision for mitigating such crises and ensuring safety of key populations.

Criminalisation of sex work – what does the evidence show?

Criminalisation of any aspect of sex work is not based on considered legal, legislative, or judicial practice, nor on any social or epidemiological evidence. There is no evidence that criminalising sex work, or aspects of sex work, has ever led to elimination of trafficking into sex work, improvement of sex workers' health and wellbeing, reduction in HIV incidence among sex workers and their clients, increased gender justice, or even to a reduction in demand for sex work[28].

On the contrary, there is a growing body of evidence showing how criminalisation of sex work exposes sex workers to increased risk of HIV, violence, and social exclusion. The evidence among sex worker communities about the violence of stigma is compelling—stigma about being a sex worker, about having sex outside of marriage or outside of intimate monogamous relationships, stigma of being arrested, or stigma of being considered a criminal because of the way one earns a living— denies sex workers access to services, restricts their freedom of movement or freedom of association and precludes them from having protection from violence.

In many countries police confiscate condoms as evidence of criminal activity (that is, sex work) severely restricting sex workers' ability to minimise HIV risk. In most countries brothel keeping is criminalised, forcing sex workers to work on their own, without the social protection of peers or managers. This makes them more vulnerable to violence as well as to HIV, as there is no peer pressure or support from peers to enforce condom use with clients.

Available evidence from many countries also shows that punitive legal environment allows police to use existing civil and administrative offences such as "loitering without purpose", "public nuisance", "move on", or "public morality" to penalise sex workers. In most cases, law enforcement officers, who are state actors, are the most common perpetrators of violence against sex workers.

[28] Strathdee et al (2014) "Dispelling myths about sex workers and HIV", Lancet 2014, published online 22 July 2014, http://dx.doi.org/10.1016/S0140-6736(14)60933-8

The other source of increased vulnerability to violence and HIV for sex workers is police action associated with enforcement of anti-trafficking laws[29]. Research shows harms done by raid, rescue, and forced rehabilitation interventions led by anti-trafficking organisations, who harness support from the police and the judiciary to routinely evict sex workers from their homes and workplaces and incarcerate them in hostile and often violent rehabilitation centres. This is done in the name of finding and rescuing 'victims' of trafficking. However, it could often lead to loss of income and housing, as well as sexual and physical violence in such rehabilitations centres or remand homes, and can be isolated from access to HIV prevention or treatment services.

2.3.2 Lack of access to HIV prevention, treatment and care services

HIV responses addressing the specific needs of key populations remain seriously under-resourced across the world. In low and middle-income countries with available data, of total spending from government budgets on HIV prevention programmes only 9 % is allocated for sex workers and 8% for MSM and people who inject drugs.[30] MSM are a distinctly under-served and under-resourced population in most settings. They have limited access to HIV prevention, treatment, and care services—with estimates of access to the most basic preventive interventions ranging from less than 1 in 100 MSM in Eastern Europe and Africa to, at best, 1 in 5 MSM in Latin America.[31]

Although scientific evidence is clear on the impact of harm-reduction programmes in preventing HIV infections among people who inject drugs, only 55 of 192 countries providing data to UNAIDS in 2013 offered the globally recommended needle exchange programmes. Only 90 sterile needles and syringes were available per year per person, while the recommended minimum is at least 200 sterile needles and syringes per person injecting drugs per year. With the exception of four countries, all others providing Opioid Substitution Therapy (OST) reached less than 10% of people injecting opioids.[32]

Investing in HIV programmes for key populations is not seen as a priority most countries in Africa. Even if key populations are mentioned in National Strategic Plans on HIV (NSPs), there is often no budget allocated for programmes - strategies or activities specified to reach key populations are inadequate and no indicators are identified to measure progress. As a result in most African countries, there are very few examples of adequate and appropriate HIV services for key population groups.

The People living with HIV (people with HIV) Stigma Index studies further highlight challenges with access to services. They show that people who experience HIV-related discrimination often do not know their rights and where or how to seek legal redress for human rights violations. Affected populations described how stigma and discrimination blocked access to health services and access to justice for rights violations. They showed how HIV laws are often narrow and fail to address the layers of discrimination people face based on HIV status as well as age, gender, sexual orientation or disability.

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[29] Decker et al. (2014) "Human rights violations against sex workers: burden and effect on HIV" Lancet 2014.published online July 22. http://dx.doi.org/10.1016/S0140-6736(14)60800-X.; Steen et al (2014) "Trafficking, sex work, and HIV: efforts to resolve conflicts", Lancet 2014, published online 22 July 2014, http://dx.doi.org/10.1016/S0140-6736(14)60933-8

[30] UNAIDS (2012) Global Fact Sheet; UNAIDS (2013) *Report on the Global AIDS Epidemic*.

[31] Beyrer, Baral *et al* (2010) "The Expanding Epidemics of HIV Type 1 Among Men Who Have Sex With Men in Low- and Middle-Income Countries: Diversity and Consistency", Epidemiologic Reviews, Vol.32: 2010, Oxford University Press and the Johns Hopkins Bloomberg School of Public Health.

[32] *ibid*.

Without access to HIV-related services and commodities, members of key populations are unable to know their HIV status, unable to effectively protect themselves from HIV and unable to get treatment when they need it. The current epidemiological evidence clearly shows that if the AIDS epidemic is to be addressed comprehensively and in a sustainable manner, the disproportionately high level of vulnerability to HIV among key populations needs to be addressed. Unless HIV programmes specifically designed to meet the particular needs of key populations are urgently scaled up and structural barriers to their access to HIV and other services are removed, the advances made towards 'ending AIDS' so far will be seriously undermined.

The WHO (2014) *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations* provides a useful summary of recommendations concerning interventions for key populations which can be used when designing services (see Annex 2).

2.3.3 Lack of data on key populations and HIV in Africa

A lack of 'evidence' is often cited as a reason for not including key populations in regional and national HIV plans, although as mentioned above, where research has been carried out, key populations and their sexual partners have been found to account for as much as 51% of new infections in Nigeria[33], 33% in Kenya[34], 27.5 % in Mozambique[35], and 80% in Morocco.[36] Although a growing body of credible evidence on key populations in Africa is now slowly being produced, there is still not enough evidence on all sub-categories of key populations from all parts of Africa. A particular gap is evidence about transgender populations for whom lack of evidence means a total lack of visibility in policy terms.

One of the reasons for the lack of data is the difficulty in conducting research among key populations for whom exposure is extremely risky. Key populations are often considered to be social outcasts and are subjected to violence, arrest and other legal sanctions. One way to address this issue is to support key population-led research initiatives where key population themselves set priorities and research questions, and they collect, analyse, interpret, and own the data. Key population-led research enables necessary steps to be taken to safeguard data so that key populations do not come to any harm through identification of themselves or of geographical sites they frequent for work or leisure.

Strengthening leadership and key population capacity for advocacy is also key to bridging the data gap. Capacity among key population champions to represent their constituencies needs to be strengthened so that international organisations or researchers are not representing key populations in decision making forums - without proper endorsement or mandate from them. Making sure that key populations can participate and have a voice and can engage effectively in decision-making forums is also extremely important not only for evidence generation but for credible analysis, interpretation and use of data. Key populations need to be much more involved in policy and programme development, just as people living with HIV have become much more engaged in these processes over the last decade or so.

[33] UNAIDS, World Bank (2010) *New HIV Infections by Modes of Transmission in West Africa: A Multi-Country Analysis*.
[34] World Bank, UNAIDS (2009) *Kenya: HIV Prevention Response and Modes of Transmission Analysis*.
[35] World Bank, UNAIDS (2010) *Analysis of Modes of HIV Transmission and National Response to HIV and AIDS*.
[36] Moroccan Ministry of Health et al. (2010) *HIV Modes of Transmission Analysis in Morocco*.

2.4 Why invest in Key Populations?

The illegality of sex work, same sex relationships, and drug use in most African countries is often presented as a major barrier to providing services for key populations. However, experience in many countries actually demonstrates that, HIV prevention, treatment and care services for key populations can be successfully implemented in spite of the complex legal and social barriers. Experience also shows that in addition to enhancing equitable and effective service provision, countries are also implementing long term structural interventions such as legal and policy reviews, strengthening capacity of law enforcement bodies, and developing the capacity of key populations.

These strategies are demonstrated in the national HIV strategic plans and frameworks of several African countries. For instance the Botswana second National Strategic Framework for HIV and AIDS 2010 – 2016, has clear strategies for increasing access to prevention services for most-at-risk populations and hard to reach populations[37] including sex workers, and other groups that may be included as necessary.[38] In Uganda, the National HIV & AIDS Strategic Plan 2011/12 to 2014/15 lists promoting safer sexual behaviour among key populations as a strategic action under the strategic objective of scaling up coverage, quality and utilisation of proven biomedical and behavioural HIV prevention interventions.[39] This is further elaborated in the National HIV Prevention Strategy that plans to set up outreach or dedicated clinics for hard-to-reach population groups, for example in providing STI services for sex workers.[40] Similarly, Nigeria's National HIV/AIDS Strategic Plan 2010-2015 specifically lists female sex workers, people who use drugs and MSM among most-at-risk populations and identifies a strategy to enhance focus on and accelerate the scale up of HIV prevention services for these groups.[41] The Strategic Plan for Intensifying Multisectoral HIV and AIDS Response in Ethiopia II (SPM II) 2009 – 2014, also makes a commitment to target tailored comprehensive prevention interventions addressing most at risk populations including female sex workers.[42]

These experiences show that despite the sometimes illegality of the practices of key population groups there is an increasing recognition that the HIV response can't be effective without adequate investment in interventions for key populations.

2.4.1 Epidemiological and public health case for investing in key populations

The *epidemiological and public health rationale* for HIV programmes to focus on key population groups is clear and persuasive. In many settings HIV incidence in the general population has either fallen or stabilised while incidence among key populations is in most cases rising. However, in most countries with generalized HIV epidemics, the response has to a large extent focused on the general population. Even when countries recognise that HIV epidemics are concentrated in key populations, interventions focus on those population groups that are considered more socially acceptable and easier to reach.

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[37] The National AIDS Coordinating Agency, Ministry of State President, Government of Botswana (2009) *The Second Botswana National Strategic Framework for HIV and AIDS 2010-2016*.

[38] *Ibid*.

[39] Uganda AIDS Commission, Republic of Uganda (2011) National HIV & AIDS Strategic Plan 2011/12 to 2014/15.

[40] Uganda AIDS Commission and the National HIV Prevention Committee (2011) The National HIV Prevention Strategy for Uganda 2011-15, Volume 3: The National HIV Prevention Action Plan.

[41] National Agency for Control of AIDS (NACA) Nigeria (2009) National HIV/AIDS Strategic Plan 2010-2015

[42] Federal HIV/AIDS Prevention and Control Office, Federal Ministry of Health, Federal Democratic Republic of Ethiopia (2009) Strategic Plan for Intensifying Multisectoral HIV and AIDS Response in Ethiopia II (SPM II) 2009 – 2014

The importance of investing on key populations in improving overall public health outcomes is illustrated in a recent study[43] on sex work and HIV which showed that:

- In Canada and Kenya, where sexual violence experienced by sex workers has an immediate and sustained effect on non-condom use, elimination of violence against sex workers by clients, police, and strangers could avert 17—20% of HIV infections among female sex workers and their clients over the next decade.

- In heavy HIV-burden settings, such as Mombasa, where antiretroviral therapy and condom access remain suboptimal, scale-up of antiretroviral therapy access to WHO guidelines of a CD4 cell count of less than 500 cells per µL for both FSWs and their clients could avert 34% of HIV infections. Even modest scale-up of sex worker-led outreach could avert 20% of HIV infections among FSWs and their clients over the next decade.

- Across both generalised and concentrated HIV epidemics, decriminalisation of sex work could have the largest effect on the course of the HIV epidemic, averting 33—46% of incident infections over the next decade through combined effects on violence, police harassment, safer work environments, and HIV transmission pathways.

2.4.2 Economic case for investing in key populations

Investing in key populations makes sound *economic sense* too. The recent move toward more strategic use of HIV resources draws attention to the value of addressing HIV in key populations.[44] 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. In addition, criminalisation of key populations, and attempts at enforcing these laws, uses funds and resources that could be more gainfully invested elsewhere. There are often contradictions in resource allocation, for example a ministry of health might allocate funds for condoms - which law enforcement then spends time and money in confiscating. In many countries, time and money is wasted enforcing municipal by-laws to arrest, harass and punish sex workers rather than encouraging them to access health care. In some countries drug laws allow for funding to be spent on involuntary committal of people who use drugs in institutions, rather than on promoting access to harm reduction.

2.4.3 Political case for investing in key populations

The *political* imperative for focusing resources on key population lies in the fact that whether a country criminalises their practices or not, key populations should be entitled to the same protections and rights, guaranteed to citizens by national constitutions. In other words, constitutional guarantees of *equity* and non-discrimination in the provision of public health and care services should guide inclusion of programmes focusing on key populations in national HIV plans - even in countries with legal systems and social and cultural traditions that may exclude key populations. Almost all countries subscribe to the principles of every individual or community's *right to health and non-discrimination in health care settings*. From that consideration alone, no one should be excluded from HIV prevention, treatment

[43] Shannon, K et al, "Global epidemiology of HIV among female sex workers: influence of structural determinants", Lancet 2014.published online July 22. http://dx.doi.org/10.1016/S0140-6736(14)60800-X.

[44] Schwartlander, et al. (2011) "Towards an improved investment approach for an effective response to HIV/AIDS", Lancet, 2011, 377(9782):2031–2041.

and care services on the basis of their occupation, sexual orientation, gender identity, or on past or current substance use.

Since 2000, there have been strong political commitments made globally and in Africa to halt and reverse the AIDS epidemic. In 2001, the Abuja *Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases*[45] recognised that stigma, silence, denial and discrimination increase the impact of the HIV epidemic and constitute major barriers to an effective response. It specifically noted the vulnerability of women and girls due to factors such as social and economic inequalities and traditionally accepted gender roles. In that same year, the African Commission on Human and Peoples' Rights' *Resolution on HIV/AIDS Pandemic*[46] recognised HIV as a human rights issue, calling upon State Parties to the African Charter on Human and Peoples' Rights[47] ('the African Charter') to ensure human rights protection for those living with HIV against discrimination.

More recently in 2013, the Declaration of the Special Summit of African Union on HIV/AIDS, Tuberculosis and Malaria—"Abuja Actions toward The Elimination of HIV and AIDS, Tuberculosis and Malaria in Africa By 2030"—made a commitment to, among other things, meaningfully engage people with HIV and members of other key populations as partners in ensuring accountability and the effectiveness of national AIDS, TB and Malaria responses.

The Global Commission on HIV and the Law (GCHL), an independent body convened in 2010 by UNDP on behalf of UNAIDS, examined the impact of laws, policies and practices on HIV. It looked specifically at the criminalization of issues such as HIV transmission, drug use, sex work and same-sex sexual relations; issues of prisoners and migrants; the rights of women; children's rights; and intellectual property laws for access to treatment. During 2011, the Global Commission held 7 regional dialogues across the world, including in Cairo for the North Africa and Middle East region and in Johannesburg for sub-Saharan Africa.[48] The Global Commission report of July 2012 cited evidence indicating that law, enforcement and justice systems that protect equality of access to health care and prohibit discrimination, are able to better the lives of HIV-positive people and help turn the HIV epidemic around. It furthermore found that "punitive laws, policies and discriminatory practices such as brutal policing, denial of access to justice for people with and at risk of acquiring HIV are fuelling the epidemic."[49]

It is clear, at this critical juncture of the AIDS epidemic, when epidemiological evidence is making a compelling case for focusing increased policy and programmatic attention on key populations, that the necessary political commitment to support such action in regions and countries is also gathering momentum.

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[45] African Commission on Human and Peoples' Rights (2001) Resolution on HIV/AIDS Pandemic – Threat Against Human Rights and Humanity, Res 53 (XXIX)01.

[46] African Charter on Human and Peoples' Rights (adopted 27 June 1981, entered into force 21 October 1986) OAU Doc. CAB/LEG/67.3.rev.5

[47] Sp/Assembly/AU/Atm/2 (I) Rev.3, Special Summit of African Union on HIV and AIDS, Tuberculosis and Malaria, Abuja, Nigeria, 2-4 May 2006.

[48] The Africa Regional Dialogue of the Global Commission on HIV and the Law was held in Pretoria from 3-4 August 2011; see www.hivlawcommission.org (Accessed 10th April 2014).

[49] Global Commission on HIV and the Law (2012) Risks, Rights & Health.

3. Strategic Framework

3.1 Goal and Impact Result

Goal: ***Contribute to significantly reducing HIV infection, HIV-related mortality and the impact of HIV amongst key populations - sex workers, men who have sex with men, transgender people and people who inject drugs in Africa.***

Impact Result: ***HIV-related trends amongst key population groups are decreasing and the impacts of HIV on key populations are reduced.***

3.2 Outcome Results

Outcome Result 1: Stigma and discrimination against key populations, particularly at service provision points is eliminated and violence against key populations is significantly reduced

Outcome Result 2: Access to prevention, treatment, care and support programmes are scaled up for key population**s**

Outcome Result 3: HIV policies and programmes are evidence-based and results-oriented

These outcome results will contribute to ensuring accelerated regional and national responses to HIV for key populations in Africa.

3.3 Output Results and Strategies

3.3.1 Eliminating Stigma and Violence

Outcome Result 1: **Stigma and discrimination against key populations, particularly at service provision points is eliminated and violence against key populations is significantly reduced**

- **Output Result 1.1:** Legal environments (including laws, policies, regulations, access to justice and law enforcement) for key populations are strengthened

Strategies	***Key actors***
1.1.1 Legal environment assessment*: Review with substantive participation of key populations the punitive and protective laws, policies, law enforcement practices applicable to key populations across the region and evidence from lived experiences of key populations to identify impact such laws, policies, and practices have on key populations and HIV outcomes.*	▪ *RECs* ▪ *Key populations organisations and regional networks.* ▪ *Research experts* ▪ *Legal experts* ▪ *Relevant UNAIDS cosponsors*
1.1.2 Regional and national dialogue*: Regional consultation and dialogue based on epidemiological and social science evidence, between key population organisations, Regional Economic Communities, Regional Institutions, key Ministries, Parliamentarians, Political leaders and other opinion leaders, to explore the scope and mechanism of revising, or putting a moratorium on, punitive laws, policies, and practices against key populations.*	▪ *RECs (in facilitating and coordinating roles)* ▪ *Key population organisations and regional networks* ▪ *Heads of States* ▪ *National political leaders* ▪ *Regional policy makers* ▪ *Regional opinion leaders* ▪ *Law and human rights experts* ▪ *Policy experts*

***1.1.3 Strengthening access to justice for key populations**: Framing, implementation and enforcement of regionally harmonised anti-discrimination and protective laws, derived from human rights standards, to eliminate stigma and violence against people from key populations.*	▪ *RECs (in facilitating and coordinating roles)* ▪ *Key population organisations and regional networks* ▪ *Heads of States* ▪ *Law and human rights experts* ▪ *Relevant UNAIDS cosponsors*

- **Output Result 1.2:** Regional and national mechanisms to document and address violence and stigma are strengthened

Strategies	***Key actors***
***1.2.1 Developing partnerships to reduce violence against key populations**: Regional systems put in place to support Member States to establish and operationalize mechanisms for preventing, documenting and responding to situations that put key populations at risk.*	▪ *RECs* ▪ *NACs* ▪ *Key population organisations and regional networks* ▪ *Civil society organisations (CSOs),* ▪ *Development partners, Relevant UNAIDS cosponsors*
***1.2.2 Developing partnerships to reduce stigma against key populations**: Technical support to Member States to adapt, implement, and report on stigma index studies for key populations at subnational and national levels.*	▪ *RECs* ▪ *NACs* ▪ *Key population organisations and regional and global networks* ▪ *Relevant UNAIDS cosponsors*

3.3.2 Access to Quality HIV Services

Outcome Result 2: **Access to prevention, treatment, care and support programmes are scaled up for key populations**

- **Output Result 2.1:** Quality of and access to evidence-based services for key populations improved

Strategies	***Key actors***
***2.1.1 Implementing a standard regional package of services for Key populations**: Technical support to Member States in the region to provide a standard package of effective, evidence-based, voluntary, community empowering HIV prevention, diagnosis, treatment, and care services to all key populations.*	▪ *RECs* ▪ *NACs* ▪ *Key population organisations and networks* ▪ *Relevant UNAIDS cosponsors*
***2.1. 2 Strengthening capacity of policy makers and health care providers**: Technical support to Member States to make HIV services available, accessible, and acceptable to key populations, based on principles of rights to health, equity, medical ethics—including non-discrimination and confidentiality, and elimination of stigma from health care settings.*	▪ *RECs* ▪ *NACs* ▪ *Key population organisations and networks* ▪ *Relevant UNAIDS cosponsor*

- **Output Result 2.2:** Funding for services for key populations increased

Strategies	Key actors
2.2.1 Identifying and sustaining resources for key population interventions: *Technical support to mobilise sufficient resources for providing sustainable scaled-up HIV services to all key population groups and to ensure that those resources are utilized effectively and equitably.*	▪ *RECs* ▪ *Heads of States and other government leaders* ▪ *NACs* ▪ *Key population organisations and networks* ▪ *Development partners*

3.3.3 Generating Evidence

Outcome Result 3: **HIV policies and programmes are evidence-based and results-oriented**

- **Output Result 3.1:** Epidemiological and social data on key populations strengthened

Strategies	*Key actors*
3.1.1 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 HIV and key populations with real involvement, ownership, and leadership of key populations.*	▪ *RECs* ▪ *Key populations organisations and regional and global networks.* ▪ *Research experts from key populations and others*

- **Output Result 3.2:** Participation of key populations in policy and programme development, implementation, monitoring and evaluation increased

Strategies	*Key actors*
3.2.1 Key population groups engaged in policy and programmes*: Develop and operationalize mechanisms to ensure that key populations groups can access data generated with information being sufficiently protected so that key populations groups are not put at increased risk.*	▪ *RECs* ▪ *Key populations organisations and regional and global networks.* ▪ *Research experts from key populations and others*

4. Implementation Arrangements

In order to sustain African-owned health gains, the AU *Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Responses in Africa* sets out practical solutions, under three action pillars, for enhancing responses to the three diseases in Africa by 2015[50]. Action Pillar Three calls for enhanced leadership and governance, including through law and human rights programmes that enable communities to know and claim their rights and to participate effectively in national health responses.

"Effective HIV responses rest on the ability of individuals and communities and their systems, particularly those most vulnerable and affected by HIV to demand and access to effective preventive and health services. Programmes that empower affected communities to know and demand their

[50] Developed by the AUC in response to AU Decision Assembly/AU/Dec.413 (XVIII) to develop "a roadmap of shared responsibility to draw on African efforts for a viable health funding with support of traditional and emerging partners to address AIDS dependency response."

rights are critical to the HIV response and need to be expanded significantly. Hence investments must be made in programmes to reduce HIV-related stigma and discrimination including roll-out of the People Living with HIV Stigma Index, provide legal aid and legal literacy, reform laws, train police on non-discrimination, engage parliamentarians and the judiciary on protective legal responses to HIV, reach out to vulnerable populations, address violence against women and train health care workers on non-discrimination, informed consent and confidentiality. Stronger and positive partnerships should be built with communities and civil society organisations, including people living with HIV, for a more transparent, accountable, rights-based and result-oriented response to HIV that addresses the protection and health needs of all those in need of services" [51]

Responsibilities for implementation are shared between the AUC, New Partnership for Africa's Development (NEPAD), Regional Economic Communities (RECs) and AU Member States with the technical support of the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Development Programme (UNDP), the World Health Organisation (WHO) and other UN partners.

Given the structural issues that exacerbate HIV behavioural risks for key populations that have been examined in the previous sections, the Framework therefore aligns closely with the AU Roadmap and its implementation arrangements.

5. Monitoring and Accountability

An effective monitoring, evaluation, and accountability mechanism to measure both public health and structural components of the Regional Strategic HIV Framework for Key Populations in Africa is essential for ensuring that required actions are taken. The monitoring and evaluation system has to be simple and practical and integrated into existing monitoring and evaluation systems and mechanisms already being implemented by the regional entities and Member States.

In addition, much like the key population-led research described in section 2.3.3, having key population groups involved in collecting data for relevant indicators and involved in helping to analyse this data will greatly increase the effectiveness and responsiveness of monitoring and evaluation systems regionally and nationally.

WHO and other UN agencies have developed frameworks for setting and monitoring targets for HIV response in key populations. These can provide guidelines for setting up monitoring and evaluation mechanisms for specific regions.[52]

[51] Developed by the AUC in response to AU Decision Assembly/AU/Dec.413 (XVIII) to develop "a roadmap of shared responsibility to draw on African efforts for a viable health funding with support of traditional and emerging partners to address AIDS dependency response."

[52] WHO (forthcoming) Tool for setting and monitoring targets for prevention, treatment and care for HIV and other sexually transmitted infections among men who have sex with men, sex workers and transgender people; WHO (2012)Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision. Available at http://www.who.int/hiv/pub/idu/targets_universal_access; UNAIDS (2012) Operational guidelines for monitoring and evaluation of HIV programmes for sex workers, men who have sex with men and transgender people; Available at http://unaids.org.cn/en/index/Document_view.asp?id=712; UNAIDS (2011) Operational guidelines for monitoring and evaluation of HIV programmes for people who use drugs, draft. Available at http://www.cpc.unc.edu/measure/tools/hiv-aids/operational-guidelines-for-m-e-of-hiv-programmes-for-people-whoinject-drugs/idu-service-delivery-level-guidelines

6. Outcome and output indicators of HIV Services for each KP group, the RECs and CSOs

KP group	Outcome 1 – Eliminating stigma and violence	Outcome 2 – Access to quality HIV services	Outcome 3 – Generating evidence
General KP indicators	1. # of laws and policies protecting the rights of MSM, SWs, IDU and TG put in place and implemented [outcome l\ 2. el] 3. # of punitive laws criminalising SW, MSM, IDUs and TG removed 4. # of KPs who know and exercise their rights 5. # of service providers (police , health workers, legal professionals) trained in human rights based approach for KPs 6. # of KPs in planning and decision making processes at national and regional levels	1. # of facilities providing basic integrated services for KPs 2. % of KPs who have access to complete range of commodities (condoms, lubricants, IEC materials, safe injecting tools, STI and ARV drugs and OST) 3. Full participation of KPs in health governance, planning and decision making processes at national and regional level 4. # of service providers healthcare workers trained in KP health needs and human rights based approach 5. # of KPs who know and exercise their rights	1. Updated size estimation data for KP groups 2. Existence of costed NSP that includes key population priorities 3. Periodic BSS for KP groups
SW Indicators	1. # of annual partnership forums at national and regional level established to discuss stigma and violence on SWs		
MSM Indicators	1. # of MSM and SW who report redress for (physical + sexual) violence within the last 12 months 2. # of SOPs in place to ensure counselling and prevention services for MSM, SW, IDUs, TG	1. # of facilities providing basic integrated services for KPs	
TG Indicators		1. Percentage of KPs satisfied with services (more than 70 % indicates satisfaction) (move it to outcome 3) 2. The type of specific commodities to be included need to be clarified	

PWID Indicators	1. # of punitive laws hindering harm reduction programs removed 2. # of SoPs put in place for harm reduction services PWID 3. # of strategies and policies that promote provision of comprehensive package of services for PWUDs	4. % of PWID who have access to complete range of commodities - safe injecting tools and OST	1. Existence of geo coded data for PWID
RECs Indicators	1. # of punitive laws removed/ reformed among member states 2. # of policies and strategies put in place by member states to reduce stigma and violence	1. # of member states including KP indicators in their M&E plans for HIV 2. # of policies and strategies of member states for provision of costed minimum basic package of services for KPs and CB population 3. # of member states with functional TWGs representing KPs in national AIDS response coordination mechanisms	1. # of member states with established geo coded data sources for PWIDs 2. # of member states having specific budget allocations for KP interventions 3. # of member states conducting BSS for KP groups (BSS includes data on prevalence) 4. # of member states implementing minimum basic package of services for KPs at cross border points
CSOs Indicators	1. Laws protecting the rights of MSM, SWs, IDU and TG put in place and implemented (outcome level) 2. # of service providers (police , HWs, legal) trained in human rights based approach 3. Full participation of KPs in planning and decision making processes at national and regional level (outcome) 4. # of policies and strategies put in place to reduce stigma and violence on KPs 5. # of KPs who know and exercise their rights	1. # of policies and strategies for provision of basic costed minimum package of services 2. Same as TG indicator number 2 Percentage of KPs satisfied with services (move to outcome 3) 3. # of KP groups and organizations participating in the design, implementation and evaluation of services	1. Updated size estimation data for KPs

Annex – the 2014 WHO Comprehensive Package for key populations

a) Essential health sector interventions
   1. Comprehensive condom and lubricant programming
   2. Harm reduction interventions for substance use (in particular needle and syringe programmes[53] and opioid substitution therapy)
   3. Behavioural interventions
   4. HIV testing and counselling
   5. HIV treatment and care
   6. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions.
   7. Sexual and reproductive health interventions[54]

b) Essential strategies for an enabling environment
   1. Supportive legislation, policy and financial commitment, including decriminalization of certain behaviours of key populations
   2. Addressing stigma and discrimination
   3. Making health services available, accessible and acceptable
   4. Community empowerment
   5. Addressing violence against people from key populations**.**

Summary of WHO Recommendations for Multisectoral Intervention for HIV Prevention, Treatment and Care Services to Key Populations

HEALTH SECTOR INTERVENTIONS
HIV prevention
1. The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key populations to prevent sexual transmission of HIV and sexually transmitted infections (STIs).
2. Among men who have sex with men, pre-exposure prophylaxis (PrEP) is recommended as an additional HIV prevention choice within a comprehensive HIV prevention package. **NEW RECOMMENDATION**
3. Where serodiscordant couples can be identified and where additional HIV prevention choices for them are needed, daily oral PrEP (specifically tenofovir or the combination of tenofovir and emtricitabine) may be considered as a possible additional intervention for the uninfected partner.
4. Post-exposure prophylaxis (PEP) should be available to all eligible people from key populations on a voluntary basis after possible exposure to HIV.
5. Voluntary medical male circumcision (VMMC) is recommended as an additional important strategy for the prevention of heterosexually acquired HIV infection in men, particularly in settings with hyperendemic and generalized HIV epidemics and low prevalence of male circumcision.
Harm reduction
6. All people from key populations who inject drugs should have access to sterile injecting equipment through needle and syringe programmes.
7. All people from key populations who are dependent on opioids should be offered and have access to opioid substitution therapy in keeping with WHO guidance.

[53] Needle and syringe programmes are important for people who inject drugs and also for transgender people who require sterile injecting equipment to safely inject hormones for
gender affirmation. Also important to HIV prevention are tattooing, piercing and other forms of skin penetration, which are particularly relevant for people in prisons and other
closed settings.

[54] Including contraception, diagnosis and treatment of sexually transmitted infections, cervical cancer screening, etc.

8. All people from key populations with harmful alcohol or other substance use should have access to evidence-based interventions, including brief psychosocial interventions involving assessment, specific feedback and advice.
9. People likely to witness an opioid overdose should have access to naloxone and be instructed in its use for emergency management of suspected opioid overdose. NEW RECOMMENDATION
HIV testing and counselling (HTC)
10. Voluntary HTC should be routinely offered to all key populations both in the community and in clinical settings. Community-based HIV testing and counselling for key populations, linked to prevention, care and treatment services, is recommended, in addition to provider-initiated testing and counselling.
HIV treatment and care
11. Key populations living with HIV should have the same access to antiretroviral therapy (ART) and to ART management as other populations.
12. All pregnant women from key populations should have the same access to services for prevention of mother-to child transmission of HIV (PMTCT) and follow the same recommendations as women in other populations.
Prevention and management of co-infections and co-morbidities
13. Key populations should have the same access to tuberculosis prevention, screening and treatment services as other populations at risk of or living with HIV.
14. Key populations should have the same access to hepatitis B and C prevention, screening and treatment services as other populations at risk of or living with HIV.
15. Routine screening and management of mental health disorders (depression and psychosocial stress) should be provided for people from key populations living with HIV in order to optimize health outcomes and improve their adherence to ART. Management can range from co-counselling for HIV and depression to appropriate medical therapies.
Sexual and reproductive health
16. Screening, diagnosis and treatment of sexually transmitted infections should be offered routinely as part of comprehensive HIV prevention and care for key populations.
17. People from key populations, including those living with HIV, should be able to experience full, pleasurable sex lives and have access to a range of reproductive options.
18. Abortion laws and services should protect the health and human rights of all women, including those from key populations.
19. It is important to offer cervical cancer screening to all women from key populations, as indicated in the WHO 2013 cervical cancer screening guidelines.
20. It is important that all women from key populations have the same support and access to services related to conception and pregnancy care, as indicated by WHO guidelines, as women from other populations.
CRITICAL ENABLERS
1. Laws, policies and practices should be reviewed and revised where necessary, and countries should work towards decriminalization of behaviours such as drug use/injecting, sex work, same-sex activity and non-conforming gender identity and toward elimination of the unjust application of civil law and regulations against people who use/inject drugs, sex workers, men who have sex with men and transgender people.
2. Countries should work towards implementing and enforcing antidiscrimination and protective laws, derived from human rights standards, to eliminate stigma, discrimination and violence against people from key populations.
3. Health services should be made available, accessible and acceptable to key populations, based on the principles of medical ethics, avoidance of stigma, non-discrimination and the right to health.
4. Programmes should work toward implementing a package of interventions to enhance community empowerment among key populations.

5. Violence against people from key populations should be prevented and addressed in partnership with key population led organizations. All violence against people from key populations should be monitored and reported, and redress mechanisms should be established to provide justice.