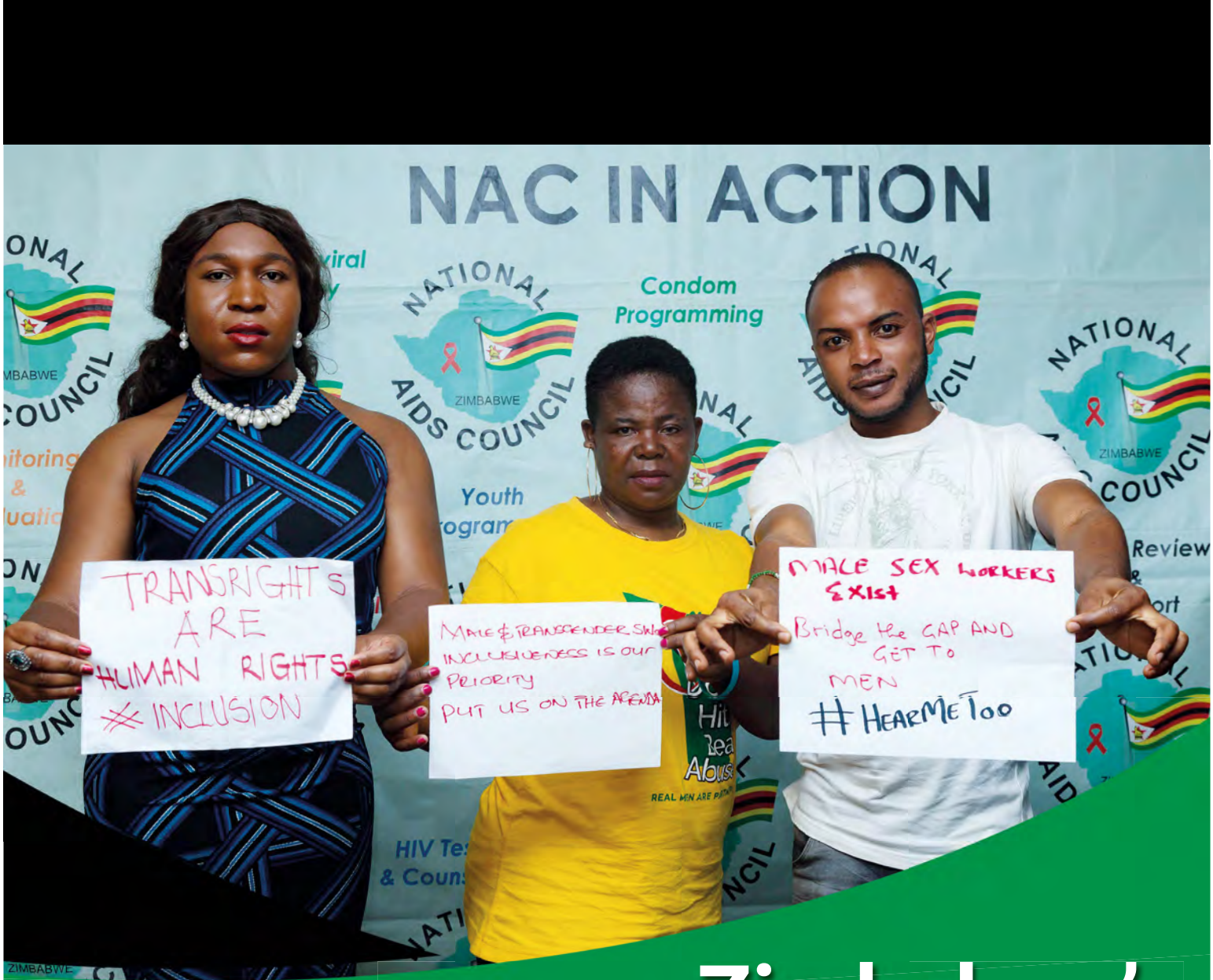




# National AIDS Council

Co-ordinating the multi-sectoral response to HIV and AIDS



## Zimbabwe's

## National Key Populations HIV and AIDS Implementation Plan

2019 -2020



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## Acronyms and Abbreviations

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ART</b>	Antiretroviral Therapy/Treatment
<b>FSW</b>	Female Sex Worker
<b>GFATM</b>	Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>HCC</b>	Health Centre Committees
<b>HIV</b>	Human Immunodeficiency Virus
<b>HTC</b>	HIV Testing and Counselling
<b>IP</b>	Implementation Plan
<b>KPs</b>	Key Populations
<b>KPIP</b>	Key Populations Implementation Plan
<b>LGBT</b>	Lesbian, Gay, Bisexual, and Transgender
<b>LGBTIQ</b>	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer
<b>MOHCC</b>	Ministry of Health and Child Care
<b>MSM</b>	Men Who Have Sex with Men
<b>MSW</b>	Male Sex Worker
<b>NAC</b>	National AIDS Council
<b>NACC</b>	National AIDS Control Council (Kenya)
<b>NASCOP</b>	National AIDS and STI Control Programme (Kenya)
<b>PEP</b>	Post-Exposure Prophylaxis
<b>PEPFAR</b>	U.S. President's Emergency Plan for AIDS Relief
<b>PLHIV</b>	Person/ People Living with HIV
<b>PrEP</b>	Pre-Exposure Prophylaxis
<b>PWID</b>	People Who Inject Drugs
<b>PWUD</b>	People Who Use Drugs
<b>STI</b>	Sexually Transmitted Infection
<b>SRHR</b>	Sexual Reproductive and Health Rights
<b>SW</b>	Sex Worker
<b>TSU</b>	Technical Support Unit
<b>UNAIDS</b>	United Nations Joint Programme on HIV and AIDS
<b>UNDP</b>	United Nations Development Programme
<b>UNFPA</b>	United Nations Population Fund
<b>USAID</b>	United States Agency for International Development
<b>WHO</b>	World Health Organization
<b>WSW</b>	Women who have sex with other women
<b>ZNASP</b>	Zimbabwe National HIV and AIDS Strategic Plan

## Glossary of Terms

### AIDS (Acquired immunodeficiency syndrome):

A medical condition in which there is severe loss of the body's cellular immunity, greatly lowering a person's resistance to infection and malignancy. It is a result of untreated HIV infection. **HIV is a manageable chronic condition**, provided medication (ARVs) is taken as prescribed. It is caused by a virus (the human immunodeficiency virus, or HIV), which is transmitted through bodily fluids during unprotected sex and through blood-to-blood transmission, as well as from an infected mother to her baby during pregnancy, delivery and breastfeeding.

### Bisexual:

A sexual orientation in which the person is attracted to both males and females. This is seen as primarily a sexual attraction but it is not only based on sex. It can also be attraction on other levels such as feelings, physical, intellectual and spiritual. Some people who identify as bisexual may be more attracted to one sex, but find both attractive at some point. Bisexuals may not be attracted to both sexes at the same time and may choose to differentiate between the types of relationships or sexual interactions they have with members of the same or opposite sex (also see MSM and WSW)

### Community Mobilization:

Is the process of uniting members of a community to utilize their intimate knowledge of vulnerability to overcome the barriers they face and realize reduced HIV risk and greater selfreliance through their collective action.

### Community Ownership:

Means that the community has control over the activities the program undertakes and significant understanding of, and influence over, service delivery. Community-owned programs have significant leadership, initiative, and oversight by communities and also have accountability systems in place to ensure that the program's interests do not supersede those of the community and that adequate representation of the community is established.

### Discrimination:

The unjust treatment of different categories of people on the grounds of race, age, sex, sexual orientation, gender, gender identity and presentation.

### Drug:

A chemical substance that when inhaled, injected, smoked, consumed, absorbed via a patch on the skin, or dissolved under the tongue causes a temporary physiological change. Drugs of abuse often affect the normal functioning of the central nervous system and have both physical and mental effects.

### Gay:

This refers to men/ males who are primarily attracted to men/ males. This is mostly based on sexual attraction but also has elements of emotional, physical, intellectual and/or spiritual attraction. It refers to both attraction and also how the person identifies. Some men who are attracted to or have sex with men do not self-identify as gay and this term should not be used for them.

### Harm Reduction:

Refers to policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are: the focus on the prevention of harm, rather than on the prevention of drug use itself; and the focus on people who continue to use drugs. Where injecting drug use is concerned, harm reduction also includes the provision of needle exchange programmes to help prevent the spread of HIV and hepatitis.

### Hotspot:

Means a public or semi-public place where people gather in significant numbers for high-risk behavior (e.g., places where sex workers solicit clients, places where men commonly seek sex with other men, places where drug users gather to inject drugs together). That means it is a geographical area or location with evidence of high prevalence of HIV, STIs or behaviors that put people at risk for acquiring HIV infection.

### Intersex:

This refers to individuals who are born with a combination of both male and female reproductive organs, chromosomes, and/or hormones that are either fully or partially developed and cannot always clearly be distinguished as female or male. In some cases, it is not possible to know a person is intersex, as the differences can be internal, or reveal themselves only at puberty. The term 'hermaphrodite is inaccurate and offensive.

### Key Populations:

Refers to groups at higher risk of HIV infection. Their active engagement is key to the success of the HIV response. They include people such as male and female sex workers (SWs); men who have sex with men, including men in prisons and other closed settings (MSM); people who use and/or inject drugs, (PWUD, PWID); transgender and intersex people (TI). There is a strong link between mobility and heightened risk of HIV, depending on the reason for mobility and the extent to which people are outside their social context and norms. Each country needs to define the specific populations that are key to their epidemic based on the epidemiological and social contexts

## Glossary of Terms *(Continued)*

### Lesbian:

A sexual identity and orientation that is an attraction between two females on various levels (emotionally, physically, intellectually, spiritually, and sexually).

### MSM or men who have sex with men:

These men can have any sexual orientation. An MSM can be hetero, bi, homosexual or trans. This is an inclusive technical, descriptive term rather than an identity.

### People who inject drugs (PWID):

Persons or people who inject drugs

### Serodiscordant couples:

Refers to an intimate couple where one partner is HIV positive and the other HIV negative.

### Sex:

A biological idea or system to classify people as male or female. 'What's in the pants'? Male genitals: penis, testes, testosterone and genetic make-up and female: breasts, vagina, oestrogen, progesterone and genetic make-up. Some people may have a combination of these, whether visible or not visible (see more on intersex).

### Sexuality:

How people experience and express themselves as sexual beings within the concepts of biological sex, gender identity and presentation, attraction and practices. Culture and religion have a huge impact on how individuals see themselves as sexual beings, especially within relations of power.

### Sexual identity:

How a person thinks of themselves in terms of to whom they are romantically or sexually attracted; whether they identify as male, female, masculine, feminine, or some combination of these, and the person's sexual orientation.

### Sexual minority:

A group whose sexual identity, orientation or practices differ from those of the majority of the surrounding society.

### Sexual orientation:

Attraction between any two people on various levels (emotionally, physically, intellectually, spiritually, and sexually). Attraction to the other person's sex and or gender presentation is the point of departure.

### Sex work:

Sex for a reward or payment. Sex work is a business transaction between two or more consenting individuals that might also include sex. Sex occurs in exchange for an amount of money that is agreed by the sex worker and the client/s before the sex takes place.

### Stigma:

This is when an individual with certain characteristics, for example, an HIV positive or trans woman, is disapproved of by a community or society because of that characteristic. Stigma goes often hand-in-hand with shame. It can result in threats and abuse and generally leads to discrimination.

### Transgender:

An umbrella term used to describe a wide range of identities and experiences, including transsexuals, non-binary, trans men, trans women, FTMs(Female to Male), MTFs(Male to Female), queer, cross dressers, drag queens, gender-queers, and many more. Commonly used to refer to a person whose gender identity differs from the sex assigned at birth. It is important to use their preferred gender pronouns and names, in other words, those of the gender they are presenting.

### Vulnerable populations:

Are groups of people who are particularly vulnerable to HIV Infection in certain situations or contexts, such as adolescents and people with disability.

### WSW:

Women who have sex with women. A sexual practice that is not related to sexual orientation or gender identity. A WSW can be hetero-, bi- or homosexual. It is a technical term, rather than an identity.

## Guiding Principles

The following guiding principles<sup>1</sup> underline the development of the implementation plan and are expected to guide its implementation:

### Build on experience and country context

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

### Do no harm

The necessary precautions that 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 IP.

### Effective partnerships

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

### 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

The implementation plan 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 IP 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

### 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 Sexual Reproductive and Sexual Rights (SRHR). They further have the following relevant rights guaranteed under international, regional and national laws: right to be free from discrimination; right to equality; right to be free from torture and cruel, inhuman and degrading treatment; right to dignity; right to security of the person; and right to information.

### Participation, inclusion and equity

Every effort has been made to ensure the substantive and meaningful engagement of Key Populations in the development of the IP. It further calls for the allocation of adequate resources, in terms of finance, time and expertise to ensure the effective participation and contribution of Key Populations during implementation.

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

### Political commitment

Political commitment is required to ensure universal access to health services by Key Populations.

### Respect for diversity

The Implementation plan acknowledges, respects and reflects the diversity of experience, sexual orientation, sexual expression, sexual identity and choice of profession among Key Populations. It recognises and is committed to upholding every person's right to equality, equity, dignity and freedom from stigma and violence.

<sup>1</sup> The Glossary of Terms in the previous section and these Guiding Principles used in this Implementation Plan are aligned to the global and regional documents such as the SADC Regional Strategy for Key Populations (2018) and the Minimum Service Package (MOHCC, 2018) and the terms that were used during the development of the Zimbabwe Concept Note to the Global Fund for the current funding cycle.

## Objective of This Implementation Plan

This Implementation Plan (IP) provides a two year road map indicating key components of work that need to be accomplished towards the development and operationalization of a five year **Key Populations Strategic Plan** post 2020. The IP purposely builds on the foundation of good work already taking place in multi sectorial efforts to reduce HIV infections and AIDS related deaths amongst Key Populations in Zimbabwe.

It is intended that this IP provides a high level overview of activities that need to be implemented in a format which distinguishes activities at National, Provincial, District, Community and at Household level as well as showing inter-sectorialities.

The purpose of this plan is to strengthen multi sectorial coordinated efforts towards Key Populations programmes in Zimbabwe, as part of our commitment to Fast Tracking 90 90 90 targets by 2020 and Ending Aids by 2030. The focus is on ensuring that the National AIDS Council (NAC) who are the custodian of this document play an effective coordination role in ensuring that national efforts to combat HIV leave no one behind.

This document is intended for Health service providers, Policy makers, Civil Society Organisations, Implementing partners, Key affected Populations, Donors, Religious entities, Traditional elders, the corporate sector and every other person and sectors who want to ensuring no one is left behind and see Zimbabwe ending AIDS by 2030<sup>2</sup>. The Implementation Plan will help your organisations to develop programmatic interventions that are evidence-based and that will help you contribute towards the universal fast-track strategy.

## How to use this Implementation Plan

Your organisations might already have strategic plans and programmatic interventions aligned to the broader national strategies such as the Extended Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2015 – 2020<sup>3</sup>. This IP will ensure we create effective coordination mechanisms for Key Populations programmes. A few things to keep in mind within your organisations;

- i. Consider forming small, focused teams to go through this implementation plan and send any questions to [secretariat@nac.org.zw](mailto:secretariat@nac.org.zw) for clarification.
- ii. Ensure your organisation describes a logical sequence of events and activities that you will undertake to align your work schedules with the activities to be undertaken through the National AIDS Council.

- iii. Implementing partners, Technical Organisations and the Donor community can extract the appropriate sections of this implementation plan to insert into their organisational strategic plans and work plans. Doing that will help to document their commitment to the collaboration and to track their efforts internally.

This implementation plan has a strong management focus that requires commitment and support from all multi sector partners. It requires best practice approaches, skills and experience to be applied. The plan requires a structured approach to thinking and communicating in the areas of (i) micro planning KP focused interventions (ii) governance, (iii) stakeholder engagement (iv) risk mitigation and risk management (v) monitoring, evaluation and learning (vi) resource mobilisation and management and (vii) effective coordination mechanisms. A structured approach will create a shared understanding among those who will drive the implementation process, from the most senior management teams to field based officers and the beneficiaries.

The IP was developed in alignment to already existing national strategies and guidelines such as the Extended ZINASP III, Minimum Health Service Delivery Package developed by the Ministry of Health and Child Care and partners, and the Zimbabwe Concept Note submitted to the Global Fund.

This Implementation Plan applies a **problem based approach** to resolve identified gaps versus target population approach, which has a risk of including all groups perceived to be Key Populations or vulnerable. Some groups will be mentioned in brief without detailed interventions, thereby providing an opportunity for dialogue to ensure their identified issues are addressed through the ZINASP.

To enhance the effectiveness of your efforts in using this implementation plan, be sure you are fully engaging your target communities as their involvement will help to assure chosen strategies fit in with their needs and will leverage ongoing support of this work during implementation. Key Populations led platforms and conversations are fully encouraged, in order to amplify their voices.

It is also important to acknowledge various interventions and good practice models that are mentioned in this implementation plan. Some of the models are derived from programmes that have already ended, and some from the current Global Fund Regional Grants on Key populations, which in 2019, are going through grant closure processes. We strongly encourage national entities, through the National AIDS Council, to consult and or partner with the Regional Key Populations Networks and Technical partners that developed the models, as well as the Principal Recipients, who will provide you with institutional memory and ensuring effective scale up and cascading of Regional interventions at country level.

## Words of encouragement:

No matter how comprehensive the implementation plan is, successful implementation hinges on the development of strong working relationships between the Key Populations Communities, National AIDS Council, Government Entities, CSOs, Donor Community, Health Institutions, Religious and Community leaders and all relevant multi sector stakeholders. A shared declaration of commitment to collaboration and acting with integrity is required fostering a clear a clear, common understanding of the outcomes sought.

## Style of writing

You will notice that this Implementation Plan is intentionally written using plain English in order to inform, explain and be sure we are understood by all multi sectorial readers including individuals at community and household level. We do not intend to impress and confuse our readership by using too much jargon. Our intention during the development of this plan was to ensure we have the reader in mind who fully understands the proposed interventions clearly and concisely so that their relevant organisations take the appropriate action(s).



<sup>2</sup> Zimbabwe's commitment towards Fast Tracking 90 90 90 targets by 2020 and Ending Aids by 2030

<sup>3</sup> Zimbabwe's commitment towards Fast Tracking 90 90 90 targets by 2020 and Ending Aids by 2030



## Foreward

The National Key Populations Implementation Plan 2019-2020 is a result of a series of participatory, iterative and interactive processes that involved the members of Key Populations, Government, Civil Society Organisations and Development partners. The development of the implementation plan was approved by the Ministry of Health and Child Care, the Technical Working group on Key Populations in Zimbabwe, the Key Populations Forum as well as funding partners, and it is in line with the Extended Zimbabwe National HIV and AIDS Strategic Plan (ZINASPIII), which acknowledges that the increasing rates of HIV infections are a huge challenge for the left behind and marginalised groups, hence the need to prioritise interventions for them.

Within the SADC region and globally, new HIV infections continue to decrease among the general population, however Key Populations have been left behind in this wave owing to their criminalised behaviour, and stigma and discrimination by the general population and service providers. In order to contribute to the ending of AIDS by 2020, there is need for commitment towards Key Populations HIV service delivery.

New HIV cases amongst female sex workers and men having sex with men continue to rise over the years demonstrating the need for targeted interventions, as HIV morbidity and mortality among the left behind groups is disproportionately high. Zimbabwe is now showing its commitment in ensuring all marginalised groups are listened to and included, these include groups previously left namely male sex workers, Transgender community and the vulnerable populations including people living with disability, men who have sex with men, women who have sex with women, people living with albinism, refugees, long distance drivers and artisan miners.

It is in this context that the National AIDS Council in collaboration with Ministry of Health, Key Population communities, HIV programmers and HIV funding and service delivery partners developed this Implementation plan specifically for Key Populations, to address their HIV and sexual reproductive health needs. The plan is intended to achieve an informed and coordinated guide to designing and implementing appropriate sexual reproductive health and HIV prevention, treatment and care programmes for Key Populations between 2019 and 2020. The plan is to be applied in conjunction with other KP documents already published including but not limited to the Minimum Service Delivery Manual, PrEP Implementation Plan, the 90 90 90 fast track targets as well as the extended ZINASP III. Our sincere gratitude goes to all multi sector stakeholders who participated in consultation meetings. We call upon all sectors in Zimbabwe to join us in the fight to ending AIDS by 2030, and to ensure no one gets left behind in our interventions.



**Mr Raymond Yekeye**  
Acting Chief Executive Officer  
National AIDS Council  
Zimbabwe

## Solidarity Messages From Partners



**UNAIDS**

### Jane Batte

Fast Track Adviser UNAIDS, Zimbabwe

The Sustainable Development Goal (SDG) on Health and the move towards Universal Health Coverage (UHC) emphasise "leaving no one behind" and special consideration to be given to key populations who have greatest HIV risk and vulnerability. UHC cannot be achieved if key populations are not reached. The development of this Key Populations Implementation Plan 2019-2020 shows the commitment of the country to achieve the Political Declaration on Ending AIDS by 2030, Fast tracking the 90 -90 -90 targets and the Global Prevention Coalition Road Map targets 2020. The United Nations in collaboration with Development Partners in Zimbabwe are committed to support the fast tracking of this plan to accelerate the multi sectorial efforts to reduce HIV infections and AIDS related deaths amongst Key Populations in Zimbabwe.

In line with the Global Human Rights guidance 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 Sexual Reproductive and Sexual Rights (SRHR). It is therefore extremely important to deliberately address structural barriers that hinder access to services such as stigma and discrimination, gender-based violence and criminalisation. The implementation of this plan will require strengthening of individual, organizational and national systems capacities at both national and subnational levels and ensuring a sustainable funding base post 2020. The United Nations and Development Partners are committed and will continue to collaborate and support the National AIDS Council, The Ministry Of Health and Child Care, Key Populations and communities both at national and the decentralised level to achieve the targets of this plan.

"WHAT MATTERS IS THE LACK OF INCLUSION AND WIDESPREAD DISCRIMINATION. IT IS CLEAR THAT WE CANNOT END THE AIDS EPIDEMIC WITHOUT TAKING CARE OF THE NEEDS OF KEY POPULATIONS."(UNAIDS 2017)



**PARLIAMENTARIAN**

### Dr Ruth Labode

Portfolio Committee Chairperson on Health and Child Care and Health Sector Champion for Key Populations

"So God Created mankind in His own image, in the image of God He created them, male and female He created." (Genesis 1 vs 27)

In the eyes of God we were all created equally in His own image and we remain as such. However too often Key Populations have to endure discrimination and criminalization in silence, while traditional, religious and political leaders play chess with their lives.

It seems mankind since time in memorial, has found it easier to enact bad laws that are both oppressive and discriminatory in nature, in the name of protecting cultural and religious values of the majority at the expense of the minority communities.

Wide spread stigma, discrimination, criminalisation of behaviours and restrictive laws put Key Populations at a heightened risk of being infected and also infecting others unchecked.

Zimbabwe has committed herself to "Leaving No One Behind" in an effort to end HIV/AIDS by 2030.

The commitment in itself has given us as Zimbabweans an opportunity to embrace and accept Sexual Diversity as a norm which we have to learn to live with. Love one another as you love yourself.

## Solidarity Messages From Partners *(Continued)*



**INTERNATIONAL  
DEVELOPMENT PARTNERS**

### Samson Chidiya

**HIV Prevention Specialist, USAID**

Recognition of the existence of key populations , plus acknowledgement and addressing their vulnerabilities is key to achieving holistic public health gains overall and HIV epidemic control in particular for them, their partners and clients of their partners within the general populations and in their own communities. Forging the complimentary supportive roles of the public, private and civil society organizations is instrumental to achieving this goal.

Ultimately, the agency of key populations' communities themselves in leading on the affairs of their own constituencies is not only desirable but a sustainable developmental approach. Hence, building their individual and collective capabilities to lead, implement, monitor, evaluate and ultimately own the interventions meant to address their health and socioeconomic issues must be the cornerstone of all efforts meant for them.

No one understands their experiences more than themselves hence, their inclusion not only brings unique contributions but also fosters their greater sense of belonging and public understanding of their issues thereby reducing stigma and discrimination. Whereas, their continued exclusion negates their constitutional rights to health and social justice.



**REGIONAL CIVIL  
SOCIETY ORGANISATIONS**

### Lois Chingandu

**SAfAIDS Executive Director**

On behalf of the Civil Society Organisations within mainstream HIV and AIDS programming in Zimbabwe, I wish to thank and congratulate all who have been, and continue to be part of this journey to end HIV by 2030. Special credit goes to the Ministry of Health and Children Care for providing the approval to the development of this implementation plan, the Technical Working Group on Key Populations and the Key Populations Forum for the invaluable input to the process. All this work would not have been possible were it not for the strategic coordination and guidance provided by the National AIDS Council.

That this implementation plan comes at the same time the Ministry of Health and Child Care is finalising the Minimum Service Package and Training Package for Provision of Key Populations Services in the Public Sector means Zimbabwe is firmly on that road to live and implement the 'leaving no-one behind' call. Now the same stakeholders' togetherness exhibited during the processes to the development of this plan is now required in its implementation.

It is only in its full implementation that the cause to leave no one behind can be realised.



**PARENT OF A KP AND  
A LEGAL PRACTITIONER**

### Mrs Ruhonde

Grief is a common emotional response for many parents who have discovered that their son or daughter identifies as gay or lesbian, and is having same sex relationships, suddenly life seems totally out of control.

Learning that a loved one is struggling with homosexuality is extremely painful but as parents we must come to terms with the reality of who the person is. Accepting we simply mean acknowledging, what is "true" not the same as approval, but accept your child as she/he is.

Don't try to argue yourselves with lots of questions like, whose fault is this? Did God do this? What did I do wrong? Supportive parenting and monitoring of children (parental involvement) is another critical factor associated with lower rates of drug abuse among our youths. Youths who are still in the closet are far more likely to use drugs for stress management.

Many factors at home can influence a child's attitudes and propensity to use drugs. Relationships with family members deteriorate and a change in personality emerges. Therefore as parents if we intervene and help our children, the higher the probability our children can reverse course and fulfill a life of promise and potential. Early intervention may prevent a lifetime of unhappiness, derailed goals, unfulfilled dreams and compromised health.



**UNITED NATIONS OFFICE ON  
DRUGS AND CRIME (UNODC)**

### Nicholas Nyamapfeni

**National Programme Coordinator , UNODC**

The UN Special Rapporteur on Extreme Poverty and Human Rights reported in 2011 that, disproportionately high numbers of the poorest and most excluded are arrested, detained and imprisoned. Thus, many prisoners have had no contact, or very limited contact, with health services in the community before they were detained in prison.

Access to, as well as quality of, health services in prison is of vital importance. This confirms that prison health is an inevitable part of public health; there is an intensive interaction between prisons and society, therefore addressing health in prisons is essential in any public health initiative that aims to improve overall public health.

People in prisons have the same right to health and health care, including preventive measures, as those outside, and their lives and health are connected to those outside in many ways.

## Solidarity Messages From Partners *(Continued)*



### CIVIL SOCIETY COORDINATION PLATFORM ON HIV/HEALTH AND SRHR

#### Taurayi Nyandoro

Director, Zimbabwe AIDS Network

An effective response to the HIV epidemic requires that we place key population (KPs) groups at the core of HIV prevention and treatment programmes. As such, Zimbabwe Aids Network (ZAN) has adopted an approach which engenders inclusivity underlined by genuine participation and representation of KP groups in our processes and governance structures.

Demonstrably, KP led and or programming organizations now constitute at least 25% of the ZAN membership and a further 30% of participants in ZAN facilitated meetings. We have rapidly sought to design and develop an incubator programme to support emerging KP organizations and contribute to the accelerated growth of the KP movement in Zimbabwe. Significantly, our approach, as articulated in the Civil Society and Communities' Charter, is premised on Zero discrimination, Social inclusion and Respect for human rights as the basis for the realization of UNAIDS 90-90-90 targets, Universal Health Coverage and Sustainable Development Goals. By and large, this entails investing in service delivery and advocacy thrusts that will increase access to comprehensive health services among KPs.

#### In view of this, ZAN thus envisions:

- Laws and policies to be aligned to promote health equity.
- The health budget that respond to the context of Key Populations.
- Health care facilities and officials to provide services in a non-discriminatory manner
- Specific services and commodities are always available
- Communities respect and protect KPs from harm, exploitation and coercion
- Inclusive participation and involvement of KPs in the development of laws and policies that affect their lives and safety



### WOMEN LIVING WITH HIV

#### Tendayi Westerhof

National Chairperson - Zimbabwe Women Living with HIV National Forum

Zimbabwe Women Living with HIV Forum appreciates and notes the diversity among women living with HIV found in certain situations among them sex workers, women with disabilities, adolescent girls and young women those in prisons and closed settings.

The time for closing the tap on new HIV infections is now as many still lack comprehensive health services such as unmet need of family planning and other reproductive health services and rights.

We welcome this initiative and as one sure way to end AIDS in 2030.

In solidarity

## Acknowledgments

This document highlights the crucial task being carried out by various HIV programmes in Zimbabwe through the increased recognition of the importance of not leaving anyone behind in response to the HIV epidemic. Discussions around Key Populations have gained momentum in recent years through acceptance by programmers that these groups are amongst the most vulnerable as they face the greatest risk to HIV infection and access to health services.

Our gratitude goes to the funders, the United Nations Population Fund (UNFPA), Ministry of Health and Child Care (MOHCC) and National AIDS Council (NAC) for allocating financial support towards the development of the implementation plan. We thank all the organisations listed in Annex 1 for their participation and contributions during this process. The multi sectoral consultations received valuable input from Key Populations led organisations, Government departments, Development and Implementation Partners, Academia and Civil Society Organizations.

Many thanks to the consultants who provided their technical expertise and led the development of this implementation plan; Sithembile Chiware (team leader), Thenjiwe Sisimayi and Diana Mailosi. The consultants were supported by individuals from Key Populations led organisations and special mention goes to Tinoashira Chikuni, Mayita Tamangani, Tichaona Mutore, and Belinda Chikerema. The support team provided logistical support during the National Stakeholder Consultation Meeting, they were responsible for managing the registration process, administering the ACE – IT interactive response pads asset register, documenting conversations that took place during focussed group discussions and ensuring the meeting provided a safe space for all participants. Having visibly friendly members of the Key Populations community to manage registration desks provided an increased level of security and a sense of safe space for participants, which enabled various stakeholders to register without any hesitation upon arrival.



This publication was commissioned by the National AIDS Council in Zimbabwe. Special thanks goes to Jeremiah Manyika and Tendai Mbengeranwa, the NAC Key Populations Coordinators, for their immense support and management. We also thank NAC Senior Management Team, the Advisory Group including Jane

Batte (UNAIDS), Carey (PSI), Roy (PSI), and the Key Populations Technical Working Group at the MOHCC coordinated by Taurai Bhatasara. We received immense strategic guidance and recommendations from the teams. **Thank you everyone!**

## An Executive Summary why this Implementation Plan is important?

The Zimbabwe National Key Population Implementation Plan is a paradigm shift from the business as usual HIV programming. By the end of the two year implementation plan (2019 -2020), we aim to see a significant shift and an improvement in systems and coordination for the Key Populations programmes in Zimbabwe at National, Provincial and District level. In summary, our strategic recommendation is to ensure we have robust systems in place in the next two years, in preparation of the upcoming five year Key Populations Strategic Plan (2021 – 2025). Our rationale is that without setting up systems nor improving a coordinated response to Key Population issues, as a priority focus area, if we are too haste and rush to activity level, we will keep experiencing recurrent gaps and challenges that can only get addressed by

ensuring we have solid structures and systems to address these challenges.

There are complex factors driving HIV infections, stigma and discrimination and violence against Key Populations, thereby affecting their access to health services. Our success in addressing these challenges is defined by the extent to which our country can clearly define a multi sectorial coordinated approach to HIV and ensuring all citizens' needs are addressed. This Implementation Plan is thus a continuation of the work began by the National AIDS Council in its role to coordinate HIV response efforts in Zimbabwe.



## An Executive Summary

### Why this Implementation Plan is important? (Continued)

This implementation plan will help clarify a number of misconceptions on who is a Key Population in Zimbabwe. We will clarify the definitions as there are groups that thought they were Key Populations when they were not, whilst others thought they were not Key Populations when in fact they were, under the universal definitions in the context of HIV. Questions around what exactly do we mean when we talk about Key Populations has been affecting programmatic interventions for the intended groups.

In the context of HIV, Key Populations are defined groups who, due to specific high-risk behaviours and factors, are at increased risk of HIV irrespective of the epidemic type or local context. Zimbabwe has traditionally considered gay men and other men who have sex with men, sex workers and their clients, transgender people and people who inject drugs as the four main key population groups, and there is recognition that prisoners and people with disability also are particularly vulnerable to HIV and frequently lack adequate access to services. The definition when implementing seemed wide and varied and needed to be focused and short. The following is the general consensus on who should be included in KP programming; (i) Gay men and Men having sex with other men (ii) Sex workers (female, male and transgender) and their clients (iii) Transgender and intersex people (iv) Prisoners and other people in closed settings and (v) People who use drugs. Increased efforts to highlight underserved and vulnerable groups in this implementation plan allowed us the opportunity to listen to their views and these are the groups

in our community who are least engaged in STI/HIV prevention, treatment, care and support namely (i) Lesbians and WSW (ii) People with disability including deaf community (iii) People living with Albinism (iv) Refugees and immigrants (v) Artisanal miners, (vi) Long Distance Drivers and (viii) Children living in the streets.

We explicitly acknowledge the immense and good work that is already underway in responding to the needs of Key Populations in Zimbabwe. These include but are not limited to contributions of the Government of Zimbabwe, Ministry of Health and Child Care in collaboration with the National AIDS Council, Donor support from the Global Fund, PEPFAR, Dutch government, USAID funded programmes, MSF, UNAIDS, UNDP and UNFPA, implementing partners<sup>4</sup> such as GALZ, ZIMSWA, Trans Smart Trust, Hands of Hope, PAPWC-ZIM, Albino Association of Zimbabwe, CEETSHA, PSI, SAFAIDS, Sexual Rights Centre, Umguza AIDS Foundation, Wilkins Hospital, ZNPP+, Zimbabwe AIDS Network, and Zimbabwe Prisons and Correctional Services (ZPCS).

All these entities have significantly contributed to the current levels of Key Populations awareness, sensitivity and programming. Its objectives and outcomes are complimenting the strategic goals of already existing documents such as the Extended ZINASP, the UNAIDS Global Coalition and the SADC Regional Strategy on Key Populations, to name a few. In line with our mandate as National AIDS Council, we are putting all the pieces together to ensure a harmonised and well-coordinated structures in addressing Key Populations needs;



Fig 1: Diagram showing the complementarity of the Key Populations Implementation Plan to existing structures.

<sup>4</sup> Some of the implementing partners are Key populations led organisations

## An Executive Summary

### Why this Implementation Plan is important? (Continued)

The diagram above highlights our increased focus for a stronger and coordinated mechanism in a simplified inclusive plan that calls for equal representation in various spaces where KP issues are addressed. The plan will work on strategies that avoid duplication of efforts for high impact.

The implementation plan is strategically structured to ensure that we also promote knowledge sharing and learning and also includes efforts currently underway at a Global and regional level as well as good practice models from our regional counterparts. We then zero in on what is happening in our country, providing a chapter on an overview of Key Populations in the context of HIV within our borders, followed by cross cutting general risk factors for HIV among Key Populations in Zimbabwe. You will find that we amplified the voices of each key population sub group, by dedicating a section on the consultation findings, the real issues they are facing and their recommendations on interventions that will drive change. There is a stronger focus to ensure relevance to the country context, religion and cultural issues. In an effort to remain focussed and to ensure our proposed interventions are highlighted in the first parts on the implementation plan, you will note we placed the detailed amplified voices from the KP communities in the annexure section.

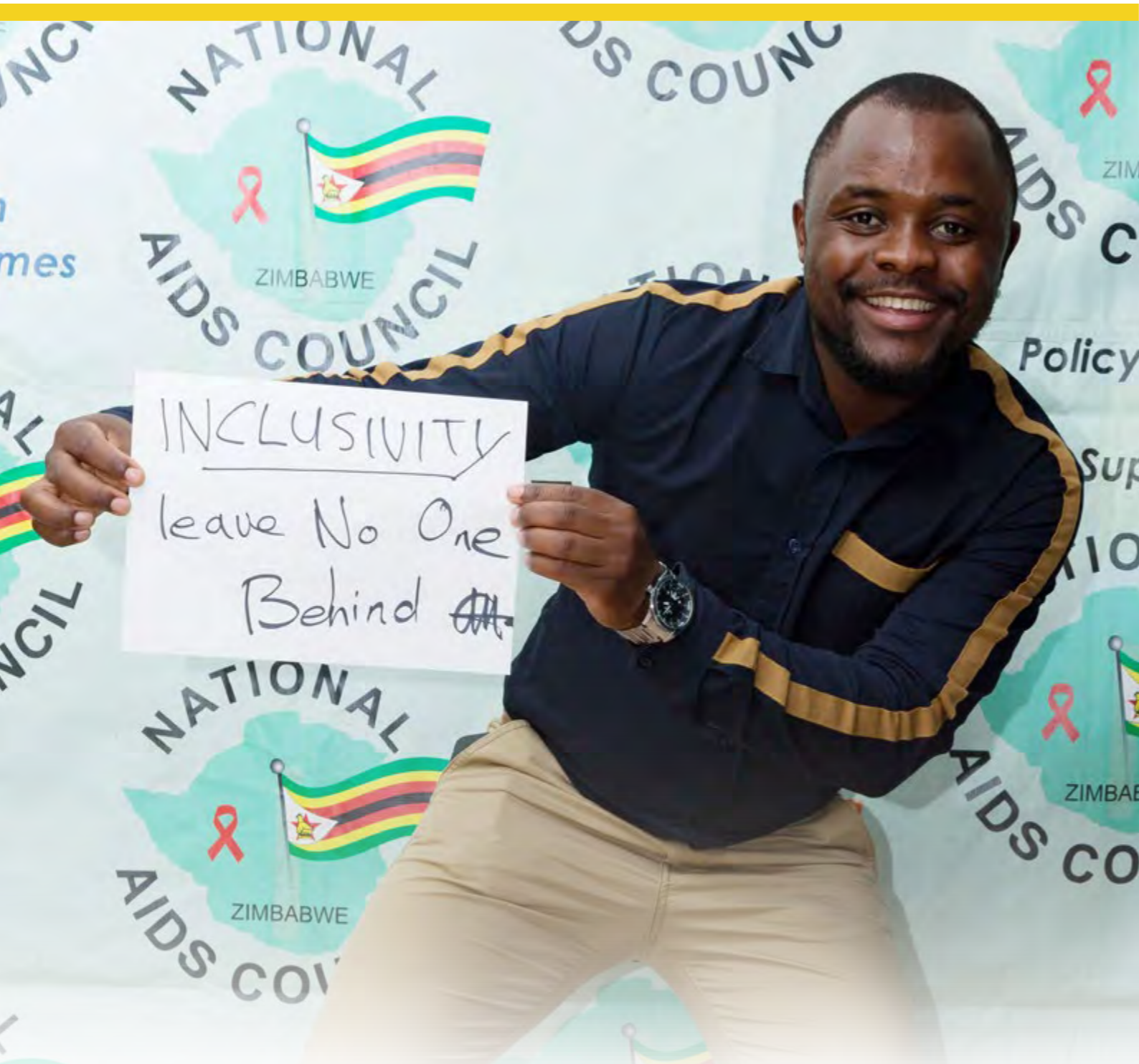
The 30 day consultation process provided a platform for the consultants to hear the views from various multi sector representatives, which resulted in the development of 10 Strategic and Interlinked Focus Areas for implementation in the next two years (2019 – 2020) for increased impact on KP programmes;

- Focus Area 1 - Holistic Approach to Service Delivery to all KP groups
- Focus Area 2 - Disaggregated Minimum Service Package and Targeted Clinical Services
- Focus Area 3 - Behavioural Change and Changing Social Norms Programmes
- Focus Area 4 - National HIV Research Programme on KPs
- Focus Area 5 – Scaling up distribution of prevention products in Prisons
- Focus Area 6 – Increased Accountability on Law Reforms and Policy Harmonisation
- Focus Area 7 – Understanding the language in Sexual Orientation and Gender Identities (SOGIE)
- Focus Area 8 - Organisational development and capacity strengthening
- Focus Area 9 – Development of HIV information packages for the under-served populations
- Focus Area 10 –Economic Inclusion and sustainability strategies

The implementation plan concludes by highlighting implementation modalities which acknowledge any efforts that are already underway in address the above strategic focus areas. This includes the recognition and important role provided by coordination, governance and oversight structures such as the Country Coordination Mechanism (CCM), the Advisory Group, the Technical Working Groups (TWG) and the multi-sectoral KP Forum. There is also a strong focus on a decentralised mechanism that does not give preference to urban and not focus on cities only.



# Section 1 - Background



# 1. Steps Towards The Implementation Plan

## LEAVING NO ONE BEHIND

### UNIVERSAL ACCESS TO HIV/ AIDS SEXUAL REPRODUCTIVE HEALTH SERVICES FOR ALL

Global evidence demonstrates that, since 2010, new HIV infections among adults (15 years and older) have remained somewhat static, at an estimated 1.9 million per annum. Members of Key Populations, including sex workers, people who inject drugs, transgender people, prisoners, men who have sex with men (MSM), and their sexual partners accounted for 45% of all new HIV infections in 2015 (UNAIDS 2016). Throughout the world, including sub-Saharan Africa, HIV prevalence is substantially higher among Key Populations when compared to the general population. As many as half of all new HIV infections occur in Key Populations, yet they often have the least access to HIV prevention, treatment and care as they face stigma and discrimination.

The Southern Africa region carries about 50% of the global burden of HIV with about 18.5 million people currently estimated to be living with HIV, yet this region has less than 2% of the world's population. Zimbabwe has seen a decline in HIV incidence rates from 2.63% in 2000 to 0.88% in 2015 and further down to 0.48% (ZIMPHIA 2016) with annual new infection of 87,000 people in 2000 to 64,000 in 2015 most possibly due to the scale up of various prevention and treatment programmes. Still, HIV prevalence remains stabilized around 15% average, predominantly affecting women showing prevalence higher at 18% than among men at 12% (ZIMPHIA 2016).

The country does not have size estimates for the different subsets of the Key Populations with statistics available only for Female Sex Workers (FSW). A study carried out by the Centre for Health Strategies (CHEST) in Zimbabwean prisons, found HIV prevalence rates of 27% for male inmates and 39% for female inmates. Further, respondent driven sample surveys by the Centre for Sexual Health, HIV and AIDS (CESHHAR) have shown extremely high HIV positivity among sex workers in Zimbabwe. HIV prevalence among sex workers is as high 57% for sex workers, with 9.6% of these getting newly infected between 2009-2014 (CESHHAR 2012). Globally, evidence shows that Key Populations are between 10 and 20 times in greater risk of HIV infection compared to other adults.

Criminalization and stigmatization of same-sex relationships, sex work and drug possession and use, and discrimination, including in the health sector, are preventing Key Populations from accessing HIV prevention service. The UNAIDS considers gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs and prisoners and other incarcerated people as the five main key population groups that are particularly vulnerable to HIV and frequently lack adequate access to services( UNAIDS 2010).

## 1.1 Justification

The evolving disease epidemiology in the country and region shows that; while HIV incidence is declining in many parts of the Southern African region, incidence among some Key Populations groups appears to be isolated from this progress. Studies conducted in the Southern Africa region have found HIV prevalence rates of 10–20 times higher among sex workers than among adults in the general population, with rates of HIV infection reaching 50% of all Sex Workers tested, and HIV prevalence reaching 86% in one study from Zimbabwe (CeSHHAR RDS Survey 2015). Among MSM, evidence shows prevalence is nine times higher than among general population in the Southern Africa region.

Zimbabwe has ratified the UNAIDS 2016–2021 strategy with a strong focus on bold action to Fast-Track the AIDS response. The strategy incorporates a human rights-based approach to development and aims to leave no one behind in the HIV/AIDS response. As such, the HIV/AIDS response in Zimbabwe as enshrined in the ZINASP 2015-2020 ought to prioritise delivering minimum comprehensive packages, human rights based and tailor made responses for Key Populations. In order to achieve the 90 90,90 fast track targets, a guided focus on Key Populations is imperative.

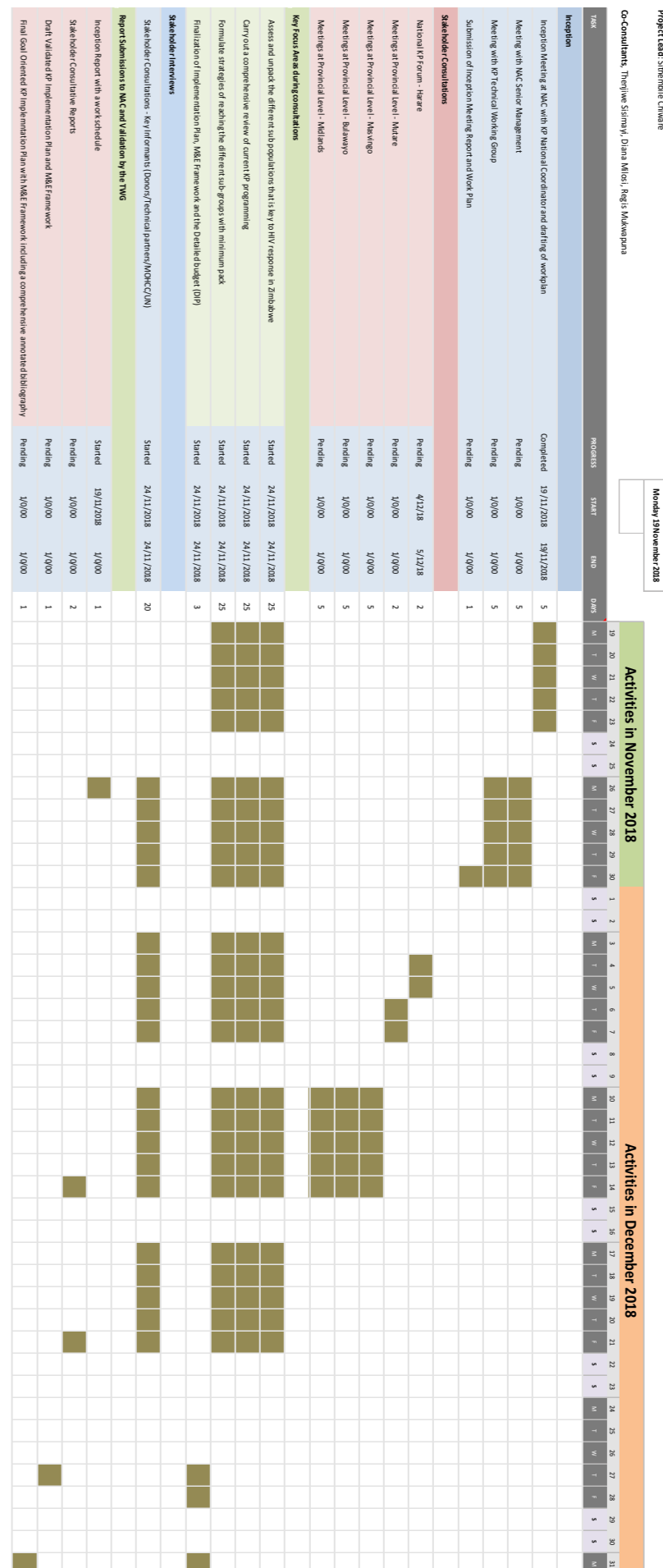
Currently, the country has received support from the Global Fund for Key Populations programming to the tune of US\$9.9 Million over the next three years. There is further support from a host of other cooperation partners among them UNFPA, USAID PEPFAR among others. The funding sets the tone for interventions aimed at preventing new infections and reducing morbidity and mortality among key population groups albeit with limited evidence on size estimates, HIV responses needs and the legal framework for a structured response. Zimbabwe has a history of resentment and outright stigma and discrimination against Key Populations. Culturally and spiritually, society has labels for members of the Key Population groups; as such there is a huge gap in terms of acceptance and recognition of human rights for Key Populations.

The currently completed Legal Environment Assessment (LEA) demonstrates that there are policy inconsistencies and much compromised legal access and recourse for members of Key Populations in Zimbabwe. The proposed Zimbabwe National Key Populations Implementation Plan (2019 – 2020) will be used as a basis to design policy guidance on targeted approaches and will recommend minimum standard implementation services for targeted Key Populations and vulnerable groups in Zimbabwe as outlined in the recently developed Key Populations minimum services package document (MOHCC 2018).

The implementation plan will also define key indicators to monitor progress on HIV/ SRHR programmes for KPs and identify who is responsible for reporting and when and how often indicators will be measured across all programs. In the plan, Key Population and vulnerable groups will be identified and specific needs and services to inform the development of key strategies and approaches will be outlined.

### 1.3 A Grant Chart Towards The Development OfThe Key Populations Implementation Plan

#### National AIDS Council (NAC) - Zimbabwe Work Plan for the development of National Key Populations Implementation Plan 2018-2020



## 1. Steps Towards The Implementation Plan (Continued)

### 1.2 Process of developing the Implementation Plan

The National AIDS Council (NAC) developed this implementation plan through a multi – sector consultation and participatory process over a two month period (December 2018 - January 2019). The implementation plan was finalized and endorsed following guidance from the NAC Key Populations Coordinators, NAC Senior Management, the Advisory Group, Technical Working Group and the Key Populations Forum.

An inception meeting was held on Monday, the 19th of November 2018, between NAC Key Populations Coordinators and the consultant team. It was learnt that NAC is responsible for coordinating a multi-sectoral response to HIV in collaboration with the chief ministry who is the Ministry of Health and Child Care (MOHCC), working with several other technical partners/funders that include GFATM, USAID/PEPFAR, PSI, UNAIDS, and UNFPA. This assignment is a product from the discussions that were held between NAC and various partners. Initially, the discussion were around creation of a five-year KP Strategic Plan, but in the end, it was agreed we develop an Implementation Plan as there are currently a number of strategies being implemented all running into the 2020.

During the inception discussions, the strong message was that the Key Population Implementation Plan (KPIP) is important not only to NAC but to its partners, as NAC plays the multi sectorial

coordination role. Most available documents are only focusing on the biomedical angle. There is need for an inter-sectoral manual that will clearly show linkages and referrals. The IP has to speak to KPs themselves as well as the programmers. There is need to segregate the KPs , the high risk groups, the people with disabilities and those not wanting to be referred to as KPs. There is also the need for strong consideration on cultural and religious issues. The IP needs to be contextualised for the Zimbabwean situation, and make clarity on a working definition of KPs and our priority areas. The goal is to leave no one behind.

During the planning meetings, it was agreed that the IP must respond to the real issues and challenges currently being faced by the Key Populations. As it is only a two year plan, it needs to focus on high impact interventions that will feed into the five year strategic plan beyond 2020.

From the inception meeting discussions, NAC coordinated a National Stakeholder Consultation meeting that took place during the Key Population Forum calendar dates these being the 4th and 5th of December 2018. NAC also set up meetings with NAC Senior Management as well as the Key Populations Technical Working Group (TWG) at the Ministry of Health and Child Care. NAC also provided an introductory letter for the consultants which they circulated to various stakeholders to pave way for face to face consultation meetings. The chart below shows the Gantt chart and timelines that were set for this 30 day consultancy;



## 1.4 National Stakeholder Consultation meetings<sup>5</sup>



Meeting held at New Ambassador Hotel, Harare, from 04 – 05 December 2018

The consultation process was held during the last Key Populations Forum of 2018, attended by more than 80 participants including representatives from provincial level. The meeting was co-facilitated by the NAC KP Coordinators and the consultant team through a highly interactive and engaging approach, where ground rules were set on the onset to ensure a safe space for an open dialogue with no fear of victimisation, in particular to those who were representing their Key Population communities. We planned not to have tables in the room to ensure closer interaction between participants and undivided attention, where participants would have normally used their laptops and other mobile devices during the process. Having only chairs in the room arranged in a circular manner also allowed free movement of the

facilitation team across the room hereby fully engaging with all the participants.

A progressive approach is also evident when NAC hosted this meeting at a hotel that shares the same premises with the Parliament of Zimbabwe. This would not have been feasible a few years ago, as safety and security of participants discussing LGBTI issues deemed 'illegal' would have been compromised.

The full occupation of the meeting room also reflects the increased safety and tolerance as well as recognition of the importance of ensuring the KP communities are not left behind in the fight against HIV and AIDS.



The flip chart in the above image highlighted the ground rules applied during the national consultation meeting.

- Value difference of opinion and experience
- Confidentiality
- Time Keeping
- Active listening
- Mobile phone and computer usage minimised
- Non-judgemental posture
- Anonymity
- Acceptance



Participants to register their credentials in a safe space thereby ensuring confidentiality

Two registration desks were placed outside the meeting room which enabled participants to register their credentials in a safe space thereby ensuring confidentiality. **Annex 2** shows the detailed national stakeholder consultation agenda which included critical elements such as (i) An Overview of Global thinking on Key Populations and examples of interventions at Global and Regional level , (ii) Organisational Development and capacity challenges faced by KP groups that affect programming, (iii) An overview of Key Population communities in Zimbabwe (iv) Feedback session and discussions (v) Interactive Response Pads (vi) Focussed break out group discussions by each KP group (vi) key messages during a photo booth session (vii) Feedback session from the breakout group discussions and (viii) Adoption of key messages and proposed interventions.

The data generated was shown on the projector thereby showing the sentiments in the room in a wide range of questions. This process truly kept all participants engaged and enthusiastic. Confidentiality to responses was guaranteed participants were responding using their unique identification numbers. A detailed report generated after the session was handed over to NAC for their files.

### Innovative and effective approaches to gather real time data during meetings

The consultants brought in innovative mechanisms to ask questions and receive responses through the use of ACE-IT Interactive Response Pads. The **Ace-IT** Interactive response pads were a powerful way to connect and communicate with participants during the consultation meeting as they provided participants with real time collective data analysis. The full featured keypad enabled the consultants to collect meaningful data and provided space for participants to ask questions. This technology significantly reduce the time spent on administering paper based questionnaires during the consultation meeting.



Meeting held at New Ambassador Hotel, Harare, from 4 – 5 December 2018

<sup>5</sup> Detailed findings are found in the completed questionnaires that were received from the multi sectoral respondents and various tools used by the consultants. All reviews, recommendations and suggestions were carefully considered and are reflected in the implementation plan.

## 1.4 National Stakeholder Consultation meetings *(Continued)*

### Key Population sub groups discussed their specific issues and interventions during FGD

Participants were split into specific Key Populations and vulnerable groups namely (Lesbians /LGBTI), Sex Workers, Transgender specific group, Refugees, People who use drugs and Prison officials. There was limited representation from other groups such as the MSM, People living with disability and People living with Albinism. The groups which were not fully consulted

during the stakeholder meeting were followed up a week later, during in-depth interviews. Below are the critical questions that were asked during the focus groups discussions where participants were encouraged to continuously visit the question corner which guided strategic discussions and key interventions for inclusion in the Implementation Plan.

N0: STRATEGIC QUESTIONS DURING THE KP SUBGROUP DISCUSSIONS	
Q1	What are the current barriers and ways of overcoming them?
Q2	Identify what has been done already or has been done elsewhere that could be usefully adapted to local settings?
Q3	What are the potential vulnerabilities for planned HIV responses for Key Populations and what strategies would better ensure their safety and security?
Q4	What do KP communities want to change/reinforce? Explain how such change/ progress will be confirmed? How will we see progress?
Q5	Are there any best practices/ promising practices regarding various interventions addressing Key Populations issues?
Q6	Do national Laws and Policies need to be updated to allow Key Populations organizations to register in Zimbabwe
Q7	What are specific ways of stigma and discrimination that are experienced by Key Populations in Zimbabwe
Q8	What are the specific types of violence experienced by Key Populations in Zimbabwe?
Q9	What resources are currently available and how can additional support be secured?
Q10	Why is integration and collaboration so important for you?
Q11	What interventions for Key Populations are in place in Zimbabwe? Who is implementing them? Which services/ models are working and which need to be stopped?
Q12	What is the level of influence of Civil Society Organisations and Key Populations on the quality of services being delivered (Accessibility, Acceptability, Affordability, Equality, Professional competence)
Q13	To what extent has the available data reduced the vulnerability of Key Populations?
Q14	If HIV prevalence amongst general population is decreasing why is it increasing for Key Populations? What are the real issues?
Q15	Amongst the Key Populations, Who are the NON- USERS of the available prevention methods and why?



The above questions were placed on a **QUESTIONS CORNER** throughout the day and this was a participatory approach which allowed participants to post responses on the wall throughout the day as well as discussing the questions in detail during their breakout sessions. A chart was also placed on each of the sub group that needed to be completed, in order to inform programming. Key sections on the chart included (i) the targeted level for each intervention (ii) activity (iii) key result areas (iv) proposed multi-sectoral partners (v) targeted KP community (vi) Monitoring and Evaluation indicators (vii) measurement of quality of service provided (viii) and recommended organizational development intervention for sustainability and self-reliance of Key Populations Communities.

**Day Two** of the National Key Populations Forum which takes place on a quarterly basis provided another platform to continue with the KPIP consultative process. The meeting also allowed the consultants to observe structure, composition, participation, dynamics and flow of conversations that take place during the forum.

A number of presentations were made by the current implementing partners followed by question and answer sessions, which allowed the consultants to capture critical issues and gaps to be addressed in the implementation plan.



Whilst the consultants captured a significantly large amount of data from the Interactive response pads and from the group discussions, it was necessary to conduct in depth interviews from the various multisectoral key stakeholders. However, because this assignment was commissioned when most organisations were closing for the December 2018 holiday season, Annex 3 shows a questionnaire that was widely circulated electronically through NAC, thereby significantly increasing the response rate. Innovative approaches were also applied where the consultants provided a platform for key respondents to share their opinions through WhatsApp voice notes, which were transcribed and immediately deleted to strengthen a do-no-harm-approach.

The increased number of emerging Key Populations Organisations in the context of HIV programmes is a very good sign to showcase our progression towards ending AIDS. However, this can only be good to the extent to which the organisations are working together with a common agenda. It becomes very difficult to direct efforts without coordination.

## SECTION 2 - AN OVERVIEW ON KEY POPULATIONS



### 2. An Introduction To Key Populations

<sup>6</sup>The global number of new HIV infections among adults has remained static, at an estimated 1.9 million, since 2010, threatening further progress towards the end of the AIDS epidemic. This is attributed to the fact that while HIV incidence in the general population has declined overall, the number of new HIV infections has remained level globally due to persistent or increased rates of HIV infection among Key Populations, which is estimated to account for approximately 40% - 50% of new infections. New HIV infections among gay men and other men who have sex with men are rising globally, and there has been no apparent reductions of new infections among sex workers, transgender people, people who use drugs and prisoners. Studies conducted in southern Africa have found HIV prevalence 10–20 times higher among sex workers than among adults in the general population, with rates of HIV infection reaching 50% of all sex workers tested, and HIV prevalence reaching 86% in one study in Zimbabwe. A synthesis of studies including more than 11 000 transgender people worldwide estimates HIV prevalence to be 19.1%.

**Key Populations** remain among the most vulnerable to HIV infections. Analysis of the data available to UNAIDS suggests that more than 90% of new HIV infections in Central Asia, Europe, North America, the Middle East and North Africa in 2014 were among people from Key Populations and their sexual partners, who accounted for 45% of new HIV infections worldwide in 2015. Reinvigorating HIV prevention among Key Populations requires domestic and international investments to provide Key Populations with tools, such as condoms and lubricants, pre-exposure prophylaxis and sterile needles and syringes, and HIV testing and treatment. However, the design and delivery of such HIV combination prevention services is often limited by a reluctance to invest in the health of Key Populations and to reach out to them. In many countries, Key Populations are pushed to the fringes of society by stigma and the criminalization of some sex relationships, drug use and sex work. Marginalization, including discrimination in the health sector, limits access to effective HIV services. There is an urgent need to ensure that Key Populations are fully included in AIDS responses and that services are made available to them.

Guidelines and tools have been developed for and with the participation of Key Populations in order to strengthen community empowerment and improve the delivery of combination prevention services by community-led civil society organizations, governments and development partners. The replication of such successes and the scale-up of combination prevention programmes in all cities and sites where Key Populations live and work, implemented by countries and community organization networks, will help prevention efforts get back on track to achieving the target of reducing new HIV infections by 75% by 2020.

#### 2.1 Groups Referred To As Key Populations In Zimbabwe

Key Populations are defined groups who, due to specific higher-risk behaviours and factors, are at increased risk of HIV irrespective of the epidemic type or local context. Zimbabwe has traditionally considered gay men and other men who have sex with men, sex workers and their clients, transgender people and people who inject drugs as the four main key population groups, but it acknowledges that prisoners and people with disability also are particularly vulnerable to HIV and frequently lack adequate access to services<sup>7</sup>. The definition when implementing seemed wide and varied and needed to be focused and short. The following is the general consensus on who should be included;

1. Gay men and Men having sex with other men
2. Sex workers (female, male and transgender) and their clients
3. Transgender and intersex people
4. Prisoners and other people in closed settings
5. People who use drugs

The **Extended ZINASP III** (2015-2020), defines Key Populations as males and females sex workers(SWs), men who have sex with men, including men in prison and other closed settings (MSM), people who use and/or inject drugs(PWUD,PWID) transgender and intersex people(TI) and sero-negative partners in sero discordant couples.

#### 2.2 Key Populations As Defined By International And Regional Organizations

According to World Health Organisation (WHO)<sup>8</sup> Key Populations are defined groups who, due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviours that increase their vulnerability to HIV. These are 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, because of the often high levels of incarceration and the increased risk behaviours and lack of HIV services in these settings are part of the Key Populations. Key Populations are important to the dynamics of HIV transmission. They also are essential partners in an effective response to the epidemic (WHO, 2016, KP guidelines on HIV prevention, treatment and care). The WHO 2016 KP guidelines also state that, in certain contexts other groups also are particularly vulnerable to HIV infection, for example, migrant workers, refugees, long-distance truck drivers, military personnel, miners, and, in southern Africa, young women. These populations are not uniformly vulnerable or equally affected across different countries and epidemic settings. Countries are expected to identify these additional populations specific to their settings, focus attention, develop and tailor services accordingly as these groups form part of Key Populations.

<sup>6</sup> [http://www.unaids.org/en/resources/presscentre/featurestories/2016/november/20161121\\_keypops-on-line-publication](http://www.unaids.org/en/resources/presscentre/featurestories/2016/november/20161121_keypops-on-line-publication)

<sup>7</sup>Extended ZINASP III

<sup>8</sup>WHO 2016 KP guidelines on HIV prevention, treatment and care

## 2.2 Key Populations As Defined By International And Regional Organizations *(Continued)*

The **UNAIDS** considers gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs and prisoners and other incarcerated people as the five main key population groups that are particularly vulnerable to HIV and frequently lack adequate access to services (UNAIDS 2016-2021). These populations often suffer from punitive laws or stigmatizing policies, and they are among the most likely to be exposed to HIV infections. 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.

The **Global Fund** Key Populations Action Plan (2014 -2017) states that Key Populations may include women and girls, men who have sex with men, people who inject drugs, transgender people, sex workers, prisoners, refugees and migrants, people living with HIV, adolescents and young people, orphans and vulnerable children, and populations of humanitarian concern, in each case based on epidemiological as well as human rights and gender considerations. For the purposes on the KP Action Plan developed by the GF, a group will be deemed to be a key population if it meets all three of the criteria below:

1. Epidemiologically, the group faces increased risk, vulnerability and/or burden with respect to at least one of the three diseases – due to a combination of biological, socioeconomic and structural factors;
2. Access to relevant services is significantly lower for the group than for the rest of the population – meaning that dedicated efforts and strategic investments are required to expand coverage, equity and accessibility for such a group; and
3. The group faces frequent human rights violations, systematic disenfranchisement, social and economic marginalization and/or criminalization – which increases vulnerability and risk and reduces access to essential services.

The **SADC** Regional Strategy on Key Populations (2018) makes reference to the Global Fund to *Fight AIDS, Tuberculosis and Malaria. Fact Sheet. Key Populations: A Definition* (July 2015) which makes reference to specific populations, namely sex workers, Men who have Sex with Men (MSM), People Who Use Drugs (PWUD), transgender persons and people in prisons. These groups are often referred to as Key Populations due to the fact that they experience an increased impact from HIV and a decreased access to services, due in part to their marginalisation and/or criminalisation.

### Under-Served Populations Of Interest (Vulnerable Groups)<sup>9</sup>

Some efforts under generalised programming need to highlight underserved and groups of interest that require targeted efforts in HIV prevention, treatment, care and support. These are groups in our communities who are least engaged in STI/HIV prevention, treatment, care and support. Regular identification of such community members is essential and these include;

1. Lesbians and WSW
2. People with disability including deaf community
3. People living with Albinism
4. Refugees and immigrants
5. Artisanal miners
6. Long Distance Drivers
7. Children living in the streets



<sup>9</sup> The Extended ZINASP III defines these groups as the vulnerable groups.

### Global Fund to Fight AIDS, Tuberculosis and Malaria. Fact Sheet. Key Populations: A Definition (July 2015)

Key Populations in the context of HIV, TB and malaria are those that experience a high epidemiological impact from one of the diseases combined with reduced access to services and/or being criminalized or otherwise marginalized. Definitions of Key Populations for the three diseases are provided in the breakout box.

#### Key Populations in the HIV response:

Gay, bisexual and other men who have sex with men; women, men and transgender people who inject drugs, and/or who are sex workers; as well as all transgender people are socially marginalized, often criminalized and face a range of human rights abuses that increase their vulnerability to HIV.

#### Key Populations in the Tuberculosis Response:

Prisoners and incarcerated populations, people living with HIV, migrants, refugees and indigenous populations are all groups that are highly vulnerable to TB, as well as experiencing significant marginalization, decreased access to quality services, and human rights violations.

#### Key Populations in the Malaria Response:

The concept of “Key Populations” in the context of malaria is relatively new and not yet as well defined as for HIV and TB. However, there are populations that meet the criteria outlined above. Refugees, migrants, internally displaced people and indigenous populations in malaria endemic areas are often at greater risk of transmission, usually have decreased access to care and services, and are also often marginalized.

People living with the three diseases: All people living with HIV, and who currently have, or have survived, TB, fall within this definition of “Key Populations”. Given that in some countries, a substantial proportion of the population has malaria, and the impact is not linked to systematic marginalization or criminalization, people who have had malaria are not included in this definition. Stigma and discrimination toward people living with HIV is a major impediment to improving health outcomes. Such stigma particularly affects sex workers, drug users, transgender people and men who have sex with men who are living with HIV and/or TB.

The Global Fund also recognizes vulnerable populations - those who have increased vulnerabilities in a particular context, i.e. adolescent/women and girls, miners and people with disabilities.

## 2.3 Factors Increasing Vulnerability of Key Populations to HIV

A range of priority issues that contribute to the high level of vulnerability of Key Populations in Africa to HIV have been identified namely;

- Stigma, violence and punitive law
- Lack of equitable and effective access to HIV prevention, treatment and care services;
- Lack of data on Key Populations and HIV in Africa.

### Stigma, violence and punitive laws

In the majority of countries across the world, 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.

For example, sex work, or aspects of it, is criminalised in 35 African countries, 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.

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’.

## 2.3 Factors Increasing Vulnerability of Key Populations to HIV *(Continued)*

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. 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." 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 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

## Criminalisation Of Sex Work – What The Evidence Shows

no provision for mitigating such crises and ensuring safety of Key Populations.

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. More research needs to be done on these aspects, in particular trafficking into sex work.

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.

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.

The other source of increased vulnerability to violence and HIV for sex workers is police action associated with enforcement of anti-trafficking laws. 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.

## 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. 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.

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.

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.

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.

## 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% in Kenya, 27.5% in Mozambique, and 80% in Morocco. 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.



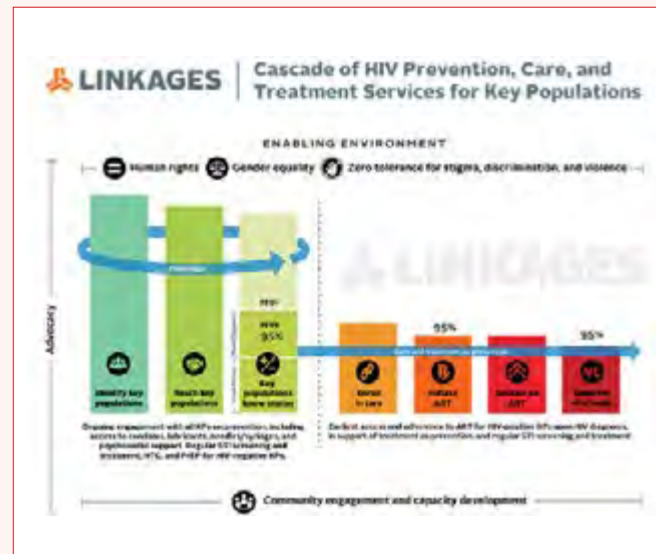


### 3. Examples Of Key Populations Guidelines And Frameworks At Global Level

#### 3.1 Linkages across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES)

This is the first U.S. Agency for International Development (USAID)-funded project that works within the mandate to focus on HIV services specifically for Key Populations. It represents the single largest USAID investment to address the HIV service delivery needs of KPs in 5 years, with over \$200 million invested in more than 30 countries. LINKAGES aims to accelerate the ability of partner governments, key population-led civil society organizations and private-sector providers to plan, deliver and

optimize comprehensive HIV prevention, care and treatment services to reduce HIV transmission among Key Populations and help those who are HIV positive live longer. LINKAGES' reach and scope has continued to exceed expectations. To date, LINKAGES has issued grants to more than 90 partners throughout multiple regions and countries around the world. Key partners are FHI 360 partners, Pact, IntraHealth International and the University of North Carolina. LINKAGES' Impact on Key Populations include;



- Access to better quality, more integrated HIV prevention, care and treatment services in welcoming settings that protect the privacy of Key Populations.
- Support from trained peers who can help Key Populations access HIV testing and counselling and other HIV services, legal aid, mental health and nutrition support and economic opportunities.
- Healthcare workers who understand and address their needs in a non-stigmatizing way.
- Safer communities with stronger crisis response systems and reduced gender-based and other forms of violence.
- Meaningful opportunities to have Key Populations community members' input in how services are delivered, improved and evaluated.
- Evidence-based information that empowers Key Populations to make decisions that lead to better health.
- Reduced threat of criminal prosecution under discriminatory laws.

Link: <https://www.fhi360.org/projects/linkages-across-continuum-hiv-services-key-populations-affected-hiv-linkages>

#### 3.2 Bridging the Gaps Programme<sup>10</sup>

The Bridging the Gaps Programme embraces pioneering and bold approaches which have been shown to work which is investing in fulfilment of the human rights of Key Populations in order to improve their health.<sup>11</sup> On a global level, the programme has contributed to strategies and frameworks to ensure Key Populations were prioritised, including the Global Fund strategy 2016-2020. All programme achievements are the result of a

remarkable joint effort by more than 90 community-based organisations in 16 countries working together with global networks and Dutch partners to achieve universal access to HIV prevention, treatment, care, and support for Key Populations, and to have their human rights fully respected. Below are some of the examples of successes registered in some countries;

<sup>10</sup>Bridging the Gaps is a joint initiative of more than 90 community-based organisations which collaborate with four Dutch non-governmental organisations, namely Aids Fonds, AIDS Foundation East-West (AFEW), COC Netherlands, and Mainline, and with five global networks, which are the Global Network of People Living with HIV (GNP+), International Network of People who Use Drugs (INPUD), International Treatment Preparedness Coalition (ITPC), Global Forum of MSM and HIV (MSMGF), and Global Network of Sex Work Projects (NSWP).

<sup>11</sup>Bridging the gaps health and rights for key populations 2011-2015



#### Ukraine

Introduction of innovative approaches to engage with underage drug-users, which complemented existing harm reduction services. These included setting up family conferences and parental support groups, establishing a psycho-social support group for minors, developing standards for psychosocial support for young drug users, and providing drop-in centres for street children and children in crisis.

#### Tajikistan

Partners have developed a minimum package of 12 services for PWUD that are delivered by NGOs in close collaboration with public health institutions. Through a system of vouchers the effectiveness of referral and the anonymous results can be measured and used to show government the effectiveness of NGO services for PWUD.

#### Georgia

Establishment of five social bureaus as contact points to disseminate the client management approach. The client management system was included in the WHO guideline as an effective intervention.

#### Kyrgyzstan

Inclusion of LGBT rights in Ombudsman's report for the first time in history. A LGBT people module to be incorporated in the Police Academy's curriculum on harm reduction developed.

#### Ecuador

Integrated health and human rights services established that address the needs of the transgender community.

#### Brazil

Online engagement strategies employed to reach men who have sex with men and LGBT people.

Link: <https://www.hivgaps.org/>

### 3.3 Global Partnership to Eliminate All Forms of HIV-Related Stigma and Discrimination.

Following a call from civil society in 2017 to accelerate and scale up action to address stigma and discrimination, UNAIDS, UN Women, the United Nations Development Programme and the Global Network of People Living with HIV (GNP+) agreed to co-convene the Global Partnership to Eliminate All Forms of HIV-Related Stigma and Discrimination. This partnership aims to translate Member States’ commitments into well-resourced programmes that are proved to work and that can result in the enjoyment of HIV-related rights for all.

The global partnership was launched on 10 December 2018 on the 70th anniversary of the adoption of the Universal Declaration of Human Rights, during an event in Geneva, Switzerland. The panellists presented programmes that have proved to be effective in reducing HIV-related stigma and discrimination in the areas in which the global partnership will focus—health care, schools, the workplace, the family, justice systems and emergency and humanitarian settings.

People living with HIV, adolescents, young people and Key Populations experience discrimination, including discrimination based on their gender and gender identity, race, ethnicity, age, drug use, sexual orientation and migration status. These added layers of stigma and discrimination increase their vulnerability to HIV and undermine their rights, including the right to health, work and education<sup>12</sup>. At the end of the event, the UNAIDS PCB nongovernmental organization delegation called on Cosponsors, Member States, civil society, Key Populations, communities and partners to join the global partnership and lead and support concrete country actions and investments to end HIV-related stigma and discrimination.

Link:[http://www.unaids.org/sites/default/files/media\\_asset/global-partnership-hiv-stigma-discrimination\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/global-partnership-hiv-stigma-discrimination_en.pdf)

### 3.4 HIV Prevention 2020 Road Map

The HIV Prevention 2020 Road Map - is a global strategy to scale up prevention as part of the Fast – Tracking comprehensive response to meet Global and national targets by 2030.

The process brought together more than 40 countries and organisations including CSOs, Networks of PLHIV, and faith based organisations, international agencies and foundations.

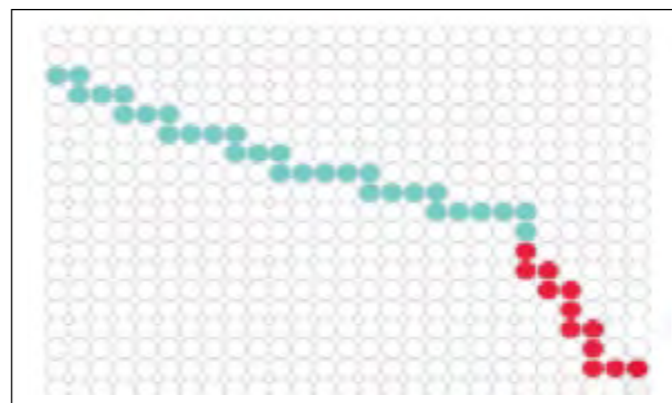
The focus of the Roadmaps is on HIV primary prevention and targets AGYW and Key Populations. The roadmap has a 10-point plan for accelerating HIV prevention at country level

Link:[http://www.unaids.org/sites/default/files/media\\_asset/global-partnership-hiv-stigma-discrimination\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/global-partnership-hiv-stigma-discrimination_en.pdf)

#### Global Partnership For Action To Eliminate All Forms Of Hiv Related Stigma And Discrimination



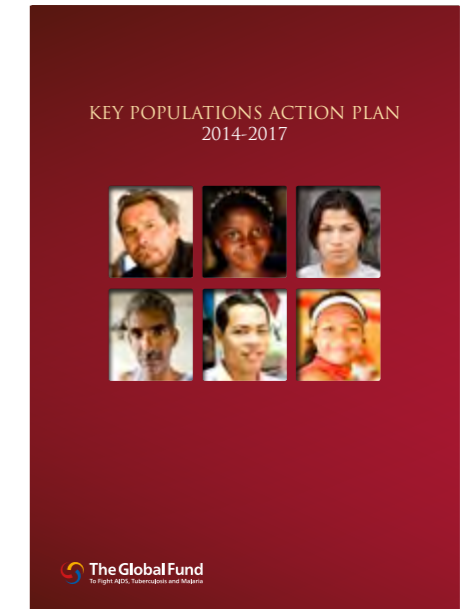
#### Towards A Global Hiv Prevention Coalition And Road Map



### 3.5 The Global Fund Key Populations Action Plan

The Global Fund’s Key Populations Action Plan (2014-2017) is a document which describes actions to strengthen the work and impact of the Global Fund in relation to Key Populations. The plan was developed in response to the recommendation that relates to the Sexual Orientation and Gender Identities (SOGI) Strategy. It was written to align with the Gender Equality Strategy Action Plan, the Joint Civil Society Action Plan (JCSAP) and other Global Fund strategy documents. It puts into action commitments made by the Global Fund Secretariat and laid out by United Nations agencies and other technical partners.

The Global Fund wants to focus its resources on services where there is the most need and where the greatest impact can be made, and it is believed that this is with Key Populations<sup>13</sup>. The Plan has five objectives to make sure Key Populations and their needs are included in every step of the grant cycle:



STRATEGIC OBJECTIVE	WHAT DOES THIS MEAN?
1. Investment levels targeting key populations	1. Increase investment in services and programs for Key Populations that are effective and that reach more people
2. Inclusion of Key Populations in country and regional processes	2. Get the voice of Key Populations heard through making sure that the organizations that support them have enough resources to do their work and to advocate for it
3. Creating measurable deliverables and improved reporting mechanisms	3. Improve the access to and use of grant funding by key population organizations
4. Reinforce knowledge among Global Fund staff and partners	4. Make sure all those involved in working with Key Populations know enough about these populations and have learnt from each other
5. Leadership and advocacy by and for Key Populations	5. Make sure all those involved in working with Key Populations are up to date with the needs and circumstances of these populations and that knowledge is shared to inform best practice

**KEY POPULATIONS ARE GROUPS THAT:**

1. Are more significantly impacted negatively by disease
2. Are more significantly impacted negatively by disease
3. Belong to populations that are criminalized or marginalized

**An Action Plan is a blueprint/roadmap for the process of how goals will be reached and impact made**

The Key Populations Action Plan was developed over seven months through a multistakeholder process that included interviews with approximately 40 internal and external technical experts, partners and advocates.

<sup>11</sup>On line article, <http://www.unaids.org/en/resources/presscentre/featurestories/2018/december/global-partnership-eliminate-hiv-stigma-discrimination>

<sup>13</sup>Regional Platform for Communication and Coordination for Anglophone Africa (Eannaso)

## 4. Examples Of Key Populations Guidelines And Frameworks At Regional Level

A Key Populations Expert Group was convened for the purposes of review and consultation. This group reviewed approximately 80 documents pertaining to the Global Fund and Key Populations. The Key Populations Expert Group, along with a broader set of partners and staff, also reviewed the initial draft of this action plan as part of an extensive internal and external validation process.

### 3.6 World Health Organisation Consolidated Guidelines on HIV preventions, diagnosis, treatment and care of Key Populations.

Updated in 2016, in this new consolidated guidelines document, WHO brings together all existing guidance relevant to 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 – and updates selected guidance and recommendations as referenced in the Model Regional Strategic Framework and other key documentation.

Link: [https://www.theglobalfund.org/media/1270/publication\\_keypopulations\\_actionplan\\_en.pdf](https://www.theglobalfund.org/media/1270/publication_keypopulations_actionplan_en.pdf)

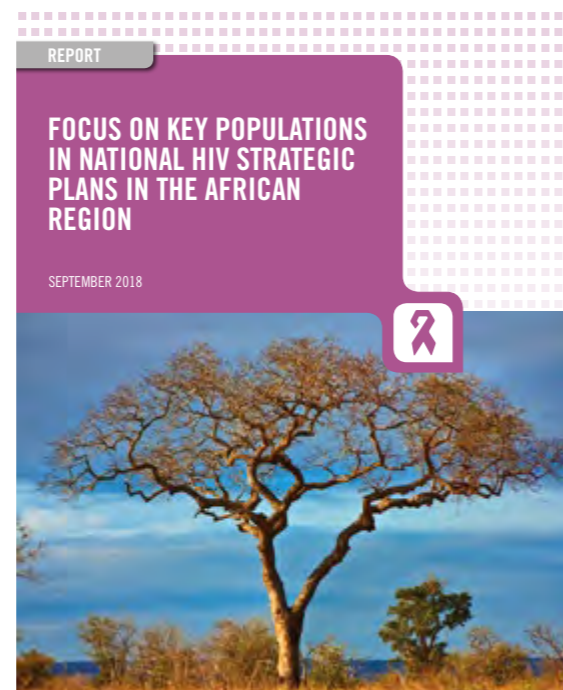
### 3.7 World Health Organisation - Focus on Key Populations in National HIV Strategic Plans in the African Region

HIV epidemics. WHO commissioned a review of the most recent National Strategic Plans of 47 countries in the WHO African Region for their coverage of Key Populations. This review sought to identify strengths, gaps and weaknesses in the way that these plans consider Key Populations. They assessed (i) how Key Populations and their HIV risk are represented in NSPs, (ii) whether the plans include epidemiologic information on the HIV epidemic among Key Populations, (iii) whether these plans include the WHO-recommended package of interventions for Key Populations; and (iv) the extent of involvement envisioned for key population communities in HIV interventions addressing these populations.

Key Populations, as defined by WHO, were included in the majority of African national strategic plans. The exception was transgender people, who were addressed in only a few NSPs. Sex workers were mentioned in all 45 plans reviewed. Sex workers were generally understood to be female; only a few NSPs specifically acknowledged male sex workers, and none mentioned transgender sex workers. Overlaps across different Key Populations were rarely mentioned, and there was very little attention given to the specific situation of youths who are part of Key Populations

The risk behaviours and vulnerabilities of Key Populations result in their being disproportionately affected by HIV in all countries and settings. These disproportionate risks reflect both behaviour common among members of these populations and specific legal and social issues that increase their vulnerability. Yet HIV services for Key Populations remain largely inadequate. In many settings HIV incidence in Key Populations continues to increase, even as incidence stabilizes or declines in the general population.

To date, WHO has developed normative guidance separately for each of the five Key Populations, but, in general, guidance has not adequately addressed overarching issues relating to Key Populations. This edition includes updates with regard to recent new WHO recommendations, in particular on ARV treatment and on Pre Exposure Prophylaxis (PrEP).



World Health Organization  
AFRICA

Link: <https://samumsf.org/sites/default/files/2018-11/WHO-AF-CDS-HIV-02.2018-eng.pdf>

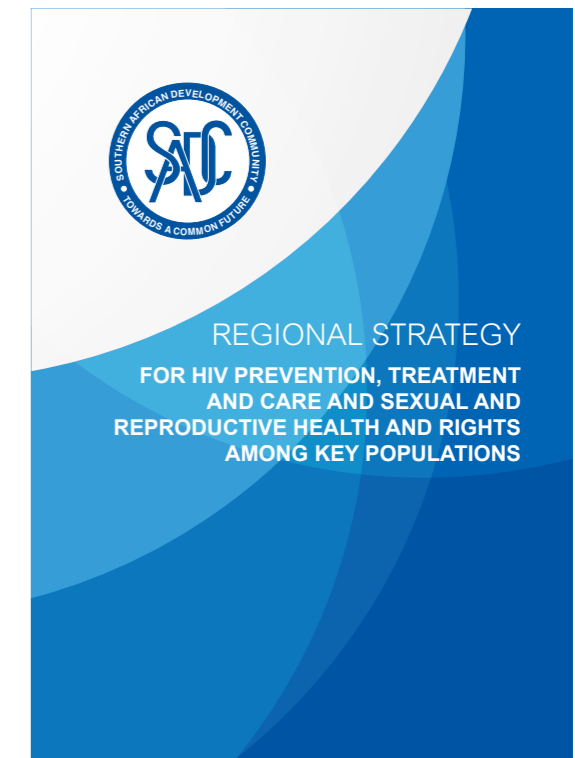
### 4.1 Southern Africa Development Committee (SADC) – Regional Strategy for Key Populations

This Regional Strategy was approved in November 2017 by SADC Ministers responsible for Health and HIV and AIDS. The 2016 High level political declaration set an ambitious target for HIV prevention where countries are set to reduce their new adult infection by 75% by 2020. This strategy serves as a guide to member states in designing and implementing appropriate SRH and HIV integration, treatment and care programmes for Key Populations. The strategy focuses on major issues that need to be addressed at policy, legal, institutional and facility level.

SADC Members of Parliament adopted Minimum Standards for Protection of Key Populations in the context of HIV and AIDS on the 4th of December 2018, in Maputo, Mozambique. The adoption happened during the 44th Plenary Assembly Session of the SADC Parliamentary Forum, which is the highest decision-making organ of the body that brings together 14 national parliaments of the SADC Region. The Minimum Standards are the first such in the SADC Region and contain key policy and legal directives from a parliamentary perspective for the protection of Key Populations.

“The Minimum Standards are designed to act as a guiding resource for parliaments as they enact their own legislation pertaining to Key Populations and have been crafted based on international best practices but customised to the Southern African region,” said Karupu, who is the Vice Chairperson of the SADC PF’s Human, Social Development and Special Programme Committee. They will thus ensure that the Executive arm and the Legislative arm of the State are adequately capacitated and equipped to protect Key Populations. (Moses Magadza/SADC PF)

Link: [https://www.sadc.int/files/2715/3060/7629/SADC-regional-strategy-hiv-srhr-key-pops\\_FINAL.pdf](https://www.sadc.int/files/2715/3060/7629/SADC-regional-strategy-hiv-srhr-key-pops_FINAL.pdf)



### 4.2 Africa Regional Grant on HIV – Removing Legal Barriers supported by The Global Fund

The Global Fund invested \$10,522,144 million over the last three years (January 2016 – December 2018) on a Regional Programme on HIV – Removing Legal Barriers. This grant was implemented in 10 countries namely Botswana, Cote D'Ivoire, Kenya, Malawi, Nigeria, Senegal, Seychelles, Tanzania, Uganda, Zambia with endorsement from all 10 Country Coordinating Mechanisms (CCMs).

The programme also works at the continental and regional levels with the African Union Commission and key Regional Economic Communities (Southern African Development Community, Economic Community of West African States and East African

### AFRICAN REGIONAL GRANT ON HIV REMOVING LEGAL BARRIERS



Community) to promote alignment of national laws and policy with regional and international human rights commitments.

The programme is supported through a three-year grant by the Global Fund to Fight AIDS, Tuberculosis and Malaria. UNDP is the Principal Recipient of the grant and implements in collaboration with four African civil society organizations - the AIDS and Rights Alliance for Southern Africa (ARASA), ENDA Santé, KELIN, and

the Southern Africa Litigation Centre (SALC) – with recognized expertise in documenting human rights violations, strategic litigation, advocacy and capacity-strengthening. The aim is to strengthen the legal and policy environment to reduce the impact of HIV and TB on Key Populations in Africa (men who have sex with men, sex workers, transgender people, people who use drugs, prisoners and people with HIV). The programme has four objectives:

- i. To strengthen regional and national evidence-based law, policy and strategy to support improved access to and delivery of HIV and TB services for Key Populations (men who have sex with men, sex workers, transgender people, people who use drugs and prisoners).

Link: <http://www.africa.undp.org/content/rba/en/home/about-us/projects/africa-regional-grant-on-hiv.html>

### 4.3 Key Populations Representation, Evidence And Advocacy For Change In Health (Kp-Reach) Supported By The Global Fund

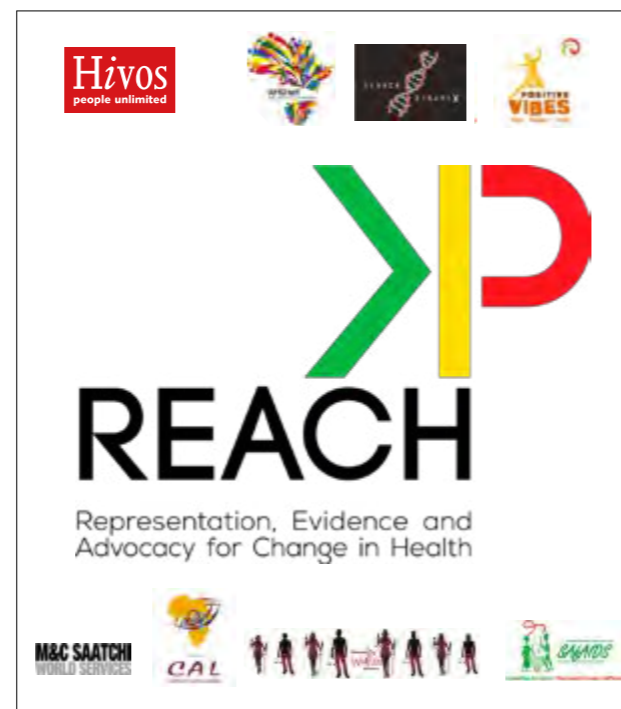
Key Populations Representation, Evidence and Advocacy for Change in Health (KP-REACH) in another Regional grant in Africa that was focused on Key Populations with an investment of \$11,465,336.00 from the Global Fund. The Programme was implemented for 3 years from January 2016 – December 2018 with the goal to reduce HIV infections and HIV-related deaths among Key Populations in Southern Africa through improved access by KPs to HIV prevention, testing and treatment. KP REACH objectives were;

- (i) Strengthening four existing and/or emerging regional KP networks in Southern Africa so that they are able to work together and with others in a strategic and efficient manner;
- (ii) Improving data collection as well as the use, management, scale up and replication of innovative best practices to enable more responsive programming and policies at the national level to improve KP access to HIV prevention, testing and treatment;
- (iii) Developing and disseminating messaging co-created with KPs to shift attitudes and beliefs for reduction in stigma and discrimination as a key barrier to preventing KPs from accessing prevention, testing and treatment for HIV;

#### Kp Reach Target Groups

Men who have sex with men	Women who have sex with women	Transgender	Sex workers

- ii. To strengthen access to justice and enforcement of supportive laws to support improved access to and delivery of HIV and TB services for these Key Populations.
- iii. To strengthen regional and national mechanisms to prevent and address human rights violations that impede key population access to HIV and TB services.
- iv. To strengthen the capacity of regional non-governmental organizations to take on Global Fund Principal Recipient roles and functions.



KP-REACH was an advocacy programme to strengthen the capacity of four key population networks and enhance their ability to work together strategically and efficiently in addressing barriers to accessing HIV services by Key Populations in the Southern African region. The programme was implemented in eight Southern African countries – Botswana, eSwatini, Lesotho, Malawi, Namibia, South Africa, and Zambia, Zimbabwe. It has contributed to improvements in the collection, management and use of key population human rights violation data, as well as learning, scale-up and replication of innovative best practices for more responsive national programmes and policies to increase access to HIV prevention, testing and treatment.

The Humanist Institute for Co-operation with Developing Countries (Hivos) was the Principal Recipient, in partnership with four Regional Key population networks – African Men for Sexual Health and Rights (AMShER), Africa Sex Workers Alliance (ASWA), Coalition of African Lesbians (CAL), Southern African Transgender Forum (SATF) – and three technical partners – M&C Saatchi World Services, Positive Vibes and SAFAIDS.

#### KP-REACH was implemented using the following five strategies.

1. Strengthening Key Population Networking and Partnerships
2. Capacity Strengthening of Key Population Networks
3. Evidence Generation for Advocacy
4. Strategic Behaviour Communication to Change Attitude towards Key Populations
5. Promoting Knowledge Exchange and Learning

Unheard Voices is a radio and digital campaign used by KP-REACH to stimulate a new social norm of displacing stigma and discrimination against LGBT and sex workers with convincing alternative narrative. Based on evidence from research conducted in the region, it included advertisements airing stories from family members and friends of the Key Populations, community members and influential leaders as well as short dramas in five languages – Zulu, South Sotho, Afrikaans, and English – online and on 32 radio stations in Botswana, Lesotho, Malawi, Namibia, South Africa and Zimbabwe. This media campaign was first of its kind in sub-Saharan Africa and a huge deviation from the often-heard negative stories of rejection and harm to Key Populations, which have been proven to reinforce perceptions of discrimination. It has increased visibility for and encouraged discussions around key population issues.

The campaign stories, dramas and advertisements are available through the campaign website:

<http://unheardvoices.africa/>

The KP REACH Programme set in-country structures aimed at sustaining key interventions beyond grant cycle such as the Key

Populations Champions Model from the health, justice, political, religious, media and traditional leaders who are involved in advocacy and sensitization on the rights of Key Populations in their communities.

The Rights Evidence Action (REAct) is a human rights monitoring and response system that records and manages information at the community level. It was developed by the International HIV/AIDS Alliance to document human rights-related barriers in accessing HIV and health services in order to provide adequate responses and to inform quality human rights-based HIV programming, policy and advocacy at national, regional and global levels.

The initiative has helped raise a crop of individuals who are skilled in victim and advocacy support and sensitization to prevent further violations. A substantial body of evidence is now available from the REAct initiative to support research and policy advocacy in the region. The KP REACH model also set up Key Correspondents structures at community level who share challenges, experience and good practices from different countries. This has strengthened regional learning in the management of human rights violations among Key Populations. The key correspondents are a group of volunteers who were trained under the KP-REACH programme to document and publish stories on issues of relevance to Key Populations, including human rights violations, lifestyle, celebrations and how Key Populations are finding solutions to their challenges.



Although some of them have training or background in communications or journalism the majority are not journalists, they are citizens who have shown interest in creating awareness about LGBTI and sex workers as a way of challenging cultural norms of stigma and discrimination.

The Regional Programme also set up a Meaningful Representation Dialogue and Advocacy Action Plan (MRDA Plan) which articulates the means by which Key Populations and marginalised people represented in the project will work towards achieving the change that they want to see. The Advocacy Action Plan addresses violence on three levels: structural, institutional and interpersonal<sup>14</sup>.

<sup>14</sup>Link:<http://kpreach.net/>

#### 4.4 Regional Strategic Framework on HIV for Key Populations in Africa

Developed by the African Key Populations Forum on HIV and supported by the United Nations Development Programme, to bring 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 Forum 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 Forum 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 Forum 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.

#### 4.5 Drawing Lessons from our Regional Counterparts

##### KENYA

In Kenya, Key Populations include female sex workers (FSW), male sex workers (MSW), men who have sex with men (MSM) and people who inject drugs (PWID)<sup>15</sup>. The Kenya National AIDS Strategic Plan III NACC and NASCOP have developed few guidelines and strategy documents to clearly define the country's position and plan to work with the Key Populations. **Eighty-one (81) interventions with Key Populations spread over 28 counties report to NASCOP on a regular basis.**

The NACC and NASCOP have recently defined the Kenya HIV prevention revolution road map stressing the need to do geographic prioritization and population driven intervention with special focus on Key Population among other priority populations. KENYA Developed and disseminated Information Education Communication materials for and by sex workers in cooperation with the Kenyan government.

<sup>16</sup>Kenya MSM programme (Kenya HIV prevention prioritization evidence note -June 2014) This programme was run by The International Center for Reproductive Health has multilevel intervention targeting male sex workers in Mombasa. Starting with the opening of a drop-in center for men who have sex with men in Mombasa, ICRH trained 40 peer educators in HIV prevention in 2007. These peer educators received information about harm reduction in the context of alcohol and drugs. In addition, there was a significant effort to distribute condoms and water-based lubricants to sex workers. In total, over 100,000 condoms and 8,000 sachets of water-based lubricants were distributed.

With support from UNDP Regional Service Centre for Africa (RSCA), Southern African Development Community (SADC) and East African Community (EAC), the Framework on HIV for Key Populations in Africa developed by the Forum 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 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 intervention also targeted the health sector with 20 service providers receiving sensitization training as well as clinical training on the specific needs of men who have sex with men including anal STIs. This project developed a HIV minimum prevention package (Peer education, Condom promotion and distribution, STI diagnosis and treatment, HIV testing and counseling, Access to other health/social services, Gender Based Violence Screening and support, Life skills education, Refer to Continuum of Care for PLHIV FSWs, FSW support groups /GSLAs, Alcohol, Referral linkages between services, Participation of FSWs in HIV prevention programs and Economic Strengthening activities as a cross cutting theme) which is an important step for advocating for quality, comprehensive and integrated health services for sex workers.

<sup>15</sup>Kenya HIV prevention, prioritisation evidence note 11th June 2014

<sup>16</sup>Kenya HIV prevention prioritization evidence note June 2014

##### TANZANIA

According to National Guideline for Comprehensive Package of HIV Interventions for Key Populations, Tanzania has made substantial headway in the scale up of HIV interventions, which have led to a significant reduction of the prevalence in the general population. Given the disproportionate burden of the HIV epidemic among the specific populations groups in the country, focus is now placed on addressing the HIV prevention, care and treatment needs of Key Populations.

As part of these efforts, the Government of Tanzania has developed National Guidelines, which guide and standardize the implementation of a comprehensive package of HIV and Health Interventions for the Key Populations who are at high risk for HIV<sup>17</sup>. Targeted interventions have been implemented with the NACP having engaged over 11,800 heroin users through outreach activities, of which 2,530 were injecting drug in 2012. A pilot program working in one of the districts in Dar es Salaam reported engaging 2,933 PWID between August 2011 and March 2012.

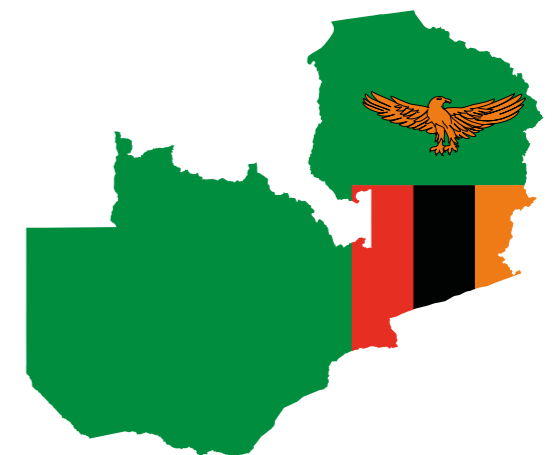


##### ZAMBIA

Zambia National AIDS Strategic Framework (2014-2015) recognizes female sex workers as one of the Key Populations in the HIV response in Zambia. Zambia Sex Worker Programme (Minimum service package for female sex workers-August 2014): FHI 360's Corridors of Hope Program Zambia and Bridge project of India funded by USAID/PEPFAR. The project targeted female sex workers and their clients including the general population through provision of comprehensive HIV and AIDS prevention services, behavior and social change interventions with improved linkages including referral networks.

Economic strengthening activities were done to reduce vulnerability. A total of 74 group savings and loan associations (GSLAs) were formed in 7 COH sites that have since graduated. Of the total 1,399 GSLA members reached out to, 1,086 were Low Income Women. The total amount of money saved and paid out amounted to \$100,000. Trained 400, 285 and 394 GSLA members in Small Plot Horticulture, Generate Your Business Idea concept and Small Livestock Husbandry. The purpose was to build the economic stability of the GSLA members to enhance resilience in times of household shocks. Expanded Gender-Based Violence (GBV) intervention to all 10 sites.

A total of 145 COH site based staff including psychosocial counsellors and over 350 peer- promoters for most at risk populations including FSW have been trained. Through a Public Private partnership in Livingstone; over 300 clients on ART at LGH are enrolled for adherence counseling in 4 community/private pharmacies, Contributed to the development of the national STI Management guidelines. The COH/FHI360 STI management flow charts have been adopted for national use.



Towards the achievement of the Zambia's goal of reducing HIV incidence by 50% by 2015, COH III have further devised the COH-Minimum Package of Services for Female Sex Workers' (COH-MPS), which includes specific timelines for service delivery and dashboard indicators for tracking of change and achievements of all COH III FSW interventions in the Zambia.

<sup>17</sup>National guideline for comprehensive package of HIV interventions for key populations –September 2014

## 4.5 Drawing Lessons from our Regional Counterparts *(Continued)*

### UGANDA

Improved health of girls and young women involved in sex work under the Bridging the gap programme <sup>18</sup> They are able to access support from local authorities, health services and an extensive vocational training apprenticeship.

The Uganda 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. 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.



### BOTSWANA

Increased access and demand for HIV prevention commodities, in this case lubricants and condoms, for men who have sex with men.

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 including sex workers, and other groups that may be included as necessary



### SOUTH AFRICA

Launch of an integrated manual and a full sensitisation training programme for health care workers on services for MSM, PWUD and sex workers in South Africa. Healthcare workers changed attitudes towards Key Populations.



### MALAWI

<sup>19</sup>Barriers to HTC and ART initiation include long distance and congestion of health facilities, concerns about lack of confidentiality and privacy, and high out-of-pocket costs (MacPherson, et al., 2012; Morin, et al., 2006; Angotti, et al., 2009). These barriers are particularly significant among certain demographics, including men, young people, impoverished rural residents (Weinreb & Stecklov, 2009) and Key Populations (i.e., SWs, MSM) (Govindasamy, Ford, & Kranzer, 2012). Therefore, current HTC strategies, which are predicated on clinic-based service delivery, need to be complemented by affordable community-based services that allow better coverage, particularly for Key Populations and rural populations in Malawi.

Based on previous work in Malawi, proactive and accountable distribution of HIV Self-Testing (HIVST) products offers the promise of providing a safe and accurate form of HIV testing and facilitating acceptable rates of linkage into HIV care. Malawi has assumed a leadership position in HIVST research with the only large scale implementation project to date. From 2012 -2015, a HIVST study was conducted in Blantyre in collaboration with the National HIV department (Choko, et al.,2015)and has produced results that have been highly influential in moving forward international policy regarding HIVST. Choko, et al. demonstrated that there was high readiness for HIVST, with pronounced user preference for HIVST over facility-based services and high accuracy of results.



These experiences from our regional counterparts show that despite the alleged or perceived illegality of the practices of key population groups, there is an increasing recognition that the HIV response cannot be effective without adequate investment in interventions for Key Populations.

Did you know, the current situation in Zimbabwe shows that 54% of Sex Workers are living with HIV and they need health care and support?



Did you know, we are building capacity of our health workforce in public sector to give services to Key Populations without stigma and discrimination?



Did you know, the Global Fund in support of Zimbabwe's commitment to ending AIDS, availed US\$ 9,909,957.57 for community based Key Populations programming between 2018 and 2020?



<sup>18</sup>Bridging the gaps health and rights for key populations 2011-2015

<sup>19</sup>HIVST RESEARCH(HIV Self-Testing Africa (STAR) Malawi: Key Populations Version 2.0 04/04/16

## SECTION 3- FOCUS ON KEY POPULATIONS IN ZIMBABWE



## 5. An Overview Of Key Populations In The Context Of HIV In Zimbabwe

### 5.1 Connecting The Dots – A Short History Of Key Populations Programmes In Zimbabwe

Programming for Key Populations in the context of HIV has taken critical baby steps to reach where it is today and collectively, we have scored some key achievements, as narrated below;

<p>As early as 1996, GALZ in response to HIV and AIDS, broadened its mandate to include education in all matters relating to human sexuality.</p>	<p>The GALZ Health Department then provided counselling and HIV-related workshops to LGBT people as well as safer sex information and safer-sex kits to members of GALZ</p>	<p>2000, The first Sexuality Seminar was hosted by SAFAIDS, Hivos and GALZ held to open up discussion within the NGO human rights network around sexuality and culture and to explore the meaning of sexual rights as a human rights issue.</p>	<p>The Positive Image Programme provided affordable health care to all members living with HIV including access to antiretroviral treatment.</p>
<p>2000, GALZ began annual conferences on human sexuality targeting NGOs involved in human rights, HIV/AIDS and gender. The aim was to stimulate new thinking on sexuality and culture in relation to HIV/AIDS.</p>	<p>UNFPA 2008-2015 has National Officer focusing on Key Affected Populations in Zimbabwe</p>	<p>In 2007, UNFPA Gender Officer, supported by NAC, IOM, UNAIDS commissioned the situation/response analysis study for Key Populations in Zimbabwe</p>	<p>PSI launches Corridors of Hope Programme at border areas</p>
<p>2009 UNFPA and piloted the FSW programme on the Harare Nyamapanda Highway and discovered immense demand for clinical services</p>	<p>2010 UNFPA and NAC supported CeSHHAR to rollout nationally to meet demand</p>	<p>In 2012, the UNFPA Regional office named and facilitated documentation of the SW programme as one of the Regional HIV Best Practices</p>	<p>In 2012, held ZIPAH Capacity Building Workshop in Kadoma, Parliamentarians pledged to support the programme and such commitment is showing through distinguished parliamentarians' effort to date.</p>
<p>2008 UNFPA finalized the Situation/Response Analysis and drafted a concept note for a pilot FSW programme in Zimbabwe.</p>	<p>2015 Registration of Sex Worker Association (Trust) being finalized and renamed WAAD (Women Against All (forms of) Discrimination</p>	<p>2013 in UNFPA, facilitated the confluence of like minds culminating in the formation of the first ever National Sex Work Forum which in 2015 has transformed to a National Forum for All Key Populations led by in NAC</p>	<p>By 2011, we had the first ever national sex work programme in Zimbabwe with a presence in every province coordinated by UNFPA and supported by the UNAIDS</p>
<p>2013 The Integrated Support Programme (ISP) supported the United Nations to launch a nationally owned programme funded by various partners (Irish Aid, Sida and UKaid) and GIZ, for supporting the implementation of sexual and reproductive health, HIV and Gender Based Violence programmes, including the expansion of the FSW from 12 to 30 sites nationally</p>	<p>2016 PEPFAR DREAMS - HIV and GBV prevention information and services, linked to care, initiated on PrEP and/or treatment for Young Women Selling Sex (YWSS).</p>	<p>2013 - 2016 FACT, a national CSO was involved in the SADC Wellness Cross Border Clinics from 2013 to 2016.</p>	<p>2015 UNFPA handed over national FSW programme to the Global Funded programmes</p>
<p>2017 to date PEPFAR OVC / DREAMS referrals for second chance education for YWSS and case management for children of FSWs to ensure they are schooled, safe, stable and health</p>	<p>2017 With technical and financial support from UNODC, Zimbabwe Prisons and Correctional Service conducted its first ever HIV Prevalence Study in prisons. The HIV prevalence was 28%. This was followed by development of their first ever HIV and AIDS Strategic Plan (2012-2015) also with support from UNODC.</p>	<p>2018 - 2020 The Global Fund supports community based Key Populations programming in Zimbabwe in collaboration with MOHCC, NAC, UNDP and many implementation partners.</p>	<p>In 2014, WHO described CeSHHAR and recommended the SW programme as an internationally recognized good practice for integrated services in their publication "CONSOLIDATED GUIDELINES ON HIV PREVENTION, DIAGNOSIS, TREATMENT AND CARE FOR KEY POPULATIONS" page 113</p>
<p>2018 the PEPFAR supported FSW Size Estimation was published. It yielded approximately 46000 FSW nationally.</p>		<p>2019 PEPFAR supported National Technical Support Committee to coordinate KP clinical (MOHCC) and community (NAC) issues and Cross Border Initiative with Botswana, Zambia and Mozambique (This point is still pending final approval from our HQ and therefore will advise as we go if you can include it in the final publication)</p>	<p>2018 PEPFAR supported piloting of a structured, social network based approach (Peer Educators and Enhanced Peer Model) for KP index case finding with promising results</p>

## Amplified Voices of the Key Populations Sub Groups

### 1. Gay Men and Men Who Have Sex with Men (MSM)

#### In brief - Epidemiology of HIV among Gay men and MSM in Zimbabwe

Same sex acts are criminalised in Zimbabwe for gay men and men who have sex with men (sometimes referred to as MSM), but silent on women who have sex with women. They face violence and inequality, and sometimes torture from the community and the police. As a consequence of this, national statistics are rarely available. Criminalising men who have sex with men drives this vulnerable group away from getting tested for HIV and finding health care to prevent and treat HIV. As a result, many do not know their HIV status, let alone access prevention and treatment services. However, Zimbabwean organisations that support the rights and access to HIV services of men who have sex with men (such as GALZ and SRC) do exist, but many are routinely punished and shutdown or have their members arrested.

UNAIDS reported in 2017 that just one in seven men who have sex with men in Zimbabwe (14.1%) are aware of their status. International donors such as the Global Fund to Fight AIDS, Malaria and Tuberculosis and PEPFAR have attempted to ensure some of their funding is directed towards men who have sex with men for HIV prevention and treatment, care and support.

#### Specific risk factors for HIV among MSM in Zimbabwe

MSM suffer a lot of stigma and discrimination and are exposed to risky sexual behaviour, with limited chances of seeking health services. This societal prejudice contributes immensely to uptake of HIV services and there is no denying the effect of the previous political leadership that shaped a lot of homophobic attitudes and prejudice. The use of the HIV argument for inclusion while strategic has also created extra stigma with communities believing that gay men and MSM are driving the epidemic.

The lesbian, gay, bisexual, transgender and intersex (LGBTI) community as a whole have legal, social, cultural and economic barriers to access to public services, which in turn affects uptake and participation in health opportunities. A lot of STI infections can easily be avoided with provision of relevant information, but difficult as sharing openly HIV prevention and SRHR information about the LGBTI community is often political, compromising effectiveness of the information. This means a lot of LGBTI members do not have access to relevant interpersonal SRHR and HIV information.



#### Key interventions that will drive change for MSM Communities

1. Propose adopting the PEPFAR MSM programme towns at national level, which are Harare, Bulawayo, Masvingo, Gweru and Mutare; and expand with 5 additional towns (large towns) with high gay men and MSM concentration. (Suggested: Chipinge, Chitungwiza, Victoria Falls, Beitbridge and Mazowe).
2. Expand the Peer Educator/Support portfolio to include Monitoring and Evaluation of services at facility level coupled with representation in Health Centre Committees (HCC) to inform quality improvement.
3. There is need for National Hot spot monitoring for clusters of MSM in the 10 major towns in the country, in close collaboration with MSM organisations. This information should help shape programming efforts.
4. Relevant sexual reproductive health rights (SRHR) and HIV education for the LGBTI community as a whole need to be expanded, and distributed from public health facilities as well.
5. There is need for a service delivery model such as DREAMS for gay men and MSM that is holistic addressing the socio-economic challenges as much as the health needs to enhance uptake of services.
6. Hosting an international gay pride<sup>20</sup>, in collaboration with the Tourism Ministry, that will help the country to dialogue on the existence and the human rights of the LGBTI community as a whole. This should be hosted in a tourist destination (suggested Victoria Falls). This has the added benefit of bringing in foreign currency that may be directed to KP programming or HIV as a whole.
7. The Key Populations Technical Working group should be supported to come up with minimum service package Gay Men and MSM, and review this regularly with changing trends and context



### 2. Male, Female and Transgender Sex Workers and their clients

#### In brief - HIV Epidemiology of Sex Workers in Zimbabwe

More than half of all sex workers in Zimbabwe are living with HIV. The most recent data in 2017 recorded prevalence of 56.2%. This is concerning in an environment where condoms are being confiscated and gender inequality makes condom use negotiations difficult. Despite this, some progress is being made; the number of sex workers reached with HIV prevention programmes in Zimbabwe has more than doubled in recent years, from 7,300 in 2014 to 16,900 in 2015.<sup>13</sup>

Sex work is illegal in the country, with police often using their powers to intimidate, arrest and harass sex workers. This exacerbates sex workers' vulnerability to HIV as fear of arrest often stops sex workers from accessing health services. Findings on police harassment and abuse by the Centre for Sexual Health, HIV and AIDS Research in 2016 found 20% of female sex workers in Zimbabwe experienced violence from the police in the past year.

Sex workers remain marginalized by the scale-up of ARV therapy in Zimbabwe despite more successful national efforts among the adult population. Sex workers reported harassment and stigma as major barriers to accessing HIV treatment.

Information characterising male sex worker (MSW) practices, contexts and needs is very limited, as these men are generally included as subsets of larger studies focused on gay men and other men who have sex with men (MSM) or even female sex workers (FSW). MSW, regardless of their sexual orientation, mostly offer sex to men, and rarely identify as sex workers, using local or international terms instead. There is however, growing evidence of a sustained or increasing burden of HIV among some MSW in the context of the slowing global HIV pandemic. Differential approaches are required to cater to the changing trends in sex work from brothel to streets, lodges and hotels, homes, rented spaces and other non-traditional hotspots.

#### Specific risk factors for HIV among Sex Workers in Zimbabwe

**Violence** - Male, female and transgender sex workers are subject to various forms of violence, more pronounced among street workers. These are physical, sexual and psychological violence. It is important to highlight how specific cultural understandings of sexuality and gender have heavily influenced and justified this violence against sex workers and the perception of the industry as a whole. The violence is experienced at the work place from managers, clients and co-workers, from intimate partners and family members, the public and the police.

**Laws and policies**, including ones that criminalise sex work, increase sex workers' vulnerability to violence. Violence or fear of violence may prevent sex workers from accessing harm

<sup>20</sup><https://www.sandiegouniontribune.com/business/economy/sdut-pride-gay-economic-impact-falconer-sanders-2016jul14-story.html>



## Amplified Voices of the Key Populations Sub Groups *(Continued)*

### Specific risk factors for HIV among Sex Workers in Zimbabwe *(Continued)*

reduction, HIV prevention, treatment and care, health and other social services as well as services aimed at preventing and responding to violence (e.g. legal, health). Modelling estimates in two different epidemic contexts (Kenya and Ukraine) show that a reduction of approximately 25% in HIV infections among sex workers may be achieved when physical and/or sexual violence is reduced. Addressing violence can make it easier for sex workers to access services and make their own choices about their long-term health and welfare.

Acquisition of HIV and other STIs are **occupational hazards of sex work**. Clients can infect sex workers who may transmit infection to other clients and from them to their sex partners. Preventing infection among sex workers thus has the potential to both improve the health of individual sex workers as well as to slow HIV and STI transmission among wider populations. Effective interventions with sex workers are an important component of comprehensive HIV prevention and treatment strategies. There is ample evidence that targeted HIV prevention programmes to reduce transmission of HIV/STI infection among sex workers are feasible and effective

**Information technology** is rapidly evolving and changing the channels of interaction between people, including how sexual partners meet and sex is transacted. Traditional sex work programming has concentrated on street work with little to no effort toward virtual workers. Sex work has begun to move from physical venues to mobile phone and web based virtual sites, particularly for male and transgender sex workers. Smart phones have become one of the primary mechanisms for soliciting.

### Specific risk factors for Female Sex workers

Sex workers have been denied eMTCT services due to a loosely implemented policy that a woman and her partner should register the pregnancy together; in a manner that increases stigma and discrimination for sex workers that have male clients known as husbands in other households. This also decreases uptake of other health services and sex workers may present late at health facilities.

Children of sex workers are also stigmatised against and may fail to benefit from Government programmes such as BEAM due to local prejudices and stigma and may in some cases face violence. This may result in school drop outs and transactional sex.

### Specific risk factors for Male Sex workers

Violence toward female sex workers is mostly misogynistic while violence toward male and transgender sex workers is best understood as having a homophobic or heterosexist

basis. Of note is that not only do sex workers suffer from such violence, but also their clients, who are given a similar perceived transgression to that of the male or transgender sex worker. The economic crisis has also pushed more and more men into sex work. Male sex workers offer services both to men and women though the majority service men. It is important to highlight that not all male sex workers are gay and programming for sex workers need to address the "risks associated" with sex work. Gay male sex workers are heavily stigmatised by other gay men and may be more accepted by their fellow sex workers. This means mobilisation of male sex workers need to use male, female and transgender sex worker peers more than gay men and MSM.

### Specific risk factors for Transgender Sex workers

Social exclusion, economic vulnerability and a lack of employment opportunities means that sex work is often the most viable form of income available to transgender people, and a high proportion of transgender people engage in sex work. There are a number of transgender sex workers who use performance enhancing drugs.

An interesting dynamic about transgender sex workers is that some of them do not engage in sex work for the financial rewards but for the validation and affirmation of their gender. This means that simply addressing the economic gaps will not address high risk sexual behaviour. Furthermore, the hormones that transgender people take may increase sex drive. Some work in the sex industry because of peer pressure and for funds to finance costly medical transition.

### Key interventions that will drive change for sex workers

#### All sex workers

1. Violence against sex workers is a risk factor for HIV and must be prevented and addressed in partnership with sex workers and sex worker led organizations. A robust violence against sex workers campaign needs to be launched to address the attitudes. Providing health services to sex workers who experience violence. Sex workers who experience physical, sexual and psychological violence may need medical care in both the short and long term. In most settings there are hardly any specialized medical services for those who experience violence. Therefore, it may be useful to consider integrating services for those who experience violence into the broader set of HIV prevention, treatment and care and other health services for sex workers. Sex workers who experience violence or any other crisis may need a trained person to provide immediate support and referrals.

2. Sex worker peers willing to embed themselves within the virtual networks should be used to reach and provide outreach services to the mobile and internet networks.
3. Offering a holistic health service to encourage health seeking behaviour and uptake of HIV services. This should include primary health care at health facilities.
4. Scale up of the HIV and STI prevention programme -PREP Investment and availability, regular sexual health check-ups for symptomatic and non-symptomatic STIs, biannual Syphilis and asymptomatic STI screening to sex workers and preventive therapy for TB [Isoniazid preventive therapy] should be considered to cover all HIV positive KP individuals across the country.
5. There is scope to enhance KP couple counselling and HIV testing for early detection. When couple testing becomes normalised, uptake of testing and treatment is increased.
6. Substance Abuse awareness programme including rehab referral facilities for sex workers.
7. With coordination from NAC, Policy-makers, parliamentarians, religious leaders and other public figures through national and provincial dialogue and public debates should work together with civil society and sex workers' organisations to confront stigma, discrimination and violence against sex workers, and discuss social norms and practices that stigmatize and marginalize sex workers and the implication on Public health.
8. A safety and security manual for sex workers with strategies to enhance the safety and security of sex workers in their workplaces and communities.
9. Legal support through engaging and linking with key lawyers and trained sex worker paralegals who can help negotiate with legal and judicial authorities about incidents of violence, advocate on behalf of sex workers, and support training and sensitization of sex workers and others on laws related to sex work.

#### Female Sex workers

1. Enhanced sex worker-led outreach to increase knowledge, coverage and utilisation of services through scale up of community based targeted testing including index case testing. This should expand the targeted testing in hot spot areas to tertiary institutions.
2. Creating safe spaces (drop-in centres) or shelters that allow sex workers to come together and discuss common issues and problems they face, including violence, and develop and exchange solutions. These can have basic service provision- HIV preventive products, information packs and referral to bio-medical services.

3. Free Antenatal clinic check-up (ANC) of all pregnant sex workers at all KP clinics and drop in centres. Full eMTCT services should be readily available at earmarked health facilities and clinics.
4. Family Centred approach in programming for sex workers which include baby sitters at sex worker programmes,
5. Strengthening the capacity of sex workers to enhance knowledge of their rights in relation to sex work and violence, and their confidence to claim these rights.
6. There is need to strengthen dual protection-contraceptive and prevention programming.

#### Male Sex workers

1. Undertake a study that will assess the nature and effect of violence against male sex workers. These surveys need to capture the range of physical and sexual violence experienced by sex workers as data collected based on such terms as "beaten or raped" may under-report the violence experienced. It may therefore be useful to conduct additional qualitative research, to better understand the context, dynamics and factors that fuel violence against male sex workers and the effect of service uptake thereof.
2. Offer services earmarked both for sex workers and MSM. The decision to accept and decline should rest with the MSW.
3. Health and HIV Literacy education for MSW individuals.
4. Paralegal training for MSW peer educators and mobilisers.
5. Transgender Sex workers
6. Offer services earmarked both for sex workers and transgender. Information relevant to both groups to be shared including referrals to health care facilities earmarked for transgender persons AND sex workers.
7. Mapping of the transgender hotspots and methods of solicitation and direct outreach service provision efforts towards these hotspots. This should be carefully done as it may create security challenges both for implementers and sex workers.
8. Research migration patterns of transgender persons particularly as they start uptaking gender affirming services and its impact on HIV programming
9. Sensitisation of the police in gender and sexuality with a focus on the needs of trans people. This has an immediate effect of reducing the level of violence among transgender people. This must be maintained for a period and may eventually be worked into policy.

## Amplified Voices of the Key Populations Sub Groups *(Continued)*



### 3. Transgender Community

#### In brief-Epidemiology of HIV among Transgender people in Zimbabwe

There have been very few epidemiological studies among transgender people, but those that exist have identified high HIV prevalence, ranging from 8% to 68%. For example, in 2013 the Joint UN Programme on HIV/AIDS estimated that young people aged 15-24 accounted for 35% of all new HIV infections in adults. Trans young people are then subject to the intersecting increased risks associated with both their youth and their gender identity.

Transgender persons suffer significant challenges when trying to access health services. Real or perceived stigma and discrimination within biomedicine and the health care provision in general may impact transgender people's desire and ability to access appropriate care.

Transgender persons are internationally recognized as a population group that carries a disproportionate burden of HIV infection. Currently, there are no national-level estimates of the prevalence of transgender identity for the country, though data and recommendations from other contexts has made it crucial for Zimbabwe to look into transgender as a key subgroup. Transgender patients often require medical interventions such as hormone therapy and/or surgery. There is very limited data and literature that speak to drug interaction between hormonal therapy and ARVs, PrEP and PEP. However, because of a lack

of medical guidelines and policies on transgender health, transgender individuals often access hormone therapy from outside the country or the black market, which could potentially have an impact on national bio-medical interventions towards the trans community.

#### Specific risk factors for HIV among Transgenders in Zimbabwe

The visible expression of transgender persons often means they are singled out of queues and public spaces (societal stigma) and can lead to self-stigma, low self-esteem, avoidance of health care and mental health issues affecting access to public health services. Social and economic marginalisation because of transphobia (negative societal attitudes towards transgender persons) often result in poverty and unstable housing, familial alienation, limited formal education, limited social support, physical and sexual violence, mental illness, trauma and victimisation, substance abuse and introduction to sex work often at an early age. The stress of social isolation may also lead to a much higher rate of drug and alcohol use among transgender people that can affect their judgement of risk and make them less likely to use condoms. These factors can result in late or no presentation to HIV medical care and poor health outcomes. Trans persons cannot access the already limited number of rehabilitation services available in Zimbabwe due to the binary gendered nature of rehabilitation services in Zimbabwe.

Numerous studies have suggested that between 16 to 60 percent of transgender people are victims of physical assault or abuse, and between 13 to 66 percent are victims of sexual assault. Intimate partner violence has also been found to be a prominent issue for transgender people. Social stigmatization and other factors may additionally lead to an under-reporting of acts of violence committed against transgender people. Intimate partner violence (IPV) and sexual and gender based violence (SGBV) are key contributors to the continued existence of the HIV epidemic.

Gender-affirming surgical and medical interventions are the most important services sought by trans people which are often inaccessible to them. While hormones or other surgical interventions may be offered for cancer treatment, contraception or reproductive health, they are frequently denied to trans people out of the belief that in their case these interventions are cosmetic, medically unnecessary, or even the expression of a mental disorder. Where they are offered, such services are prohibitively expensive and are often not covered under national or private health insurance schemes. Denying and making these essential services inaccessible to trans people makes many individuals consider unsafe hormonal injections from unqualified persons, which are purchased illegally and may carry risks of infection.

Because of the desire to validate themselves, transgender people often prioritise gender-affirmation health care over any other and this require special considerations for effective engagement in HIV medical care. Adherence may hence be a challenge when taking ARVs and STI medicines. To add to that dynamic, a lot of transgender persons have reported increased sexual drive when taking hormonal therapy, and this may result in increased risky sexual practices such as having multiple concurrent partners.

#### Key interventions that will drive change for the Transgender community

1. Focused holistic service facilities earmarked for transgender persons that provide HIV services (condom and lubricant distribution, Prep, together with gender-affirming health services including psychosocial support in the 5 major cities. (Too early for transgender integration) These can offer free primary health care for transgender individuals to encourage health seeking behaviour. Integrating hormone therapy into HIV services may optimise antiretroviral adherence, and therefore it may be beneficial that the two be integrated.
2. Key trans-health focused primary care providers, need sufficient expert training and on-the-job support to offer trans-competent care and understand the complex health and rights needs of transgender people. This cohort of

primary care providers can be at key facilities earmarked for trans-specific service delivery.

3. Capacitation of trans-peer mobilisers providing community-based HIV prevention, gender affirmation information and linking people to medical care and treatment.
4. There is need to improving the organisational and technical capacity of CBOs working with transgender communities so that their work enhances their communities' access to and uptake of HIV bio-medical interventions.
5. Use of information and communication technology and virtual networks to share information and mobilise. Online social networking and community-building can offer a safe space for trans people to explore and receive support for their gender identity and HIV without having to reveal themselves.
6. Harm reduction programmes for trans women who inject soft-tissue fillers, Botox or hormones can reduce adverse side-effects and lower the risk of infection. The gauge, size and shape of needles and syringes used for soft-tissue fillers, Botox, and hormones are different from those used to inject opioids. Needle and syringe programmes should be prepared to meet the needs for various types of syringes used by trans people.
7. Trans populations need access to high-quality voluntary HIV testing services (HTS). Given reluctance among the trans population to access government-sponsored HTS, it is very important that community options be available. HIV self-testing options, where trans populations have access to a self-administered rapid screening test through NGOs, community-led organisations or trans drop in centre.
8. Viral hepatitis diagnosis, treatment and vaccination (where applicable). When treating viral hepatitis among trans people taking hormones for gender affirmation, it is important to screen for interactions between hormone therapy and hepatitis medications. Due to the more rapid progression of hepatitis-related liver diseases in people infected with HIV, treatment for hepatitis and HIV should be prioritized in people who are co-infected.
9. In order to reduce loss along the HIV prevention, diagnosis, treatment and care continuum, trained peer navigators must be engaged to act as important mentors and guides for their peers to access and adhere to a programme. Peer navigators are community outreach workers who are knowledgeable about existing local treatment and care resources for trans people who are HIV positive. These are also used in community-led approaches are an essential link between the community and HIV prevention, diagnosis, treatment and care services.

## Amplified Voices of the Key Populations Sub Groups *(Continued)*



### 4. People Who Use Drug Users (PWUD)

#### Epidemiology of HIV among PWUD in Zimbabwe

Most discussions about drug abuse in Zimbabwe often neglect substances like cocaine, heroin and alcohol, traditionally because substance abuse has been limited to marijuana and recently prescription cough medication. But experts contend the 'imported banned substances' problem is bigger and includes drugs traditionally thought to be impossible to find in Zimbabwe and those not thought to be dangerous. "By far the drug most abused is alcohol due to its ease of acquisition and price. Illicit illegal alcoholic drinks are smuggled into the country and these are untested and their ingredients are not known. Zimbabwe's rising drug abuse epidemic is a new phenomenon. Until recently, the only available drugs were marijuana and 'bronco' – a cough syrup manufactured in South Africa. But ephedrine-based drugs such as cocaine, crystal meth, and meth cathinone codeine have made its way into the market. In some cases, both drugs and alcohol are used together.

#### Specific Risk Factors for HIV among Drug Users in Zimbabwe

People who engage in drug use or high-risk behaviours associated with drug use put themselves at risk for contracting or transmitting viral infections such as HIV/AIDS or hepatitis. It happens primarily in two main ways; when people inject drugs and share needles or other drug equipment and when drugs

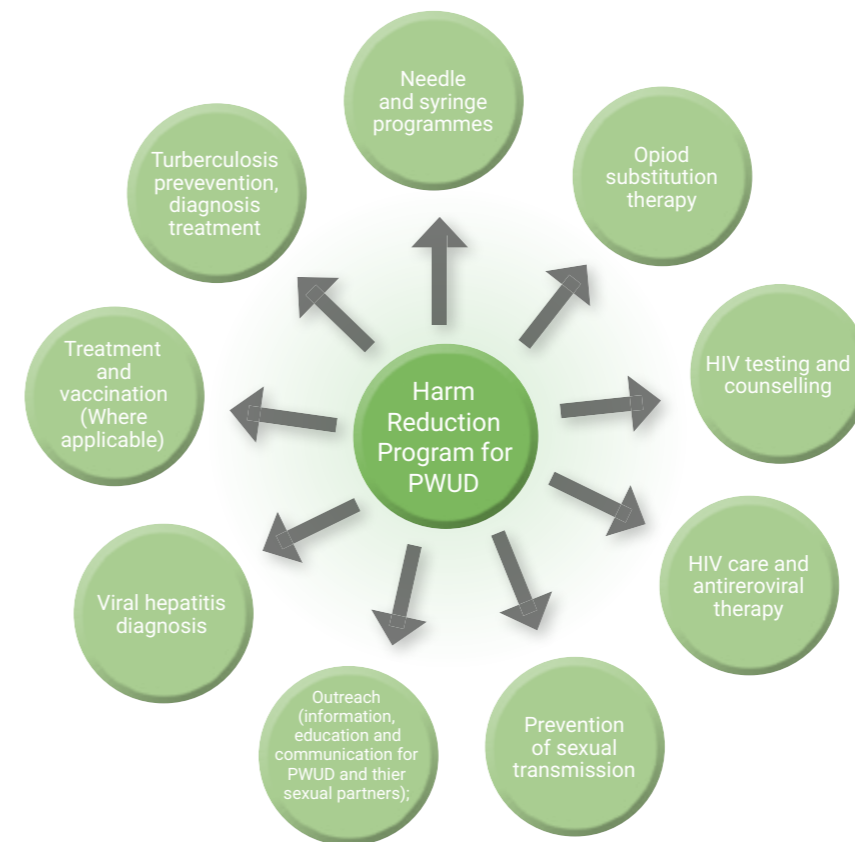
impair judgment and people have unprotected sex with an infected partner. This can happen with both men and women. Women who become infected with a virus can pass it to their baby during pregnancy, whether or not they use drugs. They can also pass HIV to the baby through breastmilk. Drug use can also affect the symptoms a person has from a viral infection. Drug use can worsen HIV symptoms, making it easier for HIV to enter the brain and causing greater nerve cell injury and problems with thinking, learning, and memory. Drug and alcohol use can also directly damage the liver, increasing risk for chronic liver disease and cancer among those infected with Hepatitis B (HBV) or Hepatitis C (HCV).

It is also important to stress the intersection of drug use with sex work, transactional sex, mental health and abuse by other Key Population groups. This may contribute to compromised negotiation of safe sex and adherence challenges. Drug interaction with ARVs and STI treatment need to be monitored.

#### Key interventions that will drive change for PWUD (Amplified Voices from the consultation Process)

1. NAC to scale up harm reduction programmes for PWUD. This refers to a comprehensive package of policies, programmes and approaches that seeks to reduce the harmful health, social and economic consequences associated with the use of psychoactive substances. The elements in the package must include the following interventions;

2. Increasing public awareness of addiction/dependence as a chronic but treatable disorder is needed to overcome stigma and promote a shift from exclusion and blame toward support and compassion. This program need to also address alcohol dependence and encourage uptake of rehabilitation services.
3. There is need to advocate for a health policy that allows for management of drug dependence, legitimising opioid substitution, maintenance and other harm reduction services for injecting drug users.
4. There is need for specialist training of health care providers to provide comprehensive HIV and rehabilitation service to people who use drugs and deal with both the clinical and the social aspects of substance dependence and harm reduction.
5. A few select specialist rehabilitative drop in centres should be identified to deal with substance dependence and harm reduction and be referral points for the PWUD programme, through programmatic collaboration with CBOs working with people who use drugs.
6. A comprehensive package of health services that seeks to reduce the harmful health, social and economic consequences associated with the use of psychoactive substances. The elements in the package should include;
  - i. Needle and syringe exchange programmes
  - ii. Opioid substitution therapy,
  - iii. HIV testing and counselling, HIV care and prevention of sexual transmission, outreach (information, education and communication for people who use drugs and their sexual partners)
  - iv. Viral hepatitis diagnosis, treatment and vaccination (where applicable)
  - v. Tuberculosis prevention, diagnosis and treatment.
  - vi. STI prevention, diagnosis and treatment



The PWUD are at high risk of co-morbidity with Hepatitis B and C. It is important to ensure timely detection and initiation of Hepatitis B or C treatment in HIV/ viral hepatitis co-infected patients to minimize hepatitis related liver disease and its long-term negative impact on HIV outcomes. Hepatitis B and C detection and treatment for PWUD should be provided at all OI/ART centres across the country.

## Amplified Voices of the Key Populations Sub Groups *(Continued)*



staff. However, little was known about Hepatitis B and C among inmates and prison staff. However, little was known about Hepatitis B and C among inmates and prison staff. Risk behaviours that inmates indulge in while serving their sentences include, sharing sharp objects like razor blades used for shaving and pins used for tattooing and men having sex with men without protection. Not many cases of injection drug use (IDU) is in the country but rather smoking mbanje and consumption of illicitly brewed beer.

The consultation process conducted during the development of this Implementation Plan noted there has been remarkable progress in generating evidence of HIV infections in prison settings. Prison inmates receive HIV testing on admission and are re-tested after six (6) months. What is critical is not test the association of HIV infection with criminal activities, and to ascertain if people are coming into prisons already infected or if they get infected within the prison settings.

### Specific Risk Factors for HIV among Prisons in Zimbabwe

It is important to note that the majority of Prisons in Zimbabwe were constructed during the colonial era and were designed to punish and humiliate hence basic things like fresh air, lighting and toilet facilities were not of concern. The sizes were not designed to take a lot of people, hence have become over crowded. However, with independence came more progressive thinking, realisation and upholding of universal human rights and the conscious movement from punitive to correctional service, the Prison service has gone and continues to go through fundamental changes. It is also important to note that most Prisons were designed for the men and not women; hence most female prisons or sections in Zimbabwe are makeshift and are not women friendly

### Key interventions that will drive change for prison populations (Amplified Voices from the consultation Process)

1. Well-designed HIV/AIDS information and education can improve prisoners' knowledge about HIV/AIDS and other infectious diseases
2. Comprehensive Prevention program in prisons- provision of condoms, service provision (HIV testing, counselling, VMMC, VIAC, STI and TB Screening). Education and informational activities for prisoners and for staff should precede the introduction of condom distribution programmes, which should be carefully prepared.
3. The prison peer education program should be intensified as well as support group formation
4. Need to strengthen provision of treatment, education and rehabilitation to those convicted for drug-related offences and self-identified drug users.

## 5. Prison Populations and Other Closed Settings

### Epidemiology of HIV among PWUD in Zimbabwe

At a global scale, there are more than 10 million men and women in prisons and other closed settings, with an annual turnover of around 30 million moving between prison and the community. Each year these over 30 million men and women spend time in prisons and other closed settings, of whom over one third are pre-trial detainees. Virtually all of them will return to their communities, many within a few months to a year. Globally, the prevalence of HIV, sexually transmitted infections, hepatitis B and C and tuberculosis in prison populations is estimated to be twice to ten times higher than in the general population. Higher HIV prevalence and HIV risk are seen among both prisoners and those working in prisons and their families in many settings. In addition to HIV risk behaviours in prison (unsafe sexual activities, injecting drug use and tattooing), factors related to the prison infrastructure, prison management and the criminal justice system contribute to increased risk of HIV, hepatitis B and C and tuberculosis in prisons. Due to the conditions of imprisonment, including overcrowding, sexual violence, drug use and lack of access to HIV prevention commodities such as condoms and lubricants, transmission risk is very high.

Overall HIV prevalence among prison inmates in Zimbabwe is at 28% with female inmates having a prevalence of (39%) while that for male inmates was at 26.8%. However, informal and adhoc operations researches which is routinely conducted by the Zimbabwe Prison and Correctional Services (ZPCS) suggests that HIV prevalence in prisons settings is considerably lower than the 28%. Subsequently, there has been some requests for a second HIV prevalence survey as the current statistics seem to be outdated. Knowledge on the modes of HIV transmission and TB is considerably high among both prisoners and prison



## 5.Under-served populations / Vulnerable Groups of interest on prevention, treatment care and support

There is need to have a stand-alone programme that focus on the underserved populations in addressing HIV prevention and treatment needs of the country. There is need to have full plan and mobilise resources to fully support the needs of these populations

### 1. Lesbian and Women who have sex with Women – their voices

When considering the issue of female-to-female sexual transmission it is important to draw a distinction between the risk of transmission by this route and diagnoses of HIV infection in women who identify as lesbian. There have been only five reported cases of woman-to-woman sexual transmission. The risk of female-to-female sexual transmission is very low.

Studies have shown lesbian and bisexual women's HIV infection pathways include unprotected sex with men, including through sex work or transactional sex; injecting drugs or partnering with a male and/or female injection drug user; artificial insemination without requisite tests; receipt of infected blood and blood products. In the Zimbabwean context, a significant number of WSW enter into relationships and marriages with men due to societal pressure and this may drive that risk. This is further increased by the economic disadvantage that comes from being isolated and ostracised driving them into sex work and transactional sex, yet are not integrated enough to easily access HIV prevention and treatment services.

The lack of data on HIV among of lesbian and bisexual women combined with the population being at 'low risk' for HIV transmission which has in turn restricted their inclusion in research, education and treatment programmes. In order to halt new HIV infections all risk behaviours are important and educational, preventative, diagnostic, and treatment opportunities should be accessible even for 'low-risk' groups. It has been recommended that rather than indicate lesbian and bisexual women at 'no' or 'low' risk, HIV prevention interventions should address specific sexual risk behaviours. Lesbians and Bisexuals can also be victims of hate crimes and violence.

### Interventions

1. Establish peer-led outreach to increase knowledge, coverage and utilisation of services.
2. Offering a holistic health service to encourage health seeking behaviour and uptake of HIV services. This should include primary health care at KP health facilities.
3. Include HIV prevention and treatment education in the MSM program



### 2. People with disability

People with disability have traditionally struggled to get comprehensive health as health care delivery has not been sufficiently designed for people with disability. HIV and health information, education and communication has not been adapted enough for the visually impaired, the deaf, physically and mentally challenged.

People with disability while faced with similar risks with the sexually active general population, they are faced with substantially

# Amplified Voices of the Key Populations Sub Groups *(Continued)*

## 2. People with disability *(Continued)*

greater barriers to care than their counterparts. These barriers include transportation needs, provider stigma and discrimination and stigma, lack of relevant information and literature (e.g. braille, sign language), confidentiality concerns, and affordability. Lack of access to services and poor retention in medical care has been shown to predict poor health outcomes for PWD.

### Interventions

1. Package HIV/AIDS prevention and treatment information and education in appropriate forms



## 3. Refugees, Immigrants and non-status people

Refugees, immigrants and non-status people represent an increasing proportion of people living with HIV. This points to the need for equitable services in prevention education, treatment and support for them. Refugees, immigrants and non-status people face complex demands; the trauma and challenges of the migration journey, the complex and confusing immigration and refugee system, the challenges of adapting to a new culture, language and lifestyle, difficulties with access to housing and employment. They also face barriers in accessing HIV-related information, treatment and support related to language and culture, health literacy and systemic discrimination of their legal status. The STI incidence is high and may already be HIV positive requiring treatment and adherence support. It is important to note that refugees also incorporate key population groups within their communities that must be not left behind. Refugees tend to be sceptical to anyone offering services who is not of their own which results in poor health seeking behaviour including HIV testing and treatment. Cultural and communication barriers are also a hindrance.

**NAC to consider establishing drop in centres in all refugee camps in Zimbabwe to provide services that include;**

- HTS
- PMTCT
- Spousal Separation
- Basic service provision especially food and sanitary
- Birth and ID registration
- Media campaign to reduce stigma and discrimination
- Refugee cards
- Sexual abuse
- Capacity strengthening of KP support groups within the camps

2. Braille and audio messaging for the visually impaired
3. Sign language messaging for the deaf
4. Offer upgrades to select public health facilities to make them physically accessible to persons with disability (e.g. wheel chair ramps)
5. Have facility based peers that can assist PWD in accessing service.
6. Train select health care providers in sign language and braille to enhance provision of services at health care centres.



There is need to address different elements of stigma and discrimination that might arise within the camps and through conflicts with local communities. Provision of interpreters to increase demand creation through peers is also required.

### Interventions

1. Drop in Centres that provide basic provisions such as HTS, PMTCT, STI/TB screening and treatment. The drop-in centres should also provide food and sanitary wear.
2. Provide demand creation peers that assist in increasing uptake and referrals to services. There is also need to provide interpreters when accessing services where necessary.
3. Basic assistance in obtaining birth and ID registration, refugee cards and other documents that may have an impact in their access to health.
4. Well-designed HIV/AIDS information and education in various languages



## 4. Artisanal miners

Zimbabwe is among the countries in sub-Saharan Africa most affected by the HIV and AIDS epidemic. Although new infection rates and AIDS-related mortality rates are declining, there are areas of high HIV transmission which include border districts, areas of increased populations (growth points, peri-urban settlement), small-scale mining areas, fishing camps and commercial farming settlements. Artisanal and small-scale mining has experienced explosive growth in recent years due to the rising value of mineral prices and the increasing difficulty of earning a living from agriculture and other activities.

Artisanal and small-scale mining is generally pursued as a route out of poverty or as an activity to complement insufficient income, especially in communities where alternative employment is hard to come by. Artisanal and small-scale mining relies on a mostly unskilled workforce using rudimentary tools and techniques. Unsurprisingly, its environmental, health and safety practices tend to be very poor. For example, dust and fine particles resulting from blasting and drilling cause respiratory illnesses. It also degrades crops and farmlands, resulting in lost food production. Streams and rivers often become polluted which makes water unsafe for drinking.

This coupled with social conditions outside the mines have been major drivers of HIV epidemic in mining areas and tuberculosis.

### Interventions

1. Community Outreach to strengthen the linkage between HIV community-based care services and clinical services provided at health facilities to artisanal and small-scale miners living in remote, underserved areas through village health workers and facility outreach staff.
2. Regular TB and STI Screening for artisanal and small-scale miners.
3. Health and HIV Literacy education



## 5. Long Distance Drivers

HIV programmes in recent years have included a scale up of interventions in border towns in an effort to reduce HIV infections amongst long distance truck drivers. A significant number of HTC clinics have been set up, including distribution of condoms. However a recent visit to Beitbridge border post by our Parliamentary Portfolio Committee Chairperson on Health and Child Care, and our Health Sector Champion for Key Populations, highlighted the need to strengthen coordinated efforts across multi sectoral partners.

Whilst the drivers acknowledged increased health delivery services in border towns, a multi-sectoral response with the Department of Immigration and Customs was deemed an urgent priority.

The extended waiting periods for goods to be cleared by border officials exposed the long distance drivers to higher risk of HIV infection. In some instances, some were made to wait for up to seven days for their trucks to get clearance whilst residing in areas where sex workers operate from.



## 6. People living with Albinism

The Albino Association of Zimbabwe in collaboration with Hands of Hope conducted a condom distribution exercise in 2018, and could notice negative reactions from some community members when a person with Albinism was receiving a condom. This affects accessibility as they shy away to receive such prevention methods. There are misconceptions that if you have sexual intercourse with a person with Albinism you will be cured of HIV.

## 5.2 Progressive interventions evidenced by current programming

Zimbabwe has ratified the UNAIDS 2016–2021 strategy with a strong focus on bold action to Fast-Track the AIDS response. The strategy incorporates a human rights-based approach to development and aims to leave no one behind in the AIDS response. This strategy further states that ending the AIDS epidemic will involve progress across the entire spectrum of rights: civil, cultural, economic, political, social, sexual and reproductive. Defending the rights of all people—including children, women, young people, men who have sex with men, people who use drugs, sex workers and clients, transgender people and migrants—is critical to ensuring access to life-saving services. Through the realization of their rights, people being left behind will move ahead, to the very forefront of the journey to end AIDS, informed and empowered, mobilized and engaged<sup>21</sup>.

As such, the HIV response in Zimbabwe as enshrined in the Extended ZINASP III (2015-2020) ought to prioritise delivering minimum comprehensive packages, human rights based and tailor made responses for Key Populations. In order to achieve the 90 90 90 fast track targets, a guided focus on Key Populations is imperative. **In Zimbabwe, Key Populations are defined as male and female sex workers (SWs), men who have sex with men, including men in prison and other closed settings (MSM), people who use and/or inject drugs(PWUD,PWID) transgender and intersex people(TI)<sup>22</sup> and sero-negative partners in sero discordant couples<sup>23</sup>.** The Gender and HIV plan (2017-2020) also highlights that Key Populations also include vulnerable populations that are groups of individuals who may be vulnerable to HIV compared with others in the population, and who also have lower access to or uptake of relevant services. These include women and girls transgender persons, partners of clients of sex workers, prisoners, refugees, migrants or internally displaced populations; people living with HIV, adolescents, and young people, orphans and vulnerable children, people with disabilities, ethnic minorities; people in low-income groups, people living in rural or geographically isolated settings .

The sexual and reproductive health rights of Key Populations are protected by Zimbabwe's Constitution Amendment (No. 20) ACT 2013 (under Chapter 2 Section 29 and Chapter 4 Section 76). It is a national public health and human rights imperative that all persons, especially those most at risk, have optimal access to health services to ensure they enjoy the right to the highest attainable standard of health.

Zimbabwe has a strong sex work programme that is being implemented in public health facilities with support from Non-Governmental Organizations and various other donor

organizations. However, the strong female sex work (FSW) programme is only addressing the needs of one of the Key Populations (KP) groups that live in Zimbabwe. The Sisters with a Voice Programme run by CeSHHAR Zimbabwe on behalf of the National AIDS Council and Ministry of Health and Child Care works to support and offers services to SWs, MSM and Transgender communities with support from the Global Fund, to improve their sexual and reproductive health; provide access to HIV prevention and referral to HIV treatment and care where appropriate and, where necessary, access to legal advice.

The Zimbabwe Constitution Amendment (No. 20) ACT 2013 (under Chapter 2 Section 29 and Chapter 4 Section 76) recognises every Zimbabwean citizen and resident's right to access healthcare, not to be turned away from any facility regardless of race, colour, religion, sexual orientation, gender identity and expression or sexual behaviour. This is particularly important for those populations who are marginalised by mainstream society; those who engage in sex work and those individuals and groups of diverse sexual orientation, as well as those who engage in risky sexual practices or who use or inject drugs. Definition of KPs in Zimbabwe: The term includes: male and Female Sex Workers (SWs); Men Who have Sex with Men, including men in prisons and in other closed settings (MSM); People Who Use and/or Inject Drugs, (PWUD, PWID); Transgender and Intersex people (TI).

## 5.3 Barriers facing Key Populations in Zimbabwe

Zimbabwe has recently developed a Minimum Services Package for Key Populations (MOHCC 2018)<sup>24</sup> and a handbook to guide healthcare providers in Zimbabwe with the knowledge and skills to enable them to provide health services that support and adequately cater for the unique healthcare needs of sex workers, men who have sex with men, transgender and non-gender conforming people, and people who inject and use drugs. Providing these groups with the proper attention and care that is their right is critical if Zimbabwe is to become HIV free. Despite the above programming documents, the following gaps have been identified.

- lack of strategic information including size estimation mapping, target and indicators,
- Limited funding for KP programme,
- Lack of specific policy and legal enforcement tools to address explicit needs of Key Populations <sup>25</sup>. According to

the Extended ZINASP III (2015-2020)<sup>26</sup>, legal barriers to HIV prevention including illegal status of sex work, sex between people of the same sex and prohibition of condom promotion in school settings still exist. Despite the current lack of legal frameworks for prevention activities with sex workers, prisoners and MSM, Zimbabwe has allowed the existence of informal lobby groups for these populations. In the meantime efforts are being made to scale up HIV services to most-at-risk populations using a public health approach.

- Lack of comprehensive package of services tailored to the specific vulnerabilities and lived realities of Key Populations ,
- Treatment cascades for sex workers also reveal significant gaps that are particularly pronounced for young sex workers (<25 years of age) as only 21% young HIV-positive sex workers are currently accessing treatment.
- Lack of a defined minimum service package for Key Populations sub groups, limited approaches to address and fight levels of stigma,
- Self-organisation for Key Populations is weak

To respond to the gaps in programming for the Key Populations as stated in the **Extended Zimbabwe National HIV and AIDS Strategic Plan** (2015-2020), Zimbabwe will need to strengthen the following:

- Undertake population size estimates for KPs and baseline community mapping.
- Undertake a baseline mapping of financial resources / investments on KPs
- Deliver a minimum comprehensive package of prevention, treatment and support services through peer-led models, using a combination of outreach and static sites approaches to provide a comprehensive package of care for Key Populations.
- Ensure harm reduction services as well as interventions to address stigma, discrimination and violence against Key Populations. These services will be combined with legal support and legal literacy, and service to prevent and respond to sexual, physical and GBV.

## 5.4 HIV Epidemiology in Zimbabwe in relation to Key Populations

The country does not have size estimates for the different subsets of the Key Populations with statistics available only for Female Sex Workers (FSW).

<sup>27</sup>A study carried out by the Centre for Health strategies (CHEST) in Zimbabwean prisons, found HIV prevalence rates of 27% for male inmates and 39% for female inmates. Further, respondent driven sample surveys by the Centre for Sexual Health, HIV and AIDS (CESHHAR) have shown extremely high HIV positivity among sex workers in Zimbabwe. HIV prevalence among sex workers is as high 57% for sex workers, with 9.6% of these getting newly infected between 2009-2014 (CESHHAR 2012). According to Extended Zimbabwe National HIV and AIDS Strategic Plan 2015-2020, HIV sub-epidemics among other key and vulnerable populations in Zimbabwe also signal the need for a more targeted response.

Preliminary results from the modes of transmission study show nearly 4000 new HIV infections a year among female sex workers (with a prevalence around 57.1%) and nearly 2000 new infections each year among men who have sex with men (MSM) (with a prevalence of about 23.5%)<sup>28</sup>.

HIV prevalence among the wider Lesbian, Gay, Bisexual, And Transgender(LGBT) community has been linked to risks associated with forced sex, a key gender-related consideration.<sup>29</sup> People with disabilities are twice as likely to self-report having HIV as those without disabilities.<sup>30</sup> Among prisoners, HIV prevalence is estimated at 28% in 2015 (26.8% among male detainees and 39% among female detainees).

<sup>31</sup>Criminalization, stigmatization and marginalization drive both higher rates of infection and lower uptake of services.<sup>32</sup> The 2014 People Living with Human Immune Deficiency Virus (PLHIV) Stigma Index found that 90.8% of sex workers, 77.8% of MSM, 64.5% of people with disabilities and 100% of prisoners reported experiencing stigma and discrimination.

<sup>26</sup>UNAIDS 2016-2021 Strategy

<sup>27</sup>CHEST-An assessment of HIV prevalence and risky behaviours among the prison population in Zimbabwe, 2011 <sup>28</sup>UNAIDS Programme data 2015

<sup>29</sup>Sandfort, T. G., Baumann, L. R., Matebeni, Z., Reddy, V., & Southey-Swartz, I. (2013). Forced sexual experiences as risk factor for self-reported HIV infection among southern African lesbian and bisexual women. *PLoS One*, 8(1), e53552

<sup>30</sup>Ministry of Health and Child Care (2013). *Living Conditions Among Persons with Disability Survey: Key Findings Report*. Online at [http://www.unicef.org/zimbabwe/National\\_Survey\\_on\\_Disability\\_2013\(1\).pdf](http://www.unicef.org/zimbabwe/National_Survey_on_Disability_2013(1).pdf)

<sup>31</sup>Zimbabwe Prison Service (2011). *Assessment of HIV Prevalence and Risk Behaviours among the Prison Population in Zimbabwe*. NAC & UNODC

<sup>32</sup>Extended Zimbabwe National HIV and AIDS Strategic Plan 2015-2020

<sup>21</sup>UNAIDS 2016-2021 Strategy

<sup>22</sup>Mo HCC KP Handbook, June 2018

<sup>23</sup>Final Gender and HIV implementation plan 2017-2020

<sup>24</sup>Promoting Health for all: Job AID for Health care providers working with key populations, Minimum service package

<sup>25</sup>Extended Zimbabwe National HIV and AIDS Strategic Plan 2015-2020

### 5.5 Legal and Policy Framework in Zimbabwe

It is a national public health and human rights imperative that all persons, especially those most at risk, have optimal access to health services to ensure they enjoy the right to the highest attainable standard of health. The sexual and reproductive health rights of Key Populations are protected by Zimbabwe's Constitution Amendment (No.20) ACT2013 (under Chapter 2 Section 29 and Chapter 4 Section 76).

There is nowhere in Zimbabwean Policy or law that states that it is illegal to provide healthcare services to members of Key Population groups. In fact, the right to healthcare of all Key Populations is protected by the Constitution. Chapter 4 Section 76 & 77, clearly states that everyone has the right to access healthcare and services and that no one may be refused emergency medical treatment. However, provision of the criminal codification act are often used as the basis for such denial or delivery of poor service.

It terms of the law, there is need for further dialogue in clarifying what is illegal and what is not. It is not illegal for one to declare their sexual orientation, what then is criminalised in the act between men. The law is silent on women. There is also the need for meaningful dialogue with religious leaders who in most cases make reference to same sex marriage, when one is making reference to same sex conduct, which are two different things. There is therefore the need to revisit the criminal code.

<sup>33</sup>Key Populations face frequent human rights violations, systematic disenfranchisement, social and economic marginalization and/or criminalization – which increases vulnerability and risk and reduces access to essential services.

SUBGROUP	MINIMUM SERVICE DELIVERY OFFERED IN ZIMBABWE
Gay men and MSM	Protective Barriers (Condoms, dental dams, finger coats), Water based lubricants, Referrals (PrEP, ART, PEP, HTS, STI& Cancer Screening)
Sex workers	Protective Barriers (Condoms), Water based lubricants, ART, HTS, STI& Cancer Screening,eMTCT), Referrals (PrEP)
Transgender people	Protective Barriers (Condoms), Literacy, Psychosocial support Referrals (PrEP, ART, PEP, HTS, STI& Cancer Screening)
People who inject drugs	*
Prisoners	ART, HTC, PEP, VMMC, eMTCT, STI diagnosis &treatment
People with disability	Protective Barriers (Condoms), Literacy, Psychosocial support Referrals (PrEP, ART, PEP, HTS, STI& Cancer Screening)

### 5.6 Key Populations Minimum Service Package in Zimbabwe

Zimbabwe in 2015/16 sensitized different health care providers which included clinicians and programmers. The training, however, was done in general without a focus on facilities that are located in sites where KPs are densely populated. Furthermore, the MoHCC is starting to roll out a KP programme in the public sector. This calls for defining a minimum service package (MSP) and going beyond sensitization to standardised training, including value exploration to deal with attitudes of health care workers. In order to effectively and efficiently implement the KP programme in Zimbabwe, there was need for the country to develop an evidence based programming and learning from best practices locally, in the region and internationally and adapt to our context.

A Key Populations consultative meeting on the Minimum Service Package and Training Package for Provision of KP Services in the Public Sector in Zimbabwe was held in February 2018. The first addition was published by the Ministry of Health and Child Care in June 2018 titled; Promoting Health for All: Participants Handbook for Healthcare Providers Focusing on Key Populations.

This Training Handbook is provided to all participants attending the national Health For All curriculum workshops, a Ministry of Health and Child Care (MoHCC)-led training programme to educate and equip healthcare providers in Zimbabwe with the knowledge and skills to enable them to provide health services that support and adequately cater for the unique healthcare needs of sex workers, men who have sex with men, transgender and non-gender conforming people ,and people who inject and use drugs. Providing these groups with the proper attention and care that is their right is critical if Zimbabwe is to become HIV free.

The Handbook accompanies the Health for All Trainers Guide and is a take-home Job Aid for participants to use in their day-to-day service provision and in their continued working towards greater inclusion in our public healthcare facilities, using the knowledge and skills gained from training.

### 5.7 An overview of selected few programmes to address Key Population needs in Zimbabwe

Target Key Population(s)	Program Name	Description of activity	Implementing partner	Funding source	Timeframe
Sex workers (Female, male, trans) MSM Transgender	Last Mile to HIV Control	Community mobilization for linkages to HIV prevention, treatment and care.Includes distribution of related commodities	Hands of Hope	PEPFAR/USAID	2019-2022
Sex workers (Female, male, trans) MSM Transgender	Last Mile to HIV Control	Community mobilization for linkages and provision of HIV prevention, treatment and care.Strengthening public sector KP roll out.Includes distribution of related commodities	Population Services International	PEPFAR/USAID	2019-2022
Sex workers (Female, male, trans) MSM Transgender	Last Mile to HIV Control	Community mobilization for linkages to HIV prevention, treatment and care. Includes distribution of related commodities	Sexual Rights Centre	PEPFAR/USAID	2019 -2022
MSM, Trans*, People who inject drugs and sex workers	KP Program	Community mobilization for linkages to HIV prevention, treatment and care. Strengthening public sector KP roll out.Includes distribution of related commodities. Health care workers and support staff training, psychosocial and community support	I-TECH/Pangea (PZAT), ZRC	I-TECH	2017-2021
Trans* and Intersex	KP Program	Psycho-social support, advocacy and activism, knowledge creation and dissemination, health care workers, religious and cultural leaders' sensitisation	Trans Intersex Rise Zimbabwe (TIRZ), SGDZT	MPACT, AVAC, CeSSHAR	2018-2020
Female, male and transgender sex workers	Last Mile to HIV Control	Community mobilization for provision and linkages to HIV prevention, treatment and care.Strengthening public sector KP roll out. Includes distribution of related commodities	CeSSHAR	PEPFAR/USAID, Bill&Melinda Gates Foundation, Elton John AIDS Foundation	2019 - 2022 April, 2019 2020
LBTQ	LBTQ Empowerment	Facilitating access to HIV and other health services for LBTQ mothers and their children through case management and support groups.	Mothers Haven, Pakasipiti,RAWO, VOVO, GALZ	Members' contributions, The Other Foundation, Planet Romeo	2019
Female and male sexworkers, MSM	HIV prevention	HIV Prevention, Treatment and Care	Key Populations Centre	Membership contributions	Ongoing
LBTQI	Health services advocacy	Advocacy for comprehensive healthcare including HIV services for LBTQI persons Inclusion of LBTQI persons within wider women's rights movement	Voice of the Voiceless (VOVO)	Membership contributions	Ongoing
Male and Female sex workers	HIV prevention, treatment and care	Link members to clinical services and provide support to those who are on treatment. Provide information, education and communication to targetted community	ZIMSWA		

<sup>33</sup>Global Fund Key Population Action Plan 2014-2017

## 5.7 An overview of selected few programmes to address Key Population needs in Zimbabwe

(Continued)

Target Key Population(s)	Program Name	Description of activity	Implementing partner	Funding source	Timeframe
Sex workers (female, male, bis-sexual, lesbian, trans diverse)	Bridging the GAPS PITCH	Mobilisation of sex workers for health, rights, literacy, safety, security trainings. Documentation of human rights violations, advocacy campaigns, sensitisation trainings, research, peer to peer support	Pow Wow	Indirect funding from Bridging the GAPS and PITCH	2019-2020
Male sex workers	HIV Prevention and Treatment	Community mobilisation covering PrEP and ART sensitization and clinic linkages.	Zimbabwe Rainbow Community	Elton John AIDS Foundation	2019 - 2020
Female sex workers	HIV Prevention, Treatment and Care	Training and facilitating peer mobilisation for HIV prevention, treatment and care linkages. Also supporting CARGS among FSW	BHASO		
LBQ Women and Transmen	HIV psycho-social support Capacity building, Wellness program, Community advocacy	HIV psycho-social support	Rise Above Women's Organisation (RAWO)	Membership contributions, The Other Foundation	2019-2020
Intersex, LGBT	Ending Ignorance (in partnership with PZAT-SHEZI)	HIV education, psycho-social support and linkages to clinical service	Intersex Community of Zimbabwe (ICoZ)	CoC Netherlands	2019
Intersex	HIV Prevention	Facilitate linkages to HIV Prevention, Treatment and Care. Sexual Health Rights education and linkages for members and children	Intersex Advocate Trust in Zimbabwe (IAZ)	Membership contributions and sourcing for funding	Ongoing
Female sex workers	KP Program	Advocating for sexual rights and stigma and discrimination	WAAD	Membership contributions and sourcing for funding	Ongoing
People who use drugs	Support Don't Punish	Harm Reduction, Drug Policy Reforms, Adoption of National Drug Policy	Zimbabwe Civil Liberties Drug Network	PITCH	2018-2020
Prison inmates and Officers	Supporting regional compliance with HIV, health and human rights principles of people in prison settings of Sub-Saharan Africa	Strengthening the capacity of national governments to put in place legal, policy and strategy instruments that adhere to UN minimum standards of HIV/AIDS and SRHR for prison populations	UNODC	Sweden, Switzerland, Norway, UNAIDS	2017-2021

Target Key Population(s)	Program Name	Description of activity	Implementing partner	Funding source	Timeframe
Prison inmates and Officers	Supporting regional compliance with HIV, health and human rights principles of people in prison settings of Sub-Saharan Africa	Building national capacity to enable adoption and implementation of measures necessary for national adherence to HIV/AIDS and SRHR minimum standards for prisoners	UNODC	Sweden, Switzerland, Norway, UNAIDS	2017-2021
Prison inmates and Officers	Supporting regional compliance with HIV, health and human rights principles of people in prison settings of Sub-Saharan Africa	Support the development of HIV/AIDS and SRHR services in prisons	UNODC	Sweden, Switzerland, Norway, UNAIDS	2017-2021
Prisoners	Kushanda Pamwe, Volunteering for development	Improving social accountability in Prisons, building resilience, Psychosocial support, improving the health status of HIV+ inmates	ZNNP+, ZACRO, BHASO	VSO-European Commission	2016-2020
Prisoners	KP Programming	Sexual and Reproductive health for inmates, Health Assessments	Jointed Hands Welfare Organisation	SRHR Africa Trust (SAT)	
Female sex workers	DREAMS	Livelihoods training, re-entry into schools and school support, life skills training	Jointed Hands Welfare Organisation	USAID	2014-2018
Internally Displaced Populations	Health services advocacy and Provision	Community Mobilisation using Arts	TAAF Zimbabwe	Membership contributions	Ongoing
All Key Population	Public Sector Programme for Key Populations	To increase health access amongst key populations. A KP Manual was developed to train health service providers, and to date, 80 health care providers have been successfully trained. The MOHCC has gone further to identify 30 health facilities in Bulawayo, Harare, Gweru, Masvingo and Mutare for KP interventions.	MOHCC	MOHCC	Ongoing
All Key Population	Coalition for Effective Community Health leadership & Accountability (CECHLA)	The goal is to increase access and availability of services, quality of services provided for KPs. These have been shared with MoHCC at local, district and provincial level.	FACT, Katswe, Citizen Health Watch, Pamuhacha, YMCA, Seke Rural Hospice	U.S. Centers for Disease Control and Prevention (CDC)	Ongoing
People Who Use Drug	National Programme for People Who Use Drugs	Funded by PSF, the programme aims at Advocacy on Drug Policy Reform, Harm Reduction and Prevention for PWUDs, at national level and it ended in August 2017. Ended in August 2017	ZIMBABWE CIVIL LIBERTIES AND DRUG NETWORK	PSF	Ended



## 6. GENERAL RISK FACTORS FOR HIV AMONG KEY POPULATIONS IN ZIMBABWE

### 6.1 Structural Factors

**Discriminatory laws and policies** - Discriminatory laws and policies such as criminalisation of sex work and soliciting; drug use and some same sex acts contribute to and reinforce low levels of uptake of and access to public health services. There is a lack of legal protection for key population individuals, organisations and KP programmers. KP organisations, individuals and participants at KP events have been arrested and harassed, further compromising participation of KPs in HIV programmes and access to life saving medicines.

**Public health care system** - Public health facilities are generally still not conducive for Key Populations with relatively high levels of stigma from health care workers at service point. While a number of trainings with service providers have been conducted, a significant amount of these trainings have been attended by administration personnel who have very limited interaction with KPs. There is still no integration of KP services in most public health facilities. Providing KP focused services has significantly improved access of KPs to services, there are a lot of KP individuals such as in rural and mining towns, who still have no access as these select centres are inaccessible. The continued lack of KP friendly services at public health facilities may hinder access for KPs outside of major centres such as Harare, Bulawayo, Mutare, Gweru and Masvingo. Sexual and physical abuse may easily occur in the community, in the workplace, in schools and other social places; and such violence may go unreported because of the legal framework and social prejudice.

### 6.2 Societal Factors

**Stigma and discrimination** - It is very difficult for gay men and MSM, transgender, sex workers and drug users to be open about who they are and often prevents individuals from health seeking and disclosing to health care providers.<sup>34</sup> Stigma, discrimination and societal rejection have been major barriers to access healthcare service delivery for KPs as far as the spread of HIV is concerned. This result in high risk of mental health problems and mental illness, leading to a cycle of abuse, high morbidity and poor health outcomes. There is a lot of linkage between the various KP groups as a sex worker can also be gay, or a drug user. Socially, they face layered stigma and hence there is need to have programmatic linkages that take advantage of KPs that fall into more than one sub-group.

**Gender based violence** - Gender-based violence (GBV) is an umbrella term for any harm that is perpetrated against a person's will and that results from power inequalities based

on gender roles. GBV is prevalent among KP individuals and their permanent partners and clients, and may undermine HIV prevention, treatment, access to healthcare and justice. GBV is highly relevant to KP's ability to successfully negotiate condom use and engage in healthcare. In our setting of criminalised sex work, an integrated, multisectoral GBV-HIV strategy that attends to structural risk is needed to enhance safety, HIV prevention and access to care and justice. Female sex workers (FSWs) are at risk of physical and sexual gender-based violence. Most global estimates of GBV implicitly refer only to the experiences of cisgender<sup>35</sup>, heterosexual women, which often comes at the exclusion of male sex workers, feminine gay men and transgender populations. Those who perpetrate violence against these groups often target gender nonconformity, gender expression or identity and perceived sexual orientation and thus these forms of violence should be considered within broader discussions of GBV.

**KP Support backlash** - Health service providers, implementers and families who are known to be KP friendly may also experience some levels of stigma and discrimination by their peers thus affecting their interest to support the community and may withdraw such support. This may be selective (specific KP group) or generalised.

**Negotiation of safer sex** - Prevention education continues to be key among Key Population individuals. However, there are negotiation dynamics that come into play when sex workers are offered more money for unprotected sex or when young gay men and MSM enter into sexual relationships with older men. There is need to expand the efforts to target clients of sex workers, older gay men and MSM and drug users. There is need to fully address intersectionality among the various groups.

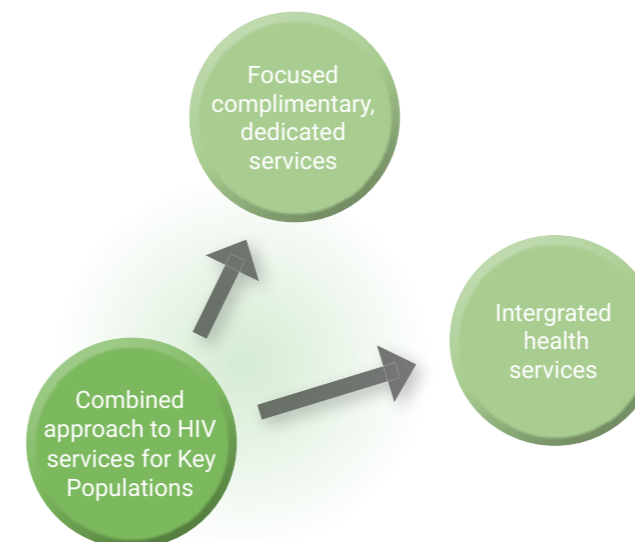
**Information** - There is very little HIV prevention information specific to Key Populations available in public health facilities. The available information does not differentiate and disaggregate the message assuming that KPs are a homogenous group. Public awareness programmes speak very little to key population access to services and may directly contribute to low uptake of services. This lack of relevant information may be contributing to some risky sexual practices that increase STI and HIV incidence.

**Economic Disadvantage** - Because of social stigma and rejection, this also affects KPs in accessing education and employment, which creates a layer of vulnerability that contribute to high HIV and STI incidence rates among KPs. Gay men, transgenders, sex workers and ex-prisoners are often ostracised from families, church, work and other spaces compromising in some cases their ability to integrate and access the same opportunities as everyone else. In the work place, a lot of KP individuals hide their identities as they fear being dismissed, being treated differently or being overlooked for valuable promotions and opportunities in the work place. There is some evidence around effectiveness of including economic empowerment as part of a holistic approach to HIV programming.



### 6.3 Key Interventions That Will Drive Change<sup>36</sup>

**Focused, complementary, dedicated public health services and integrated health services for Key Populations.** There is need for combined approach that will offer both focused health services for Key Populations at selected centres and integrated services within public health facilities. This combined approach also requires significant investment in creating demand among KP groups, encouraging feedback after services that can be used to measure acceptability and effectiveness of the services.



#### a) Focused complimentary, dedicated public health services

Focused health services means health services specifically designed for Key Populations provided outside the general health system. For example, NGOs or community-led facilities provide HIV and other specific services for Key Populations, such as harm reduction.<sup>37</sup> More facilities offering KP specific services need to be fully supported and set up. The best practice models of service delivery at these facilities may be used to support integration initiatives at other public health facilities.

#### b) Integrated services

Integrated services are services that are managed and delivered in a way that ensures people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at different levels and sites of care within the general health system, and according to their needs throughout their life course (WHO, 2015).<sup>38</sup> The training and systemic support on providing KP friendly services of front line health care providers at public health facilities need to be scaled up. Inclusion of KP responsive programming in the health training curriculum should be considered and advocated for.

<sup>36</sup>The Zimbabwe People Living with HIV Stigma Report 2014

<sup>37</sup>COC Bridging the Gap For Key Populations: Lessons learnt and best practices

<sup>38</sup>COC Bridging the Gap For Key Populations: Lessons learnt and best practices

<sup>34</sup>The Zimbabwe People Living with HIV Stigma Report 2014

<sup>35</sup>Cisgender is a term for people whose experiences of their own gender agree with the sex they were assigned at birth.

## 6. GENERAL RISK FACTORS FOR HIV AMONG KEY POPULATIONS IN ZIMBABWE *(Continued)*

### 6.3 Key Interventions That Will Drive Change<sup>36</sup> *(Continued)*

There is need to dedicate key KPs support personnel at provincial levels and reporting to the Technical Support Unit (TSU) to increasing the uptake of services by KPs and improves accessibility of the service point. This should be done incrementally starting with larger facilities, and eventually decentralisation of KP services to provincial, district and rural health centres.

#### Key Population Sensitisations

**Looking In, Looking Out** (LILO) Training is a series of curricula and methods designed to support people from Key Populations and those working with KPs. It functions as a vehicle for the activation of an inside-out approach and combine the Freirean theory of personalisation and conscientisation with aspects of positive psychology. This has been strongly recommended for the various sensitisations.

**National KP Programme teams** This may also help the coordination and active strengthening of KP sector networks. NAC KP team should have annual learning exchange visits to other National coordinating bodies with KP programming for skills and idea exchange and enhance KP programming.

**Law Enforcement** sensitisation using a human rights-based approach of key strategic leadership for support and buy in and front-line officers who interact with Key Populations. NAC to carry out an exchange learning visit with Swaziland Police where a KP sensitisation manual for the law enforcement agents was developed under the KP REACH programme with support from AMSHeR

**Key Populations Champions** There is need to recruit and hold a series of dialogues and engagements with multi sectoral KP Champions who will take lead on anti-discrimination campaigns on Key Populations. The role of KP Champions needs to be very clear in the fight against HIV and this has to be broadened to include more sectors.

#### Anti-stigma and discrimination Programming

There is need to reiterate anti-discrimination by developing a policy for consideration by legislature that apply to public service providers coupled with explicit mention of anti-discrimination of Key Population in the patient's charter.

Awareness campaigns should also be intensified to combat stigma and discrimination in the community and the church

through in-country scaling up and disseminating the UNHEARD Voices Campaign. Political champions and the private sector may be key.

A **key population specific stigma index** is necessary to explore issues of stigma in the public health facilities, communities and so on and effect on access to HIV services. Finding can be used to shape anti-stigma programming in the next KP strategy.

Advocacy and communication activities by the NAC structures in collaboration with MoHCC to desensitize on KP needs and challenges, working closely with KP advocacy groups. NAC shall look into the possibilities of scaling up the KP REACH UNHEARD Voices Campaign at Provincial and district level using already existing content and toolkits.

#### Community systems strengthening (CSS)

There should be an active process of supporting KP networks to strengthen their organisational and technical capacity. It is very difficult to direct efforts without effective coordination of KP organisations particularly the different levels of capacity among the respective KP organisations. KP programming is so much about advocacy, hence engagement of policy makers at national and sub-national level is crucial. However, advocacy work is often under-budgeted as programmers chase targets. There is need to set up subnational structures to advocate for KP programming at provincial/district level as decentralising coordination will enhance subnational coverage and to strengthen the role and effectiveness of Key Populations

KP community members must continually be appointed and be supported/trained in key positions of leadership, management, resource mobilisation and monitoring and evaluation of KP projects, to improve the efficiency, effectiveness and ownership of KP programs. There should be representation in Health Centre Committees at facility level to enhance KP friendliness of facilities.

Support KP groups to set up and maintain Community ART refill groups (CARGs) and support groups which has a direct effect on uptake of services and adherence. These can also be used to pilot and encourage self-testing and other key HIV interventions with help from clinical partners.

#### National KP Surveillance and Research Programme

This is need for a regular systemic research and epidemiological assessments of Key Populations health issues. Carrying out research work on Key population health interventions is important to inform national programming. There is also the need to assess the numbers of KPs accessing health services over time using agreed standard indicators.

#### Epidemic surveillance

- There is need for a surveillance system that periodically provide quality data on the nature and trends of the HIV epidemic among Key Populations over the years that can be used for epidemiological projections and effective resource allocation.
- There is need for an Integrated Bio-Behavioural Surveillance (IBBS) to analyse trends of HIV prevalence among Key Populations. This should also include annual STI incidence analysis among Key Populations.
- Of importance would be population size estimates for MSM, Transgender and PWUD/PWID populations, with age and geographic disaggregation.

#### Strengthening Programme Monitoring and Evaluation

The implementation plan will aim to strengthen collection, management, analysis and use of various information sources that are the key for monitoring the epidemic, and evaluating the response at different levels. The systems developed will allow for programme monitoring and evaluation to be undertaken in a rigorous and timely manner.

- There is need for a Strategic Information Management System (SIMS) for Key Populations that can be used to record and manage programmatic data. This should allow real-time data entry with brief analysis that enables rapid corrective actions for programme implementers. The system will also allow for programmatic baseline surveys on Key population health interventions.
- There is need to standardise monitoring and evaluation indicators that KP groups and implementers collect. This will ensure programmatic consistency and reliability of data analysis.

#### Demand creation

Demand creation efforts should continue, taking advantage of peer educators and mobilisers. KPs leading the community mobilisation activities for access to bio-medical interventions as they know the community better. This may also include moonlighting to reach key population hotspots to increase uptake of Health and HIV services. Health facilities and Clinical partners should continue and scale up outreach service delivery programmes into communities and sharing KP specific health information packs. As part of outreach, STI and TB screening to be included. The IEC materials should shift emphasis from awareness-generation to behaviour change.

#### Key Populations Information Portal

There is need for a KP information portal that is comprehensive on Key Populations guidelines, tools, good practice models, reports and data that can be collected in real time at various locations and a map of the various players working on HIV in the country. This can be curated by NAC or the TSU.

The portal may also house already existing toolkits and good practice models from KP interventions outside Zimbabwe, in particular those from the Regional Grants to ensure sustainability.

#### Minimum Service Delivery

The Key Populations Implementation Plan aims to ensure at least 90% of the KPs should be reached with at least three service delivery interventions. Each interaction must offer at least three of the following services:

- Interpersonal communication- including referral points and services offered,
- HIV and STI prevention- lubricants, condoms, PrEP, STI/TB screening, HIV testing (including self-testing)
- Treatment – ART Initiation, viral load testing and
- Care and Support



## Section 4 - 10 STRATEGIC FOCUS AREAS



## 7. Strategic Focus Areas On Key Populations Programming In Zimbabwe (2019 – 2020)

The National Key Population Programme has seen a progressive and incremental shift in leadership and support. The Ministry of Health and Child Care (MoHCC) has recently completed guidelines for Public Sector Key Population programming and have set up a KP Technical Support Unit .

<sup>39</sup>NAC has successfully adopted from the UNFPA and continually coordinated the KP Forum. The programmes have gained recognition from major donors including USAID, Global Fund, UN family and EU as well as DFID. Some public sector clinics have housed NGOs/CBOs working with KPs. Advocacy work around HIV prevention have created space for programming and service delivery. However, more needs to be done in the KP programming.



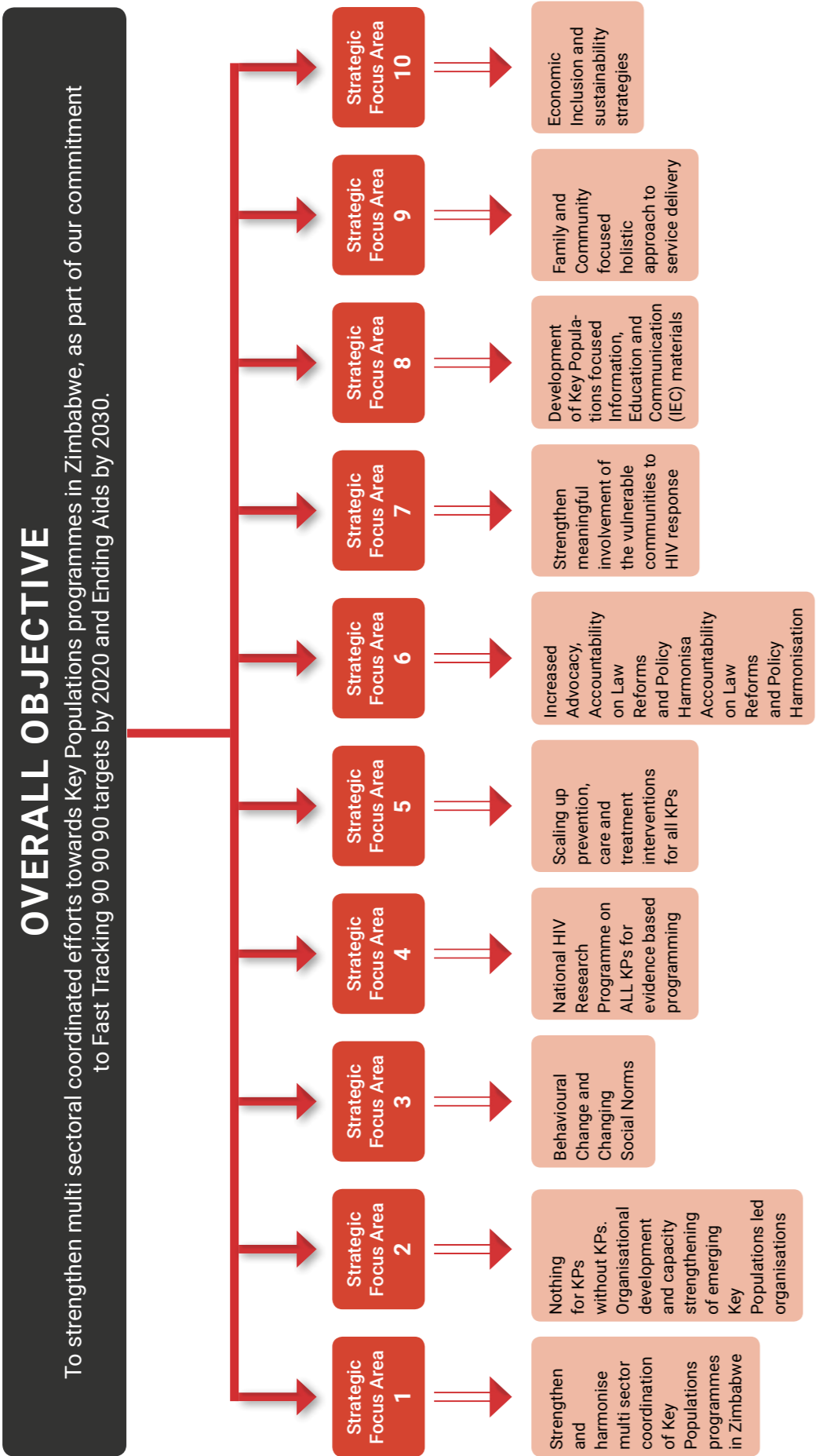
- Recommendations from Key Populations led organisations on Programme Design
- Scaling up HIV combination prevention services, invest in the health of Key Populations and reaching out.
- More Sensitization programs are needed to address stigmatization and discrimination.
- Prevention programmes in prisons are in high demand and must be scaled up.
- There is need for clear roles being played by different stakeholders to avoid duplication.
- There is need to build trust with and within KP communities.
- Uptake of referral services should be strengthened by actively supporting clients after referral to visit public facilities.
- Roll out the UNHEARD Voices campaign at Provincial and District level.

- A comprehensive size estimate needs to be conducted, or incorporate into the next Zimbabwe Demographic Health Survey.
- There is need to invest in psychosocial support, employability assistance and legal assistance.
- Roll out already existing good practice models and manuals from the Key Populations Regional Networks and Regional Programmes.
- Mainstream Economic Strengthening activities within the broader KP programmes.
- Ensure KP led organisations create a mechanism that allows one unified voice for advocacy messages and avoidance on duplication of programmatic activities.
- A robust national Human Rights program that address barriers to access to services.
- Consider nationally coordinated needle exchange and harm reduction approaches for PWUD.

The two year Key Populations Implementation Plan (2019 – 2020) aims to address **key gaps identified** during the consultation meetings through the following focus areas;

<sup>39</sup>Recent developments with regards to establishment of the TSU are that NAC and MOHCC are both very interested in a TSU, and there is PEPFAR funding to support this. PSI is currently helping to facilitate a high-level dialogue between NAC and MOHCC on next steps, roles and responsibilities. The coordination of the TSU remains to be discussed and decided between NAC and MOHCC.

7.1 Key Populations 10 Point Implementation Plan in Action



Zimbabwe National Key Populations HIV and AIDS Implementation Plan

7. Strategic Focus Areas On Key Populations Programming In Zimbabwe (2019 – 2020)

Strategic Focus Areas	Why these focus areas are important towards Fast Tracking 90 90 90 targets by 2020 and Ending Aids by 2030
<p><b>Strategic Focus Area 1</b></p> <p>Strengthen and harmonise multi sectoral coordination of Key Populations programmes in Zimbabwe</p>	<ul style="list-style-type: none"> <li>There is need to establish and strengthen a <b>Technical Support Unit (TSU)</b> at National and Subnational Level in line with the new Government’s devolution strategy. Provincial structures are already developing their micro plans hence the need to ensure KP issues are discussed and addressed at all levels.</li> <li><b>Mainstreaming of the Key Populations interventions into government sub structures</b> and utilise already existing structures. This can be through coordination with the Health Service Board (HSB) to ensure inclusion of an addendum to Terms of Reference and Job Descriptions of the Health service providers.</li> <li><b>Coordination</b> is also very critical with the local authorities who are the custodians of land use and designations. For example, clarity needs to be sought if sex work can be allowed to operate in undesignated areas, or there is need to develop a code of practice that will improve monitoring and security systems and to ensure sex workers are not associated and exposed to criminals that might be harmful to them. •Development of a strong, comprehensive and strategic <b>Zimbabwe Key Populations Information Portal</b> and ensure all KP programmes are feeding into the DHIS2 through standardising indicators, methodologies and reporting templates across all KP programmes.</li> </ul>
<p><b>Focus Area 2</b></p> <p>Nothing for KPs without KPs. Organisational development and capacity strengthening of emerging Key Populations led organisations</p>	<ul style="list-style-type: none"> <li>There is need to scale up Organizational Development Activities currently being undertaken by a number of NGOs such as Population Service International (PSI) to address capacity gaps within many KP led organisations. There is need for emphasis on the importance of capacity building for effective, sustainable community responses. These include; (i) Retention of highly skilled staff due to predominantly voluntary positions and low salary scales, (ii) Appointment of KP community members on key positions that they may not have received adequate training for their roles and responsibilities, (iii) Weak Human Resources and Financial management mechanisms to ensure transparency and accountability of funds, (iv) Weak Programme management and M&amp;E systems, (v) Weak Governance and Leadership policies and procedures, (vi) Limited resource mobilisation skills and organizational core funding thereby affecting sustainability of KP led originations and (vii) Lack of legal registration, organizational constitutions and strategic plans.</li> </ul>
<p><b>Strategic Focus Area 3</b></p> <p>Behavioural Change and Shifting Social Norms to reduce stigma and discrimination</p>	<ul style="list-style-type: none"> <li>There is a lack of a nationally coordinated social behavioural change strategy despite overwhelming evidence of risky sexual practices among Key Populations. There is also very little addressing the stigma and discrimination that has been highlighted as a barrier to accessing health services at the national level and KP groups lack the necessary support when raising awareness around structural challenges affecting both uptake and access to services.</li> <li>The stigma and discrimination experienced is at different levels; (i) Self Stigma of KP members themselves, (ii) Stigma and discrimination from externals, (iii) stigma experienced by families and friends of KP members, and (iv) stigma experienced by non-KP professionals working on KP interventions (stigma of association). There needs to be a change of mind-sets within various organisations associated with health interventions for KP, communities and across various sectors through a changing social norms media campaign.</li> </ul>
<p><b>Strategic Focus Area 4</b></p> <p>National HIV Research Programme on all KPs to generate information for focused action.</p>	<ul style="list-style-type: none"> <li>There is a lack of well researched prevalence and incidence data among all identified Key Populations groups. With exception of female sex workers, there is limited knowledge around the population size and geographic distribution of other groups. There is also limited national research that interrogate the different factors affecting the various KP subgroups and their access to HIV services.</li> <li>Except programmatic data, there is little evidence of the effectiveness of the current KP programming by NAC and MoHCC that target specific communities. Good practice models for service delivery are not being documented and shared at national level.</li> <li>There is also the need to strengthen M&amp;E systems for capturing data for KPs in confidentiality. Health facilities have been attending to KPs in most cases without capturing data specific for KP interventions. This affects the ability to implement cascading and referral systems, thereby affecting the number of KPs who access minimum service package, in the absence of such linkages.</li> </ul>

## 7. Strategic Focus Areas On Key Populations Programming In Zimbabwe (2019 – 2020) *(Continued)*

Strategic Focus Areas	Why these focus areas are important towards Fast Tracking 90 90 90 targets by 2020 and Ending Aids by 2030
<p><b>Strategic Focus Area 5</b></p> <p>Scaling up prevention, care and treatment interventions for all KPs</p>	<ul style="list-style-type: none"> <li>• There is need to scale up PrEP provision among KPs and increase retention levels on such programmes.</li> <li>• Combining conventional outreach approaches, such as peer education, with social networking and technological innovations can successfully reach hidden populations.</li> <li>• The prevention programme in prisons is mainly HIV prevention information and education coupled with VMMC and services such as STI, TB and cancer screening and treatment. There is reluctance to distribute protective products such as condoms, lubricants and PrEP. Some prisons do not have established clinics and have to refer to other prisons, which compromise the quality of service delivery to prisoners.</li> <li>• Strengthened complementarity with the Minimum Service Package by developing disaggregated data and Monitoring and Evaluation (M&amp;E) indicators of all the subgroups. The sex work program has limited male sex worker data, while the MSM programme absorbs the transgender data under M&amp;E.</li> <li>• There is need to ensure we set up health facilities (clinic committees) with meaningful involvement of KP client experts for increased quality of service assurance and reach. The clinic committees must have Standard Operating Procedures (SOPs) and this committee can assess the quality of service provided by the Enhance Peer Mobilisers (EPMs) at facility level. It is noted there are also Community Advisory Boards facilitated by PSI, hence the need to increase coordinated efforts between these three communities based structures. Another similar intervention that needs to be considered for coordination is the Expert Covert Clients Community programme (GALZ) that developed a checklist of quality of service delivered that may affect the scaling up of health services towards Key Populations. Pangea, also has a programme on mystery clients where they provide assistance to Key Populations in navigating health facilities to increase access and Trans Smart using a score card to measure quality of health service received by their members at community level. All these are good practice models that urgently require a coordinated approach.</li> </ul>
<p><b>Strategic Focus Area 6</b></p> <p>Increased Advocacy, Accountability on Law Reforms and Policy Harmonisation to ensure a rights based approach on service delivery.</p>	<ul style="list-style-type: none"> <li>• <b>Advocacy:</b> Need to include issues of advocacy, legal and include leadership- parliament, traditional leaders, local authorities, church/leaders, for effective buy in. There is need to establish multi sector champions adopting the KP REACH model currently being implemented by SAfAIDS</li> <li>• There is also need to advocate for the repealing of laws criminalising HIV and KPs. Such laws enhance exclusionary tendencies as well as stigma and discrimination. Policy harmonisation within and across Ministries such Health, Home Affairs, Gender and Education is key. Short term policies may need to be considered to enhance service delivery.</li> <li>• There is need ensure Key Population issues are discussed at the National Plan of Action for the Implementation of the Universal Periodic Review (UPR) which were compiled through the Ministry of Justice, Legal and Parliamentary Affairs, Zimbabwe, with support from UNDP. The Universal Periodic Review (UPR) is a relatively new and unique human rights mechanism of the Human Rights Council created by the United Nations (UN) General Assembly to review implementation of human rights in all the UN Member States once every four and half years. It is a State driven process that provides the opportunity for each State to identify key human rights issues and challenges as well as to periodically declare what actions it has taken to improve, and fulfil international human rights obligations. To date Zimbabwe has undergone two reviews by the Human Rights Council. The UPR National Steering Committee, made up of lead Government Ministries and Departments and stakeholder representatives, such as civil society organisations (CSOs), Independent Commissions, Labour Market institutions as well as the UNCT sitting in an advisory capacity, was established to oversee and monitor implementation of the NPA.</li> </ul>

Strategic Focus Areas	Why these focus areas are important towards Fast Tracking 90 90 90 targets by 2020 and Ending Aids by 2030
<p><b>Focus Area 7</b></p> <p>Strengthen meaningful involvement of the vulnerable communities to HIV response.</p>	<ul style="list-style-type: none"> <li>• There is need to strengthen meaningful involvement of the vulnerable groups, in particular people living with disabilities.</li> <li>• There are no sign language interpreters in courts of law and health centres for speech impaired communities and it is important that a disability information desk be established at government institutions including at health centres.</li> <li>• There is need to scale up people living with disability friendly clinics for the deaf and visually impaired.</li> <li>• There is need to increase the number of peer educators from the PLWH community to scale up adherence and treatment literacy</li> <li>• Train nurses in OI clinics in basic sign language and disability management this worked for Harare and can work for the rest of the country.</li> <li>• Disaggregated statistics that show levels of health seeking behaviour of PWDS and levels of testing • Explicit provisions in the Health Act on access for persons with disabilities</li> </ul>
<p><b>Focus Area 8</b></p> <p>Development of Key Populations focused Information, Education and Communication (IEC) materials</p>	<ul style="list-style-type: none"> <li>• There is need to understand the language in Sexual Orientation and Gender Identities (SOGI) through the development of a standardised Understanding Key Populations Glossary of Terms reference book with terms specific to particular Key Populations. It is important to fully understand these terms as service providers and programmers to both enhance understanding of issues affecting the individuals they may come across in the course of their work and to support better communication with those in health care. Such terms include but not limited to<sup>40</sup>;</li> <li>• Development and Outreach of HIV information packages for the under-served populations. Outreach plays a vital, often lifesaving role for underserved Key Populations, especially in contexts where an enabling environment is hindered by many structural and cultural factors. Some key information components are not included at service provision point e.g Prevention information for under-served populations namely (i) Lesbians and WSW, (ii) People with disability, (iii) People with Albinism (v) Refugees and immigrants, (vi) Artisanal miners, (vii) Truck Drivers</li> </ul>
<p><b>Strategic Focus Area 9</b></p> <p>Family and Community focused holistic approach to service delivery</p>	<ul style="list-style-type: none"> <li>• Due to the urgency to achieve HIV epidemic control, the national response has inclined more to biomedical interventions. KP issues transcend health concerns alone. A more <b>holistic strategy needs to be in place to cover combination approaches</b> in a manner similar to DREAMS/OVC interventions that are family centred and layered to ensure linkages and access to other services including socio-economic push and pull factors. <b>The needs of children of KPs</b> and to an extent, <b>sex workers' clients</b> and <b>wider families</b>, often make it difficult for KPs to make choices for safe sexual encounters. The needs of <b>younger KPs and older KPs</b> are not homogeneous and implementation has not looked into typologies and hence disaggregation for sub interventions within the broader interventions to effectively answer to the needs of the different target groups.</li> </ul>
<p><b>Focus Area 10</b></p> <p>Economic Inclusion and sustainability strategies</p>	<ul style="list-style-type: none"> <li>• We strongly recommend that initiatives, activities and programs intended for KPs also provide equitable remuneration, employment opportunities, and professional development for KP community members themselves. "Nothing about us without us"</li> <li>• GALZ have dealt with cases in which once orientation is discovered that an employee is from the LGBTI community, in some of the private sector entities, immediately one is put on notice or dismissed.</li> </ul>

<sup>40</sup>See the diagram below

# Multi Sector Implementation Plan for Key Populations (2019 – 2020)<sup>41</sup>

Strategic Focus Area 1	Programmatic Intervention <sup>42</sup>	IP <sup>43</sup>	Implementation Timelines								M&E Framework Work Plan Tracking Measure <sup>44</sup>		
			2019				2020						
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8			
Strengthen and harmonise multi -sectoral Coordination of Key Populations Programmes in Zimbabwe	<b>Act 1.1</b> - Establishment of Technical Support Unit to be co-housed at the NAC / MOHCC	NAC / MOHCC	x	x								Technical support unit established by second quarter 2019.	
	<b>Act 1.2</b> - Strengthen multi-sectoral partnerships and collaboration opportunities focused on innovation and best practice models on KP interventions, through drafting clearly defined TORs for the KP Forum. Ensure equal representation of all KP communities and active participation from all relevant sectors through cascading the Forum at Provincial level.	NAC	x	x	x	x							1. KP Forum TORs drafted and endorsed by the TWG and Advisory Group. 2. Number of partners indicating best practice models on KP interventions.
	<b>Act 1.3</b> - Strengthen coordination with all relevant Government structures including local authorities by mainstreaming Key Populations interventions into government sub-structures.	NAC		x									1. Number of relevant local authorities mainstreaming key population interventions into their sub structures. 2. Number of relevant government structures mainstreaming key population interventions into their sub structures.
	<b>Act 1.4</b> - Strengthen human resources capacities by liaising with the Health Service Board and the MOHCC to define core competencies for health workers in provision of comprehensive HIV services for Key Populations.	TBA				x							List of core competencies for health workers in provision of comprehensive HIV services for KP defined and shared and endorsed by HSB and MoHCC.
	<b>Act 1.5</b> - Create a Zimbabwe Key Populations Information Portal – and continuously house reports from all KP implementing partners in the country. The portal will include best practices models, case studies, toolkits and innovative service delivery models and documentaries.	TBA				x							1. Zimbabwe Key Populations Information Portal created. 2. Number of KP implementing partners housing reports on best practice models, case studies, tool kits, documentaries and service delivery models on the information portal.
	<b>Act 1.6</b> - Integration of data generated from KP programmes into the Demographic Health Information System 2 (DHIS2). Ensure increased linkages and integration of HIV strategic information systems with broader health information systems, including those focusing on coinfections and other comorbidities (TB, viral hepatitis, STIs)	TBA				x							1. The KP programme indicators for reporting into DHIS2 system developed. 2. Percentage of KP indicators reported into the DHIS2 on a quarterly basis.
	<b>Act 1.7</b> - Strengthen cross - border sharing of information with our Regional counterparts in particular the Key Populations Regional Networks, and our neighboring entities working with under-served populations / vulnerable groups such as refugees, migrants and mobile populations.	TBA							x				1. Number of cross border meetings held with the KP Regional Networks and country implementers. 2. Number of South-South learning exchange programmes conducted.

Strategic Focus Area 2	Programmatic Intervention <sup>42</sup>	IP <sup>43</sup>	Implementation Timelines								M&E Framework Work Plan Tracking Measure <sup>44</sup>		
			2019				2020						
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8			
Nothing for KPs without KPs. Organisational development and capacity strengthening of emerging Key Populations led organisations	<b>Act 9.1</b> – Coordinate the legal registration of KP organizations	TBA			x	x	x	x					1. Percentage of KP led organisations legally registered. 2. Percentage of KP led organisations with PVO registration.
	<b>Act 9.2</b> - Scale up Programme Management, M&E and Financial Management skills for all KP organizations and vulnerable groups, in liaison with the Technical Working Group.	TBA			x	x	x	x					Number of KP with improved Programmes management, M&E and financial management skills
	<b>Act 9.3</b> - Facilitate dialogue towards a formalised establishment of KP National Networks for unified voices in the response to HIV.	TBA			x	x	x	x					Number of KP national networks that are formalized, responding to HIV activities
	<b>Act 9.4</b> - Foster leadership and governance skills through mentoring and training management teams from KP led organisations	TBA			x	x	x	x					Number of KP organizations mentored and trained in leadership and governance.

<sup>41</sup> It was agreed during the Key Populations Technical Working Group (TWG) meeting held on the 8th of March 2019, that due to the current operation environment in Zimbabwe, where we are in early phases of the new monetary policies, a separate process will need to be conducted to come up with the most realistic budget for each Strategic Focus Area.

<sup>42</sup> World Health: Consolidated Guidelines on HIV preventions MMT, diagnosis, treatment and care of Key populations. 2016 Update

<sup>43</sup> The implementation partners shall be coordinated by the NAC and selection of implementers will be conducted in accordance to NAC policies and procedures.

<sup>44</sup> A Work Plan Tracking Measure will be applied to monitor the 10 point plan as most activities are process oriented and not predominantly service delivery. A four-point performance scale will be applied as follows; (0) Not started = No progress against planned milestone or target (1) Started, (2) Advancing, (3) Completed.

## Multi Sector Implementation Plan for Key Populations (2019 – 2020) (Continued)

Strategic Focus Area 3	Programmatic Intervention <sup>42</sup>	IP <sup>43</sup>	Implementation Timelines								M&E Framework Work Plan Tracking Measure <sup>44</sup>	
			2019				2020					
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8		
Behavioral Change and Shifting Social Norms to reduce stigma and discrimination	<b>Act 3.1</b> – Cascade and scale up the Unheard Voices Campaign developed by the KP REACH Regional Global Funded Grant. Disseminate the radio dramas, messages and toolkits at Provincial and District level to increase community dialogue and community engagement. The toolkits are also available in local languages.	TBA			x	x	x	x	x	x		1. Number of Partners implementing the Unheard Voices Campaign. 2. Percentage increase in scaling up the Unheard Voices campaign compared to the previous quarter. 3. Number and type of communication models for community dialogue implemented. 4. Number of local languages used to cascade <i>Unheard Voices tool kits</i>
	<b>Act 3.2</b> - Address all forms of violence (structural, institutional and interpersonal) including Gender based violence experienced by all Key Populations and underserved community members. Cascade the Regional REAct Model by Positive Vibes by developing a country rapid response mechanisms to provide care and support for victims of violence, including the provision of post-exposure prophylaxis and psychosocial support	TBA			x	x	x	x	x	x		1. Develop a centralized database to record various types of human violation cases experienced by the Key Populations. 2. Number of human rights abuses cases on Key Populations recorded in a centralized database. 3. Percentage of reported cases attended to and fully addressed.
	<b>Act 3.3</b> - Use innovations in digital and information technology including social media and the use of social networks to strengthen combination prevention and reduction in stigma and discrimination.	TBA			x	x	x	x	x	x		Number of ICT innovations developed to strengthen combination prevention, and reduction in stigma and discrimination through social media.
	<b>Act 3.4</b> - Sensitize existing personnel in various multi – sector entities on key population issues through scaling up of the Looking-In-Looking-Out (LILO) trainings. This training will also ensure reduction of victimization and stigma of association, also being experienced by non-KPs, working in KP programmes	TBA			x	x	x	x	x	x		Number of sensitizing workshops (LILO trainings) held with personnel in various multi-sector entities on KP issues.

Strategic Focus Area 4	Programmatic Intervention <sup>42</sup>	IP <sup>43</sup>	Implementation Timelines								M&E Framework Work Plan Tracking Measure <sup>44</sup>	
			2019				2020					
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8		
National HIV Research Programme on all KPs to generate information for focused action.	<b>Act 4.1</b> – Collect and analyse timely, high-quality epidemiological Data in every district to understand how, where and among whom new HIV infections are occurring and increase the accuracy of the numbers, locations, and groups of all Key Populations within the district. Monitor risk behaviors and estimates the Key Populations size in need of health services	TBA			x	x	x	x	x	x		1. Develop a district data base to collect and analyze HIV epidemiological data among KPs, that feeds to the national database. 2. Number of reports produced and shared with NAC that show risk behaviors observed and estimates of KPs in need of HIV related health services
	<b>Act 4.2</b> - Collect and analyse high-quality granular data on the HIV response for Key Populations, (disaggregated by age, sex, population, geographic location etc.) to evaluate health systems performance and measure impact and guide more focused interventions and areas of investment.	TBA			x	x	x	x	x	x		An output tracker that evaluates health systems performance and areas of investment on HIV response for KP developed.
	<b>Act 4.3</b> – Conduct an evaluation to assess the efficiency, effectiveness and value for investments of the already existing Key Populations' programmes and its specific components in order to scale up high impact interventions during implementation of the upcoming five year strategic plan.	TBA			x	x	x	x	x	x		An evaluation report developed and shared that assesses the efficiency, effectiveness and value for investment for the already existing KP programmes
	<b>Act 4.4</b> – Develop the capacity of implementing partners and KP communities to undertake research to identify new and transferable service delivery models, and improve the transfer of research into programming.	TBA			x	x	x	x	x	x		Number of capacity building workshops conducted on transferring research on KPs into programming.
	<b>Act 4.5</b> – Develop IEC material on norms and standards for good research practice and ethical considerations for Key Populations; and facilitating the translation of evidence into affordable health technology and evidence-informed policy.	TBA			x	x	x	x	x	x		IEC material developed and disseminated on norms and standards of good research practice and ethical considerations for Key Populations.

## Multi Sector Implementation Plan for Key Populations (2019 – 2020) (Continued)

Strategic Focus Area 5	Programmatic Intervention <sup>42</sup>	IP <sup>43</sup>	Implementation Timelines								M&E Framework Work Plan Tracking Measure <sup>44</sup>
			2019				2020				
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	
Scaling up prevention, care and treatment interventions for all KPs	<p><b>Act 5.1</b> – Remove barriers for Key Populations in accessing HIV services. Increase HIV combination prevention with focus on transmission in Key Populations, with the inclusion of Service delivery approaches such as pre-exposure prophylaxis (PrEP) and Post-exposure prophylaxis (PEP), distribution of male and female condoms, lubricants and Voluntary Medical Male Circumcision (VMMC).</p> <p><b>Act 5.2</b> - Establish of harm reduction initiatives for PWUD including drug dependence treatment programmes.</p> <p><b>Act 5.3</b> – Scale up preventive benefits of antiretroviral by increasing ART coverage amongst Key Populations to achieve national and regional targets. Closely monitor ART success by implementing regular resistance to HIV drugs check-ups, and use the data to inform national policies and guidelines on ART.</p> <p><b>Act 5.4</b> – Increase coverage of HIV testing services via expanded range of approaches amongst Key Populations and ensure early linkage to treatment, care and prevention services. These include community and outreach testing, testing in closed settings and self-testing.</p> <p><b>Act 5.5</b> – Scale up treatment for opportunistic infection, comorbidities and provide chronic care to Key Populations living with HIV and address age-related health needs to ensure an improved quality of life;</p> <p><b>Act 5.6</b> – Scale up psychological and social support programmes for Key Populations living with HIV and empower them to manage their condition by improving their health literacy, enabling self-management of their condition and improving Treatment adherence.</p>	TBA	x	x	x	x	x	x	x	x	Percentage increase in coverage for HIV combination prevention activities for KPs reported every quarter.
		TBA	x	x	x	x	x	x	x	x	Number of harm reduction initiatives established for PWUD.
		TBA	x	x	x	x	x	x	x	x	1. Percentage increase of ART coverage amongst KP sub groups every quarter. 2. Number of HIV drug resistance tests done amongst key population sub groups. 3. Number of policies and guidelines amended on ART influenced by results of HIV drugs resistance tests amongst KP sub groups.
		TBA	x	x	x	x	x	x	x	x	Percentage increase in coverage for HIV testing via expanded range of approaches among KP sub groups per each quarter.
		TBA	x	x	x	x	x	x	x	x	1. Percentage increase in KPs receiving treatment for opportunistic infections, co-morbidities per quarter. 2. Number of chronically ill KP persons receiving quality of care services.
		TBA	x	x	x	x	x	x	x	x	1. Percentage increase in coverage of psychological and social support programmes registered every quarter. 2. Number of KP persons living with HIV reporting improved quality of life and positive living.

Strategic Focus Area 5	Programmatic Intervention <sup>42</sup>	IP <sup>43</sup>	Implementation Timelines								M&E Framework Work Plan Tracking Measure <sup>44</sup>
			2019				2020				
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	
Scaling up prevention, care and treatment interventions for all KPs	<p><b>Act 5.7</b> – Recognize and certify health services centers that practice a high standard of acceptance of all key population groups with zero stigma and discrimination policies in place and adhered to.</p> <p><b>Act 5.8</b> – Strengthen community outreach workers to providing support to enable and motivate underserved/vulnerable populations to utilise health services, such as fostering self-confidence and reducing self-stigma, as well as providing case management, follow-up support and accompaniment to services after referral.</p> <p><b>Act 5.9</b> – Strengthen complementarity with the Minimum Service Package developed by the MOHCC by defining minimum service packages specific for different KP and vulnerable groups at service delivery points, and ensure a no out of pocket expense service delivery to ensure demand creation.</p> <p><b>Act 5.10</b> - Strengthen M&amp;E tools and systems for consolidation of Key Populations Data at the Ministry of Health and Child Care. Disaggregate M&amp;E indicators for the minimum service package of all the KP subgroups and vulnerable groups. The MOHCC needs to consolidate various tools being used by different partners including harmonies client profiles for in-depth analysis.</p> <p><b>Act 5.11</b> - Harmonies our community based volunteers for the Key Populations namely Peer Educators, Enhanced Peer Mobilisers and Peer Navigators ensuring well-coordinated and harmonized incentives.</p> <p><b>Act 5.12</b> - Set up health facilities (clinic committees) with meaningful involvement of KP client experts for increased quality of service assurance and reach. The clinic committees must have Standard Operating Procedures (SOPs) and harmonized and coordinated with already existing structures such as Enhance Peer Mobilisers (EPMs), Community Advisory Boards, Expert Covert and Mystery clients.</p>	TBA	x	x	x	x	x	x	x	x	Number of Health service centres that practice a high standard of acceptance of all KP recognized and certified every quarter.
		TBA	x	x	x	x	x	x	x	x	Number of community outreach workers trained to support vulnerable populations in accessing /utilizing health services.
		TBA	x	x	x	x	x	x	x	x	1. Percentage of minimum service packages for specific KP sub groups developed. 2. Number of minimum service packages for specific KP sub groups disseminated at service delivery sites. 3. Number of health service delivery points publicly displaying “No user fee statement” at their clinics or hospitals.
		MOHCC	x	x	x	x	x	x	x	x	List of disaggregated M&E indicators for the minimum service package for KP subgroups developed.
		MOHCC	x	x	x	x	x	x	x	x	1. Harmonised incentive package for Community Health Workers in place. 2. Well defined CHW/Cadre with a clear job description.
		MOHCC	x	x	x	x	x	x	x	x	Guidelines for establishment of clinic committees developed and percentage of KP Representatives in the committees



## Multi Sector Implementation Plan for Key Populations (2019 – 2020) (Continued)

Strategic Focus Area	Programmatic Intervention <sup>42</sup>	IP <sup>43</sup>	Implementation Timelines								M&E Framework Work Plan Tracking Measure <sup>44</sup>		
			2019				2020						
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8			
Strategic Focus Area 6 Increased Advocacy, Accountability on Law Reforms and Policy Harmonisation to ensure a rights based approach on service delivery.	<b>Act 6.1</b> – Set up a Multi Sector Key Populations Champions Group to work closely with the newly established Universal Periodic Review (UPR). The Champions to ensure that legal and regulatory frameworks respect the human rights of Key Populations and facilitate multi sectoral partnerships to expand access to health services. They will also advocate for a national service delivery model that promotes equity and human rights, universal health coverage from prevention to palliative care for the Key Populations. <b>Act 6.2</b> – Launch a campaign for the repealing of laws criminalizing Key Populations in the context of HIV and leaving no one behind. <b>Act 6.3</b> - Facilitate policy harmonisation within and across government ministries such Health, Home Affairs and Immigration, Gender and Education, Social Welfare and Finance. <b>Act 6.4</b> - Develop Policy harmonization brief <b>Act 6.5</b> - Conduct legal-rights training to health service providers, law enforcement agents and to Key Population communities.	TBA			x	x	x	x	x	x	x	Target Indicators / Milestones 1. A multi Sector Key Populations Champions group set up and is working according to terms of reference. 2. Number of multi sectoral partnerships that are expanding access to health services for Key Populations and reduction in stigma and discrimination.  Campaign launched for the repealing of laws criminalizing KP.  1. Number of meetings held to facilitate policy harmonization across and within government ministries. 2. Number of policies that have been harmonized.  Policy harmonization brief developed and disseminated.  1. Number of health service providers trained every quarter on legal rights. 2. Number of law enforcements agents trained every quarter on legal rights 3. Number of key population communities trained on legal rights every quarter.	
					x	x	x	x	x	x	x		
					x	x	x	x	x	x	x		x
					x	x	x	x	x	x	x		x
					x	x	x	x	x	x	x		x
					x	x	x	x	x	x	x		x

Strategic Focus Area	Programmatic Intervention <sup>42</sup>	IP <sup>43</sup>	Implementation Timelines								M&E Framework Work Plan Tracking Measure <sup>44</sup>	
			2019				2020					
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8		
Strategic Focus Area 7 Strengthen meaningful involvement of the vulnerable communities to HIV response	<b>Act 7.1</b> - Increase friendly clinics for the deaf and visual impaired. <b>Act 7.2</b> - Increase the number of peer educators from the PLWD community to scale up adherence and treatment literacy <b>Act 7.3</b> - Training nurses in OI clinics in basic sign language and disability management, this worked for Harare and can work for the rest of the country. <b>Act 7.4</b> - Provision of sign language interpreters in health centers. <b>Act 7.5</b> - Disaggregated statistics that show levels of health seeking behavior of PLWDS and levels of testing. <b>Act 7.6</b> - Explicit provisions in the Health Act on access for persons with disabilities <b>Act 7.7</b> - Provision of sign language interpreters in court for speech impaired communities. <b>Act 7.8</b> – Provision of disability desks at government institutions to ensure information and services are accessible by all.	TBA			x	x	x	x	x	x	x	Target Indicators / Milestones Percentage of health facilities that are friendly to the deaf and visual impaired.  Number of peer educators trained and deployed from the PLWD community  Number of nurses trained in basic sign language and disability management.  Percentage of health facilities with a dedicated sign language interpreter.  Disaggregated data on health seeking behaviors of PLWD  Addendum added to the existing Health Act on explicit health services for PLWD  Percentage of courts in Zimbabwe with dedicated sign language interpreters  Percentage of government institutions with a dedicated disability desk.
					x	x	x	x	x	x	x	
					x	x	x	x	x	x	x	
					x	x	x	x	x	x	x	
					x	x	x	x	x	x	x	
					x	x	x	x	x	x	x	
					x	x	x	x	x	x	x	
					x	x	x	x	x	x	x	
Strategic Focus Area 8 Key Populations focused Information, Education and Communication (IEC) materials adopted in the local context.	<b>Act 8.1</b> – Develop a standardised Understanding Key Populations Glossary of Terms reference book aligned to the local context. <b>Act 8.2</b> - Development of HIV information packages for the vulnerable populations and disseminate at service delivery points.	TBA			x							Target Indicators / Milestones Standardized KP glossary of Terms reference book aligned to local context developed  Percentage of health service delivery points displaying HIV IEC material for the vulnerable groups.
					x							
					x							

Multi Sector Implementation Plan for Key Populations (2019 – 2020) (Continued)

Strategic Focus Area	Programmatic Intervention <sup>42</sup>	IP <sup>43</sup>	Implementation Timelines								M&E Framework Work Plan Tracking Measure <sup>44</sup>
			2019				2020				
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	
Strategic Focus Area 9 Family and Community focused holistic approach to service delivery	<p><b>Act 9.1</b> – Development and disseminations of IEC material of family centered approaches for Key Populations.</p> <p><b>Act 9.2</b> - Development and dissemination of IEC materials for religious and traditional sectors' response to HIV programmes amongst Key Populations.</p>	TBA	x	x	x	x	x	x	x	x	<p><b>Target Indicators / Milestones</b></p> <p>1. Number of IEC materials on family centered approaches for KP developed.</p> <p>2. Percentage of health centers where the IEC materials is disseminated</p> <p>1. Number of IEC materials developed for religious leaders' response to HIV amongst Key Populations.</p> <p>2. Percentage of IEC materials disseminated to the religious leaders by the KP Champions.</p> <p>3. Number of IEC materials developed for traditional leaders' response to HIV amongst Key Populations.</p> <p>2. Percentage of IEC materials disseminated to traditional leaders by the KP Champions.</p>
			x	x	x	x	x	x	x	x	
Strategic Focus Area 10 Family and Community focused holistic approach to service delivery	<p><b>Act 10.1</b> – Development and disseminations of IEC material of family centered approaches for Key Populations.</p> <p><b>Act 10.2</b> - Development and dissemination of IEC materials for religious and traditional sectors' response to HIV programmes amongst Key Populations.</p>	TBA	x	x	x	x	x	x	x	x	<p><b>Target Indicators / Milestones</b></p> <p>1. Number of IEC materials on family centered approaches for KP developed.</p> <p>2. Percentage of health centers where the IEC materials is disseminated.</p> <p>1. Number of IEC materials developed for religious leaders' response to HIV amongst Key Populations.</p> <p>2. Percentage of IEC materials disseminated to the religious leaders by the KP Champions.</p> <p>3. Number of IEC materials developed for traditional leaders' response to HIV amongst Key Populations.</p> <p>2. Percentage of IEC materials disseminated to traditional leaders by the KP Champions.</p>
			x	x	x	x	x	x	x	x	

7.2 Multi-sectoral roles and responsibilities

The cross-sectoral nature of multiple determinants contributing to increased HIV infections and AIDS related deaths amongst Key Populations requires an urgent multi-sectoral, multi-faceted response. Government sectors and businesses are affected in many ways by this epidemic and all have an important stake in participating in HIV prevention, care and support at all levels, but especially in ensuring focused, sustained, large-scale programmes.

This implementation plan explicitly highlights the following responsibilities unique to each sector, whilst calling for holistic inter-organizational and inter-agency efforts that promote active involvement of Key Populations and underserved communities.

A multi-sectoral response means involving all sectors of society - governments, business, civil society organisations, communities and people living with HIV/AIDS, at all levels. There is need for political will, leadership and coordination, to develop and sustain new partnerships and ways of working, and to strengthen the capacity of all sectors to make an effective contribution.

The National Aids Council



National AIDS Council (NAC) is an organization established through the Act of Parliament of 1999 to coordinate and facilitate the national multi-sectoral response to HIV and AIDS. It is also mandated to administer the National AIDS Trust Fund (NATF) collected through the AIDS Levy i.e. the 3% collected from every workers taxable income (PAYE) and corporate tax. NAC will be responsible for leading, coordinating, monitoring and evaluating implementation of this plan. NAC will mobilize resources in support of the implementation plan and will coordinate the selection of implementing partners.

Key Populations



Key Populations led organisations play a crucial role in ensuring they have unified voices in HIV programming for their communities. They can draw upon their strengths and capacities as community-oriented institutions. They have the capacity to ensure no KP member is left behind in seeking health services thereby playing a significant role in Ending AIDS.

MOHCC and Health Sector



Their roles shall look into the following strategic areas (i) train providers across a wide variety of health services to recognize and address stigma and discrimination against Key Populations (ii) respond to the immediate health needs of the Key Populations (iii) revise institute protocols for treatment, referral and data collection (iv) documentation that guarantee confidentiality of individuals identified as Key Populations (v) provide physical and sexual violence-related treatment free judgement and (vi) and be prepared to provide forensic evidence and testimony in court where required.

Psychosocial Sector



Their roles shall look into the following strategic areas (i) provide on-going psychological assistance (ii) engage social workers and community outreach workers (iii) facilitate referrals for health and judicial services (iv) provide wellness services.

Legal / Justice Sector

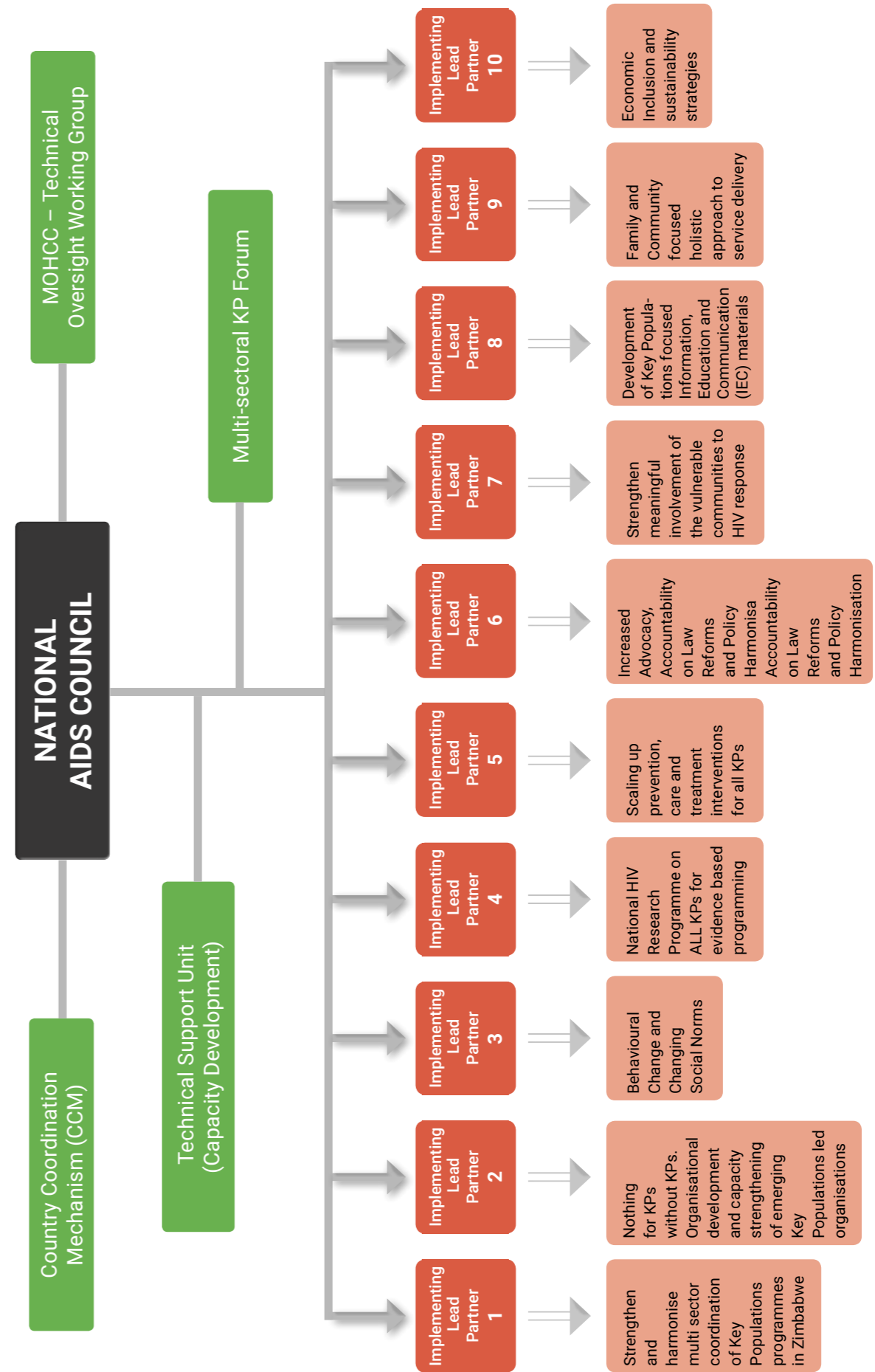


Their role shall create mechanism for (i) provision of free or low-cost legal counselling, representation and other court support to Key Populations who have been exposed to violence; (ii) review and revise laws that reinforce criminalisation and violence against Key Populations; (iii) enforce laws that protect Key Populations and punish perpetrators; (iv) monitor court cases and judicial processes; (v) provide orders of protection and other legal safety mechanisms for victims and (vi) monitor perpetrators' compliance with court-ordered rehabilitation.

### 7.2 Multi-sectoral roles and responsibilities (Continued)

<b>Security Sector</b>	 <p>The role of Police, military and other security personnel shall look into (i) being sensitised about violence against Key Populations, (ii) be trained on how to appropriately intervene in cases experienced by KP communities (iii) creating safe spaces by providing private rooms to ensure confidentiality and safety of victims (iv) providing a disability dedicated desk (v) institute protocols for referrals to other sectors (vi) collect standardized and disaggregated data on incidents for reporting to the MOHCC and NAC and (vii) create specialized units to address violence against Key Populations.</p>
<b>Corporate Sector</b>	 <p>The role of corporate sector shall look into (i) indiscriminate in corporate sector recruitments (ii) income generating small scale grants for Key Populations led organisations to ensure economic self-sufficiency (iii) monitor workplace and sexual harassment against Key Populations and integrate human rights into the corporate sector.</p>
<b>Civil Society Organisations</b>	 <p>By collaborating with National AIDS Council, the CSOs can support the implementation of the implementation plan in various ways. They can increase demand of HIV health services through community mobilization and advocacy. They can support distribution of information as well as monitor the quality of health services offered to key populations.</p>
<b>Development Agencies</b>	 <p>Development agencies can play an important role in documenting and promoting good practices and partnerships within innovative interventions and programming. They can play a technical advisory role as well as ensuring they advocate for commitments towards financing the implementation manual.</p>
<b>Religious Leaders</b>	 <p>Religious leaders in the context of ending AIDs have a significant role in addressing barriers to HIV services experiences by the key populations. These include stigma and discrimination from communities. The contribution that religion can make to ending violence and stigma can have greater impact. They have the capacity to mobilize community, nation, and international support for ending AIDS through leaving no one behind.</p>
<b>Traditional Leaders</b>	 <p>Traditional leaders play a social role in rural communities and therefore help in rural community development through stimulating participation in development programs. They can champion to cause towards ending AIDS through meaningful engagement and involvement of their KP community members through dialogue. The traditional leaders can influence the levels of stigma and do have the capacity to increasing access of health services by KPs.</p>
<b>Cross Cutting Government Departments</b>	 <p>Some sectors will have cross cutting functions such as the Department of Immigration whose role shall include (i) dignified, safe and confidential handling of members from the Key Population communities at border posts, (ii) referral networks, information sharing where help is required by the KPs.</p>

### 7.3 Multi-sector Implementation Arrangements



**The Lead Implementing Partners will be supported by sub-grantees for effective implementation at Provincial and District Level**

## Section 5 - OUR INVESTMENT CASE



## 8. Leaving No One Behind - Meaningful Inclusion Of Key Populations

### 8.1 Why should we increase our focus on 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.

#### 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. Investing on Key Populations improves the overall public health outcome for our country.

It is a national public health and human rights imperative that all persons, especially those most at risk, have optimal access to health services to ensure they enjoy the right to the highest attainable standard of health. The sexual and reproductive health rights of Key Populations are protected by Zimbabwe's Constitution Amendment (No. 20) ACT 2013 (under Chapter 2 Section 29 and Chapter 4 Section 76).

#### 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. 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.

#### 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 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* 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* recognised HIV as a human rights issue, calling upon State Parties to the African Charter on Human and Peoples' Rights ('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

## 8. Leaving No One Behind - Meaningful Inclusion Of Key Populations *(Continued)*

### 8.1 Why should we increased our focus on Key Populations? *(Continued)*

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.

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."

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.

#### Aligning the Key Populations Implementation Plan to the Zimbabwe Combination HIV Prevention Strategy

Core Program Areas	Delivered in combination (Wherever effective) through	Tailored to the needs of and involving
HTS	<b>Combined service delivery (biomedical)</b> <ul style="list-style-type: none"> <li>Service provider capacity</li> <li>Referral system / intergration</li> <li>Service models</li> </ul>	Adult men
Behavior change & demand creation		Adult men
e-MTCT	<b>Combined communication (behavioral)</b> <ul style="list-style-type: none"> <li>Mass media</li> <li>Interpersonal</li> <li>Sexuality education</li> <li>Advocacy with leadership</li> </ul>	Young men
Condoms		Young woman
Prevention with positives	<b>Combined communication (behavioral)</b> <ul style="list-style-type: none"> <li>Mass media</li> <li>Interpersonal</li> <li>Sexuality education</li> <li>Advocacy with leadership</li> <li>Legal and policy reform: advocacy</li> </ul>	Children & adolescent
Male Circumcision		Sero-discordant couples/ PLHIV
		Key populations <ul style="list-style-type: none"> <li>Sex workers</li> <li>Prisoners</li> </ul>

Considering age groups and areas most affected

NAC will ensure the following Key Populations are included and not left behind the combination HIV prevention strategy:

- Gay men and Men having sex with other men
- Transgender and intersex people
- People who use drugs
- Prisoners and other closed settings
- Vulnerable populations (Lesbians, WSW, People with Disability, Refugees and immigrants, Artisanal miners and truck drivers).

## Section 6 - ANNEXURES



## ANNEX 1 - Organisations reached out to during development of the implementation plan<sup>45</sup>

1. Advocacy Core Team	39. Wilkins Hospital
2. National AIDS Council – Midlands	40. CFI
3. K.P.C.Z	41. SOFM
4. AIDS Healthcare Foundation	42. Worship Ministries
5. Nazarene Church	43. CFC
6. Family Covenant Church	44. Space for Marginalised Groups in Diversity in Zimbabwe Trust
7. Albino Association of Zimbabwe	45. Zimbabwe Association for Crime Prevention and Rehabilitation of the Offender
8. New Bethel International Ministry	46. DHMI
9. FMHE	47. Trans Smart Trust
10. Alliance Church	48. Zengeza Baptist
11. Pan African Positive Women's Coalition Zimbabwe (PAPWC-Zim)	49. Evangelical Lutheran Church
12. Femmen Health Access +	50. The AIDS & Arts Foundation
13. AFM Church	51. Zimbabwe Civil Liberties and Drug Network
14. Pamuhacha	52. Gays and Lesbians of Zimbabwe
15. Médecins Sans Frontières - Belgium (MSF)	53. Trans and Intersex Rising in Zimbabwe
16. ASM Church	54. ZINERELA
17. P.O.A.Z	55. Hands of Hope
18. M.F.F	56. NN
19. AVAC	57. ZNCWC
20. Population Services International (PSI)	58. Midlands AIDS Service Organisation
21. Ministry of Health and Child Care Officials	59. Trans and Intersex Rising in Zimbabwe
22. Batanai HIV & AIDS Service Organisation (BHASO)	60. Zimbabwe National Network of People living with HIV
23. Pangea Zimbabwe AIDS Trust (PZAT)	61.
24. Multiple Therapy Trust	62. UCCZ
25. Baptist Church	63. Zimbabwe Prisons and Correctional Services (ZPCS)
26. Rise Above Women's Organisation	64. INERELA
27. National AIDS Council – Head Office	65. Umuza AIDS Foundation
28. Centre for Sexual Health and HIV/AIDS Research (CESHHAR)	66. Zimbabwe Rainbow Community
29. RCZ	67. ISCAM
30. National AIDS Council – Manicaland	68. United Nations Development Programme (UNDP)
31. Chido Kaseke (Individual)	69. Individual(s) – Noria Shumba
32. SAFAIDS	70. Individual(s) - Pastor Caroline Maposhere
33. Women Against All Discrimination	71. United Nations Population Fund (UNFPA)
34. Christ Like Ministries	72. United States Agency for International Development (USAID)
35. Sexual Rights Centre (SRC)	73. United Nations Office on Drugs and Crime (UNODC)
36. WCC EHAIA	74. Jointed Hands Welfare Organisation (JHWO)
37. Endless Possibilities	
38. Sheepfold Eternal Ministries	

<sup>45</sup>The consultants noted a significantly high number of organisations address themselves in abbreviations of their entities. It is critical that NAC maintains a database of organisations' full names, type of registration, focus areas and population and geographical reach.

## ANNEX 2 - Agenda National Stakeholder Consultation Meeting

### AGENDA

National Stakeholder Consultation Meeting

Development of National Key Populations Implementation Plan 2018-2020

Tuesday 04 December 2018

New Ambassador Hotel, Harare

### Specific Objectives towards the development of a National Key Populations Implementation Plan

1. To assess and unpack the different sub populations that is key to the HIV response in Zimbabwe.
2. To carry out a comprehensive review of current Key Populations programming.
3. To formulate strategies of reaching the different sub-groups with a minimum package of HIV services for reduction of HIV morbidity and mortality.
4. To identify strategies and approaches to enhance the accessibility and equitability of HIV programmes to the identified sub-population groups.
5. To make recommendations on effective coordination and reporting mechanisms for the Key Populations sector HIV and AIDS response
6. To develop a monitoring and evaluation framework for identified interventions.

Time	Meeting	Facilitator
08:00 - 08:30	Arrivals and Registration	NAC
08:30 - 09:00	An Overview of Global thinking on Key Populations and examples of interventions at Global and Regional Level	Consultant (s)
09:00 – 09:30	Organisational Development and capacity challenges faced by KP groups that affect programming	Consultant (s)
09:30 - 10:00	An overview of Key Population communities in Zimbabwe	Consultant (s)
10:00 – 10:30	Feedback Session and Discussions	Consultant (s)
10:30 – 11:00	<p style="text-align: center;"><b>HEALTH BREAK</b></p> Distribution of Interactive Response Pads <b>Key Notes;</b> • During tea break, each participant will be handed out a Response Pad they will need to sign for upon collection and when returned. Please visit the response pads station during the health break	Consultant (s)
11:00 – 12:00	Consultation session using Interactive Response Pads <b>Key Notes;</b> • Each participant will be given an interactive mobile device that they will use to respond to questions that will be asked by the facilitators on a projector. The mobile devices will produce real time data through the projector that will inform focus areas to discuss in detail.	Consultant (s)
12:00 – 13:00	Break Out (s) on various thematic areas in line with the above objectives	Consultant (s)
13:00 – 14:00	<p style="text-align: center;"><b>LUNCH BREAK</b></p> <b>Key Notes;</b> During lunch break, we will have a photo booth session where we will request volunteers from participants who are willing to get their pictures taken including their key messages to Policy Makers, Programmers, Donor Communities and the General public. Some of these strategic messages will be added in the implementation plan. We also need to hear why it is important to have the National Key Populations Implementation Plan and what it will mean for KP communities and on an individual level.	
14:00 – 15:00	Feedback Session from the breakout group discussions	Consultant (s)
15:00 – 16:00	Adoption of key messages and proposed interventions	Consultant (s)
16:00	Closing Remarks	NAC

# ANNEX 3 - Multi-sectoral Questionnaire

## Development of National Key Populations Implementation Plan 2018-2020

### MULTI-SECTORAL QUESTIONNAIRE

#### DEAR RESPONDENT

We are a team of Consultants working under the National AIDS Council (NAC) Assignment for the Development of **National Key Populations Implementation Plan 2018-2020** in Zimbabwe. We are reaching out to multi stakeholders in order to obtain your views and opinions about Key Populations in our country, their access to HIV prevention, treatment and care services.

Our consultation process is focused on a DO NO HARM approach, you are free to leave out sections that you may feel makes your identification being known, if that is a perceived risk to yourself. What is important are your honest answers to these questions, which will help us better understand the kind of interventions that are working and showing high impact, those that are not that need to be removed, and new innovative good practice models we can replicate from other countries. We would greatly appreciate your help in responding to this survey.

Thank you for being part of this very important process.

Sithembile Chiware - Themby (Lead) - +263 774 236 326 / thembyc@yahoo.com / Skype ID: themby4

### IDENTIFICATION

Date:	
Your Name / Preferred Name (Optional):	
Organisation:	
Type of your organisation (Government, International, Multi-lateral, CSO, CBO, Private Sector, Religious etc.):	
Geographical reach of your organisation:	
In which Province is your organisation based?	
If you are a KP organisation; (i) are you registered, (ii) tell us about your registration status (iii) how many people are you reaching out to (iv) are you a membership based organisation:	
Designation / Your role in your organisation:	

### Question 1 – Identifying Key Populations in Zimbabwe

- i. Does your organisation / company / institution work with individuals identified as Key Populations?
- ii. Who do you consider to be the Key Populations in Zimbabwe?
- iii. What is your basis for such a selection?
- iii. What is your basis for such a selection?

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### Question 2 – Please tell us about your current KP programming

How are you involved in KP Programming in Zimbabwe? Tell us about;

- i. your interventions (both bio-medical and non-medical)
- ii. the KP communities you are working with
- iii. Geographical reach?
- iv. What have been your key results and success stories?
- v. How your data is generated, and is it shared with the National AIDS Council or Ministry of Health and Child Care to inform policy direction and key decision making processes?
- vi. If you are not a Key Populations led organisation, tell us about the dynamics and experiences you face in working with, and for KP interventions. What needs to improve or to be addressed for change to happen on identified gaps?

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### Question 3 – Key Populations vulnerabilities to HIV infection, prevention, care and treatment

- i. From the above groups you consider as Key Populations, tell us how they are vulnerable to HIV infections and access to health service delivery?
- ii. Do you have any particular case study you can share in brief to help us understand why it is important not to leave anyone behind?

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## ANNEX 3 - Multi-sectoral Questionnaire *(Continued)*

### Question 4 – Good practice models for high impact

- i. What good practice models and case studies you have encountered that you feel must be rolled out for higher impact? These models can be from in-country programmes, regional and global.

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### Question 5 – Enabling environment for Key Populations Programming in Zimbabwe

- i. Do you think our country has been progressive in inclusion of Key Populations to HIV response? Why do you say that?
- ii. What are the gaps that you are still identifying that will help in leaving no one behind?

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### Question 6 – Safety and Security for Key Population in Zimbabwe

- i. What multisectoral response mechanisms do you think will be effective, in ensuring all individuals who identify themselves as KPs are safe? Do you have any case studies we must be aware of?

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### Question 7 – Identifying the real issues to be addressed in the National Implementation Plan

- i. From your observations or experiences, what are the real issues?
- ii. What must be reinforced in ensuring we leave no-one behind in our response to HIV?
- iii. Explain how such change/ progress will be confirmed or measured over time? How will we see progress?

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### Question 8 – Law and Policy Reforms

- i. Which policies and laws need to be addressed to allow an enabling environment towards the reduction of HIV infections and AIDS related deaths amongst Key Populations in Zimbabwe?
- ii. Do you have any case studies to share with us?

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### Question 9 – Addressing Stigma and Discrimination

- i. What are the social challenges that affect 'access' to health or uptake of health services amongst Key Populations in Zimbabwe? Please do share any case studies that will help us shape programmatic interventions?
- ii. Do you know of any identified multisectoral Champions who are addressing stigma and discrimination? What approaches are they taking that we may scale up for increased impact?

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### Question 10 – Capacity Strengthening / Organisational Development

- i. From your experience and observations, may you tell us Organisational Development and capacity issues that Key Populations organisation face?
- ii. What sustainable interventions would you propose to resolve such challenges?

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### Question 12 - Funding gaps to inform future programming

Lastly, before you send us your responses, we need information on known/perceived funding gaps as this will help us in connecting to proposed interventions.

- i. What are the funding gaps in current KP Programming?
- ii. Which interventions do you think are not currently covered by current KP programming?
- iii. What is the desired level of reach/target group for such intervention?

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### Question 13 – Your key strategic message

Do you have any additional key messages you would want us to be aware of?

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## ANNEX 3 - Multi-sectoral Questionnaire *(Continued)*

### 11 - Mapping of Key Populations Programmes in Zimbabwe

May you share with us to the best of your knowledge, programmes that have been implemented for Key Populations in Zimbabwe? Please include past programmes that you are aware of so we can trace how far back KP programmes were implemented in our country.							
Targeted KPs and population size	Name of Programme	Implementation Partners	Geographical Coverage	Funding Sources	Budget Allocation (if known)	Implementation Timelines (by years)	M&E Framework. What data is generated and is it shared with the NAC / MOHCC? If not, which alternative platforms are available?

## ANNEX 4 – Public Sector KP Programme identified clinics with trained service providers

Harare	Bulawayo	Gweru	Masvingo	Mutare
Parirenyatwa Clinic	Pelandaba Clinic	Mkoba 1	Rujeko Clinic	City Clinic
Mabvuku Poly Clinic	Nketa Clinic	Child Welfare	Runyararo Clinic	Florida Clinic
Mbare Poly Clinic	Cowdray Park Clinic	Senga	Mucheke Clinic	Dangamvura Clinic
Malberrign Clinic	Old Pumula Clinic		Masvingo Gen Hospital	Chikanga Clinic
Malborough Clinic	North End Clinic			City Management
Kuwadzana Poly Clinic	Mzilikazi Clinic			
Hatcliff Poly Clinic				
Highlands PCC				
Warren Park Poly Clinic				
Rutsanana Clinic				
Budiriro Poly Clinic				
Wilkins Hospital				
Hopley Clinic				

A total of 80 health care providers from the above 30 facilities have received on improving HIV prevention, treatment care and support of the Key Populations

## ANNEX 5 Sexual Orientation and Gender Identities Terminology

Addiction	Agender	Bipolar disorder	Coming out	Downer
Bisexual	Bodily Integrity	Cisgender:	Anal Sex	Drug/ substance dependence
Chlamydia	Aftercare	Craving	Anxiety	Back-loading
Chancroid	Chipping	Dental dams	Bottom	Frottage
Corrective' rape	homophobic rape	Alcohol	Dead name	Lubricant
Amphetamine	Asexual	Depression	Androgyny:	Detoxification or detox:
Decriminalisation	Bare-backing	Discharge	Frontloading	Concurrent sexual partners
Anal taboo	Co-infection	Discrimination	Flashback:	FTM/ trans man
Gang rape	Gay	Lesbian	Homosexual	
	Gender binary	Gender dysphoria		Harm reduction
Gender equality:	Genderqueer	Intersex	Gender	Internalised homophobia
Junkie	Homophobia	Identity	Human Rights	Heterosexual/ straight
Gender identity	Hotspot	Incidence	Infanticide	Insertive partner
	Gender-based violence	Hallucination	Gender expression	Indoor work
Genital	Hate speech:	Herpes	Gender role	Medical male circumcision
Normalise	Open Relationship	Heteronormative	Outing	Oral sex
Paraphernalia	Patriarchy	Pansexual	Misgender	Outbound work
Psychosis	Prevalence	Prisoners	Positive sexuality	People who inject drugs
Rectum	Rimming	Queer	Relapse	Responsible sex
Serodiscordant couples	Marijuana or cannabis	Refugees	Non-binary (person):	People with disability
Sero-sorting	Sexuality	Sexual behaviour	Self-determination	Receptive anal sex or 'bottom'
Sexual identity	Sexual minority:	Sexual orientation	Sexual fluidity	PREP
Stigma	Stimulant	Sex work	Stigmatise	Sexual risk assessment
Phobia	Methamphetamine	Stereotype	Mutilating	Street work
Sexual practices	Post-traumatic stress disorder	Popping or skin popping	Post-exposure prophylaxis or PEP	Prejudice
Substance dependence	TasP	Monosexual	They/ them (as a pronoun):	Transactional sex
Morphine	Transgender	Trans man	Transphobia	Transsexual
Multiple stigma	Transitioning	Trans woman	Uppers	Transvestite
PMTCT	Tribadism	Versatile	Vaginal sex	MTF/ transwoman
WSW	Needle (syringe):			

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# Notes

Dotted lines for note-taking.



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**Zimbabwe National AIDS Council (2019)  
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